



***Study to Develop Options for Access, Specialty Diagnostic
Treatment and Ambulatory Surgery Services for
Geographically Dispersed Populations***

Interim PAFAC Report



Portland Area Indian Health Service

October 30, 2009



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Project Background

Introduction

American Indians and Alaska Natives (AI/ANs) across the nation receive healthcare services from facilities operated by Tribes or the Indian Health Service (IHS). The level of healthcare services available at any healthcare facility is dependent primarily on the number of people served. Larger populations justify more comprehensive direct healthcare and in some cases those direct services include specialty and inpatient care. However in many cases it is cost-effective for Tribes with smaller populations to provide only limited if any primary care and no specialty care as direct care services. The smaller Tribes must rely on Contract Health Service (CHS) funding for specialty care and inpatient care. Because of inadequate funding, CHS is often used only for those individuals with the most critical need. Those with less critical conditions are forced to go untreated.

The Portland Area IHS assisted in the development of the Portland Area Health Services Master Plan. This document, adopted in 2005, outlines the requirements for three future regional facilities to serve the Portland Area Tribes. Regional facilities are intended to provide healthcare services and resources not affordable as a direct service for smaller Tribes. Regional collaborations provide the opportunity to reduce dependency on CHS funding and provide for care often denied by CHS. Such collaborations also provide an opportunity for direct care revenues generated by the regional facilities to be reinvested in the respective regions.

Problem

The IHS methodology for the development of health services need and health facility size to be delivered at a new or expanded healthcare facility is based upon the user population of the service area. This user population number is almost exclusively driven by patients seeking primary care at IHS, tribal, or contract health services facilities within a 45 mile radius. However, in today's health care delivery system, many primary care delivery points refer patients to regional centers for specialty consults, diagnostics, treatment, ambulatory surgery, etc. that are beyond 200 miles. The IHS health services preliminary planning process is capable of developing preliminary sizes for Primary Care Outpatient Facilities and Inpatient Facilities. However, the IHS health services preliminary planning process does not currently have a mechanism to determine the demand for and preliminary sizing of an outpatient regional referral center for geographically dispersed and autonomous user populations.

Scope of Work

The purpose of this study was to discuss and document different means or methods for determining the demand for regional referral centers in a cross-section of IHS areas. The product generated through this process is a recommendation to adapt or modify the existing IHS health services preliminary planning process to identify the demand for referral health services beyond primary care for geographically dispersed multi-tribal populations. The study determined that there is a supportable need for a new category of health services delivery and an identification of additional facilities needs across Indian country. As a result, an accommodation should be made to the Health Care Facilities Construction Priority System (HFCPS) to ensure these facilities are scored and ranked.

Process

The work was overseen by the Portland Area Facilities Advisory Committee (PAFAC), with administrative and technical support from the Portland Area IHS. The work was accomplished in three (3) phases, with one (1) optional phase still remaining (if exercised, the optional phase will be applied to two (2) existing, proposed or potential regions from other IHS Areas).



To achieve this recommendation, the following steps were taken in consultation with and presentation to the PAFAC:

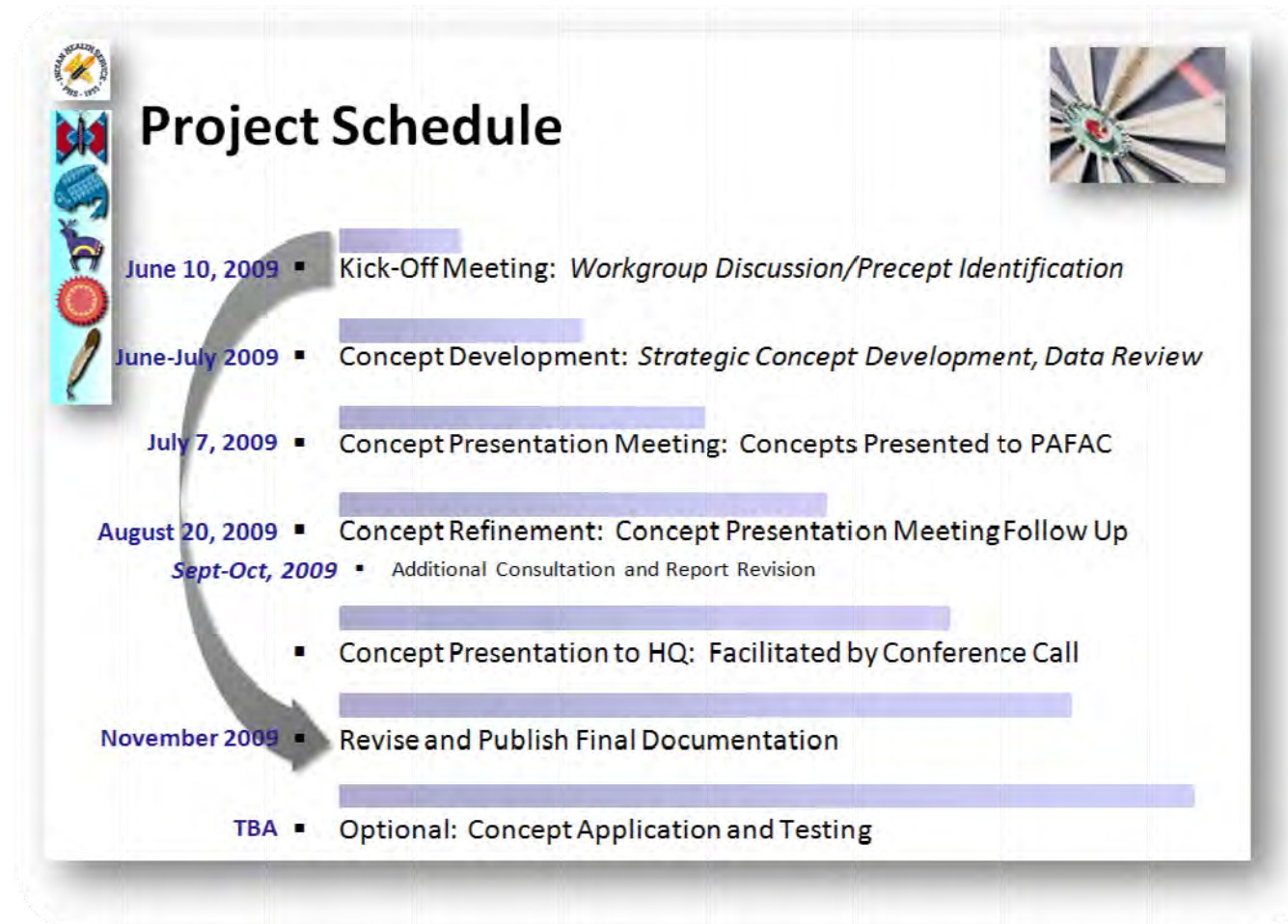
- Consultation with PAFAC
 - Review need, motive, concept and ideas for Regional Centers
 - Review existing HFCPS
 - Identify deficiencies of HFCPS related to Regional Centers
 - Brainstorm solutions
 - Consider concerns from IHS Headquarters
- Distillation of Critical Issues
- Creation of draft Regional Center single user population entry
 - Development of Market Share calculation table
 - Development of Market Share erosion assumptions
 - Refinement of erosion assumptions and their application
- Creation of potential user population for Primary Care if utilized in Regional Centers
 - Study of User Populations and Service Populations in counties with facilities offering regional type services
 - Projection of potential reclaimed service population
- Development of HSP files to support the creation of Draft Regional Centers in 3 Portland Area locations for PAFAC consideration based upon appropriate user population entry and primary care services selection
- Consultation with PAFAC regarding resulting services, space and staffing
- Creation of draft concept to alter existing HFCPS to accept Regional Centers
- Creation of draft concept to score multiple proposed Regional Centers against each other
- Creation of draft report for PAFAC consideration and feedback
- Creation of a PAFAC Draft Report for consultation/presentation to the Northwest Portland Area Indian Health Board (NPAIHB)
- Collection of NPAIHB feedback and integration into Final Report
- Creation of the Final Report

Some of the final steps above represented additional work than the original scope provided for. However, this was deemed necessary to ensure the all critical stakeholder input was considered and integrated into the final report.

The schedule for this project is presented on the following graphic on the next page. The schedule shown represents work effort changes made since the initiation of the project.



Schedule



Regional Center Definition

The PAFAC identified the concept of a Regional Center as driven by the following needs common to AI/AN populations:

- Isolation
- Cost of care for people that are referred out
- Unmet need because of the contract health system (day surgery, endoscopy, etc.)
- Health disparities
- Limited specialty providers in our area
- Inappropriate treatment of patients by specialty providers...
 - non-Indian, insensitive, costly, and there's a feeling that we could do much better than we're currently doing in the existing structure
- CHS dependency
- Tribal members that don't live within CHSDA that can't get specialty services
- 3 urban populations for whom the system does not adequately recognize needs



- Poor outcomes because patients don't come in soon enough because they hear the "we're on **PRIORITY ONE***" message all the time

In short, a Regional Center is defined by the following characteristics according to the PAFAC:

- A place with specialty care available, colonoscopy exams, endoscopic exams, cardiac stress tests, etc. (typical "Priority 2" CHS)
- A location with access to inpatient care
- An operation that does not incur the high cost of maintaining a hospital
- A place with no 24/7 inpatient care
- Culturally friendly
- No primary care
- A concept that does not currently fit in to the system (again, its secondary care AI/ANs in that region normally don't have access to)

Whether Regional Center is an appropriate name or not should be considered further. Other suggestions included

- Referral Center
- Specialty Care Diagnostic Center
- Multi-tribal Center
- Multi-tribal Specialty Referral Center

For the purposes of this report all of the above terms shall be identified from this point forward as Regional Specialty Referral Center.

** PRIORITY ONE – Emergent/Acutely Urgent Care Services: Diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible health care available. Priority One represents those diagnosis and treatment of injuries or medical conditions that, if left untreated, would result in uncertain but potentially grave outcomes.*



Participants

This project is indebted to the following participants who have given of their time to be thought leaders in this effort

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Glossary

This project employs its own terminology, one not always known to all document users or process participants. The terms below are defined in an attempt to give some help in understanding how these terms are generally used, verbally as well as within the deliverable documents.

- AI/AN..... American Indian and/or Alaskan Native.
- Alternative Care Alternative rural or urban hospitals accessible by patients anywhere in route to a proposed regional referral center.
- Area..... The IHS consists of 12 large geographic and/or tribally organized administrative units responsible for the planning and provision of healthcare within each of their Service Areas.
- BGSM..... Building Gross Square Meters.
- CHS..... Contract Health Services. Healthcare services that must be purchased from Non-IHS providers, based upon threshold issues or high acuity. These are generally facility and professional services of greater scope and intensity than are available through IHS facilities and providers.
- CHSDA..... Counties defined all or in part as the Contract Health Services Delivery Area. To receive CHS payment for needed services outside of the IHS delivery system, a Native American must reside within this area.
- Deliverable A specific planned report from The Innova Group given to the Planning workgroup, Area Office and/or PSA.
- DGSM..... Department Gross Square Meters.
- Discipline A specific medical specialty (e.g.: primary care, dentistry or radiology).
- Health Services Master Plan..... An Area wide planning exercise driven by a “ground-up” consideration of who should access care at each of the Area’s healthcare facilities, a breakdown of their age and sex by which to project workloads for a target planning year, typically 10 years out. Workloads by service line are then considered for delivery options: delivery needed care on-site, through CHS, referral to the Service Unit, or through some regional partnership. On-site workloads are converted into needed space and staff. CHS workloads are converted into need dollars. All service areas are “rolled-up” into an Area-wide Summary.



HFCPS	Healthcare Facilities Construction Priority System – IHS’ methodology for scoring and ranking facility projects for funding and ultimately construction and staffing. It currently scores applicants out of 850 possible points for Phase 1, and 150 possible points for Phase 2. Projects that score the highest may be place on the Priority System for funding as it becomes available.
HSP	Health Systems Planning process software - the computer application that manages the IHS tool for the planning, programming and design of health facilities.
IHS	The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes.
Justification	Used within the context of whether or not workload, criteria and market assessment “justify” the placement of resources or services at an identified location.
KC (Key Characteristic).....	The recognized significant component of a discipline’s ability to deliver care (e.g.: physician, radiology room).
Market Share.....	The percentage of the user population from a specific community that is expected to be served at a facility for a specific discipline.
Market Erosion	The effect of distance, competitors, and payment ability on patients who seek care at a given facility. For example, if 92% market share is planned for a facility, it means the full market (100%) has been eroded by 8%. Such erosion may occur because some users will not drive that far, or because their service is not covered, or because they simply chose to go somewhere else.
NPAIHB	Northwest Portland Area Indian Health Board - established in 1972, the NPAIHB is a non-profit tribal advisory organization serving the forty-three federally recognized tribes of Oregon, Washington, and Idaho. Each member tribe appoints a Delegate via tribal resolution, and meets quarterly to direct and oversee all activities of NPAIHB.



PAFAC	Portland Area Facility Advisory Committee – established to provide recommendations to the Director of the Portland Area IHS on issues related to healthcare facilities and staffing.
Payor Profile.....	An analysis of the payor mix for a Service Area, typically focusing on Medicare, Medicaid, Veterans and other third party payors that may or may not affect the Service Area’s ability to raise third party billing thereby increasing revenue.
Primary Care Service Area	A group of communities and its population for which, at a minimum, the primary care disciplines are being planned and resourced. Referred to as the PSA.
Project Cost.....	The sum of construction and equipment costs for a facility project. This does not include site acquisition and preparation.
RRM	Resource Requirements Methodology: The IHS staffing methodology.
Regionalization/Referral Partners	The grouping of workload from different PSAs for the purpose of stretching resources and improving access. A region may be as simple as a referral pattern among facilities creating effective leverage to purchase commonly needed services, or it may be a facility where on site resources are justified and can be offered to one or more PSAs thereby stretching CHS dollars.
RPMS	Registered Patient Management System: the IHS standard Patient record system that forms the data basis for the master planning process.
Service Area.....	The communities and its population intended to be supported by a specific discipline’s resources.
Service Population	The IHS understanding of the number of Native Americans living within a county which may or may not be users. Census based and projected into the future. Primarily used for growth projection and market opportunities.
Service Unit.....	An administrative unit overseeing the delivery of healthcare to a specific geographic area. May consist of one or more facilities, Service Areas, or PSAs.
Threshold	The minimum workload and/or remoteness necessary to justify the provision of a specific discipline.
Travel Distance	The distance a User has to travel from his home to a facility to receive care.



User..... A Native American that has received or registered to receive healthcare in the past three years.

User Population..... The number of Active Indian Registrants in the healthcare system from a specified area that have utilized the system in the past 3 years.



Pilot Study Purpose

The purpose of this Pilot Study was to document different methods for determining the demand for Regional Specialty Referral Centers in a cross section of IHS areas, and provide a recommendation to adapt the existing IHS preliminary planning and priority process accordingly.

The demand and viability of a Regional Specialty Referral Center for one location in the Portland Area has been established through a methodology developed as part of this effort that can be applied to other IHS areas. And while a recommendation to adapt the HFCS is identified as the desired outcome of this study, the analysis determined that a practical demonstration of viability and the ensuing lessons learned formed an essential first step in shaping any effective, defensible HFCS amendments concerning Regional Centers. Therefore, this Pilot Study proposes a Demonstration Project as an important and necessary first step in creating supportable recommendations to the existing HFCS.

Pilot Study purpose was accomplished...

The optimal path forward is different than anticipated.

Recommendation for a Demonstration Project

The PAFAC recommends IHS fund a Demonstration Project in Seattle Washington (Portland Area) to test the viability of Regional Specialty Referral Centers for improved access to secondary care for AI/ANs and gather necessary, and presently unavailable, data to further inform planning metrics/thresholds for the future benefit of regional secondary care for all IHS Areas. This Demonstration Project and its findings will ultimately inform the development of appropriate and supportable adaptations to the existing HFCS for more effective scoring of such facility projects.

A Demonstration Project is recommended.

The PAFAC recommends Scenario 4 from this report for the Demonstration Project. This scenario provides the necessary specialty/diagnostic and ambulatory surgery care for users from the dispersed populations it is intended to serve. It also relies on a projected Primary Care user population base in the Seattle market of approximately 24,000, representing 7 existing Primary Service Areas within 60 minutes travel time, and the aggressive use of Telemedicine to increase market capture of distant specialty care users.

In acknowledgement of the distant specialty care users who fall outside the Seattle market, and in an effort to improve access to specialty care for all eligible users in the Portland Area, the PAFAC conceives of the Demonstration Project as "Phase 1" of a 3-phased plan, or the first of 3 regional specialty care facilities. In this plan, one specialty care facility would serve each Region (as identified in the Portland Area Health Services Master Plan). The PAFAC envisions these 3 specialty care facilities operating as a network or system, capitalizing on the efficiencies of telemedicine. In this way, the Demonstration Project (or Phase I) will serve all eligible users until Phases II and III may be implemented.

The PAFAC makes this recommendation...

- in keeping with their charter to provide recommendations to the Director (Portland IHS) on issues related to healthcare facilities and staffing... specifically, modifications to IHS facility systems and methodologies to allow regional healthcare facilities and Area-wide medical centers to be ranked under the revised IHS HFCS;
- after considering available data/analyses of Portland Area need for secondary care;
- in cooperation with the Portland Area Health Services Master Plan;
- in consultation with the Portland IHS, Northwest Portland Area Indian Health Board, and external consultative expertise experienced in IHS related work;

Recommendation is based on broad Program and Stakeholder consideration...



- in keeping with IHS' mission to raise the physical, mental, social and spiritual health of American Indian and Alaska Natives to the highest level;
- in support of improving the applicability and efficacy of the HFCPS for all facility types in all IHS Areas;
- in support of IHS Internal Reform Initiatives as expressed at the 2009 NCC annual meeting and area offices in the summer of 2009, envisioning a patient services package where intermediate medical services would be delivered through regional/in-network referral facilities that can provide high quality care efficiently;
- and to ultimately facilitate the appropriate scoring of Regional Specialty Referral Centers in the HFCPS for construction/staffing funding.

Why a Demonstration Project?

A demonstration project emerged as the most viable means of forwarding the intent of this Pilot Study and responding to the chronic shortage of secondary care for AI/ANs for the following reasons:

1. This Pilot Study clearly demonstrates that the appropriate scoring of a Regional Specialty Referral Center is not possible under the existing HFCPS. The current inputs do not provide for the appropriate quantification of specialty care, diagnostic and surgical workload apart from Primary Care or Inpatient Care, neither of which form part of the concept of operation for such a center.
2. As a result, either a new *category* must be created in the HFCPS to allow a means of scoring such centers, or the HFCPS scoring mechanics must be globally amended to create a more elastic prioritization environment that fosters innovation in healthcare facility concept design and delivery.
3. Accomplishing either path will involve many years based upon the time already taken to develop the existing HFCPS. And assuming amendments are eventually made, they face the insurmountable challenge of gaining approval without historical validation, since IHS typically approves projects for placement on the HFCPS that are justified using historically validated planning metrics.
4. Such historically validated planning metrics are simply not available for Regional Specialty Referral Centers, since the concept of operations does not include Primary or Inpatient Care. This reality leads toward two possible options for addressing the need for accessible Secondary Care for AI/ANs:
 - a. Continue study efforts (this and others yet to be authorized) to collect planning data and market analysis necessary to provide formidable support to the Regional Specialty Referral Center concept, leading to an extended process to amend the existing HFCPS. Significant funds will be expended in the pursuit of such over the course of many years while the need to provide accessible Secondary Care remains unmet. Or...
 - b. Create a mechanism by which needed reliable planning metrics can be developed more quickly in a risk mitigated environment while beginning to provide needed Secondary Care at the same time. The PAFAC found this option more reasonable, cost/time effective, and favorable for all stakeholders and AI/ANs.
5. Analysis to date suggests that not only is a Regional Specialty Referral Center viable but also offers potential to provide revenue and decrease CHS expenditures.
6. The chronic shortage of CHS dollars for a highly dependent IHS Area (the Portland Area Health Services Master Plan demonstrated that most PSAs are funded at only 10-20% of Total CHS demand) provides an optimal setting in which to measure the impact of such a center on Secondary Care access and costs in comparison to

A Demonstration Project is the most effective means of securing historically validated planning metrics.

A Demonstration Project is the most efficient way of initiating innovative access to Secondary Care quickly.



increased CHS funding directly to the tribes (assuming such an increase could happen; when historically it has not).

7. The Seattle Market place offers a unique environment in which to test the concept of operation for a Regional Specialty Referral Center because of the close proximity of a sizeable existing Primary Care population base that could be relied on to support such a new venture without having to provide Primary Care on-site.
8. Other IHS Areas are interested in this concept, lending critical concern that the metrics applied to all are reliable and tested in the most appropriate environment with all due haste.

From a strategic perspective, funding a Demonstration Project not only validates IHS' intent to move in a bold new direction that would facilitate capability for innovation in facility planning and scoring, but it also provides a venue to act on Dr. Roubideaux's expressed priority of "...improving quality of, and access to care". This is a unique opportunity to support her conviction that "...in order for us to get the support that is so desperately needed, we need to demonstrate a willingness to change and improve." ¹

Adapting the Existing IHS Preliminary Planning & Priority Process

Presently the HFCPS, as developed, does not provide for the prioritization of Regional Specialty Referral Centers. The HFCPS' two essential drivers, Primary Care User Population and Inpatient Patient days are not applicable for this new operational model.

As the Demonstration Project moves forward, the PAFAC encourages an adaption of the HFCPS as outlined in the HFCPS Concept Development section of this document. These adaptations are intended to measure priorities across all facility types. In summary these adaptations might include:

- Determine *Facility Size Deficiency* via a baseline HSP
- Redefine and better articulate local *Health Status*
- Include CHS dependency as a prime driver of *Access*
- Include *Innovation* in Phase 1
- Replace Phase 2 criteria with *Cost Effectiveness*

These adaptations suggest and necessitate that IHS commit to the following work in order to successfully include future Regional Specialty Referral Centers in their HFCPS. These adaptations were felt appropriate for all facilities, not just this new operational model.

1. Further investment in the HSP. Of particular concern would be the seamless integration of the RRM, specific to regional specialty care.
2. Develop a more granular data set in support of Health Status. Currently the data is available only for an area-wide level.
3. Develop a mutually agreed upon methodology of calculating CHS Dependency.
4. Specify innovation categories to help project developers / thought leaders understand how innovation works and what aspects most support IHS' mission.

Necessitates
further
investment in IHS
planning tool
development...

These adaptations, while developed in the context of regional facility discussions, were deemed appropriate by the PAFAC for all facilities not just this new operational model.

¹ Roubideaux, Yvette; *Open Letter to Tribal Leaders*, June 2, 2009, page 1



The Big Picture

The Demonstration Project recommendation, and pursuant conceptual HFCPS amendments, provide both the mechanism for understanding regional center referral metrics, as well as a path forward for refining the priority system, to support a facility funding and construction process that truly supports IHS' mission, strategy, and planning challenges. They support critical planning challenges underpinning the IHS Strategic Plan 2006-2011. Specifically they...

1. Support a new (non-historical) approach toward closing the gap between disparities in health status and funding for AI/ANs through non-anticipated appropriations for implementation by providing secondary care, typically and often ineffectively addressed by limited CHS funding.
2. Support the development of an adequate workforce for IHS in specialty care by ensuring placement of these centers in urban areas supporting recruitment and retention efforts as well as entry points for AI/AN specialty physicians into the IHS system of care.
3. Allow an inevitable symbiotic relationship between Regional Specialty Referral Centers and the performance driven private sector inpatient facilities to which they would relate to influence the performance of all participating tribes/PSAs.
4. Implement a truly innovative model of health care for IHS and the tribes.

Consistent with
IHS' Strategic
Plan for 2006-
2011...

The Demonstration Project recommendation and HFCPS conceptual amendments also...

1. Support IHS' stated mission to raise the health of AI/ANs to the highest level by improving their access to needed secondary care. The Portland Area is not unique in its expending of CHS dollars to refer users out to expensive secondary care. Portland does, however, face a unique challenge since the HFCPS does not account for so many small tribes with no single concentration of user pop to drive the scoring of a facility that would support secondary care.
2. Affirms IHS' commitment to innovative delivery of healthcare. By supporting a Demonstration Project to inform innovation, and by moving Innovation to Phase 1 of the HFCPS, all Areas benefit from forward thinking creative solutions to perennially challenging and financially draining problems. Many of the best ideas for addressing the healthcare needs of AI/AN's could be missed unless innovation is scored in Phase 1.
3. Facilitate consistent, accurate, and discreet planning of all facility types as part of Phase 1 in the HFCPS through enhancing and utilizing the HSP. The HSP is currently used in Phase 2 as a means of validating Phase 1 facility assumptions. However, utilizing an enhanced HSP as proposed in Phase 1 allows all facility types to be scored more accurately due to sensitivity to multiple service area populations, erasing the limitations imposed by single inputs for user population or patient days. All Area projects will benefit from the increased planning accuracy provided by an enhanced HSP.

Supports all
facility types...

Supports
innovation in
delivery...

These benefits respond to the challenges identified in the Strategic Plan, providing a tangible and immediate opportunity for "IHS to redefine its approaches and improve collaboration and synergy across the Indian Health network". In addition, these recommendations support two IHS Strategic Goals: provide accessible, quality health care, and foster collaboration and innovation across the Indian Health Network.

Supports IHS'
Strategic Goals...



Demonstration Project Recommendation Overview

The PAFAC recommends IHS fund a Demonstration Project in Seattle Washington (Portland Area) to test the viability of Regional Specialty Referral Centers for improved access to secondary care for AI/ANs and gather necessary, and presently unavailable, data to further inform planning metrics/thresholds for the future benefit of regional secondary care for all IHS Areas. This Demonstration Project and its findings will ultimately inform the development of appropriate and supportable adaptations to the existing HFCPS for more effective scoring of such facility projects.

The PAFAC recommends Scenario 4 from this report for the Demonstration Project. This scenario provides the necessary specialty/diagnostic and ambulatory surgery care for users from the dispersed populations it is intended to serve. It also relies on a projected Primary Care user population base in the Seattle market of approximately 24,000, representing 7 existing Primary Service Areas within 60 minutes travel time, and the aggressive use of Telemedicine to increase market capture of distant specialty care users.

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? **How does this help Portland Area Tribes?**

1. Positions Portland Area Tribes for accessible Specialty Care
2. Places Portland Area first in line for a Demonstration Project
3. Does not affect Primary Care assets “at home”
4. Begins to stretch limited CHS funds for the benefit of all

? **How does this help IHS?**

1. Cooperates with IHS’ mission, strategy and goals
2. Affirms IHS’ commitment to innovation
3. Shows IHS’ intent to demonstrate change
4. Provides mechanism to study referral metrics

? **How does this help the Priority System (HFCPS)?**

1. Provides historically validated planning metrics
2. Allows demonstration to inform improved criteria
3. Tests conceptual amendments suggested by this report
4. Leads to appropriate scoring of Regional Specialty Referral Centers

? **How does this help other IHS Areas?**

1. Allows other Areas to observe regional referral care
2. Demonstrates IHS’ willingness to engage innovation
3. Encourages further testing/formation of concept in other Areas
4. Does not interfere with current priority system funding

Demonstration Project
Key Features

- 133.9 FTE
- 93,545 Square Feet
- \$45.8 Million Project Cost
- \$14.6 Million Annual IHS Funding
- Audiology
- Medical Specialties
- Surgical Specialties
- Ambulatory Surgery
- Advanced Imaging: Fluoroscopy, Mammography, CT and MRI
- Occupational & Speech Therapy
- Telemedicine



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Priority System Conceptual Amendments

Developing the conceptual amendments found in the previous section of this report resulted from a careful analysis of the existing HFCPS and how it may or may not support Regional Specialty Referral Centers.

The graphic below illustrates how criteria in the existing HFCPS does or does not appear to facilitate the scoring of Regional Specialty Referral Centers. The black “Regional Center” row identifier, read to the right, identifies such:

- green shading signifies “does appear to facilitate scoring”
- rose shading signifies “does not appear to facilitate scoring”
- yellow shading signifies “uncertainty in facilitating scoring”

The grey cells below that, read to the right, identify how existing criteria appears to facilitate (✓) or does not appear to facilitate (✗) appropriate scoring of existing facility categories.

Schedule =>	Phase 1											Phase 2			
	Facility Deficiency (400 Pts)					Health Status (200 Pts)					Isolation (100 Pts)	Facility Size (150 Pts)	Facility Deficiency (400 Pts)	Barriers to Service (50 Pts)	Innovation (100 Pts)
	Required Space		Adjusted Existing Space			Birth Disparities Index	% Pop over 55	Composite Poverty Index	Disease Disparities Index	Distance from ER	Size of Facility (smaller = better)	Required Space	Yes/No	5 Possible Elements	
	User Pop	IP Days	Facility Age	Condition Adjustment (FEDS)	Cost/SM to Replace							HSP (Un-deviated)			
Inputs =>															
Regional Center	Could Harm Scoring - Insufficient Entry Capability	Could Harm Scoring - OP/Ancillary Sensitivity Required	Could Help Scoring for a New RC	Presently Irrelevant for New RC, will work in future	Presently Irrelevant for New RC, will work in future	Impact Unclear Despite More Appropriate Use of Data	Impact Unclear Despite More Appropriate Use of Data	Impact Unclear Despite More Appropriate Use of Data	Impact Unclear Despite More Appropriate Use of Data	Unclear - rural location could help; urban could harm	Would Likely Harm Scoring Rank	Could Help Scoring for a New RC	Could Help Scoring for a New RC if Population Centric	Could Help Scoring for a New RC	
Outpatient Facility	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Unclear	Unclear	
Inpatient Facility	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Unclear	Unclear	
Small Ambulatory Care	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Unclear	Unclear	
Other	Unclear	Unclear	✓	✓	✓	Unclear	Unclear	Unclear	Unclear	✓	✓	✓	Unclear	Unclear	

Criteria that appear to facilitate the scoring of Regional Specialty Referral Centers under the existing system in Phase 1 include:

- Facility Age (there are no Regional Specialty Referral Centers currently so such a facility would garnish the highest possible score)

Criteria that appear uncertain in facilitating the scoring of Regional Specialty Referral Centers include:

- Health Status (data available is “area wide”, thus unable to show the specific health status of dispersed rural populations that might benefit most from a Regional Specialty Referral Center)
- Barriers to Service and Innovation (while they are shaded green in the table above, they both appear in Phase 2, potentially eliminating any benefit for scoring Regional Specialty Referral Centers).

Criteria that do not appear to facilitate the scoring of Regional Specialty Referral Centers include:



- Condition Adjustment (such facilities are currently non-existent)
- Cost/SM to Replace (such facilities are currently non-existent)
- Isolation (there appears to be no simple geo-political center for dispersed populations accessing care)
- User population (the existing Phase 1 formulation of user population to drive facility size is limited for projecting specialty care space)
- Inpatient Days (a Regional Specialty Referral Center would not have inpatient days)
- Size of Facility (this appears to simply reward smaller facilities)

This report offers a conceptual revision that can be visualized in the following graphic.

Criteria =>	Phase 1										Phase 2
	Facility Deficiency				Health Status		Access to Care	Innovation			Cost Effectiveness
Points =>	200				100		400	150			150
Inputs =>	Required Space (baseline HSP)	Facility Age	Condition Adjustment (FEDS)	Cost/SM to Replace	Birth Disparities Index (>0 points)	Disease Disparities Index (>0 Points)	CHS Dependency (400 Points)	# of tribes in longer term governance partnership (50 points)	Staff Retention Ability (>0 points)	Cost & Revenue Sharing Agreement (50 Points)	Operational savings \$ / capital expenditure (150 Points)
Remarks =>	Establish policy on definition of baseline RRM. Correlate HSP and RRM non compatibility issues relative to regional planning, specialty care and staffing. Create an integrated facility answer that recognizes the sensitivity required in accurate facility/staff planning.				Population needs to be verifiably sick, measured in geographically precise manner. Data on Service Unit level must be fostered/validated.		Single most critical measurement defining an area's access to care.	Pull innovation into Phase 1, rewarding partnerships that solve problems, cut costs, and project better outcomes. Drive the system away from "small" vs. "large", toward better, sustainable, and affordable care.			Demonstrate proposed operational saving as compared to IHS authorized operating budget.
Multi-Tribal Specialty Referral Center	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outpatient Facility	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Inpatient Facility	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Small Ambulatory Care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Other	✓	✓	✓	✓	Unclear	Unclear	✓	✓	✓	✓	✓

The primary elements of the concept include:

- Integrate Facility Deficiency scoring into an enhanced HSP, thereby providing an accurate, RRM related, planning tool by which to understand and rank facility need that does not have to be re-done in a later Phase (clarify an HSP baseline SF policy and use it in the initial formula)
- Reduce Health Status criteria to those inputs that are specifically health related (Birth Disparities and Disease Disparities), while calling for greater granularity in the data (to at least the Service Unit level) supporting greater specificity in the identification of need
- Clarify Access as CHS Dependency, believing that this single factor incorporates issues previously quantified by "distance to care", "distance to next IHS facility", etc.



- Prioritize Innovation in areas that are historically and ultimately critical success factors in improving outcomes and optimizing operational success as part of Phase 1
- Convert Phase 2, in its entirety, to a Cost Effectiveness scoring, whereby higher points would be awarded to projects that could demonstrate proposed operational savings as compared to the IHS authorized operating budget.

The concept effectively removes the following current inputs:

- User population – a single population input is insufficient to project facility size for facilities where specialty care for dispersed populations is offered (the HSP is the current IHS planning tool and remains the correct mechanism by which to accurately project staff and space)
- Inpatient Days – this data point is unavailable for non-existent facilities and is limited in its ability to project space demand (see note on HSP above)
- % Population over 55 – while related to healthcare expenditures, it does not automatically identify the relative health of one 55+ population group to another 55+ population group
- Composite Poverty Index – the use of CHS Dependency better addresses the relationship of poverty to accessing care
- Isolation – the use of CHS Dependency better addresses the relationship of isolation to accessing care
- Facility Size – this criterion has a limited relationship to quality care, improved outcomes, and most efficient use of resources. As it favors small facilities, it may oversimplify the idea of supporting the greatest need.
- Barriers to Service – the use of CHS Dependency better addresses the relationship of barriers to service in accessing care

This concept is concerned with more than simply creating a new slot in the existing system for the consideration of Regional Specialty Referral Centers. Rather, it is concerned with moving the HFCPS toward a criteria that allow for placement of delivery systems on the priority list that provide better outcomes, culturally sensitive care, and optimal use of resources. In short, this concept allows the discreet planning capability required to support IHS' internal reform efforts in the years ahead. As such, these criteria support not only the concept of Regional Specialty Referral Centers, but other known, and yet to be conceptualized, facility types as well.

Critical concerns and follow-on work growing out of this include:

1. Further investment in the HSP. Currently this tool is utilized in Phase 2. Moving it to involvement in Phase 1 will not only produce a more accurate score for Facility Deficiency but demand additional development of the this planning tool and training for those who use it. Of particular concern would be the seamless integration of the RRM, specific to regional specialty care.
2. Develop a more granular data set in support of Health Status. Currently the data is available only for an area-wide level. To suggest that a data set for the Tucson Area is comparable, for facility scoring purposes, to a data set from the Nashville Area is difficult. It would be far more helpful if Health Status could be quantified on a Service Unit level.
3. Develop a mutually agreed upon methodology of calculating CHS Dependency. Past Health Services Area Master Plans have included this metric (at a Service Unit level) as part of each final report. It would appear that such a metric could be further developed in the interest of all since deficient CHS dollars is the primary concern of most PSAs.
4. Specify innovation categories that help projects understand how innovation works and what kind is desired. Proposed in the idea above are 3 criteria of real historical concern:
 - a. "Number of Tribes in long term governance partnership" recognizes that AI/AN healthcare issues will best be addressed as tribes work together. And facilities such as Alaska Native Medical Center attest to the fact that complex and beneficial long term tribal



- partnerships can work. A potential formula might be: *(No. of tribal governance or tribal partnership, 0, # of tribes x years of partnership, x=max 25, x/ 25 x 50)*
- b. "Staff Retention" identifies a chronic problem that stands apart from facility size and staffing. The ability to acquire staff facilitates care; the opposite is also true. Scoring such criteria reduces the risk of understaffed services for any facility category. A potential formula might be: *accessibility to secondary, tertiary, or medical school = (if all 3 available within 40 km then 1, if 2 then .67, if 1 then .67, if 0 then 0)*50*
- c. "Cost and Revenue Sharing" further empowers tribal governments to collaborate, sharing the rewards relative to the risks. Such collaboration naturally fosters interest in best practices and optimal outcomes. A potential formula might be: *(No agreement, 0, 2-5 tribal government agreement, tribe #/5, >5 tribal governments, 1) *50*

Current Process (Background)

The existing HFCPS, established in 1991, facilitates IHS' compliance with a directive from the Indian Healthcare Improvement Act to provide Congress with a list of the 10 highest priority inpatient and outpatient facilities construction projects. 6 criteria are applied during 2 phases to determine ranking for 4 facility types or categories. The process works as follows:

Phase 1 – The Facility Needs Assessment Process

This phase permits IHS to develop a categorized, preliminary ranking of all healthcare facilities using available data in the IHS Services and Facilities Database. 4 criteria are applied with various weighting to score a potential project's suitability for being selected for Phase 2, with the maximum score possible being 850 points.

- Health Status – 20% or 200 points maximum possible score
- Isolation – 10% or 100 points maximum possible score
- Facility Size – 15% or 150 points maximum possible score
- Facility Deficiency – 40% or 400 points maximum possible score

At the conclusion of Phase 1 projects are grouped into 1 of 4 categories. The highest composite scoring projects by facility type are then considered for Phase 2 validation, depending on anticipated congressional funding. These categories include:

- Category A: Comprehensive Health Care Center – ambulatory care facility, 40 hours per week, basic health team and services for acute and chronic ambulatory problems (could include alternative rural hospital)
- Category B: Comprehensive Inpatient Facility/Medical Facility – Inpatient and ambulatory care, usually providing general surgery and full service OB/Gyn. Meets minimum IHS ADPL ≥ 15 .
- Category C: Small Health Clinic – ambulatory care facility designed to serve populations generating 4,400 PCPVs or less.
- Other: Other – facilities other than those described above, including but not limited to youth regional treatment centers, dental units, etc.

Phase 2 – Project Prioritization Process

This phase permits IHS to use the categories and preliminary rankings to focus resources on a group of projects for more intensive validation, evaluation and possible selection for funding and prioritization under one of the authorized healthcare facilities construction programs. 2 additional criteria are added to the 4 from Phase 1, adding 150 points generating a maximum possible score of 1,000 points:



- Barriers to Service – 5% or 50 points maximum possible score
- Innovation – 10% or 100 points maximum possible

In addition, Facility Size from Phase 1 is recalculated using the Health Systems Planning (HSP) software IHS typically utilizes for PJD/POR and Joint Venture approval.

The resulting formula is shown below:

Facility Deficiency = Facility Deficiency Criteria Score $(1 - (\text{Adjusted Existing Space} \times ((\text{Space Adjustment Factor (if Age Adjustment Factor (if age } \leq 10, 0, \text{ if (age } \leq 50, .0125, 0.5)) + \text{Condition Adjustment Factor (cost/SM to repair} - \text{cost/SM to replace} > .75, 1, (\text{cost/SM to repair} - \text{cost/SM to replace})) \leq 1, \text{ Age Adjustment Factor} + \text{Condition Adjustment Factor, 1}) - 1) \times \text{Existing Space})) / \text{Required Space (If (OP facility (then } 200 \text{ SM} + (.8 \text{ SM} \times \text{user pop})) \text{ or IP facility (then } 5,500 \text{ SM} + (3.5 \text{ SM} \times \text{Projected IP Days}))) \times 400$

Plus...

Facility Size = Facility Size Criterion Score $(= \text{if (Required Space } \leq 1200, 1, (\text{if (Required Space } \leq 6000, 1 - ((\text{Required Space} - 1200) \times 0.00006), (\text{if (Required Space } \leq 12800, 0.712 - ((\text{Required Space} - 6000) \times 0.0000428), 0.416 - ((\text{Required Space} - 6000) \times 0.0000135)))))) \times \text{Required Space (If (OP facility (then } 200 \text{ SM} + (.8 \text{ SM} \times \text{user pop})) \text{ or IP facility (then } 5,500 \text{ SM} + (3.5 \text{ SM} \times \text{Projected IP Days}))) \times 150$

Plus...

Health Status = Health Status Criteria Score $((\text{Health Disparities Index} \times .25) + (\% \text{ of population } > 55 \text{ years old} \times .25) + (\text{Composite Poverty Index} \times .25) + (\text{Disease Disparities Index} \times 25)) \times 200$

Plus...

Isolation = Isolation Criteria Score $(\text{if (km from ER} < 40, 0, (\text{if (km from ER} \geq 40 \text{ and } \leq 90, \text{ km from ER} / 90, (\text{if (km from ER} \geq 90, 1) \times 100$

= Phase 1 Score (Maximum 850)

Barriers to Service = Barriers to Service Criteria Score $(\text{if Barriers to Service exist, } 1, 0) \times 50$

Plus...

Innovation – Innovation Criteria $(.2 \times \# \text{ of Verified Innovation Elements (up to 5)}) \times 100$

= Phase 2 Score (Maximum 1,000)

Note – Required Space in Phase 2 will be recalculated by the HSP

Relationship of Present Process to Regional Specialty Referral Centers

Regional Specialty Referral Centers do not find support from the existing system for the following reasons

- There is no facility category suitable for Phase 2 validation.
- Inputs driving criteria scores do not appear to facilitate scoring of Regional Specialty Referral Centers



- user population entry does not allow for multiple service areas typical of Regional Specialty Referral Centers
- inpatient days do not allow for or respect varying service area sizes for outpatient or ancillary functions
- condition adjustment, based on FEDS deficiencies, are not applicable to this category
- cost per square meter to replace is not applicable to this category
- Isolation appears difficult to calculate since there is no “anchor point” for a geographically dispersed population. A Regional Specialty Referral Center is intended not to be “isolated”.
- Facility size rewards smaller facilities to the detriment of scoring a Regional Specialty Referral Center

PAFAC Consideration of Criteria

The PAFAC debated what criteria would most relate to appropriately ranking Regional Specialty Referral Centers if such a category existed. The following factors gathered significant group support:

- CHS deficiency: this can be calculated for a local service area, a service unit or an area. It has been calculated throughout the master planning process of the last several years. CHS deficiency suggests the distress a service area/region is experiencing due to an inability to access secondary care.
- Projected Specialty Care visits: this projection can be calculated for a local service area, a service unit or an area. It has been calculated throughout the master planning process of the last several years. Specialty visits identify the demand for specialty care on a global level. In order to identify the true number of visits to be considered at a Regional Center one of two strategies might be required:
 - Utilize the HSP to determine the unmet need
 - Subtract specialty visits occurring at the PSA level from the total visits anticipated for a region
 - Utilize the master planning regional planning process to roll-up visits for consideration at a regional level
- Disease Disparity: of all the Health Status indicators currently employed in the HFCPS this one provides the most promise in relationship to scoring regional needs. This indicator simply identifies which area is losing the battle with prevalent health issues, often driven by the lack of access to higher level care. Birth, age over 55 and poverty were all disparities currently employed that were deemed to be subservient to disease in its relationship to scoring Regional Specialty Referral Centers.
- Isolation: though for the Portland Area emphasis was placed on this being about access more than geography. In other words, isolation is poor when a native patient must pay for services; and it is good when a native patient does not have to pay for services. Distance to that point of care is secondary or irrelevant.
 - As a sub-point, distance from an IHS or Tribal hospital, or distance from the proposed location of the Regional Specialty Referral Center to the closest IHS or Tribal facility offering comparable services still appears important to consider.
- Recruitment: the ability to find and retain qualified staff is critical to the success of any Regional Specialty Referral Center. This factor could score this as a component of following variables:
 - Distance from urban center
 - Population of that urban center
 - Presence of secondary/tertiary care in nearby urban center
 - Presence of academic medical facilities in nearby urban center



Adapting the Priority System

The PAFAC also considered the larger question of whether or not the attempt to secure a place for Regional Specialty Referral Centers in the HFCPS simply called for the addition of a new category with supporting criteria in Phase 1 or rather called for broader adaptation of the structure and phasing in the HFCPS itself.

The workgroup felt some level of larger system adaptation was appropriate. To cite one example, they felt Phase 2 should be moved to before Phase 1.

- Since innovation is valued by IHS, then reward innovative delivery systems by recognizing and scoring them in the first Phase of the HFCPS.
- Since cooperation should be rewarded wherever it occurs. This could perhaps be identified by measuring the number of tribal governments participating in a Regional Specialty Referral Center venture.

In conclusion, the PAFAC identified the following criteria for consideration in a concept for adapting the existing HFCPS to appropriately score Regional Specialty Referral Centers:

- Phase 2 should precede or be embedded in Phase 1
- Criteria utilized for scoring should include:
 - CHS Dependency
 - Access to Care (Staff Retention/Recruitment)
 - Facility Deficiency
 - Health Status
 - Innovation

These became the foundational drivers for the conceptual amendments proposed at the beginning of this tab.

In Support of Internal Reform

The efforts of the PAFAC also support the expressed intent of initial IHS conversations related to Internal Reform. Leadership has pointed toward a “Layer Delivery System” whereby healthcare to AI/ANs is delivered directly at Core Primary Sites and a Network of Intermediate Sites, while advanced services are purchased. There is a natural concern over whether or not the HFCPS aligns with the planning/prioritization needs suggested by such. The conceptual amendments identified above would move the HFCPS not only toward greater alignment, but also toward flexibility in planning innovative systems. For example, the Regional Specialty Referral Center concept, though fitting most with Level 2 of the 3 tiered system of care, acknowledges that 24/7 staffing is costly. Its operational concept presents an innovative alternative to that. The proposed adaptation of the HFCPS could facilitate this and many other innovations to come for the benefit of all tribes.

Overview Summary

A one page overview summarizing how these conceptual amendments might help the HFCPS score Regional Specialty Referral Centers and other project types is shown on the following page.



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Conceptual Amendments for Consideration in Adapting the Health Care Facilities Construction Priority System to Score Regional Specialty Referral Centers

Conceptual HFCPS Inputs											
	Phase 1						Phase 2				
Criteria =>	1 Facility Deficiency				2 Health Status		3 Access to Care	4 Innovation			5 Cost Effectiveness
Points =>	200				100		400	150			150
Inputs =>	Required Space (Baseline HSP)	Facility Age	Condition Adjustment (FEDS)	Cost/SM to Replace	Birth Disparities Index (50 points)	Disease Disparities Index (50 Points)	CHS Dependency (400 Points)	# of tribes in longer term governance partnership (50 points)	Staff Retention Ability (50 points)	Cost & Revenue Sharing Agreement (50 Points)	Operational savings \$ / capital expenditure (150 Points)
Remarks =>	Establish policy on definition of baseline RRM. Correlate HSP and RRM non compatibility issues relative to regional planning, specialty care and staffing. Create an integrated facility answer that recognizes the sensitivity required in accurate facility/staff planning.				Population needs to be verifiably sick, measured in a geographically precise manner. Data on Service Unit level must be fostered/validated.		Single most critical measurement defining an area's access to care.	Pull innovation into Phase 1, rewarding partnerships that solve problems, cut costs, and project better outcomes. Drive the system away from "small" vs. "large", toward better, sustainable, and affordable care.			Demonstrate proposed operational saving as compared to IHS authorized operating budget.
Regional Specialty Referral Center	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Existing Facility Types: Outpatient, Inpatient, Small Ambulatory, Other	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

What's Different?

1
Facility Deficiency scoring is handled by the Health Systems Planning software instead of the existing single input method, to create a more accurate and "facility flexible" space need estimate. Instead of using the HSP in Phase 2, it is moved to Phase 1.

2
Health Status is trimmed from 4 criteria down to 2. Status directly related to health are utilized: Birth Disparities and Disease Disparities. % Pop over 55 and Poverty Index are removed.

3
Access is defined as CHS Dependency rather than Isolation. The critical assumption is this: If an AI/AN can have care covered, then they have good access. Distance to care is secondary to this point.

4
Innovation is moved from Phase 2 to Phase 1 in support of IHS' stated desire for innovation approaches. This rewards innovative planning "up front".

5
Phase 2 is scored by how efficiently the project is projected to operate. Those demonstrating operational savings and efficiencies benefit. Everyone wins.

How does this help IHS?				How does this help the HFCPS?			
Encourages Operational Savings	Identifies IHS as a rewarder of Innovation	Creates capacity for innovative project types	Removes "small vs. large" mentality				
Re-invests in IHS Primary Planning tool (HSP)	Rewards performance based culture	Improves accuracy in Round 1	Promotes enhanced data granularity for disparities				
Links HSP with RRM for seamless planning	Lessens likelihood of inappropriate funding	Removes needless applicants from Round 1	Rewards multi-tribal partnerships/ventures				



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Concept of Operation

The concept of operation that supports a Regional Specialty Referral Center that will serve geographically dispersed populations considers the following components:

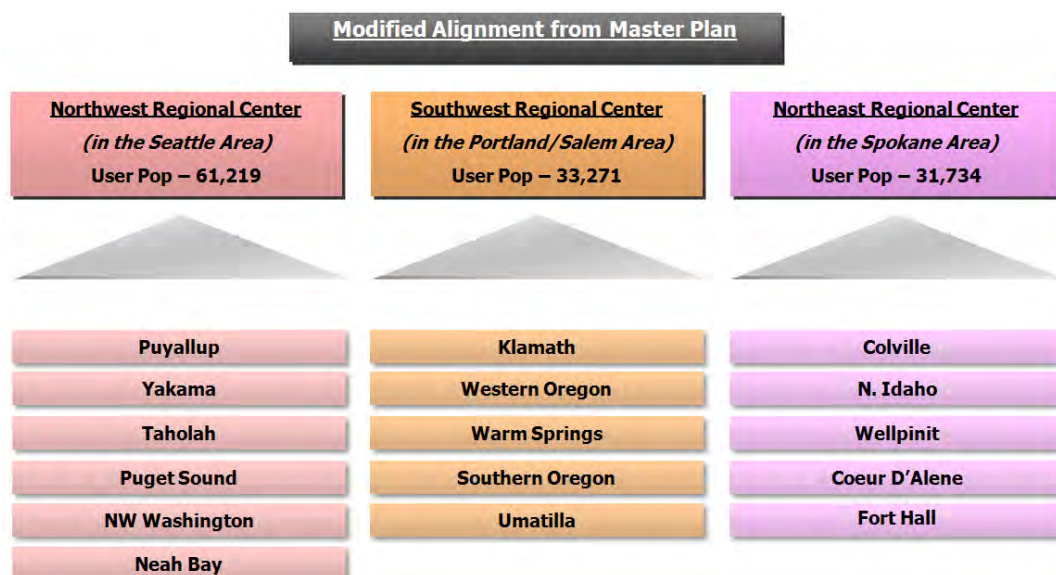
- Populations
 - Market Erosion
- Primary Care
- Projected Services
- Governance
- Financial Performance
- Market Share (Erosion)

Populations

The original Portland Area Health Services Master Plan included a placeholder for Regional Specialty Referral Centers at 3 locations. Each Regional Specialty Referral Center was supported by a corresponding population grouping. For this study, those definitions were carried forward for the most part. Four important differences should be noted:

- First, Service Units were not split for this study. In the original Master Plan sensitivity was included to the PSA level and how their populations tended to access care (which did not always follow Service Unit patterns).
- Second, Populations were drawn directly from the 2009 HSP.
- Third, Unassigned or Non-Service Unit HSP populations were not assigned to any Regional Specialty Referral Center.
- Fourth, Ft. Hall was assigned to the Northeast Regional Specialty Referral Center location. In the Master Plan Ft. Hall was not directly assigned to any location due to distance.

These points account for the variations between this report’s Regional Specialty Referral Center populations and the Master Plan’s. The assignments and populations of Service Units to their corresponding Regional Center location are shown below.





Market Erosion

The difference between populations projected for Regional Specialty Referral Centers in the Health Services Master Plan and this study are significant, due to market erosion. The former assumed 100% market share while the later does not. In other words, the market has been “eroded” to some percentage less than 100 for multiple reasons. For example, the Northwest Regional Specialty Referral Center (Seattle) would not reasonably expect to serve 61,219 users because such would represent 100% market share. In reality, far less than 100% of the regional user population would access such care in Seattle for a variety of reasons:

- Distance
- Lack of transportation
- Bad weather
- Geography (mountain passes)
- Economic hardship
- Third party coverage/insurance (choice)

Market Erosion = the effect of multiple variables (distance, competitors, economy, etc.) on patients who might seek care at a facility, thereby “eroding” what might otherwise be 100% market share

In addition to these reasons, some just simply may not come. Calculating the impact or “erosion” of this against the full or 100% market is based on a series of assumptions. For a full explanation of how the market share erosion methodology functions see the **Market Erosion** section of this report. Below, however, is a summary of the assumptions and how they impact the full market.

- User payor data was gathered from the Portland Area IHS allowing the creation of a 100% market by payor group (Direct Care only, Direct Care/CHS, and Direct Care/CHS/3rd Party Payor).
- User payor groups were then “eroded” by Service Unit or Primary Service Area (depending on which was available) according to the following assumptions:
 - First, all users regardless of payor grouping were assumed to erode by 7% per tier, beyond 90 minutes travel time, of increasing distance according to the following table. The highest market share assigned to users less than 90 minutes from a Regional Specialty Referral Center is 100%. The lowest, assigned to users beyond 240 minutes from a Regional Specialty Referral Center is 79%.

by Distance	High (H) Reliance	Moderate (M) Reliance		Low (L) Reliance	
	Direct Care Only No 3P	Direct Care, CHS		DC, CHS, Medicaid	Direct Care, CHS, 3P
		No Choice	Choice	No Choice	Choice
Drive Time to Regional Center (< than in Minutes)	% likely to drive	% likely to drive	% likely to drive	% likely to drive	% likely to drive
60	100%	100%	100%	100%	100%
90	100%	100%	100%	100%	100%
120	93%	93%	93%	93%	93%
240	86%	86%	86%	86%	86%
240+	79%	79%	79%	79%	79%

- Second, users by payor group were eroded based upon whether or not they would “drive by” alternative care options on the way to a Regional Specialty Referral Center. This erosion was higher for users who had 3rd party coverage, and therefore a choice, than for those who did not. The “no choice” segments are “high reliance”, while the “choice” segments are “low reliance”. The table below shows how the various market segments erode.



- In short, when no choice is available, 100% of the distance eroded market segment is assumed for care at a Regional Specialty Referral Center no matter how many alternative care options are passed in route.
- When choice is available, the Direct Care/CHS/3rd Party Covered (least reliance) segment is assumed to essentially erode by 20% for each tier, while the Direct Care/CHS (moderate reliance) segment is assumed to erode less drastically – by the average of the least reliant percentage and the “no choice” segment percentage.

by Alternative Care	High (H) Reliance	Moderate (M) Reliance		Low (L) Reliance	
	Direct Care Only No 3P	Direct Care, CHS		DC, CHS, Medicaid	Direct Care, CHS, 3P
		No Choice	Choice	No Choice	Choice
	Secondary or Tertiary Alternative Care Options "in route"	% likely to drive	% likely to drive	% likely to drive	% likely to drive
1	100%	100%	90%	100%	80%
2	100%	100%	80%	100%	60%
3	100%	100%	70%	100%	40%

This erosion methodology results in a percentage of total users that might reasonably be anticipated at a Regional Specialty Referral Center for specialty care. This percentage can then be applied toward geographically dispersed HSP user populations uniformly to create a distance and alternative care eroded market share. For Seattle (this report’s example), 75.3% market share should be planned for when CHS and Medicaid payors are directed to the Regional Specialty Referral Center for care, while 70.6% market share should be planned for when those market segments are not directed to the Regional Specialty Referral Center for care.

Service Area	Market %			Entry	Market Share			
	H Reliance	M Reliance	L Reliance	CHSDA	=51*52+54*53		=51*53+56	
	Direct Care Only No 3P	Direct Care, CHS	Direct Care, CHS, 3P	Total Users (or)	M Reliance - CHS No Choice & Medicaid Only		M Reliance - Choice	
	All/CHSDA Blended	All/CHSDA Blended	All/CHSDA Blended	CHSDA Users	Total Users	% of User	Total Users	% of User
Seattle Reg Ctr	15.7%	17.8%	54.8%	52,946	39,859	75.3%	37,405	70.6%
Portland Reg Ctr	23.2%	15.1%	49.2%	28,748	19,918	69.3%	18,842	65.5%
Spokane Reg Ctr	17.0%	27.6%	53.2%	18,893	15,331	81.1%	14,979	79.3%

70.0% is the resulting market share applied in the final of four scenarios developed in this report.

Note: The market share percentage modeled in this report does not consider the following two realities: first, referrals would undoubtedly be made to this facility for those residing in the other two regions considered for Regional Specialty Referral Centers in the Portland Area (Portland and Spokane). AI/ANs requiring specialty care would likely come from Portland, Spokane and the surrounding geographic areas until such centers are provided closer to them. Second, users from Southeast Alaska currently access Seattle for referral care. While the impact of neither of these is quantified in this study, an impact is likely nonetheless, at the very least supporting projected staff and space, and at the worst increasing space and staffing demands.



Primary Care

One of the critical questions facing Regional Specialty Referral Center planning is “should Primary Care be planned for at a Regional Specialty Referral Center?” The question elicits both positive and negative responses.

Negative responses include:

- User population must essentially be speculated on in order to determine how to size the Primary Care aspects of the Regional Specialty Referral Center facility
- User population in the urban center selected will likely swell beyond the size of the rural user populations the center is intended to serve. This raises concerns about governance and resource utilization.
- User population increase is not always viewed as a good thing, especially by elders who may view the increasing drain on a one payor system paying out of many pockets further strained by newly recognized tribes, new delivery systems, and diluted blood quantum. Their concern could essentially be expressed as follows: *“we don’t have resources to serve the current AI/ANs so how are we going to significantly increase our user population in an urban center and have additional money to cover their primary care and our specialty care?”*
- Allowing for the Northwest’s urban population sets a precedent for the entire country potentially resulting in huge resource requirements.

Positive responses include:

- An “in place” user population to support adequate facility utilization. A Primary Care base mitigates the risk of less than expected specialty care utilization. Such utilization is difficult to predict because of the lack of historical market share data for such a center. While it is a risk to project who will drive 3 hours across 2 mountain ranges to access specialty care, it is less of a risk to project that a significant AI/AN population will take advantage of Primary Care in a major urban area when they live less than 30 minutes away. Additionally, those AI/AN primary care users form a more reliable base from which to recruit providers, administrative and support staff to anchor the facility until specialty care utilization rises to anticipated levels.
- A larger Primary Care population base at the Regional Specialty Referral Center location also enlarges and enhances the Specialty Care that can be provided to all. More users equal more providers, more services and more space. This obviously makes the Regional Specialty Referral Center’s magnetism and regional “draw” more powerful and supportable.
- Needed provision of care for a previously neglected component of AI/ANs. There are many significant urban AI/AN populations around the country that cannot access Primary Care at the same level that their on-reservation populations can. Such an operational concept might serve as a path toward better serving such populations.
- IHS Headquarters has expressed specific concern that Primary Care be considered in the PAFAC’s deliberations.

The PAFAC agreed that it was important to consider Primary Care as part of the Regional Specialty Referral Center operational concept, especially in light of the original market share projections as identified in the appendices of this report. During the first phases of analysis, market share was planned more conservatively (43.6%); deemed overly so as the project evolved. This made the inclusion of Primary Care necessary for the desired specialty services to become supportable.

So the PAFAC developed multiple scenarios attempting to address the question *“...at what level should Primary Care be included?”* Four different scenarios are modeled in this report, two of which include Primary Care:



- Scenario 1 shows only Specialty Diagnostic/Ambulatory Surgery services, with no primary care
- Scenario 2 shows Specialty Diagnostic/Ambulatory Surgery services *plus* a Primary Care component sized to serve 82.19% of anticipated users from the five county Seattle market
- Scenario 3 shows Specialty Diagnostic/Ambulatory Surgery services *plus an essential or limited* Primary Care component sized to serve 39.3% of anticipated users, primarily from King County in the Seattle market.
- Scenario 4 shows only Specialty Diagnostic/Ambulatory Surgery services, with no primary care for an enhanced market share as identified above (70.0%)

How can Primary Care be considered?

The most obvious way to consider Primary Care is by quantifying what is already known about urban locations where it is offered to AI/AN populations. Consider the following table:

State	County	Region	Total 2005 User Pop	2005 Service Pop	User Pop to Service Pop
AK	Anchorage	Anchorage	34,048	24,602	138.4%
AZ	Maricopa	Phoenix	64,634	76,433	84.6%
AZ	Pima	Tucson	23,652	33,453	70.7%
MI	Chippewa	(Sioux St. Marie) Bemidji	6,571	6,341	103.6%
NV	Washoe	(Reno/Sparks) Phoenix	5,347	7,848	68.1%
NM	Bernalillo	Albuquerque	25,654	29,062	88.3%
SD	Pennington	(Rapid City) Aberdeen	11,153	9,018	123.7%
Totals - All			125,858	153,137	82.19%

Each of the locations identified above offer services of a regional nature to dispersed populations though they are not a “Regional Specialty Referral Center” under this report’s definition. It is important to note that the ratio of user to service population is high. In 3 of the 7 examples it exceeds 100%. Averaging these percentages provides a fairly reliable, historically based, metric by which to anticipate what service populations near a proposed Regional Specialty Referral Center location should be considered as potential users for Primary Care.

This is typically referred to as “un-served service population”, or AI/ANs identified in the census that are not already served at any PSA location. This population would be composed only of non-users of the current system so no one is counted twice. In other words, no PSA clinics would lose existing active users/patients, and no local resources would be lost or threatened.

The table above suggests 82.19% of a collocated population for a Regional Specialty Referral Center could be considered for planning purposes.

The next step is to identify what service populations would be reasonable to consider for calculating a primary care user population. In other words, since service population is quantifiable only on a county level, what counties are close to the proposed Regional Specialty Referral Center location and what percentage of their service populations are already users? The steps to accomplish this are as follows:

- Identify the counties within reasonable proximity to a proposed Regional Specialty Referral Center (60 minutes travel time was utilized)
- Map those counties and understand where their population centers and fringes are
- Remove counties that already have a tribal or IHS facility in them providing reasonable access for predominantly rural AI/AN populations
- Calculate the projected 2020 user population for the relevant counties

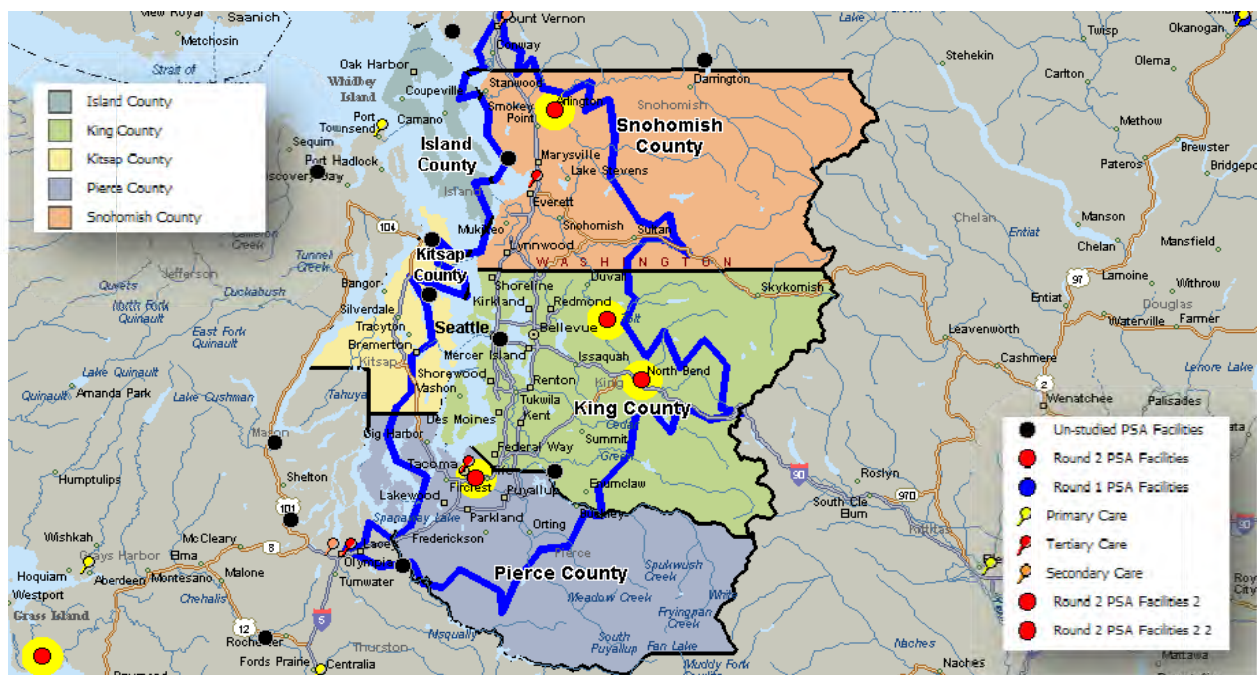


- Calculate the projected 2020 service population for the relevant counties
- Identify the potential market for Primary Care for the relevant Regional Specialty Referral Center as the difference between the projected Service Population multiplied by the percentage identified above (82.19%) less the projected User Population which will already be planned for at other facilities

This process yields a projected primary care user population for the Seattle location of 31,287, utilized in Scenario 2.

- $67,858$ (projected service pop in 2020) \times 82.19% = $55,772$ (projected total users)
- $55,772$ (projected total users) – $24,485$ (users planned for at other facilities) = $31,287$
- $31,287$ = the number of users considered for primary care at the Seattle Regional Specialty Referral Center

The map below shows the counties identified as relevant for considering and projecting potential user populations for primary care at the Seattle Regional Specialty Referral Center location. The table below it incorporates the counties identified above, showing the projected user and service populations, the applied 82.19% metric and the resulting populations to consider for Primary Care at the Seattle location.



Regional Area	State	Counties w/in 60 minutes	Projected 2020 User Pop w/in 60 minutes	Projected 2020 Service Pop w/in 60 minutes	New PC Potential Market (at 100%)	Projected % User Pop to Service Pop	Tribal or Federal Facility Available for PC	Planned % User to Service Pop	Planned PC Market
Seattle - NWRC	Washington	Island	82	1,035	953	7.9%	NO	82.19%	769
Seattle - NWRC	Washington	King	3,444	25,214	21,770	13.7%	YES	82.19%	17,279
Seattle - NWRC	Washington	Kitsap	2,557	6,325	3,768	40.4%	YES	82.19%	2,642
Seattle - NWRC	Washington	Pierce	11,599	20,277	8,678	57.2%	YES	82.19%	5,067
Seattle - NWRC	Washington	Snohomish	6,803	15,007	8,204	45.3%	YES	82.19%	5,531
Seattle - NWRC	Total		24,485	67,858	43,373	36.1%		82.19%	31,287



For Scenario 3, the projected user population for primary care is further reduced to 17,145, thereby creating a total Regional Specialty Referral Center user population of 43,046 – a minimum for obtaining many of the specialty/diagnostic services desired.

How Does Primary Care Impact the Regional Specialty Referral Center?

	SCPVs	37,370
Total Provider Visits (TPV)		162,432
Services	KC #	DGSM
Ambulatory		
Primary Care (Providers)	30.2	3,905.0
Case Management (FTE's)	0.0	0.0
Eye Care (Optometrist)	5.7	554.2
Audiology (Audiologist)	2.3	220.0
Dental Care (Dentist)	37.8	2,749.4
Dental Specialists	0.0	0.0
Specialty Care		
Medical Specialties	0.0	1,728.4
Cardiologist	1.0	0.0
Dermatologist	0.6	0.0
Neurologist	0.4	0.0
Other Medical Specialist	3.3	0.0
Surgical Specialties	0.0	0.0
General Surgeon	1.4	0.0
Ophthalmologist	1.6	0.0
Orthopedist	1.5	0.0
Other Surgical Specialist	0.8	0.0
Otolaryngologist	0.7	0.0
Urologist	0.7	0.0
Preventive		
Public Health Nutrition (FTE's)	5.5	67.2
Health Education (FTE's)	6.9	100.8
Public Health Nursing (FTE's)	45.8	693.0
Wellness Center (FTE's)	14.3	689.0
Ancillary		
Surgery (OR's)	1.0	226.0
Laboratory (FTE's)	25.5	265.0
Diagnostic imaging	0.0	693.0
Radiography (Rooms)	2.0	0.0
Fluoroscopy (Rooms)	1.0	0.0
Ultrasound (Rooms)	1.0	0.0
Mammography (Rooms)	1.0	0.0
CT (Rooms)	1.0	0.0
MRI (Rooms)	1.0	0.0
Bone Mineral Density (Rooms)	0.0	0.0
Pharmacy (FTE's)	38.2	1,352.5
Physical Rehab Services		1,279.5
Physical Therapist	10.8	0.0
Occupational Therapist	2.4	0.0
Speech Pathologist	1.1	0.0
Behavioral Health (FTE's)	72.2	1,855.3
Administration		
Administration (FTE's)	32.5	420.0
Information Management (FTE's)	17.6	248.4
Business Office (FTE's)	75.7	604.8
Health Information Management (FTE's)	80.4	806.3
Security (FTE's)	4.3	14.4
Facility Support		
Clinical Engineering (FTE's)	4.0	88.7
Facility Management (FTE's)	20.0	199.2
Support Services		
Medical Supply (FTE's)	0.0	0.0
Property & Supply (FTE's)	10.5	1,352.7
Housekeeping & Linen (FTE's)	19.6	109.0
DGSM		21,374.3
Total RRM FTE's	874.8	0.0
BGSM	0.0	29,282.7

The inclusion of Primary Care at the Regional Specialty Referral Center impacts delivery options in many ways.

Using the Seattle location as an example, assuming unconstricted access for 82.19% of potential users (Scenario 2), it first adds a predictably reliable user population base of 31,287 that will not only support approximately 30 Primary Care providers, but also increase ancillary capabilities, staff and space. This can be quantified as shown in the table to the left.

KCs are typically the most expensive aspect of any service line of care; a doctor, room, or bed. It is the clearest single metric to use in understanding and comparing care scenarios.

DGSM represents department gross square meters.

The table shows the difference or increase specifically, in all services as a result of the inclusion of Primary Care. Services shaded green are those impacted.

- Primary Care: 30.2 additional PC providers, 5.7 additional optometrists, 37.8 additional dentists, greatly enhanced specialty dental care
- Specialty Care: 12 additional specialists across medical and surgical specialties
- Ancillary: 1 additional OR, 25.5 additional lab techs
- Diagnostic Imaging: 7 additional imaging rooms including 1 Fluoro, 1 CT and 1 MRI.
- Physical Rehab: 14.3 additional therapists, 2.4 additional occupational therapists
- 874.8 additional FTE
- 29,282.7 additional BGSM
- 37,370 additional Specialty Care visits
- 162,432 additional Total Provider visits

In Scenario 2, Primary Care Population is projected to be 31,444. Regional Specialty Care User Population is projected to be 25,901. Combined User Populations are projected to be 57,345.



Projected Services with Primary Care

The inclusion of Primary Care (in both Scenario 2 and 3) would add the following services at the Regional Specialty Referral Center. These services would serve the local Primary Care user population only:

- Primary Care
- Case Management
- Eye Care
- Dental Care
- Preventive Care including
 - Public Health Nursing
 - Health Education
 - Public Health Nursing
 - Wellness Center
- Pharmacy
- Rehab including:
 - Physical Therapy
 - Speech Therapy
- Behavioral Health

Those services offered to local Primary Care user populations only reflect services offered at the PSA level for regional users or services that do not make sense to offer for a regional user population. For example, patients accessing Physical Therapy need to go 3 times a week – a routine impractical for users that must drive significant distances. Preventive Care is a unique offering associated with Primary Care, as is Pharmacy. Regional users would be expected to return to their PSA for non-specialty care related Pharmacy needs. The Pharmacy migration rate for regional specialty care users would need to be carefully considered.

The services immediately below would serve the Regional Population that must travel for care as well as the local Primary Care user population:

- Audiology
- Specialty Care (Medical & Surgical)
- Telemedicine
- Surgery
- Lab
- Radiology
- Fluoroscopy
- Ultrasound
- Mammography
- CT
- MRI
- Occupational & Speech Therapy

Dental Specialist, Podiatry, Psychiatry, and Chemotherapy would also be considered at the regional level but no simple quantification of these services is presently available.

Conclusions Regarding the Inclusion of Primary Care

The conclusion of the PAFAC was that a more robust and defensible market share supportive of a true Specialty Care Referral Center without Primary Care was the correct concept to move forward with because:



- Such a concept is truer to the intentions of the Pilot Study,
- The inclusion of Primary Care creates significant demand for new users on an already overburdened system,
- It establishes a precedent of providing care for urban AI/ANs that could have overwhelming implications for the national system,
- It overlooks the presence of a reliable Primary Care user population base within 60 minutes travel time that would eagerly access such a facility in Seattle (a unique “plus” for locating a Regional Specialty Referral Center in the Seattle market).

As a result, Scenario 4 was developed, and is recommended as the Demonstration Project. It reflects the original intent of the study as first modeled in Scenario 1, but supported by a more robust market share (detailed in the Market Erosion Appendix which assumes 100% market share for all specialty care users within 90 minutes). This market share embraces an aggressive use of Telemedicine to extend services not only to the fringe of the projected service area boundaries but beyond. It is envisioned that Telemedicine services could make this center accessible to much of the entire Portland Area for the foreseeable future.

Moreover, Scenario 4 would be anchored by the close geographical proximity of approximately 24,000 projected users from 7 existing PSAs within 60 minutes travel time, embedded in the greater Seattle area:

- Stillaguamish
- Tulalip
- Snoqualmie
- Muckleshoot
- Puyallup
- Nisqually
- Suquamish
- Port Gamble Sklallum

Projected Services – Scenario 4

The services immediately below would serve all Portland Area users referred for specialty diagnostic treatment and ambulatory surgery services.

- Audiology
- Specialty Care (Medical & Surgical)
- Telemedicine
- Surgery
- Lab
- Radiology
- Fluoroscopy
- Ultrasound
- Mammography
- CT
- MRI
- Occupational & Speech Therapy

Dental Specialist, Podiatry, Psychiatry, and Chemotherapy would also be considered at the regional level but no simple quantification of these services is presently available. Telemedicine likewise is not currently calculated by the HSP so it is not shown. But it would be developed as an important service supporting as many service offerings as possible. A complete list of projected services and characteristics, for all four scenarios is shown on the following page.



Services by Scenario

Scenario #	1		2		3		4	
	Seattle Regional Center - Eroded MS (43.6 %)				70.0% MS			
	w/out PC		with full PC		with essential PC		w/out PC	
2020 Primary Care Service Area User Pop	0		31,444		17,145		0	
2020 Specialty Care Service Area User Pop	25,901		57,345		43,046		43,027	
PCPV's	0		125,062		68,264		0	
SCPV's	27,997		65,367		47,717		46,986	
Total Provider Visits (TPV)	27,997		190,429		115,981		46,986	
Services	KC #	DGSM	KC #	DGSM	KC #	DGSM	KC #	DGSM
Ambulatory								
Primary Care (Providers)	0.0	0.0	30.2	3,905.0	16.0	2,252.0	0.0	0.0
Case Management (FTE's)								
Eye Care (Optometrist)	0.0	0.0	5.7	554.2	3.2	325.0	0.0	0.0
Audiology (Audiologist)	2.4	81.0	4.7	301.0	3.7	220.2	3.7	222.6
Dental Care (Dentist)	0.0	0.0	37.8	2,749.4	20.6	1,662.0	0.0	0.0
Dental Specialists								
Specialty Care (Supported by Telemed)								
Medical Specialties								
Cardiologist	0.7		1.7		1.3		1.3	
Dermatologist	0.5		1.1		0.8		0.8	
Neurologist	0.4		0.8		0.6		0.7	
Other Medical Specialist (incl. Rheuma.)	2.4		5.7		4.2		4.1	
Surgical Specialties		475.6		2,204.0		1,619.7		1,674.8
General Surgeon	1.0		2.4		1.7		1.7	
Ophthalmologist	1.1		2.7		2.0		1.9	
Orthopedist	1.2		2.7		2.0		1.9	
Other Surgical Specialist	0.6		1.4		1.0		1.0	
Otolaryngologist	0.6		1.3		0.9		0.9	
Urologist	0.4		1.1		0.8		0.8	
Preventive								
Public Health Nutrition (FTE's)	0.0	0.0	5.5	67.2	2.1	21.0	0.0	0.0
Health Education (FTE's)	0.0	0.0	6.9	100.8	4.3	60.2	0.0	0.0
Public Health Nursing (FTE's)	0.0	0.0	45.8	693.0	25.4	410.2	0.0	0.0
Wellness Center (FTE's)	0.0	0.0	14.3	689.0	11.0	577.9	0.0	0.0
Ancillary								
Surgery (OR's)	2.0	625.0	3.0	851.0	3.0	851.0	3.0	851.0
Laboratory (FTE's)	4.4	183.0	29.9	448.0	18.2	330.0	7.4	218.0
Diagnostic imaging								
Radiography (Rooms)	1.0		3.0		2.0		1.0	
Fluoroscopy (Rooms)	0.0		1.0		1.0		0.0	
Ultrasound (Rooms)	1.0		2.0		2.0		1.0	
Mammography (Rooms)	1.0	287.0	2.0	980.0	2.0	917.0	2.0	663.6
CT (Rooms)	0.0		1.0		1.0		1.0	
MRI (Rooms)	0.0		1.0		1.0		1.0	
Bone Mineral Density (Rooms)	0.0		0.0		0.0		0.0	
Pharmacy (FTE's)	0.0	0.0	38.2	1,352.5	35.4	821.0	0.0	0.0
Physical Rehab Services								
Physical Therapist	0.0	169.0	10.8	1,448.5	6.0	990.8	0.0	272.5
Occupational Therapist	1.9		4.3		3.2		3.2	
Speech Pathologist	0.0		1.1		0.8		0.9	
Behavioral Health (FTE's)	0.0	0.0	72.2	1,855.3	40.7	1,132.6	0.0	0.0
Administration								
Administration (FTE's)	9.8	224.0	42.3	644.0	28.2	478.8	12.7	282.8
Information Management (FTE's)	3.7	90.0	21.3	338.4	13.5	250.8	5.1	111.6
Business Office (FTE's)	13.7	166.6	89.4	771.4	54.7	480.2	22.6	219.8
Health Information Management (FTE's)	19.9	358.8	100.3	1,165.0	61.6	722.5	32.0	545.0
Security (FTE's)	1.4	15.6	5.7	30.0	4.6	25.2	2.2	15.6
Facility Support								
Clinical Engineering (FTE's)	1.6	42.0	5.6	130.7	3.7	84.0	2.3	42.0
Facility Management (FTE's)	7.1	99.0	27.1	298.2	21.4	176.0	10.7	99.0
Support Services								
Medical Supply (FTE's)	0.7	122.0	0.7	122.0	0.7	122.0	0.7	122.0
Property & Supply (FTE's)	1.7	331.0	12.2	1,683.7	7.5	1,025.5	2.5	437.0
Housekeeping & Linen (FTE's)	7.7	56.0	27.3	165.0	22.2	84.0	11.2	84.0
DGSM		3,729.2		25,103.4		16,709.6		6,343.5
Total RRM FTE's	93.4		968.2		592.0		133.9	
BGSM		5,109.0		34,391.7		22,892.2		8,690.6
BGSM/TPV	0.133		0.132		0.144		0.135	
BGSM/SCPV	0.133		0.384		0.350		0.135	



Governance

In preparation for the initial meeting in Portland, conversations were held between the consultant and 5 IHS/Tribal centers offering services to regional populations in various parts of the country. As the image below shows, these ranged in size from Service Unit hospitals offering care under informal partnership agreements with other Service Units nearby on a “service line by service line” basis, to major urban medical centers offering an extensive spectrum of outpatient and inpatient services (as in the case of Alaska Native Medical Center and Phoenix Indian Medical Center).



Questions were asked of contact persons willing to give opinions on what did and did not work well at each location:

- What is their history of service delivery?
- What was their mission and opportunity?
- What challenges do these centers face?
- What are the PSA & ESA structures upon which their healthcare delivery rests?
- Is service delivery truly driven by regional populations they were commissioned to serve?

A summary of answers to various questions is found on the following table.



Portland Area Indian Health Service

Concept of Operation

	Alaska Native Medical Center	Crow / Northern Cheyenne Hospital	Phoenix Indian Medical Center	Gallup Indian Medical Center	Sioux San Indian Hospital
Who are the Willing Partners?	231 Federally Recognized Tribes in the state of Alaska. Entire state 638 compacted.	Crow Service Unit and Northern Cheyenne Service Unit. Hospital at Crow, OP Clinic at N. Cheyenne. IHS facilities.	IHS owned for benefit of all tribes in Phoenix Area. Partners with Service Units in proximity. Partners with 3 states. Tribes don't have a direct say specifically; might disassemble if they did.	IHS facility offering regionally sized services to Navajo, Zuni and Hopi populations without formal partnership.	IHS facility... no one tells a government entity what to do. 3 tribes invited to sit on governing body: Pine Ridge, Rose Bud, Cheyenne (all Sioux).
What is the Board / Management Structure?	Alaska Native Tribal Health Consortium: 15 members (13 from tribal health organizations, 2 at large). South Central Foundation: reps from Anchorage and surrounding area. Joint Commission Accredited Campus: 5 members from ANTHC, 3 from SCF	No formal board structure aside from Governing Body that reviews "score card" and progress. CEO to CEO relationship on coordinated services.	Leadership Board in Hospital (CEO and 3-4 associate directors). OP services board (Leadership Board plus reps from participating 6 SU tribes). IP service board (Leadership plus rep from each state for Area Services)	Governing Body: IHS employees and executive from SU and Area. Health Board community members selected by hiring practice.	Governing Body is an advisory group to CEO.
What is their Frequency of Meeting?	ANTHC - every 2 months. SCF - uncertain/as needed. Joint Operating Board - 5 times a year	Governing Body meets 4 times a year for each facility	Quarterly for IP services board; OP groups meets weekly or more or as needed (the lines blur between the OP and Leadership Board)	Governing body: 2x/year. Health Board: 4x/year.	Governing Body meets 4x/year. Really they are the GB for the Service Unit, not the facility.
Who is Responsible for What?	ANTHC: statewide tertiary and secondary care. SCF: SU primary care services. JCAC: medical center day-to-day operations. Complex.	Bodies are combination of CEO, AO, Director of Nursing, executive leadership and executives from Area Office. General coordination.	Leadership Board: day to day hospital operations. OP services: services for immediate participating SUs. IP services: care affecting entire area. Responsibilities not always clearly distinguished.	Governing Body: executive authority for us, safety issues, disciplinary actions, union issues. Health Board input on programs for SU.	Governing Body makes decisions or recommendations that are largely followed. Day to day responsibilities go to the CEO and leadership team.
How are Costs Shared?	Multiple level cost sharing based on agreements formed through their 4 tiered system: village clinic, health clinic, regional hospital, ANMC. It is very complex.	Billings Area office moves funds according to agreements arranged by CEOs at each facility. Crow manages Hospital; N. Cheyenne the clinic.	All tribal shares are kept at PIMC for Planning, IT, etc. Only shares disbursed from Area Office are PHN, Dental, etc.	IHS facility - don't really "share" costs.	IHS facility - don't really "share" costs. However, SUDs/CEOs talking about sharing costs on referrals made to referral center (i.e.: Rosebud).



	Alaska Native Medical Center	Crow / Northern Cheyenne Hospital	Phoenix Indian Medical Center	Gallup Indian Medical Center	Sioux San Indian Hospital
How are Revenues Shared?	For services at JCAC there is a general split of 1/3 to SCF and 2/3 to ANTHC. It is complex.	IHS facilities - not an issue.	Any profit reinvested in PIMC or distributed by Area Office to tribes. Tribes not satisfied with this historically.	IHS facility - revenues not "shared"	IHS facility - revenues not "shared". However, when there is a legitimate payor for a referral they usually go to the private sector. Revenue is lost.
What seems to be experiencing Effective Management?	Most things are managed effectively.	Seems to be working adequately.	Not much evidence of effective management. Facility is deeply in the red.	Works fairly well on the whole.	Happens when partner tribes hear no complaints about service in Rapid City.
What seems to be experiencing Ineffective Management?	Behavioral Health because ANMC doesn't have these services. As a result they are provided by SCF. IP treatment occurs at regional level.	Could be more proactive in taking advantage of regional services opportunities.	No good leadership group for Regional Services. Many leaders are on both boards. IP leadership makes most decisions. Use of center by significant non-CHS eligible population. Spreading care across tri-state area by visiting professionals.	Complaints from some SUs that our services are scheduled too far out. We are sent people who don't have insurance. Seem to retain folks for PC that originally came to us for surgery.	When there is a legitimate payor for referral they usually go to the private sector. Revenue is lost.
What would or should be done differently?	Nothing specific identified. Invited to talk with leadership further.	Structure of actual partnership doesn't need much alteration.	More true collaboration. Distinctly staffed Leadership boards. IP & OP serve different populations and needs.	Not enough top-down management. Area comes to us more as a consultant than giving directives.	Separate entity to manage any regional services. Critical piece to consider is 638 process because tribes may take shares and eliminate regional opportunities.

These responses were reviewed by the PAFAC. The PAFAC discussed general concerns related to cooperative tribal representation, equitable cost sharing, equitable revenue sharing, and responsiveness to regional needs. They also heard and discussed specific concerns from IHS headquarters such as patient access, operational concept, economic viability, and of course, governance issues.

Many of the ideas generated in that meeting were responses to the following question: *“How would you ensure you had cooperative tribal representation on a Regional Specialty Referral Center board?”*

Answers are shown below:

- The first step in meaningful progress toward appropriate governance is to consult with the tribes.
- We would need to pursue Regional Specialty Referral Center with the understanding that *“as we build one, it's going to serve everyone until we build another”*.
- More clarification is needed as to whether Portland Tribes would want to allow a 638-ed tribe/organization to take over operations if IHS built it.
- The existing health board could act as the contracting entity on behalf of the tribes.



- NPAIHB could manage the equitable cost and revenue sharing (workgroup responded well to this idea).
- *Could monies collected be reinvested in the facility itself like a utility?* The thought was that this might not work.
- Members affirmed the idea that *"If it does not pay its own bills then cost sharing is going to be a problem. Our assumption is that cost would not be a problem because it comes with federal operational funds attached."*
- Revenue should just be split up equitably (other suggestions included: let it go back to the center or funds for patient travel).
- Regional Specialty Referral Center facilities should have a pharmacy that only fills scripts from visits to that location.
- A Regional Specialty Referral Center would require its own administration.
- An EHR would be very helpful for a Regional Specialty Referral Center.
- Telemedicine should be considered to help with consults back at the home clinic (it helps access issues as well).
- *What about CHS?* The Regional Specialty Referral Center would send tertiary referrals back to the source tribe for CHS approval.

Additional development is needed in the area of governance to produce a firm schematic of the appropriate structure, defining not only board but management assignments/responsibilities. Additional conversation should be pursued that should inform the final executive staffing for this project. The guidelines below should be considered as a starting point.

1. A Regional Specialty Referral Center Governing Body would benefit from community representation from participating/stakeholder service units.
2. The NPAIHB would be appropriate for ensuring the needs of participating tribes are well served at the Regional Specialty Referral Center because of their existing regional awareness, composition and charter.
3. An effective Governing Body model should consider management, community and Service Unit representation. Membership should consider including the CEO, Clinical Director, Nursing Representative, Service Unit Director and Clinical Director representatives from other SUs and Area Health board representatives (to represent all Portland Area tribes as opposed to only the SUs in which they reside). Balance should presuppose equal membership from operational/management and tribal communities.
4. Regional Specialty Referral Center Management should implement strategic direction defined by the Governing Body. However, the Governing Body should evaluate the CEO. This could be retained by the Area Office, shared with the NPAIHB or belong exclusively to the NPAIHB.
5. If the Regional Specialty Referral Center is significantly larger than the Area Office, it should consider functioning as independently as possible. If it is a federally run facility, its governmental oversight should be as streamlined as possible.
6. Healthy relationships with nearby hospitals where Regional Specialty Referral Center specialists would need privileges can be maintained by including them through representation on the Governing Body.
7. As plans proceed toward reality, it should be understood that some programs/service lines, despite their viability in the planning stage, may be difficult to maintain due to recruiting challenges that exist despite a major urban center location (ex: Orthopedics).
8. Of the Regional Specialty Referral Center dental specialties desired, pediatric dentistry may provide the only cost effective service to provide. Others tend to be cost prohibitive to implement.
9. Senior Executive leadership for a Regional Specialty Referral Center should demonstrate a set of core competencies: leading change, leading people, performance improvement, building coalitions/communication and business acumen. Such a skill set is typically built on



undergraduate/graduate education in healthcare or public health administration with responsive analytical or administrative management experience in the healthcare field. Experience in operations as an advisory or director is also beneficial.

10. Regional Specialty Referral Center Leadership should be prepared for and expect an ever changing environment presenting challenges related to standards development, staff shortages, budget and reimbursement issues, regulations, and more.



Financial Snapshot

Assumptions

Financial models are an estimate of projected revenues and expenses based on a given set of assumptions. These assumptions rely on the best information available at the time, which may or may not be correct. The better the information used to create these projections, the more accurate the projections are. The following is a list of critical assumptions used to develop each of the four (4) scenarios (*a matrix of all the assumptions is provided at the end of this section*).

- The annual IHS funding amount is based on the average salary per FTE for the clinic based on the FTE mix of each scenario. The FTE's cost is based on the average salary by job classification for the State of Oregon as Published by Pay Scale, Inc. and American Medical Group Association (AMGA) and not on IHS GS level assignment by job description.
 - Best information would be assignment of each FTE to a GS pay level
- Limited financial data from the Portland area was available to be used. The revenue and reimbursement assumptions are based on Seattle area IHS clinics. For non-salary expenses, The Innova Group utilized financial data from its data base of various tribal programs. A range of expense drivers were created for each expense category from the data base.
 - Best information would be data from various Portland Area clinics for expenses
- It is assumed that 38.2% of all medical services visits are from patients that have no other third party coverage. 40.9% of all dental services are from patients that have no other third party coverage. The rest are a combination of third parties consisting of private insurance, Medicare, and Medicaid. These are based on the information from the IHS clinics that would be serviced by this clinic and is based on their active patient primary insurance profile.
- Provider Revenue per visit is based Seattle area IHS clinics. Ancillary services revenue per unit of service is based on Medicare weighted average billed revenue for the State of Washington for surgical services and rehab services. The other ancillary services are based on average weighted billed amounts from Intelli-Med using a national average.
 - Best information would be claims processing information from the Portland Area for these ancillary services
- Average salary rates by job function are based on averages for the State of Oregon. Medical Provider's salaries are based on the FTE mix by specialty, which is a weighted average blend of all physicians. Dentist salaries are based on an annual amount of \$150,800. Other job functions are based on the weighted average salary for the State of Oregon as published by Pay Scale, Inc for a person with five (5) years experience.
 - Best information would be assignment of each FTE to a GS pay level or the amount that would be needed to recruit that position



- Medical/pharmaceutical supplies under the primary care model assume having a full formulary of medications and dispensing from the clinic. Under the specialty care services only model, the assumption is that patients would be issued prescriptions that would be taken back to their service units to be filled. Pharmaceuticals are the largest single supply expense item.
 - Best information would be development of pharmaceutical cost for Portland area on a per visit basis

Scenarios

There are four financial scenarios that were modeled.

Scenario 1 provides for specialty care and ancillary services only. Primary care and the services that support primary care are anticipated to be provided at the service unit level.

IHS Annual Funding Amount	\$ 8,951,421
Salaries and Benefits	\$ 6,885,709
Non-Salary Expenses	\$ 2,037,739
Total Operating Expenses	\$ 8,923,448
Net Margin from IHS funding	\$ 27,973
Third Party Collections	\$ 5,259,354
Net Operating Income	\$ 5,287,327
Depreciation	\$ 1,242,683
Net Income	\$ 4,044,644

Scenario 2 provides “full” primary care, dental care, and pharmacy services in addition to specialty care and ancillary services.

IHS Annual Funding Amount	\$ 94,212,787
Salaries and Benefits	\$ 72,471,374
Non-salary Expenses	\$ 21,047,889
Total Operating Expenses	\$ 93,519,263
Net Margin from IHS funding	\$ 693,524
Third Party Collections	\$ 40,255,102
Net Operating Income	\$ 40,948,626
Depreciation	\$ 8,365,279
Net Income	\$ 32,583,347



Scenario 3 provides “essential” or “limited” primary care, dental care, and pharmacy services in addition to specialty care and ancillary services.

IHS Annual Funding Amount	\$ 55,349,095
Salaries and Benefits	\$ 42,576,227
Non-salary Expenses	\$ 12,614,688
Total Operating Expenses	\$ 55,190,915
Net Margin from IHS funding	\$ 158,180
Third Party Collections	\$ 24,659,042
Net Operating Income	\$ 24,817,222
Depreciation	\$ 5,589,987
Net Income	\$ 19,227,236

Scenario 4 provides specialty care and ancillary services using a higher capture rate of specialty referrals from primary care.

IHS Annual Funding Amount	\$ 14,620,006
Salaries and Benefits	\$ 11,246,159
Non-salary Expenses	\$ 3,394,633
Total Operating Expenses	\$ 14,640,792
Net Margin from IHS funding	\$ (20,786)
Third Party Collections	\$ 8,905,435
Net Operating Income	\$ 8,884,649
Depreciation	\$ 2,113,944
Net Income	\$ 6,770,705

Net Income is the income from clinic operations before expenses that are not related to operations or depreciation such as CHS and indirect expenses due to services provided by area or tribal offices.



Advantages/Disadvantages

Each of these scenarios carries advantages and disadvantages.

Scenario 1 (without Primary Care)

Advantages

- Avoids competing with Primary Care services at the service unit level. Collections for third party visits provided at the service unit level stay at the service unit.
- Requires less IHS funding, therefore stands a greater chance of receiving funding
- Less number of FTE's needing to be recruited and retained

Disadvantages

- Less medical and dental visits generate less third party
- Relies on referrals from service units which are located some distance away
- Large amount of native population without close primary care access

Scenario 2 (with "full" Primary Care)

Advantages

- More Primary Care visits generates more Specialty Care visits
- More visits generates more potential third party revenue
- IHS is funding primary care for an additional 31,444 patients
- More services are available that are culturally sensitive towards the Native American population
- If Specialty Care is available, primary care physicians will generate more referral visits rather than treating patients themselves
- Increase the health status of the Native American population by having services available to them

Disadvantages

- More visits generate more need for CHS dollars
- More specialization creates harder to recruit positions
- If Specialty Care is available, physicians will generate more referrals for services which in turn can increase the cost per episode of care for patients served by the system than is now being experienced by the Portland area.



Scenario 3 (with “essential” Primary Care)

Advantages

- Provides minimal primary care in order to support maximizing the specialty care visits
- More visits generates more potential third party revenue
- IHS funding requirements are less than with a fully supported primary care program
- More services are available that are culturally sensitive towards the Native American population
- Increase the health status of the Native American population by having services available to them

Disadvantages

- More visits generate more need for CHS dollars
- Creation of additional primary care resources which gives the patients the option of receiving services from outside their local primary care service unit
- More specialization creates harder to recruit positions
- Specialty Care generally is more expensive and could probably generate the need for additional diagnostic and treatment services that are not available through IHS sources

Scenario 4 (Improved capture of specialty referrals)

Advantages

- Avoids competing with Primary Care services at the service unit level. Collections for third party visits provided at the service unit level stay at the service unit.
- Requires reduced IHS funding compared to scenarios involving providing additional Primary Care; therefore stands a greater chance of receiving funding
- Less professional FTE's need to be recruited and retained and this scenario does not compete with existing service area's professional staff.
- Avoids the confusion of CHS eligibility for the urban Indian population of Seattle

Disadvantages

- Less medical and dental visits generate less third party
- Relies on referrals from service units which are located some distance away
- Large amount of native population in the Seattle area are still without close primary care access, they will need to travel to outlying service units.

**Recommendation**

Based on the financial considerations and the number of patients being served, Scenario 4 (with increased secondary care referral capture) provides greatest benefit to the native population in the Portland area and particularly those in the Seattle area. It avoids opening up the question of access for the urban Indian population in the Seattle area and the additional costs needed to provide primary care services to a population of 31,000 Native Americans. It forces primary care out to the existing service units and avoids the confusion of CHS eligibility. This option also minimizes the annual funding amount for IHS in comparison to the scenarios which include providing additional primary care resources to this urban population. Therefore, the annual funding amount provided by IHS is less, but a high level of specialty services, not traditionally found in areas without IHS acute care facilities, is developed and maintained.



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Scenario 1

Financial Projections

Seattle Clinic without Primary Care			
Total Clinic	Administrative & Support	Medical Services	Dental Services

Revenues

Ancillary

Surgical Services	\$ 2,915,932	\$ -	\$ 2,915,932	\$ -
Imaging Services	\$ 1,287,825	\$ -	\$ 1,287,825	\$ -
Rehab Services	\$ 874,482	\$ -	\$ 874,482	\$ -
Pharmacy	\$ -	\$ -	\$ -	\$ -
Laboratory	\$ 118,044	\$ -	\$ 118,044	\$ -
Eye Care	\$ -	\$ -	\$ -	\$ -
Audiology	\$ 163,740	\$ -	\$ 163,740	\$ -
Other	\$ -	\$ -	\$ -	\$ -
Total Ancillary Revenue	\$ 5,360,023	\$ -	\$ 5,360,023	\$ -

Provider Revenue

Primary Care	\$ -	\$ -	\$ -	\$ -
Specialty Care	\$ 9,301,919	\$ -	\$ 9,301,919	\$ -
Total Provider Revenue	\$ 9,301,919	\$ -	\$ 9,301,919	\$ -
Gross Patient Revenue	\$ 14,661,942	\$ -	\$ 14,661,942	\$ -

Deductions from Revenue

Ancillary

Medicare	\$ 86,296	\$ -	\$ 86,296	\$ -
Medicaid	\$ 881,574	\$ -	\$ 881,574	\$ -
HMO/PPO Managed Care	\$ 899,894	\$ -	\$ 899,894	\$ -
IHS Direct Care	\$ 2,047,529	\$ -	\$ 2,047,529	\$ -
Private Pay	\$ -	\$ -	\$ -	\$ -
Total	\$ 3,915,293	\$ -	\$ 3,915,293	\$ -

Provider

Medicare	\$ 99,493	\$ -	\$ 99,493	\$ -
Medicaid	\$ 788,282	\$ -	\$ 788,282	\$ -
HMO/PPO Managed Care	\$ 1,046,187	\$ -	\$ 1,046,187	\$ -
IHS Direct Care	\$ 3,553,333	\$ -	\$ 3,553,333	\$ -
Private Pay	\$ -	\$ -	\$ -	\$ -
Total	\$ 5,487,295	\$ -	\$ 5,487,295	\$ -

Third Party Collections (Net Revenue)	\$ 5,259,354	\$ -	\$ 5,259,354	\$ -
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Annual IHS Funding	\$ 8,951,421	\$ 8,951,421	\$ -	\$ -
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Total Operating Revenue	\$ 14,210,775	\$ 8,951,421	\$ 5,259,354	\$ -
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Portland Area Indian Health Service

Concept of Operation

Scenario 1

Financial Projections

Seattle Clinic without Primary Care

	Total Clinic	Administrative & Support	Medical Services	Dental Services
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Operating Expenses

Salaries

Provider	\$ 2,193,387	\$ -	\$ 2,193,387	\$ -
RN	\$ 632,320	\$ 395,200	\$ 237,120	\$ -
Aides	\$ 150,758	\$ -	\$ 150,758	\$ -
Tech/Specialist	\$ 258,752	\$ -	\$ 258,752	\$ -
Support	\$ 1,311,598	\$ 1,224,737	\$ 86,861	\$ -
Administrative	\$ 952,952	\$ 792,792	\$ 160,160	\$ -
Total Direct Wages	\$ 5,499,767	\$ 2,412,729	\$ 3,087,038	\$ -
Benefits	\$ 1,385,941	\$ 608,008	\$ 777,934	\$ -
Total Wages & Benefits	\$ 6,885,709	\$ 3,020,737	\$ 3,864,972	\$ -

Supplies

Medical	\$ 489,948	\$ -	\$ 489,948	\$ -
Office	\$ 28,308	\$ 18,083	\$ 10,225	\$ -
Other	\$ 5,574	\$ 4,288	\$ 1,286	\$ -
Total Supplies	\$ 523,830	\$ 22,371	\$ 501,459	\$ -

Purchased Services	\$ 69,463	\$ 1,430	\$ 68,033	\$ -
Recruitment	\$ -	\$ -	\$ -	\$ -
Bad Debt	\$ 184,077	\$ -	\$ 184,077	\$ -
Repairs & Maintenance	\$ 101,154	\$ 55,994	\$ 45,160	\$ -
Utilities	\$ 406,861	\$ 184,118	\$ 222,743	\$ -
Rent/Lease	\$ 15,000	\$ 15,000	\$ -	\$ -
Non-Income Taxes & Liability Insurance	\$ 8,951	\$ 8,951	\$ -	\$ -
Travel & Workshops	\$ 17,864	\$ 12,870	\$ 4,994	\$ -
Other Operating Expenses	\$ 710,539	\$ 447,571	\$ 262,968	\$ -
Total Operating Expenses	\$ 8,923,448	\$ 3,769,043	\$ 5,154,405	\$ -
Net Operating Income	\$ 5,287,327	\$ 5,182,378	\$ 104,948	\$ -
Depreciation	\$ 1,242,683	\$ 1,242,683	\$ -	\$ -
Net Income	\$ 4,044,644	\$ 3,939,696	\$ 104,948	\$ -
FTE's @ 85% of RRM	79.4	57.2	22.2	-
Square Feet	54,993	24,886	30,107	-



Portland Area Indian Health Service

Concept of Operation

Scenario 2

Financial Projections

Seattle Clinic with "Full" Primary Care				
Total Clinic	Administrative & Support	Medical Services	Dental Services	

Revenues

Ancillary

Surgical Services	\$ 6,785,472	\$ -	\$ 6,785,472	\$ -
Imaging Services	\$ 5,429,200	\$ -	\$ 5,429,200	\$ -
Rehab Services	\$ 1,401,916	\$ -	\$ 1,401,916	\$ -
Pharmacy	\$ 29,468,376	\$ -	\$ 29,468,376	\$ -
Laboratory	\$ 735,504	\$ -	\$ 735,504	\$ -
Eye Care	\$ 431,466	\$ -	\$ 431,466	\$ -
Audiology	\$ 371,760	\$ -	\$ 371,760	\$ -
Other	\$ -	\$ -	\$ -	\$ -
Total Ancillary Revenue	\$ 44,623,694	\$ -	\$ 44,623,694	\$ -

Provider Revenue

Primary Care	\$ 47,495,258	\$ -	\$ 27,315,630	\$ 20,179,629
Specialty Care	\$ 21,717,988	\$ -	\$ 21,717,988	\$ -
Total Provider Revenue	\$ 69,213,247	\$ -	\$ 49,033,618	\$ 20,179,629
Gross Patient Revenue	\$ 113,836,941	\$ -	\$ 93,657,312	\$ 20,179,629

Deductions from Revenue

Ancillary

Medicare	\$ 692,783	\$ -	\$ 692,783	\$ -
Medicaid	\$ 7,339,348	\$ -	\$ 7,339,348	\$ -
HMO/PPO Managed Care	\$ 7,514,853	\$ -	\$ 7,514,853	\$ -
IHS Direct Care	\$ 17,046,251	\$ -	\$ 17,046,251	\$ -
Private Pay	\$ -	\$ -	\$ -	\$ -
	\$ 32,593,235	\$ -	\$ 32,593,235	\$ -

Provider

Medicare	\$ 505,733	\$ -	\$ 505,733	\$ -
Medicaid	\$ 5,327,338	\$ -	\$ 4,155,305	\$ 1,172,033
HMO/PPO Managed Care	\$ 8,171,223	\$ -	\$ 5,531,728	\$ 2,639,495
IHS Direct Care	\$ 26,984,310	\$ -	\$ 18,730,842	\$ 8,253,468
Private Pay	\$ -	\$ -	\$ -	\$ -
	\$ 40,988,604	\$ -	\$ 28,923,607	\$ 12,064,996

Third Party Collections (Net Revenue)	\$ 40,255,102	\$ -	\$ 32,140,469	\$ 8,114,632
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Annual IHS Funding	\$ 94,212,787	\$ 94,212,787	\$ -	\$ -
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Total Operating Revenue	\$ 134,467,888	\$ 94,212,787	\$ 32,140,469	\$ 8,114,632
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Portland Area Indian Health Service

Concept of Operation

Scenario 2

Financial Projections

Seattle Clinic with "Full" Primary Care				
Total Clinic	Administrative & Support	Medical Services	Dental Services	

Operating Expenses

Salaries

Provider	\$ 21,260,616	\$ -	\$ 16,284,216	\$ 4,976,400
RN	\$ 9,006,348	\$ 5,074,368	\$ 2,430,480	\$ 1,501,500
Aides	\$ 3,806,650	\$ -	\$ 2,449,824	\$ 1,356,826
Tech/Specialist	\$ 11,773,216	\$ 925,038	\$ 10,848,178	\$ -
Support	\$ 8,329,951	\$ 6,433,490	\$ 1,609,820	\$ 286,641
Administrative	\$ 3,707,704	\$ 3,387,384	\$ 240,240	\$ 80,080
Total Direct Wages	\$ 57,884,484	\$ 15,820,280	\$ 33,862,758	\$ 8,201,446
Benefits	\$ 14,586,890	\$ 3,986,711	\$ 8,533,415	\$ 2,066,764
Total Wages & Benefits	\$ 72,471,374	\$ 19,806,991	\$ 42,396,173	\$ 10,268,211

Supplies

Medical	\$ 6,664,011	\$ -	\$ 5,236,798	\$ 1,427,213
Office	\$ 335,505	\$ 102,900	\$ 66,650	\$ 165,955
Other	\$ 54,842	\$ 22,295	\$ 28,564	\$ 3,983
Total Supplies	\$ 7,054,358	\$ 125,195	\$ 5,332,012	\$ 1,597,151

Purchased Services	\$ 2,134,297	\$ 12,005	\$ 462,742	\$ 1,659,550
Recruitment	\$ -	\$ -	\$ -	\$ -
Bad Debt	\$ 1,408,929	\$ -	\$ 1,124,916	\$ 284,012
Repairs & Maintenance	\$ 636,621	\$ 244,013	\$ 327,773	\$ 64,836
Utilities	\$ 2,738,806	\$ 802,356	\$ 1,616,661	\$ 319,788
Rent/Lease	\$ 25,000	\$ 25,000	\$ -	\$ -
Non-Income Taxes & Liability Insurance	\$ 141,319	\$ 141,319	\$ -	\$ -
Travel & Workshops	\$ 185,164	\$ 77,175	\$ 86,299	\$ 21,690
Other Operating Expenses	\$ 6,723,394	\$ 4,710,639	\$ 1,607,023	\$ 405,732
Total Operating Expenses	\$ 93,519,263	\$ 25,944,693	\$ 52,953,600	\$ 14,620,970
Net Operating Income	\$ 40,948,625	\$ 68,268,093	\$ (20,813,130)	\$ (6,506,338)
Depreciation	\$ 8,365,279	\$ 8,365,279	\$ -	\$ -
Net Income	\$ 32,583,347	\$ 59,902,815	\$ (20,813,130)	\$ (6,506,338)
<i>FTE's @ 85% RRM</i>	<i>823.0</i>	<i>343.0</i>	<i>383.6</i>	<i>96.4</i>
<i>Square Feet</i>	<i>370,189</i>	<i>108,450</i>	<i>218,515</i>	<i>43,224</i>



Portland Area Indian Health Service

Concept of Operation

Scenario 3

Financial Projections

Seattle Clinic with "Essential" Primary Care			
Total Clinic	Administrative & Support	Medical Services	Dental Services

Revenues

Ancillary

Surgical Services	\$ 4,813,564	\$ -	\$ 4,813,564	\$ -
Imaging Services	\$ 3,463,600	\$ -	\$ 3,463,600	\$ -
Rehab Services	\$ 851,640	\$ -	\$ 851,640	\$ -
Pharmacy	\$ 17,961,108	\$ -	\$ 17,961,108	\$ -
Laboratory	\$ 451,688	\$ -	\$ 451,688	\$ -
Eye Care	\$ 236,250	\$ -	\$ 236,250	\$ -
Audiology	\$ 271,920	\$ -	\$ 271,920	\$ -
Other	\$ -	\$ -	\$ -	\$ -
Total Ancillary Revenue	\$ 28,049,770	\$ -	\$ 28,049,770	\$ -

Provider Revenue

Primary Care	\$ 25,913,005	\$ -	\$ 14,909,998	\$ 11,003,008
Specialty Care	\$ 15,853,829	\$ -	\$ 15,853,829	\$ -
Total Provider Revenue	\$ 41,766,835	\$ -	\$ 30,763,827	\$ 11,003,008
Gross Patient Revenue	\$ 69,816,605	\$ -	\$ 58,813,597	\$ 11,003,008

Deductions from Revenue

Ancillary

Medicare	\$ 451,601	\$ -	\$ 451,601	\$ -
Medicaid	\$ 4,613,402	\$ -	\$ 4,613,402	\$ -
HMO/PPO Managed Care	\$ 4,709,276	\$ -	\$ 4,709,276	\$ -
IHS Direct Care	\$ 10,715,012	\$ -	\$ 10,715,012	\$ -
Private Pay	\$ -	\$ -	\$ -	\$ -
Total	\$ 20,489,291	\$ -	\$ 20,489,291	\$ -

Provider

Medicare	\$ 329,050	\$ -	\$ 329,050	\$ -
Medicaid	\$ 3,188,009	\$ -	\$ 2,607,050	\$ 580,959
HMO/PPO Managed Care	\$ 4,899,201	\$ -	\$ 3,460,008	\$ 1,439,193
IHS Direct Care	\$ 16,252,012	\$ -	\$ 11,751,782	\$ 4,500,230
Private Pay	\$ -	\$ -	\$ -	\$ -
Total	\$ 24,668,271	\$ -	\$ 18,147,889	\$ 6,520,382

Third Party Collections (Net Revenue)	\$ 24,659,042	\$ -	\$ 20,176,417	\$ 4,482,625
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Annual IHS Funding	\$ 55,349,095	\$ 55,349,095	\$ -	\$ -
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Total Operating Revenue	\$ 80,008,137	\$ 55,349,095	\$ 20,176,417	\$ 4,482,625
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Portland Area Indian Health Service

Concept of Operation

Scenario 3

Financial Projections

Seattle Clinic with "Essential" Primary Care				
Total Clinic	Administrative & Support	Medical Services	Dental Services	

Operating Expenses

Salaries

Provider	\$ 11,223,083	\$ -	\$ 8,659,483	\$ 2,563,600
RN	\$ 4,661,696	\$ 2,877,056	\$ 1,264,640	\$ 520,000
Aides	\$ 2,449,824	\$ -	\$ 1,809,101	\$ 640,723
Tech/Specialist	\$ 7,749,622	\$ 679,224	\$ 7,070,398	\$ -
Support	\$ 5,023,450	\$ 3,604,723	\$ 1,140,772	\$ 277,955
Administrative	\$ 2,898,896	\$ 2,258,256	\$ 560,560	\$ 80,080
Total Direct Wages	\$ 34,006,571	\$ 9,419,259	\$ 20,504,954	\$ 4,082,358
Benefits	\$ 8,569,656	\$ 2,373,653	\$ 5,167,248	\$ 1,028,754
Total Wages & Benefits	\$ 42,576,227	\$ 11,792,913	\$ 25,672,203	\$ 5,111,112

Supplies

Medical	\$ 3,967,670	\$ -	\$ 3,189,478	\$ 778,193
Office	\$ 138,672	\$ 30,780	\$ 17,404	\$ 90,488
Other	\$ 18,568	\$ 10,901	\$ 3,270	\$ 4,398
Total Supplies	\$ 4,124,910	\$ 41,681	\$ 3,210,152	\$ 873,078

Purchased Services	\$ 1,191,699	\$ 4,990	\$ 281,834	\$ 904,875
Recruitment	\$ -	\$ -	\$ -	\$ -
Bad Debt	\$ 863,066	\$ -	\$ 706,175	\$ 156,892
Repairs & Maintenance	\$ 423,004	\$ 160,171	\$ 223,554	\$ 39,279
Utilities	\$ 1,823,032	\$ 526,670	\$ 1,102,628	\$ 193,735
Rent/Lease	\$ 20,000	\$ 20,000	\$ -	\$ -
Non-Income Taxes & Liability Insurance	\$ 55,349	\$ 55,349	\$ -	\$ -
Travel & Workshops	\$ 113,220	\$ 44,910	\$ 56,475	\$ 11,835
Other Operating Expenses	\$ 4,000,407	\$ 2,767,455	\$ 1,008,821	\$ 224,131
Total Operating Expenses	\$ 55,190,915	\$ 15,414,138	\$ 32,261,840	\$ 7,514,936
Net Operating Income	\$ 24,817,222	\$ 39,934,957	\$ (12,085,424)	\$ (3,032,311)
Depreciation	\$ 5,589,987	\$ 5,589,987	\$ -	\$ -
Net Income	\$ 19,227,236	\$ 34,344,970	\$ (12,085,424)	\$ (3,032,311)
<i>FTE's @ 85% RRM</i>	<i>503.2</i>	<i>199.6</i>	<i>251.0</i>	<i>52.6</i>
<i>Square Feet</i>	<i>246,409</i>	<i>71,187</i>	<i>149,036</i>	<i>26,186</i>



Portland Area Indian Health Service

Concept of Operation

Scenario 4

Financial Projections

Seattle Clinic without Primary Care			
Total Clinic	Administrative & Support	Medical Services	Dental Services

Revenues

Ancillary

Surgical Services	\$ 4,942,948	\$ -	\$ 4,942,948	\$ -
Imaging Services	\$ 2,335,375	\$ -	\$ 2,335,375	\$ -
Rehab Services	\$ 1,536,712	\$ -	\$ 1,536,712	\$ -
Pharmacy	\$ -	\$ -	\$ -	\$ -
Laboratory	\$ 198,360	\$ -	\$ 198,360	\$ -
Eye Care	\$ -	\$ -	\$ -	\$ -
Audiology	\$ 274,860	\$ -	\$ 274,860	\$ -
Other	\$ -	\$ -	\$ -	\$ -
Total Ancillary Revenue	\$ 9,288,255	\$ -	\$ 9,288,255	\$ -

Provider Revenue

Primary Care	\$ -	\$ -	\$ -	\$ -
Specialty Care	\$ 15,610,957	\$ -	\$ 15,610,957	\$ -
Total Provider Revenue	\$ 15,610,957	\$ -	\$ 15,610,957	\$ -
Gross Patient Revenue	\$ 24,899,212	\$ -	\$ 24,899,212	\$ -

Deductions from Revenue

Ancillary

Medicare	\$ 149,541	\$ -	\$ 149,541	\$ -
Medicaid	\$ 1,527,658	\$ -	\$ 1,527,658	\$ -
HMO/PPO Managed Care	\$ 1,559,405	\$ -	\$ 1,559,405	\$ -
IHS Direct Care	\$ 3,548,113	\$ -	\$ 3,548,113	\$ -
Private Pay	\$ -	\$ -	\$ -	\$ -
	\$ 6,784,717	\$ -	\$ 6,784,717	\$ -

Provider

Medicare	\$ 166,975	\$ -	\$ 166,975	\$ -
Medicaid	\$ 1,322,935	\$ -	\$ 1,322,935	\$ -
HMO/PPO Managed Care	\$ 1,755,764	\$ -	\$ 1,755,764	\$ -
IHS Direct Care	\$ 5,963,385	\$ -	\$ 5,963,385	\$ -
Private Pay	\$ -	\$ -	\$ -	\$ -
	\$ 9,209,059	\$ -	\$ 9,209,059	\$ -

Third Party Collections (Net Revenue)	\$ 8,905,435	\$ -	\$ 8,905,435	\$ -
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Annual IHS Funding	\$ 14,620,006	\$ 14,620,006	\$ -	\$ -
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Total Operating Revenue	\$ 23,525,441	\$ 14,620,006	\$ 8,905,435	\$ -
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Portland Area Indian Health Service

Concept of Operation

Scenario 4

Financial Projections

Seattle Clinic without Primary Care			
Total Clinic	Administrative & Support	Medical Services	Dental Services

Operating Expenses

Salaries

Provider	\$ 4,405,440	\$ -	\$ 4,405,440	\$ -
RN	\$ 869,440	\$ 395,200	\$ 474,240	\$ -
Aides	\$ 527,654	\$ -	\$ 527,654	\$ -
Tech/Specialist	\$ 646,880	\$ -	\$ 646,880	\$ -
Support	\$ 1,572,180	\$ 1,441,889	\$ 130,291	\$ -
Administrative	\$ 960,960	\$ 800,800	\$ 160,160	\$ -
Total Direct Wages	\$ 8,982,555	\$ 2,637,889	\$ 6,344,666	\$ -
Benefits	\$ 2,263,604	\$ 664,748	\$ 1,598,856	\$ -
Total Wages & Benefits	\$ 11,246,159	\$ 3,302,637	\$ 7,943,521	\$ -

Supplies

Medical	\$ 822,255	\$ -	\$ 822,255	\$ -
Office	\$ 47,528	\$ 30,361	\$ 17,167	\$ -
Other	\$ 10,015	\$ 7,704	\$ 2,311	\$ -
Total Supplies	\$ 879,799	\$ 38,065	\$ 841,733	\$ -

Purchased Services	\$ 115,796	\$ 1,620	\$ 114,176	\$ -
Recruitment	\$ -	\$ -	\$ -	\$ -
Bad Debt	\$ 311,690	\$ -	\$ 311,690	\$ -
Repairs & Maintenance	\$ 163,765	\$ 70,341	\$ 93,424	\$ -
Utilities	\$ 692,086	\$ 231,292	\$ 460,794	\$ -
Rent/Lease	\$ 15,000	\$ 15,000	\$ -	\$ -
Non-Income Taxes & Liability Insurance	\$ 14,620	\$ 14,620	\$ -	\$ -
Travel & Workshops	\$ 25,605	\$ 14,580	\$ 11,025	\$ -
Other Operating Expenses	\$ 1,176,272	\$ 731,000	\$ 445,272	\$ -
Total Operating Expenses	\$ 14,640,792	\$ 4,419,156	\$ 10,221,636	\$ -
Net Operating Income	\$ 8,884,649	\$ 10,200,850	\$ (1,316,201)	\$ -
Depreciation	\$ 2,113,944	\$ 2,113,944	\$ -	\$ -
Net Income	\$ 6,770,705	\$ 8,086,906	\$ (1,316,201)	\$ -
FTE's @ 85% of RRM	113.8	64.8	49.0	-
Square Feet	93,545	31,263	62,283	-



Portland Area Indian Health Services

Financial Assumptions

Assumptions

Administrative	Medical	Dental
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Volumes

These were determined based on HSP guidelines using calculated user populations.

Annual IHS Funding Amount

This is calculated using the weighted average total salary and benefits for the entire facility for each scenario and multiplying that by 85% of the RRM projected FTE's and then multiplying the salary amount by 30% to achieve the overhead factor. The average facility salary for each scenario is:	1-\$86,727
	2-\$88,062
	3-\$84,610
	4-\$98,823

Revenue factors

Medical Providers per visit revenue was based on Washington State data reports generated by Portland area office for the Seattle area facilities.	Primary Care-\$218.42	Specialty Care-\$332.25
Dental Providers per visit revenue was based on Washington State data reports generated by Portland area office for the Seattle area facilities.	Primary Care-\$303.99	Specialty Care-\$274.00
Surgical Service per case revenue used the Medicare average billed amount for the State of Washington for free-standing Ambulatory Surgical Centers.	\$ 2,396.00	
Imaging Services per exam revenue used the Medicare average billed amount for the State of Washington for a weighted Diagnostic Imaging exams.	\$ 175.00	
Rehab services per visit revenue used average billed amounts from OP rehab service entities in the Innova Group data bank.	\$ 47.00	
Pharmacy services per script revenue used average billed amounts from facilities based Pharmacies contained in The Innova Group data base.	\$ 12.00	
Laboratory services per billable revenue used the averaged weighted billed amounts from Intelli-Med data which uses the average nationally.	\$ 4.00	
Eye Care revenue per visit was based on the averaged weighted billed amounts from Intelli-Med data which uses the average nationally.	\$ 42.00	
Audiology revenue per visit was based on the averaged weighted billed amounts from Intelli-Med data which uses the average nationally.	\$ 60.00	

Payor Utilization Rates

Medicare is the percentage of total active patients with Medicare as their primary insurance from clinics RMS system associated with this Seattle clinic.	2.8%	0.0%
Medicaid is the percentage of total active patients with Medicaid as their primary insurance from clinics RMS system associated with this Seattle clinic.	26.4%	26.4%
Private Insurance is the percentage of total active patients with Private Insurance as their primary insurance from clinics RMS system associated with this Seattle clinic .	32.6%	32.6%
IHS is the percentage of total active native patients with no type of insurance coverage from clinics RMS system associated with this Seattle clinic .	38.2%	41.0%

Payor Reimbursement %

Providers

Medicare percentage for provider is based on Medicare average discount for the State of Washington on a per visit basis.	38.2%	0.0%
Medicaid percentage for provider is based on Medicaid average discount for clinics associated with this clinic.	26.4%	20.0%
Private Insurance percentage for provider is based on private insurance average discount for clinics associated with this clinic.	34.5%	40.0%
IHS assumes NO reimbursement from outside sources for this class of patients.	100.0%	100.0%



Portland Area Indian Health Services

Financial Assumptions

Assumptions

	Administrative	Medical	Dental
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Ancillary

Medicare percentage for ancillary services is based on Medicare average weighted discount for the State of Washington on a per visit basis.		57.5%	0.0%
Medicaid percentage for ancillary services based on Medicaid weighted average discount for ancillary service from The Innova Group data base.		62.3%	0.0%
Private Insurance percentage for ancillary services is based on private insurance weighted average discount for clinics in The Innova Group data base this clinic.		51.5%	0.0%
IHS assumes NO discount from outside sources for this class of patients.		100.0%	0.0%

Salaries

Provider salaries are based on a physician salary rates by specialty published by the American Medical Group Associates for 2008 using 2007 data; and a weighted average based on FTE RRM requirements by physician type. Dental provider salary is based on average mid-range salary for a general dentist in Oregon as published by Payscale, Inc.		1-\$354,054 2-\$264,789 3-\$276,665 4-\$352,426		\$ 150,800.00
RN and Dept manager's salaries are based on Oregon average physician practice RN salary for an RN having 5 years experience as published by Payscale, Inc.	\$ 79,040.00	\$ 79,040.00		
Hygienist salaries are based on Oregon average Hygienist salary having 5 years experience as published by Payscale, Inc.				\$ 65,000.00
Medical/Dental Assistants are based on Oregon average assistant's salary having 5 years experience as published by Payscale, Inc.	\$ 37,689.60	\$ 37,689.60	\$ 37,689.60	
Technicians and Specialists are based on a weighted average for Lab Technicians, Pharmacists, X-ray Technicians, Physical Therapists, Occupational Therapists, Wellness Trainers, etc. based on Oregon average for positions having 5 years experience as published by Payscale, Inc.	\$ 64,688.00	\$ 64,688.00		
Support salaries are based on a weighted average for clerical support, billers, medical records clerks, maintenance workers, HVAC technicians, janitorial workers, based on Oregon average for these positions having 5 years experience as published by Payscale, Inc.	\$ 28,953.60	\$ 28,953.60	\$ 28,953.60	
Administrative salaries are based on a weighted average for medical clinic administrators with more than 50 physicians, lead pharmacist, lead physical therapist, lead physician clinic RN, fiscal directors, etc. based on Oregon average for these positions having 5 years experience as published by Payscale, Inc.	\$ 80,080.00	\$ 80,080.00	\$ 80,080.00	

Benefits

Benefits is based on the average percentage of total salaries as calculated from The Innova Group data bases of various IHS clinics.	25.2%	25.2%	25.2%	
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Supplies

Medical supplies is based on average cost per provider visit as published by MGMA and using The Innova Group data base of various IHS clinics.	\$ -	\$ 27.50	\$ 21.50	
Office supplies is based on average cost per FTE as published by MGMA and using The Innova Group data base of various IHS clinics.	\$ 0.62	\$ 0.35	\$ 2.50	
Other supplies is based on average cost per FTE as published by MGMA and using The Innova Group data base of various IHS clinics	\$ 0.50	\$ 0.15	\$ 0.12	

Purchased Services

Purchased services is based on average cost per provider visit as published by MGMA and using The Innova Group data base of various IHS clinics for Medical and Dental and on a per FTE bases for Administrative	\$ 25.00	\$ 2.43	\$ 25.00	
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Bad Debt

This is based on the average of net revenue and accounts for patient's co-insurance and deductibles for patients with primary coverage from a billable third party. This average is based on The Innova Group data base of various IHS clinics.		3.5%	3.5%	
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Portland Area Indian Health Services

Financial Assumptions

Assumptions

	Administrative	Medical	Dental
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Repairs & Maintenance

This is based on the cost for repairs and maintenance per square foot as calculated from various clinics that are less than 10 years old from The Innova Group data base of various IHS clinics

	\$ 1.50	\$ 1.50	\$ 1.50
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Utilities

This is based on the cost for utilities per square foot as calculated from various clinics that are less than 10 years old from The Innova Group data base of various IHS clinics

	\$ 2.72	\$ 2.72	\$ 2.72
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Rent & Lease

This is based on lump sum estimated based on the services offered and the number of FTE's present in the clinic. This assumes some of the equipment will be leased such as copiers, mail machines, and some IS programs. This estimated is based on similar size clinics in The Innova Group data base of IHS clinics

	Scenario 1, 4	Scenario 2	Scenario 3
	\$ 15,000.00	\$ 20,000.00	\$ 25,000.00

Regulatory Fees, Taxes, Insurance

This expense category is based on a percent of billable revenue as calculated from other IHS clinics in The Innova Group data base.

	0.1%		
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Travel & Workshops

Travel & Workshops is based on average cost per FTE as published by MGMA and using The Innova Group data base of various IHS clinics

	\$ 225.00	\$ 225.00	\$ 225.00
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Other Operating Expenses

This expense category is based on a percent of collected revenue as calculated from other IHS clinics in The Innova Group data base.

	5.0%	5.0%	5.0%
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Depreciation

This expense category is based on a project life of 30 years for building, 15 years for fixed equipment, 10 years for major moveable which includes imaging equipment, and 5 years for minor equipment. To estimate the project cost, the model for a health center using the IHS Quick Budget Generator-May 2009 which excluding land and site development costs was used. The project cost being depreciated is:

	Scenario 1	Scenario 2	Scenario 3
			\$121,332,715
	\$ 26,972,798	\$ 181,571,436	Scenario 4 \$ 45,883,849



Critical Assumptions

This page summarizes all critical assumptions that drive the concept of operations. The assumption, its measure, its source, and its capacity for adjustment, are all identified.

Assumption	Measure	Source	Adjustable?
Regional Populations Served	Yakama, Quileute, Neah Bay, Lower Elwha, Hoh, Jamestown S'Klallum, Skokomish, Chehalis, Squaxin Island, Nisqually, Quinault, Shoalwater Bay, Puyallup, Muckleshoot, SIHB, Port Gamble, Suquamish, Snoqualmie, Samish, Stillaguamish, Sauk-Suiattle, Lummi, Tulalip, Swinomish, Upper Skagit, Nooksack	The Portland Area Health Services Master Plan	Perhaps, though there are geographic factors driving population groupings for regional care.
Projected Users in 2015	61,219	HSP	No.
Market Share of Projected Users	70.6% (Supported by aggressive utilization of Telemedicine)	Market Erosion Analysis in this Report	Yes - pending stakeholder buy-in.
Market Erosion by Distance	100% of the market eroding by 7% per driving time distance category to a minimum of 79%.	Market Erosion Analysis in this Report	Yes - pending stakeholder buy-in.
Market Erosion by Alternative Care	High Reliant users will drive by all alternative care. Moderate and Low Reliant users will drive by up to 3 alternative care options with varying degrees of impact: ranging from an eroded market of 80% down to 40%.	Market Erosion Analysis in this Report	Yes - pending stakeholder buy-in.
Primary Care User Population	Three measures: 0 for Scenario 1 and 4, 31,444 for Scenario 2, and 17,145 for Scenario 3	HSP and analysis of unserved service population found in this report	Perhaps, though reducing the Primary Care User Population based below Option 3 begins to deteriorate desired services.
Projected Regional Services	See Projected Services in this report.	HSP	Perhaps, though the grouping of these services grows out of the Health Services Master Plan and is natural.
Financials	Annual IHS Funding Amount, Revenues per service, costs per service, salaries, etc.	Financial Snapshot section of this report.	Yes - pending stakeholder buy-in and defensible assumptions driving analysis



Demonstration Project Recommendation

The recommendation to IHS to fund a Demonstration Project for Regional Specialty Referral Centers is based on tribal need for better access to secondary care, the need for reliable metrics that can only emerge from such a center fully functioning, as well as clear and repeated language embedded in recent IHS reform documentation. Comments such as those below strengthen the appropriateness of what is proposed by this report.

- *Forces acting over decades are inexorably shaping America's healthcare landscape. Wide-ranging forces such as demographic trends (aging and sedentary living habits), expanding medical technology and practice, and fundamental economic forces generated by rising prices are driving healthcare change across the board, including change in our system.*
- *Medically necessary services are restricted, deferred or unavailable*
- *Our organizational configuration has changed little in 50 years. We tend to look within traditional geographic and organization spheres for solutions rather than across and among them*
- *Rising costs of advanced specialty care consumes ever more \$ that would otherwise expand other services*
- *The future of our health system requires continuing evolution and adaptation to historic and emerging health challenges. Our vision is to work in partnership with Tribal governments; Indian people; and Federal, State, and local governments to respond in every way possible to preserve and improve our health system for future generations of Indian people.*
- *Intermediate services would be delivered through regional/in-network referral facilities that can provide high quality care efficiently.*
- *The future of our health system requires continuing evolution and adaptation to historic and emerging health challenges. Our vision is to work in partnership with tribal governments; Indian people; and federal, state, and local governments to respond in every way possible to preserve and improve our health system for future generations of Indian people.*

However, that being said, there remained the dilemma of which model should be recommended and why. A proposal must consider the need, opportunity, and risks. Four different recommendations were possible, each with positive and negative aspects to consider. In addition, the well founded concerns of IHS headquarters needed due consideration.

The table on the following page summarizes the scenarios in terms of...

- A brief description
- Why that scenario should be recommended
- Why that scenario should not be recommended
- The projected number of Full Time Equivalents (FTE), IHS Annual Funding Amount, Building Gross Square Meters (BGSM), and Project Cost (construction and equipment, does not include cost of land)

Finally, the recommendation for the best scenario is identified (also found in the executive summary).



#	Description	Why?	Why Not?	FTEs	Annual Funding Amount	BGSM	Project Cost
1	Specialty Diagnostic Treatment and Ambulatory Surgery <u>only</u>	This would provide what Portland originally desired. It does not risk additional resource requirements for serving a potentially significant Primary Care user base.	The risks of opening and operating such a center without a primary care user base are unknown but real. <i>What are the chances of dispersed populations not coming to the center for care?</i>	93.4	\$8,951,421	5,119.2	\$26,972,798
2	Specialty Diagnostic Treatment and Ambulatory Surgery <u>plus unstricted</u> Primary Care for all anticipated users	This would address concerns expressed by IHS HQ, increasing the likelihood of necessary facility traffic, <u>without constriction</u> , to support specialty care, diagnostic and ambulatory surgery services.	The risks of funding a Primary Care user base of this size in an untested urban environment could present a huge drain on already strained direct care resources and cause over-utilization of projected specialty care resources if dispersed users show up as or more than anticipated.	968.2	\$94,212,787	34,391.7	\$181,571,436
3	Specialty Diagnostic Treatment and Ambulatory Surgery <u>plus essential</u> Primary Care for essential specialty services support	This would address concerns expressed by IHS HQ, increasing the likelihood of necessary traffic <u>solely</u> to support specialty care, diagnostic and ambulatory surgery services, <u>while lowering the risk of new resources requirements</u> to serve a potentially significant Primary Care user base.	Constricting Primary Care prior to "opening the doors" may create a frustrated potential user population and immediate political challenges for increasing direct care services and facility expansion.	592.0	\$55,349,095	22,892.2	\$121,332,715
4	Specialty Diagnostic Treatment and Ambulatory Surgery <u>only with increased market share</u>	This would provide what Portland originally desired while addressing the need for a reliable and significant Primary Care user population base within close geographical proximity. It also utilizes a more robust market share supported by aggressive telemedicine utilization	There is no actual primary care user base planned for "in-house". <i>Are the assumptions concerning existing PSA users within 60 minutes travel time utilizing this facility accurate?</i>	133.9	\$14,620,006	8,690.6	\$45,883,849



Recommendation

The PAFAC recommends IHS fund a Demonstration Project in Seattle Washington (Portland Area) to test the viability of Regional Specialty Referral Centers for improved access to secondary care for AI/ANs and gather necessary, and presently unavailable, data to further inform planning metrics/thresholds for the future benefit of regional secondary care for all IHS Areas. This Demonstration Project and its findings will ultimately inform the development of appropriate and supportable adaptations to the existing HFCPS for more effective scoring of such facility projects.

The PAFAC recommends Scenario 4 from this report for the Demonstration Project. This scenario provides the necessary specialty/diagnostic and ambulatory surgery care for users from the dispersed populations it is intended to serve. It also relies on a projected Primary Care user population base in the Seattle market of approximately 24,000, representing 7 existing Primary Service Areas within 60 minutes travel time, and the aggressive use of Telemedicine to increase market capture of distant specialty care users.

In acknowledgement of the distant specialty care users who fall outside the Seattle market, and in an effort to improve access to specialty care for all eligible users in the Portland Area, the PAFAC conceives of the Demonstration Project as "Phase 1" of a 3-phased plan, or the first of 3 regional specialty care facilities. In this plan, one specialty care facility would serve each Region (as identified in the Portland Area Health Services Master Plan). The PAFAC envisions these 3 specialty care facilities operating as a network or system, capitalizing on the efficiencies of telemedicine. In this way, the Demonstration Project (or Phase I) will serve all eligible users until Phases II and III may be implemented.

Population Threshold

Scenario 4 provides the minimum specialty and diagnostic services supportable by the HSP and needed by the dispersed populations it is intended to serve. HSP planning thresholds identify the following population requirements for each line of care.

Specialty Care	Provider Threshold	Workload Threshold	Population Threshold	Minimum
Medical Specialties				
Cardiologist	1.25	3,251	40,231	2.0
Dermatologist	0.70	2,926	30,361	1.0
Neurologist	0.70	1,680	42,957	1.0
Other Medical Specialist		2 exam rooms minimum until >4 physicians		
Surgical Specialties				
General Surgeon	1.25	2,048	28,800	2.0
Ophthalmologist	0.70	2,601	14,876	1.0
Orthopedist	1.25	3,483	14,876	2.0
Other Surgical Specialist		2 exam rooms minimum until >3 physicians		
Otolaryngologist	0.70	1,950	29,439	1.0
Urologist	1.25	3,483	62,162	2.0

A user base of about 43,000 appears to be the threshold for desirable services IHS would support and Portland Regional Users require (those shown above with the exception of urology).



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Market Erosion

One of the critical questions in planning for a regional center is simply this: “who can be counted on to come?” In other words, what market share should be planned for? Planning for an IHS or tribal ambulatory or inpatient facility typically uses the Health Systems Planning (HSP) user population report as a basis. This user population report is generated on past clinic users* projected toward an appropriate planning year and grown in proportion to the service or census ANAI population.

Anticipating how many users might show up for specialty care services at a regional center, however, is problematic because there is no common utilization history from which to project how dispersed rural populations might access specialty care at a common point. As a result, a **Market Erosion Calculation Table** was created to help answer that question. It integrates the following components:

- Current user data by payor by Service Unit or Primary Service Area (PSA) utilized to create a potential market picture by payor (Uneroded Market)
- Assumptions concerning how distance users must travel to access regional care will affect the percentage that should be planned for (Market Erosion by Distance)
- Assumptions concerning how alternative care might erode the percentage of users that might travel to regional care (Market Erosion by Competitor)
- A resulting blended eroded market share, represented as a percentage of all users from dispersed populations potentially receiving care at a regional that should actually be planned for (Market Share)

Data from the Portland Area IHS Office forms the basis of market share calculation. RPMS data detailing CHSDA and Total Users by payor from 77% (34 of 44) of the IHS/tribally run facilities in the Portland Area was received and utilized. The following example shows the format of the raw data.

Users by Payor designation are shown as part of either “All Users” or “CHSDA Users”. For example, Colville has 959 Direct Care Only Active Total Users and 535 Direct Care Only Active

“Other Eligibility” represents the status of “pending” or “ineligible” users

Colville			No 3P Coverage	W/in CHSDA	w/3P Coverage	W/in CHSDA
Medicaid Only	1826	Non Indian Active Users	39	26	49	26
Private Ins Only	1478				4246	3346
Medicare A Only	36	CHS Eligibile Active Users	1999	1599	3246	2688
Medicare B Only	1	Direct Only Active Users	959	535	1000	658
Medicare Part A & B Only	257	Other Eligibility	12	8	6	4
Medicare Part D	204	Totals	2970	2142	4252	3350
Medicaid & Medicare	44					
Medicaid & Private Ins	298					
Medicare & Private Ins	102					
Medicaid, Medicare, & Private Ins	2					
Total	4248					

Third Party Payors are stratified by type. The Total at the bottom of the table to the left essentially corresponds with the Total “All Users” w/3P coverage in the table above. Medicaid users are identified and shown as a % in the **Market Erosion Calculation Table** (highlighted in bright yellow on next page).

The Market Erosion Calculation Table, shown in an abbreviated form, is found on the following three pages. Green shading indicates the Service Units/PSAs for which supporting data was acquired. Source data is not shown on this version to allow ease of reading. Step by step table explanations are found following the table itself. The unabbreviated table is found in the appendices of this report.

* A “user” is an AI/AN active registrant who has utilized healthcare services at the PSA in the last 3 years. This is not the same as all past clinic users. Rather, it identifies only “active” patients or users.



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Portland Area Indian Health Service

Market Erosion

Market Erosion Calculation Table (Abbreviated)

Service Area	Market %			Entry	Uneroded Market			Regional Center Location	SU/PSA Drive Time to RC (in minutes)	Market Erosion by Distance						Sub Market Erosion by Competitors			Market Share									
	H Reliance	M Reliance	L Reliance	CHSDA	H Reliance	M Reliance	L Reliance			=42+43+45+46		=42+44+46		=51+52+54+55			=51+53+56											
	Direct Care Only No 3P	Direct Care, CHS	Direct Care, CHS, 3P	Total Users (or)	Direct Care Only No 3P	Direct Care, CHS	Direct Care, CHS, 3P			Direct Care Only No 3P	Direct Care, CHS (No Choice)	Direct Care, CHS (Choice)	Direct Care, CHS, 3P (Medicaid Only)	Direct Care, CHS, 3P (Medicaid Reduced)	Direct Care, CHS, 3P	M Reliance No Choice	M Reliance Choice	# of Alt Care in route (Sec or Trty)	Direct Care Only No 3P	Direct Care, CHS (No Choice)	Direct Care, CHS (Choice)	Direct Care, CHS, 3P (Medicaid Only)	Direct Care, CHS, 3P (Medicaid Reduced)	Direct Care, CHS, 3P	M Reliance - CHS No Choice & Medicaid Only	M Reliance - Choice		
	All/CHSDA Blended %	All/CHSDA Blended %	All/CHSDA Blended %	CHSDA Users	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage			w/out 3rd Party	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage	w 3rd party Coverage	w 3rd party Coverage	Net Users	Net Users		w/out 3rd Party	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage	w 3rd party Coverage	w 3rd party Coverage	Total Users	% of User Pop	Total Users	% of User Pop
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
Coeur D'Alene Service Unit*				0				Spokane, WA							0	0								0	0.0%	0	0.0%	
Benewah Medical Center*				0				Spokane, WA	61						0	0	0							0	0.0%	0	0.0%	
Colville Service Unit	11.5%	28.4%	59.9%	5,492	632	1,560	3,287	Spokane, WA	122	544	1,341	1,341	715	2,212	2,827	4,812	4,712	0	544	1,341	1,341	715	2,212	2,827	4,812	87.6%	4,712	85.8%
Inchelium - Health Clinic				0				Spokane, WA	130							0	0	0							0	0.0%	0	0.0%
Nespelem - Colville Health Center				0				Spokane, WA	122							0	0	0							0	0.0%	0	0.0%
Omak - Dental Facility				0				Spokane, WA	166							0	0	0							0	0.0%	0	0.0%
Keller - Keller Health Station				0				Spokane, WA	165							0	0	0							0	0.0%	0	0.0%
Fort Hall Service Unit				0				Spokane, WA	471							0	0	1							0	0.0%	0	0.0%
NW Band of Shoshone				0				Spokane, WA	480							0	0	2							0	0.0%	0	0.0%
Fort Hall - Not-tsoo Gah-nee Health Center	20.8%	30.2%	48.7%	6,528	1,355	1,970	3,179	Spokane, WA	471	1,070	1,556	1,556	131	2,408	2,511	5,165	5,138	1	1,070	1,556	1,401	131	1,926	2,009	4,684	71.7%	4,480	68.6%
Klamath Service Unit*	13.4%	22.9%	61.8%	3,086	413	707	1,906	Portland, OR	274	326	558	558	381	1,205	1,506	2,471	2,391	4	326	558	391	381	482	602	1,747	56.6%	1,320	42.8%
Klamath Tribal Health Center - Klamath Falls*				0				Portland, OR	306							0	0	4							0	0.0%	0	0.0%
Klamath Tribal Health Center - Chiloquin*				0				Portland, OR	274							0	0	4							0	0.0%	0	0.0%
Neah Bay Service Unit				0				Seattle, WA								0	0								0	0.0%	0	0.0%
Neah Bay - Neah Bay Indian Health Center	8.3%	23.9%	61.7%	2,004	166	478	1,237	Seattle, WA	246	132	378	378	246	783	977	1,539	1,487	0	132	378	378	246	783	977	1,539	76.8%	1,487	74.2%
Jamestown S'Kallum Tribal Health Clinic*				0				Seattle, WA	101							0	0	0							0	0.0%	0	0.0%
Lower Elwha Clinic*	8.7%	3.9%	33.2%	2,723	238	106	904	Seattle, WA	145	205	91	91	284	534	778	1,113	1,073	0	205	91	91	284	534	778	1,113	40.9%	1,073	39.4%
Quileute Tribal Health Clinic	8.5%	1.6%	47.3%	1,550	132	24	733	Seattle, WA	220	113	24	24	385	299	630	821	767	0	113	24	24	385	299	630	821	53.0%	767	49.5%
North Idaho Service Unit*				0				Spokane, WA								0	0								0	0.0%	0	0.0%
Kootenai Tribal Clinic*	16.0%	30.2%	37.5%	227	36	69	85	Spokane, WA	136	36	69	69	3	82	85	190	190	0	36	69	69	3	82	85	190	83.7%	190	83.7%
Nimiipuu - Kamiah Health Facility*				0				Spokane, WA	199							0	0	0							0	0.0%	0	0.0%
Nimiipuu - Lapwai Health Center*	17.7%	25.9%	54.3%	3,995	708	1,034	2,171	Spokane, WA	139	609	889	889	175	1,716	1,867	3,390	3,365	0	609	889	889	175	1,716	1,867	3,390	84.9%	3,365	84.2%
Northwest Washington Service Unit				0				Seattle, WA								0	0								0	0.0%	0	0.0%
Lummi Health Center	16.9%	18.4%	62.5%	4,857	821	894	3,036	Seattle, WA	98	763	831	831	668	2,202	2,824	4,465	4,418	0	763	831	831	668	2,202	2,824	4,465	91.9%	4,418	91.0%
Nooksack Community Clinic*	13.7%	38.2%	47.5%	1,184	163	452	562	Seattle, WA	103	151	421	421	115	416	523	1,103	1,095	2	151	421	337	115	250	314	936	79.1%	801	67.7%
Samish Indian Nation*	0.5%	14.2%	84.8%	426	2	61	361	Seattle, WA	83	2	61	61	15	323	336	400	399	0	2	61	61	15	323	336	400	93.8%	399	93.6%
Swinomish Health Clinic*	20.0%	15.3%	57.2%	1,583	316	242	905	Seattle, WA	80	294	225	225	235	623	841	1,377	1,361	0	294	225	225	235	623	841	1,377	87.0%	1,361	86.0%



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Portland Area Indian Health Service

Market Erosion

Market Erosion Calculation Table (Abbreviated)

Service Area	Market %			Entry	Uneroded Market			Regional Center Location	SU/PSA Drive Time to RC (in minutes)	Market Erosion by Distance						Sub Market Erosion by Competitors			Market Share									
	H Reliance	M Reliance	L Reliance	CHSDA	H Reliance	M Reliance	L Reliance			=42+43+45+46		=42+44+46		=51+52+54+55			=51+53+56											
	Direct Care Only No 3P	Direct Care, CHS	Direct Care, CHS, 3P	Total Users (or)	Direct Care Only No 3P	Direct Care, CHS	Direct Care, CHS, 3P			Direct Care Only No 3P	Direct Care, CHS (No Choice)	Direct Care, CHS (Choice)	Direct Care, CHS, 3P (Medicaid Only)	Direct Care, CHS, 3P (Medicaid Reduced)	Direct Care, CHS, 3P	M Reliance No Choice	M Reliance Choice	# of Alt Care in route (Sec or Trty)	Direct Care Only No 3P	Direct Care, CHS (No Choice)	Direct Care, CHS (Choice)	Direct Care, CHS, 3P (Medicaid Only)	Direct Care, CHS, 3P (Medicaid Reduced)	Direct Care, CHS, 3P	M Reliance - CHS No Choice & Medicaid Only	M Reliance - Choice		
	All/CHSDA Blended %	All/CHSDA Blended %	All/CHSDA Blended %	CHSDA Users	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage			w/out 3rd Party	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage	w 3rd party Coverage	w 3rd party Coverage	Net Users	Net Users		w/out 3rd Party	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage	w 3rd party Coverage	w 3rd party Coverage	Total Users	% of User Pop	Total Users	% of User Pop
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
Upper Skagit Tribal Health Clinic	14.7%	11.2%	59.3%	614	90	69	364	Seattle, WA	80	84	69	69	131	217	339	501	492	0	84	69	69	131	217	339	501	81.6%	492	80.1%
Puget Sound Service Unit				0				Seattle, WA								0	0								0	0.0%	0	0.0%
Muckleshoot Tribal Clinic*	4.1%	20.4%	56.8%	2,699	111	551	1,534	Seattle, WA	40	111	551	551	344	1,189	1,534	2,195	2,195	0	111	551	551	344	1,189	1,534	2,195	81.3%	2,195	81.3%
Nisqually Health Clinic*				0				Seattle, WA	65							0	0	0							0	0.0%	0	0.0%
Port Gamble S'Kallum Clinic*	0.0%	8.6%	41.4%	825	0	71	342	Seattle, WA	66	0	71	71	263	73	318	407	389	0	0	71	71	263	73	318	407	49.3%	389	47.1%
Sauk-Suiattle Health Clinic*				0				Seattle, WA	90							0	0	1							0	0.0%	0	0.0%
Seattle Indian Health Board*				0				Seattle, WA	4							0	0	0							0	0.0%	0	0.0%
Skokomish Health Center*	16.0%	26.7%	49.7%	1,003	160	267	498	Seattle, WA	97	149	249	249	118	353	463	869	861	0	149	249	249	118	353	463	869	86.7%	861	85.8%
Snoqualmie (North Bend/Tolt)				0				Seattle, WA	34							0	0	0							0	0.0%	0	0.0%
Squaxin Island Tribal Health Clinic*	20.9%	39.2%	38.5%	538	113	211	207	Seattle, WA	80	105	196	196	14	179	193	495	494	0	105	196	196	14	179	193	495	91.9%	494	91.8%
Stillaguamish Tribal Clinic	18.8%	36.5%	11.9%	464	87	169	55	Seattle, WA	52	87	169	169	3	52	55	312	312	0	87	169	169	3	52	55	312	67.2%	312	67.2%
Suquamish (Port Madison IR)*				0				Seattle, WA	53							0	0	0							0	0.0%	0	0.0%
Tulalip Health Clinic*				0				Seattle, WA	48							0	0	0							0	0.0%	0	0.0%
Puyallup Service Unit				0				Seattle, WA	35							0	0	0							0	0.0%	0	0.0%
Puyallup Tribal Health Authority	25.2%	13.7%	53.9%	11,180	2,823	1,532	6,024	Seattle, WA	35	2,823	1,532	1,532	1,353	4,672	6,024	10,379	10,379	0	2,823	1,532	1,532	1,353	4,672	6,024	10,379	92.8%	10,379	92.8%
Southern Oregon Service Unit				0				Portland, OR								0	0								0	0.0%	0	0.0%
Coos Umpqua Health Center*	45.3%	11.3%	41.1%	1,404	635	159	578	Portland, OR	230	546	136	136	53	451	497	1,187	1,180	4	546	136	95	53	180	199	916	65.3%	841	59.9%
Coquille Community Health Center*	2.6%	43.1%	51.6%	699	18	301	361	Portland, OR	232	18	259	259	33	282	310	592	587	4	18	259	181	33	113	124	423	60.5%	323	46.2%
Cow Creek Health Center	0.7%	1.5%	45.4%	2,244	17	34	1,019	Portland, OR	158	17	34	34	9	869	876	928	927	5	17	34	23	9	348	351	406	18.1%	391	17.4%
Cow Creek South (new)				0				Portland, OR								0	0								0	0.0%	0	0.0%
Taholah Service Unit				0												0	0								0	0.0%	0	0.0%
Chehalis Community Health Center*	11.9%	17.7%	62.7%	1,023	122	181	641	Seattle, WA	91	113	168	168	168	440	596	890	878	0	113	168	168	168	440	596	890	87.0%	878	85.8%
Cowlitz North PSA (Tribal Health Ctr)	22.1%	6.7%	69.2%	671	148	45	465	Portland, OR	54	148	45	45	95	370	465	658	658	1	148	45	40	95	296	372	584	87.0%	561	83.5%
Cowlitz South PSA (New)				0				Portland, OR								0	0								0	0.0%	0	0.0%
Hoh Tribe				0				Seattle, WA	224							0	0	0							0	0.0%	0	0.0%
Roger Saux Health Center (Quinalt)*	19.6%	7.4%	67.0%	2,542	498	189	1,704	Seattle, WA	178	428	163	163	364	1,152	1,465	2,107	2,056	3	428	163	114	364	461	586	1,416	55.7%	1,128	44.4%



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Market Erosion Calculation Table (Abbreviated)

Service Area	Market %			Entry	Uneroded Market			Regional Center Location	SU/PSA Drive Time to RC (in minutes)	Market Erosion by Distance						Sub Market Erosion by Competitors						Market Share						
	H Reliance	M Reliance	L Reliance	CHSDA	H Reliance	M Reliance	L Reliance			=42+43+45+46			=42+44+46			=51+52+54+55						=51+53+56						
	Direct Care Only No 3P	Direct Care, CHS	Direct Care, CHS, 3P	Total Users (or)	Direct Care Only No 3P	Direct Care, CHS	Direct Care, CHS, 3P			Direct Care Only No 3P	Direct Care, CHS (No Choice)	Direct Care, CHS (Choice)	Direct Care, CHS, 3P (Medicaid Only)	Direct Care, CHS, 3P (Medicaid Reduced)	Direct Care, CHS, 3P	M Reliance No Choice	M Reliance Choice	# of Alt Care in route (Sec or Trty)	Direct Care Only No 3P	Direct Care, CHS (No Choice)	Direct Care, CHS (Choice)	Direct Care, CHS, 3P (Medicaid Only)	Direct Care, CHS, 3P (Medicaid Reduced)	Direct Care, CHS, 3P	M Reliance - CHS No Choice & Medicaid Only	M Reliance - Choice		
	All/CHSDA Blended %	All/CHSDA Blended %	All/CHSDA Blended %	CHSDA Users	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage			w/out 3rd Party	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage	w 3rd party Coverage	w 3rd party Coverage	Net Users	Net Users		w/out 3rd Party	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage	w 3rd party Coverage	w 3rd party Coverage	Total Users	% of User Pop	Total Users	% of User Pop
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	
Queets Health Center (Quinalt)*				0				Seattle, WA	200						0	0	3							0	0.0%	0	0.0%	
Shoalwater Bay Tribal Clinic	9.2%	0.3%	27.1%	1,264	117	4	343	Seattle, WA	237	100	4	4	60	243	295	407	399	2	100	4	3	60	146	177	310	24.5%	280	22.1%
Umatilla Service Unit*				0				Seattle, WA							0	0								0	0.0%	0	0.0%	
Yellowhawk Tribal Health Center*	25.9%	26.4%	45.1%	3,258	844	860	1,469	Seattle, WA	261	667	679	679	92	1,088	1,161	2,526	2,507	2	667	679	543	92	653	696	2,091	64.2%	1,907	58.5%
Warm Springs Service Unit				0				Portland, OR							0	0	0							0	0.0%	0	0.0%	
Wada-tika Health Center (Burns Paiute)	9.3%	32.9%	57.9%	214	20	70	124	Portland, OR	343	20	70	70	18	84	98	192	188	2	20	70	56	18	50	59	158	73.9%	135	63.0%
Warm Springs - Warm Springs Health and Wellness Center	16.7%	26.3%	55.9%	5,183	865	1,361	2,899	Portland, OR	128	744	1,170	1,170	475	2,085	2,493	4,474	4,407	0	744	1,170	1,170	475	2,085	2,493	4,474	86.3%	4,407	85.0%
Wellpinit Service Unit				0				Spokane, WA							0	0								0	0.0%	0	0.0%	
Kalispell				0				Spokane, WA	72						0	0	0							0	0.0%	0	0.0%	
Wynecoop Memorial Clinic (Spokane Tribe)	18.4%	21.9%	50.2%	2,651	489	580	1,332	Spokane, WA	65	454	539	539	327	935	1,238	2,255	2,232	0	454	539	539	327	935	1,238	2,255	85.1%	2,232	84.2%
Western Oregon Service Unit				0				Portland, OR							0	0								0	0.0%	0	0.0%	
Grand Ronde Health Center	17.7%	3.3%	45.9%	5,625	997	188	2,581	Portland, OR	79	927	175	175	93	2,314	2,400	3,509	3,502	1	927	175	157	93	1,851	1,920	3,046	54.2%	3,005	53.4%
Salem - Chemawa Health Center (Western Oregon SU)	54.1%	5.1%	40.1%	5,881	3,181	302	2,360	Portland, OR	38	3,181	302	302	278	2,082	2,360	5,844	5,844	0	3,181	302	302	278	2,082	2,360	5,844	99.4%	5,844	99.4%
Siletz Community Health Center	7.1%	32.3%	49.6%	3,741	264	1,209	1,857	Portland, OR	146	227	1,040	1,040	194	1,430	1,597	2,891	2,864	2	227	1,040	832	194	858	958	2,319	62.0%	2,017	53.9%
Yakama Service Unit	11.5%	23.5%	63.7%	13,209	1,518	3,104	8,418	Seattle, WA	152	1,305	2,669	2,669	2,119	5,417	7,239	11,510	11,214	2	1,305	2,669	2,135	2,119	3,250	4,343	9,344	70.7%	7,784	58.9%
Toppenish - Yakama Comprehensive Health Care Facility				0				Seattle, WA	152							0	0	2							0	0.0%	0	0.0%
White Swan - White Swan Health Clinic				0				Seattle, WA	178							0	0	2							0	0.0%	0	0.0%
Seattle Reg Ctr	15.7%	17.8%	54.8%	52,946																				39,859	75.3%	37,405	70.6%	
Portland Reg Ctr	23.2%	15.1%	49.2%	28,748																				19,918	69.3%	18,842	65.5%	
Spokane Reg Ctr	17.0%	27.6%	53.2%	18,893																				15,331	81.1%	14,979	79.3%	

In the final market erosion calculations, the following assumptions were amended to create a more robust and optimistic market share: PSAs within 90 minutes travel time were assumed to drive past all alternative care to access the Seattle Regional Specialty Referral Center (shown by red font under "# of Alt Care in route") and erosion percentages for each driving time tier were increased as a result of the anticipated impact of Telemedicine.



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Market Erosion Calculation Table Explanation

The supporting data is either Service Unit inclusive (as in the case of the Colville example above), meaning it provides data for 4 points of care (Inchelium, Keller, Nespelem, and Omak) or it is PSA specific as in the case of Lummi (though it belongs to the Northwest Washington Service Unit). Payor data was entered into the **Market Erosion Calculation Table** as shown below. Percentages were calculated by grouping relative to both "Total Users" and "CHSDA Users" for each Service Unit / PSA.

1 Direct data entries from the Payor Profiles are related to user population resulting in a % Payor grouping. In this Neah Bay example, 204 Direct Care Only "All Users" equals 9.4% of "All Users", while 145 Direct Care Only "CHSDA Users" represents 7.2% of "CHSDA Users".

Service Area	Users		Direct Care Only								Direct Care/CHS												
	All	CHSDA	All				CHSDA				All				w 3rd Party (Medicaid Only)			CHSDA					
			No 3rd Party Coverage	w 3rd Party Coverage	No 3rd Party Coverage	w 3rd Party Coverage	No 3rd Party Coverage	w 3rd Party Coverage	No 3rd Party Coverage	w 3rd Party (All)				No 3rd Party Coverage	w 3rd Party (All)	w 3rd Party (Medicaid Only)							
	Total	Total	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%					
Neah Bay Service Unit	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
Neah Bay - Neah Bay Indian Health Center	2,175	2,004	204	9.4%	246	11.3%	145	7.2%	198	9.9%	501	23.0%	1,317	60.6%	548	25.2%	495	24.7%	1,261	62.9%	N/A	25.2%	
Jamestown S'Kallum Tribal Health Clinic*																						N/A	
Lower Elwha Clinic*	2,811	2,723	257	9.1%	444	15.8%	227	8.3%	417	15.3%	108	3.9%	934	33.2%	1,026	36.5%	107	3.9%	904	33.2%	N/A	36.5%	
Quileute Tribal Health Clinic	1,573	1,550	134	8.5%	260	16.5%	131	8.5%	250	16.1%	25	1.6%	745	47.4%	961	61.1%	24	1.5%	731	47.2%	N/A	61.1%	

2 Shading relates the Payor Grouping to a blended Market % (specifically an average of each payor group from "All" and "CHSDA" user populations). For example, the average of Neah Bay's 9.4% Direct Care Only Payor group for "All Users" and 7.2% Direct Care Only Payor group of "CHSDA Users" averages to 8.3% as shown below.

! This part of the **Market Erosion Calculation Table** is found only on the unabbreviated version found in the Appendices of this report.

3 Each resulting shaded blended percentage is then used to calculate an Uneroded Market (based on "CHSDA Users"). For example, Neah Bay's 8.3% Direct Care Only Users related to a CHSDA user population of 2,004 identifies 166 highly reliant, or Direct Care Only users to be considered as the starting point for the erosion calculation process.

Service Area	Market %			Entry	Uneroded Market		
	H Reliance	M Reliance	L Reliance		H Reliance	M Reliance	L Reliance
	Direct Care Only No 3P	Direct Care, CHS	Direct Care, CHS, 3P	Total Users (or) CHSDA Users	Direct Care Only No 3P	Direct Care, CHS	Direct Care, CHS, 3P
Neah Bay Service Unit				0			
Neah Bay - Neah Bay Indian Health Center	8.3%	23.9%	61.7%	2,004	166	478	1,237
Jamestown S'Kallum Tribal Health Clinic*				0			
Lower Elwha Clinic*	8.7%		33.2%	2,723	238		904
Quileute Tribal Health Clinic	8.5%	1.6%	47.5%	1,550	132	24	733

4 The base user/payor profile is now ready to erode by Distance and Competitor based on a set of commonly applied assumptions. In this case, Neah Bay's payor percentages and corresponding users are shown in matching shades.



The uneroded market was then eroded by distance. Again, shading was included to show the continuing relationship between each payor group and assumptions being applied to them. The image at the bottom of this page shows the next sequence in the **Market Erosion Calculation Table**. Travel time in minutes to the corresponding Regional Center by location is identified. Erosion is effected based upon how the uneroded payor group is impacted by the percentages shown in the Market Erosion Table (by distance) immediately below.

5 The primary assumption guiding erosion by distance is that all payors face common geographical and/or transportation constraints. Therefore, all payors groups will experience a common erosion % by distance.

! The percentages applied are calculated from erosion rates drawn from the **Dartmouth Atlas of Healthcare** and **Solucient Data**. Detail for erosion logic is found in **Market Erosion by Distance Logic** in the Appendices.

by Distance	High (H) Reliance	Moderate (M) Reliance		Low (L) Reliance	
	Direct Care Only No 3P	Direct Care, CHS		DC, CHS, Medicaid	Direct Care, CHS, 3P
		No Choice	Choice	No Choice	Choice
Drive Time to Regional Center (< than in Minutes)	% likely to drive	% likely to drive	% likely to drive	% likely to drive	% likely to drive
60	100%	100%	100%	100%	100%
90	100%	100%	100%	100%	100%
120	93%	93%	93%	93%	93%
240	86%	86%	86%	86%	86%
240+	79%	79%	79%	79%	79%

6 For example, Lower Elwha's uneroded market of 238 Direct Care Only Users must travel 145 miles to the Seattle Regional Center. The assumption is that 86% of users less than 240 minutes away (but greater than 120 minutes away) will show up for care. This represents an erosion of 14%, or a remaining market of 86%. This logic is applied consistently for all payor groups by travel time. So 205 (or 86%) of Lower Elwha's Direct Care Only users are planned for.

Service Area	Uneroded Market			Regional Center	SU/PSA Drive Time to RC (in minutes)	Market Erosion by Distance						=42+45+46 =45+44+46	
	H Reliance	M Reliance	L Reliance			Direct Care Only No 3P	Direct Care, CHS (No Choice)	Direct Care, CHS (Choice)	Direct Care, CHS, 3P (Medicaid Only)	Direct Care, CHS, 3P (Medicaid Reduced)	Direct Care, CHS, 3P	M Reliance No Choice	M Reliance Choice
	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage			w/out 3rd Party	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage	w 3rd party Coverage	w 3rd party Coverage	Net Users	Net Users
Neah Bay Service Unit				Seattle, WA							0	0	
Neah Bay - Neah Bay Indian Health Center	166	478	1,237	Seattle, WA	246	132	378	378	246	783	977	1,539	1,487
Jamestown S'Kallum Tribal Health Clinic*				Seattle, WA								0	0
Lower Elwha Clinic	238	106	904	Seattle, WA	145	205	91	91	284	534	778	1,113	1,073
Quileute Tribal Health Clinic	132	24	733	Seattle, WA	220	113	24	24	385	299	630	821	767

7 When appropriate eroded payor groups are totaled, 2 potential markets emerge: "No Choice" is the sum of eroded payor groups assuming CHS eligible and Medicaid payors can be directed to the Regional Center. "Choice" is the sum of eroded payor groups where all payors with coverage can choose where they receive care.



The distance eroded market was then eroded by alternative care. Again, shading was included to show the continuing relationship between each payor group and assumptions being applied to them. Erosion is effected based upon how the distance eroded payor group is impacted by the percentages shown in the Market Erosion Table (by Alternative Care) below. Assumptions were made that 100% of highly reliant and “choice directed” payors would pass all alternative care. However, where choice was an option (due to 3rd party coverage or CHS) erosion was assumed at the percentages shown below.

by Alternative Care	1	2	3	4	5
	High (H) Reliance	Moderate (M) Reliance		Low (L) Reliance	
Direct Care Only No 3P		Direct Care, CHS		DC, CHS, Medicaid	Direct Care, CHS, 3P
Secondary or Tertiary Alternative Care Options "in route"		No Choice	Choice	No Choice	Choice
	% likely to drive	% likely to drive	% likely to drive	% likely to drive	% likely to drive
1	100%	100%	90%	100%	80%
2	100%	100%	70%	100%	60%
3	100%	100%	70%	100%	40%

8 Low Reliance payor groups, if allowed choice, were eroded in 20% increments, with final group assigned a residual 40%.

9 Moderately Reliant populations free to choose where to access CHS care were eroded by the average of the “No Choice” and the Low Reliance “Choice” assumptions

For a detailed explanation of how this methodology was developed, see **Alternative Care Erosion Methodology** in the Appendices.

Service Area	Sub Market Erosion by Competitors						Market Share			
	Direct Care Only No 3P	Direct Care, CHS (No Choice)	Direct Care, CHS (Choice)	Direct Care, CHS, 3P (Medicaid Only)	Direct Care, CHS, 3P (Medicaid Reduced)	Direct Care, CHS, 3P	M Reliance - CHS No Choice & Medicaid Only		M Reliance - Choice	
	w/out 3rd Party	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage	w 3rd party Coverage	w 3rd party Coverage	Total Users	% of User	Total Users	% of User
Southern Oregon Service Unit							0	0.0%	0	0.0%
Coos Umpqua Health Center*	546	136	95	53	180	199	916	65.3%	841	59.9%
Coquille Community Health Center*	18	259	181	33	113	124	423	60.5%	323	46.2%
Cow Creek Health Center	17	34	23	9	348	351	406	18.1%	391	17.4%
Cow Creek South (new)							0	0.0%	0	0.0%

10 For example, Coos Umpqua’s 546 Direct Care Only distance eroded Direct Care Only users are anticipated to drive by 4 alternative care options in route. However, their 497 Low Reliance 3rd Party Covered Users (not shown in this image) will erode by 60% due to 4 alternative care options in route, leaving only 199 covered users potentially seeking care at the Seattle Regional Center. This logic is consistently applied to all distance eroded payor groups.

Assumptions produce a projected 65.3% of Coos Umpqua users will use a Seattle Regional Center if CHS/Medicaid users are directed there. If they are not, a 59.9% projection is anticipated.

11



Regional Center user population percentage assumptions for each Service Unit/PSA are totaled at the bottom of the **Market Erosion Calculation Table** to produce a total percentage of anticipated users who would access care at each Regional Center. For the purposes of this report, only one number is reflected in the service projected: the “Choice” Market Share for the Seattle Regional Center location, representing the most conservative of the two percentages for that center.

Service Area	Market %			Entry	Market Share			
	H Reliance	M Reliance	L Reliance	CHSDA	=51+52+54+55		=51+55+56	
	Direct Care Only No 3P	Direct Care, CHS	Direct Care, CHS, 3P	Total Users (or)	M Reliance - CHS No Choice & Medicaid Only		M Reliance - Choice	
	All/CHSDA Blended	All/CHSDA Blended	All/CHSDA Blended	CHSDA Users	Total Users	% of User	Total Users	% of User
Seattle Reg Ctr	15.7%	17.8%	54.8%	52,946	39,859	75.3%	37,405	70.6%
Portland Reg Ctr	23.2%	15.1%	49.2%	28,748	19,918	69.3%	18,842	65.5%
Spokane Reg Ctr	17.0%	27.6%	53.2%	18,893	15,331	81.1%	14,979	79.3%

For this report, the more conservative of the two Market Share projection percentages for the Seattle Regional Center location was utilized. 70.6% of the User Population for Service Units / PSAs planned to receive care at that location was used in creating projected services and supporting space and staff.

Directing Markets (Choice or No Choice)

While validation appears needed to determine both if and how certain payor groups could be directed to regional locations for specialty care, participants at the PAFAC meeting in Seattle in July 2008 overwhelmingly affirmed the following notion:

Assuming you were CHS eligible, would you accept removal of your choice regarding where you could receive specialty care if you could access care at an IHS Regional Center?

100% of participants said “yes”

Thinking again about the question above, would you accept removal of your choice if it produced greater reliance among all CHS eligible patients on an IHS Regional Center?

Again, 100% of participants said “yes”.

Participants further supported the idea of directing all Medicaid patients to any planned Regional Center in order to improve market share. Discussion seemed to affirm that this was likely doable and supportable among Portland area tribes.

These two understandings, that CHS eligible users can be directed and that Medicaid users can be directed, form the core assumption for the “No Choice” market share calculations.



Appendices

- Market Erosion Table 79
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Note: The page header for this project was updated for this report. As a result, some of the Appendices reflect an earlier iteration. Those pages not reflecting the current page header are from past presentations and are presented here as they were at the time. Blank and updated pages show the current page header.



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Market Erosion Table

by Distance	1	2	3	4	5
	High (H) Reliance	Moderate (M) Reliance		Low (L) Reliance	
	Direct Care Only No 3P	Direct Care, CHS		DC, CHS, Medicaid	Direct Care, CHS, 3P
		No Choice	Choice	No Choice	Choice
Drive Time to Regional Center (< than in Minutes)	% likely to drive	% likely to drive	% likely to drive	% likely to drive	% likely to drive
60	100%	100%	100%	100%	100%
90	100%	100%	100%	100%	100%
120	93%	93%	93%	93%	93%
240	86%	86%	86%	86%	86%
240+	79%	79%	79%	79%	79%

Remarks

The primary assumption driving erosion by distance is that all payor groups (patients) face the same geographical constraints when travelling to care. In other words, whether one is highly reliant or covered by a generous third party insurer, both have to travel to the same first opportunity for care regardless of how far away it is. So the issue is simply "is there any reason why any payor (patient) would not travel any distance to receive care?" The PAFAC workgroup at the Seattle meeting responded "yes" to such a question by 80%. Transportation limitations, Patient Education and Distance were all cited multiple times by attendees as reasons why even if a payor (patient) had 3rd party coverage they still might not travel to receive care. As a result, it follows that the farther from care one is, the more erosion will occur. At the same time, however, the PAFAC anticipates aggressive use of Telemedicine will compensate for many reasons that normally would erode the market because of distance. For detail on how the percentages above were calculated see **Market Erosion by Distance Logic**.

by Alternative Care	1	2	3	4	5
	High (H) Reliance	Moderate (M) Reliance		Low (L) Reliance	
	Direct Care Only No 3P	Direct Care, CHS		DC, CHS, Medicaid	Direct Care, CHS, 3P
		No Choice	Choice	No Choice	Choice
Secondary or Tertiary Alternative Care Options "in route"	% likely to drive	% likely to drive	% likely to drive	% likely to drive	% likely to drive
1	100%	100%	90%	100%	80%
2	100%	100%	80%	100%	60%
3	100%	100%	70%	100%	40%


Remarks

The primary assumption driving erosion by Alternative Care is that it will happen essentially in fifths with each urban area a payor (patient) drives through on the way to a Regional Center offering secondary or tertiary care. Column 5 reflects this with the caveat that there will likely be a remnant of covered payors (patients) willing to bypass alternative care for undefined reasons (family, shopping, recreation, etc.). Column 3 shows a simply average of Column 2 (the No Choice market) and Column 5 (the Choice market).



Market Erosion by Distance Logic

Table below shows how markets (cities/zip codes) experience utilization erosion in relationship to a benchmark (center of comparative care)



Source	Innova Group	Dartmouth Atlas of Healthcare						Solucient			Innova Group		
Date	2009	2001-2005		2001-2005		2006		2007		2007		2009	PAFAC
Data	Meeting 1 - Presentation Assumption	Medical specialist visits per decedent during last 2 years of life		Total FTE medical specialist labor inputs per 1,000 decedents during last 2 years of life		Total specialists per 100,000 residents		Average of office consultations to population by zip code		Average of office medical visits to population by zip code		Simple average of Dartmouth & Solucient Ratios	Assumption assumes ease of Seattle market access and aggressive use of Telemedicine
% / Ratio	% likely to drive	Ratio to Benchmark	Remark Notation	Ratio to Benchmark	Remark Notation	Ratio to Benchmark	Remark Notation	Ratio to Benchmark	Remark Notation	Ratio to Benchmark	Remark Notation	% likely to drive	% likely to drive
Other	Direct Care - High Reliance	Assumed High Reliance	Remark Notation	Assumed High Reliance	Remark Notation	Assumed High Reliance	Remark Notation	Reliance Undetermined	Remark Notation	Reliance Undetermined	Remark Notation	Mixed Reliance	Mixed Reliance
60	100%	100%	1	100%	1	100%	1	75%	5	78%	5	91%	100%
90	100%	N/A		N/A		N/A		75%	6	77%	6	76%	100%
120	100%	77%	2	73%	2	82%	2	75%	7	77%	7	77%	93%
240	100%	73%	3	75%	3	73%	3	64%	8	68%	8	71%	86%
240+	100%	79%	4	79%	4	80%	4	N/A		N/A		79%	79%

Remark Notations

- 1 HHR = Seattle, WA (Everett and Tacoma not included - RC location assumption is Seattle)
- 2 HHR = Olympia, WA
- 3 HHR = Yakima, WA
- 4 HHR = Spokane, WA
- 5 Represents Tertiary Care Center of Tucson, AZ extending to Rio Rico, Three Points, and Benson
- 6 Represents area outside of "5" above including Nogales, Sells, and Sierra Vista
- 7 Represents area outside of "6" above with no noteworthy population centers
- 8 Represents area outside of "7" above including Douglas, Safford, Ajo

Innova Group Presentation Assumptions for HQ Conference Call

Erosion of market share by distance alone is difficult to project for a variety of reasons, including:

- accurate service line projections should be age/sex specific
- the erosion by distance from one urban center transitions into increasing market share for another
- other factors such as shopping, infrastructure, etc. may influence distance willingly travelled (current scope does not allow for analysis)

Consequently, a two data source approach was utilized to calculate percentages identified on the right column above (13):

- Statistics from a reliant population (last 2 years of life) were gathered from the Dartmouth HC Atlas
- Urban data for such places as Seattle, Olympia, and Yakima were aligned with relevant distances for comparison
- Solucient data for southern Arizona by visit by zip code was analyzed for erosion in relationship to the Tucson market
- Percentages were tabled above, averaged and standardized by Innova as follows:

- percentages of the 5 available data points for 60 minutes of travel time or less were averaged (91%)
- percentages of the 5 available data points for 120 minutes of travel time or less were averaged (77%)
- average between 91% and 77% was applied for 90 minutes of travel time or less (84%) since only 2 data points available
- relative erosion for each (7%) was applied to 240 minutes of travel time or less (70%) or 240 minutes plus (63%)

Final PAFAC assumptions for potential users within 90 minutes were increased to 100% due to ease of Seattle Market access, and diminished by 7% for the remaining tiers - assuming a higher rate than the standard average due to aggressive use of Telemedicine.



Source Data Snapshot

From *Dartmouth Atlas of Healthcare* http://cecsweb.dartmouth.edu/atlas08/datatools/datatb_s1.php

Hospital Referral Regions (HRR)			Rates for 2001-2005				Rates for 2006	
			Medical specialist visits per decedent during the last two years of life		Total FTE medical specialist labor inputs per 1,000 decedents during the last two years of life		Physicians per 100,000 by HRR	
Area	Distance by Minutes	*Population	Rates	Ratio to Benchmark	Rates	Ratio to Benchmark	Total Specialists per 100,000	Ratio to Benchmark
*Seattle, WA	0	41,300	18.79	1 100.0%	6.73	1 100.0%	139.8	1 100.0%
Everett, WA	31	9,245	13.07	70.0%	5.21	77.0%	117.5	84.1%
Tacoma, WA	37	11,725	17.83	95.0%	6.6	98.0%	143.8	102.8%
Olympia, WA	63	7,010	14.46	2 77.0%	4.95	2 73.0%	114.2	2 81.7%
Yakima, WA	126	6,350	13.74	3 73.0%	5.08	3 75.0%	101.4	3 72.5%
Spokane, WA	242	32,375	14.81	4 79.0%	5.31	4 79.0%	112.1	4 80.2%

Number labels above and below correspond to % entries on the table on the previous page

Southern Arizona Solucient Data - Analysis Results

Travel in Minutes	Calculation	Ratio to Benchmark by Distance by Visit Type		
		Average of 2007 Ophth Visits	Average of 2007 Office Cons	Average of 2007 Office Med Visits
< 60	Average	59.5%	5 74.9%	5 78.1%
	Median	58.0%	76.7%	79.5%
< 90	Average	64.6%	6 75.4%	6 77.1%
	Median	66.6%	77.0%	79.9%
< 120	Average	62.4%	7 75.3%	7 76.6%
	Median	64.2%	78.2%	78.2%
< 240	Average	50.7%	8 63.7%	8 67.8%
	Median	46.7%	61.4%	66.1%

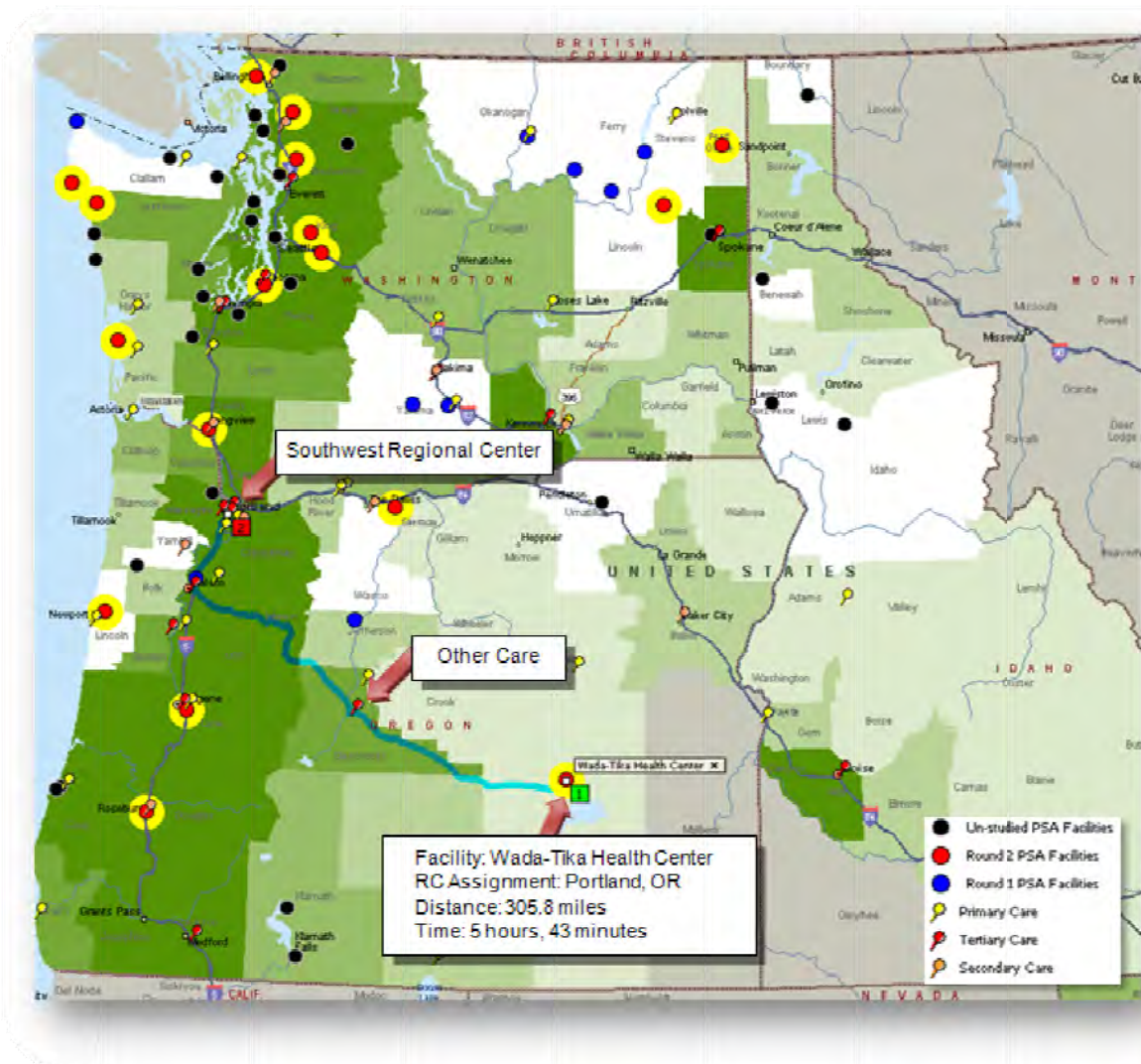
%s by zip code are averaged by driving time from the larger Solucient data set and shown in the table above.

Solucient Data Projections for 2007 (based on 2002 data for southern Arizona)

Zip	Ratio of Benchmark (Green Valley, Yuma, Rancho Vistoso removed)					zip codes within travel time (minutes)			
	2007 Office Cons	2007 ED Visits Emerg	2007 ED Visits Urgent	2007 Office Med Visits	2007 Ophth Visits	< 60	< 90	< 120	< 240
85624	78.2%	88.9%	79.4%	77.8%	67.6%			85624	
85625	87.5%	67.6%	74.0%	87.9%	83.7%			85625	
85629	68.7%	40.6%	38.0%	72.7%	52.4%	85629			
85630	77.0%	52.1%	64.1%	79.9%	69.4%		85630		
85632	74.0%	63.1%	82.4%	76.5%	64.7%				85632
85634	50.2%	52.4%	61.5%	55.4%	36.6%				85634
85635	70.9%	43.7%	58.4%	74.1%	57.6%		85635		
85637	96.6%	77.1%	59.7%	95.6%	84.3%		85637		
85638	81.6%	65.2%	73.4%	81.9%	74.4%		85638		
85640	87.7%	100.0%	89.0%	87.4%	75.3%	85640			
85641	74.8%	39.3%	34.1%	78.4%	56.9%	85641			



Alternative Care Erosion Methodology



Using Microsoft Map Point, The Innova Group was able to identify Indian health clinics and their distance to their particular Regional Center (RC) assignment. The following settings were used to standardize driving time between the health center and the RC assignment:

- no driving breaks were allotted,
- all driving speeds on the various types of roadway were set to “average”,
- and segments were based on preferred roads rather than the quickest route or shortest distance.

If a Service Unit was specified, the distance was calculated using the primary point of care (ex: for the Colville Service Unit, Nespelem was used). If a PSA was specified, the distance was calculated using the PSA. Map Point made it possible to count the number of alternative secondary and tertiary care options between the health center and the RC assignment. Any alternative care sites that were within 15 miles distance of the planned route were counted as a possible care sites. Any alternative care sites located in a RC assignment were not counted as possible care sites. The total number passed “in route” was entered on the Market Share projection table. Only secondary and tertiary alternative care was considered.



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Meeting Participant Questionnaire

Results

Please complete this short questionnaire and return to Anthony Laird of The Innova Group at the start of the meeting

- 1 How many hours would you drive to an IHS Regional Center for specialty care if you had no 3rd party coverage?

1 hour 2 hours 3 hours 4 hours > 4 hours

- 2 Is there any reason why a person without 3rd party coverage would not drive to an IHS Regional Center for specialty care?

No Yes

If "Yes" above, what would that reason(s) be?

8	Transportation Limitations
3	Patient Education
2	Distance
1 each	support system/family needs, natural barriers, health, RC housing

- 3 If you were covered by 3rd party insurance, how many alternative care options would you drive past to receive specialty care at an IHS Regional Center?

1 2 3 4 > 4

- 4 If you were covered with 3rd party insurance, how far would you drive to receive coverage at an IHS Regional Center, regardless of alternative care options?

1 hour 2 hours 3 hours 4 hours > 4 hours

- 5 Assuming you were CHS eligible, would you accept removal of your choice regarding where you could receive specialty care if you could access care at an IHS Regional Center?

Yes No

- 6 Thinking again about the question above, would you accept removal of your choice if it produced greater reliance among all CHS eligible patients on an IHS Regional Center?

Yes No





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Regional Centers and the HFCPS (Healthcare Facility Construction Priority System)



Portland Area IHS

Presentation/Work Session with the PAFAC
Portland, Oregon

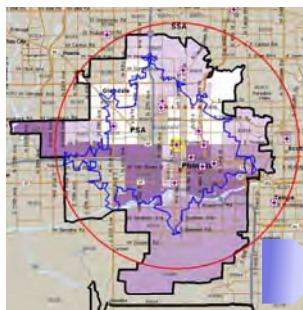
June 10, 2009



1



The Innova Group




Our goal is to create a responsive partnership with our clients by assisting them in identifying their needs, translating those needs into solutions, and facilitating the implementation of the solutions.

Goal & Process



2



Agenda



9:00 am Welcome

9:15 am Regional Centers: *Definition & History*

9:30 am Project Scope

9:45 am Regional Center Planning Tools: *Health Systems Planning (HSP)*

10:15 am Break

10:30 am Regional Center Planning Tools: *Healthcare Facilities Construction Priority System (HFCPS)*

11:00 am Existing Regional Centers

11:30 am Headquarters' Concerns

11:45 am Lunch

1:00 pm Portland's Response : *Critical Questions / Initial Precepts*

2:00 pm *Workgroup Brainstorming*


2:30 pm Break

2:45 pm *Precept Identification*
Precept Prioritization
Precept Selection for Concept Development


4:00 pm Adjourn

A presentation and discussion led by the Innova Group


A brainstorming work session with the PAFAC




3






Let's Talk...



- *What is the motivation for a Regional Center?*
- *Why do this?*



4

Regional Centers – History

- Master Plan Round 1 (February 2003)

Kickoff Meeting Discussion

Portland Area weaknesses identified at the Kickoff meeting pertaining to regionalization include:

- Demand for care exceeds ability to provide care / backlog of needed services
- Tribes lack access to over worked tribal Service Units
- Not enough doctors and RNs for Community Progress
- Imbalance in access to care
- Lack of comprehensive approach to optimizing returns from Direct PC and CHS resources for specialty and hospital care
- Lack of money (and \$ for ref to SC)
- Inadequate programs/limiting services
- Coordination of IHS service providers and tribal programs
- Specialty Care coordination
- Little pooling of assets for larger good
- Inability to negotiate rates with local non IHS providers
- Too many \$ spent on Contract Care

Priority determinants from the meeting pertaining to regional definition included:




- a 2 hour drive time to services,
- an area that pools resources,
- a common source of reasonable access to basic core services.

- Master Plan Round 2 (October 2004)
- Portland Area Indian Health Board (July 2005)
- Master Plan Final Documentation (October 2005)

- 2 Hour Access Time
- Pools Resources
- Access to Basic Core Services

THE IHSVA GROUP

5

Regional Centers – History

- Master Plan Round 1 (February 2003)
- Master Plan Round 2 (October 2004)

Definitions of a "Region" from Participants (Groupthink #4 Results)

- Provides benefits that exceed cost (i.e. money, distance, time)
- Cost reduction
- Expanded and/or increased access to specialty services
- Provides for all the healthcare services needed for a designated population within a reasonably accessible area (i.e. travel distance defined depending on service)
- Would provide a full array of services with the majority of services being those that can not be provided at individual health centers
- Center would have both inpatient and outpatient capability with no restriction to available services up to and including acute care, intensive care, surgical services, etc.
- The center would be in a location that was mutually beneficial to the health centers within that "region" allowing varying degrees of travel but no significant travel
- Accessibility to many specialties, reduced cost, and place to stay
- Consortium of TCs supporting access to specialty care, hospital

- Portland Area Indian Health Board (July 2005)
- Master Plan Final Documentation (October 2005)

- Cost Reduction
- Services not provided at individual health centers
- Both IP & OP capability

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6




Regional Centers – History

- Master Plan Round 1 (February 2003)
- Master Plan Round 2 (October 2004)
- Portland Area Indian Health Board (July 2005)



- Conf. Calls
- Tribal Input



The Portland Area Health Services Master Plan Recommended Regions

Referral Partners working together to...
Improve care
Lower CHS dependency
Produce revenue
Negotiate higher level care



A Presentation to
 The Northwest Portland Area Indian Health Board
 July 19, 2005

August 10-12, 2005 (10:00 am – 12:00 noon)	September 8, 2005	September 30, 2005
Conference Calls to Discuss Identified Regional Center Opportunities with affected Service Units and Primary Service Areas (PSAs)	Draft Services Master Plan Meeting (Pre-Final) in Portland	Completion of Portland Area Health Services Master Plan
August 10 – Northeast Regional Center <ul style="list-style-type: none"> • Colville • N. Idaho • Wapinit • Coeur D'Alene Service Units with respective PSAs invited to participate	<ul style="list-style-type: none"> • Incorporation of all PSA Requesting and Priority needs into Summary • Review of Regional Center & Area Medical Center Conference Call Decisions • Identification of remaining issues needing resolution to complete Master Plan 	<ul style="list-style-type: none"> • Receive all outstanding data & information from PSAs • Update PSA Financial Summary from Pre-Final Meeting • Finish plans and send to PSAs and Portland Area Office
August 11 – Northwest Regional Center <ul style="list-style-type: none"> • Puyallup • Yakama • Taholah • NW Washington • Nesh Bay Service Units with respective PSAs invited to participate		
August 12 – Southwest Regional Center <ul style="list-style-type: none"> • Klamath • Western Oregon • Warm Springs • Umatilla • Southern Oregon • Cowitz Service Units with respective PSAs invited to participate		

- Master Plan Final Documentation (October 2005)




7

Regional Centers – History


- Master Plan Round 1 (February 2003)
- Master Plan Round 2 (October 2004)
- Portland Area Indian Health Board (July 2005)
- Master Plan Final Documentation (October 2005)



- Driven by "at-large" interest from Portland Service Areas and the NPAIHB
- A "top-down" approach



Developing a Regional Plan can be accomplished either by a "bottom-up" or a "top-down" approach. This final report offers both perspectives.

- The Regional Delivery Plan Summary is comprised of two summary tables detailing requests for services as identified in PSA delivery plans: the **Regional Visiting Professional Summary** and the **Regional Referral Summary**. Together these represent a "bottom-up" approach. In short, local PSA delivery plans are requesting these providers/referrals.
- The **Regional Opportunities Summary** is driven by suggested groupings of PSAs/populations to support shared services of potential benefit to all tribes. These groupings are not the result of formal requests by the tribes as a result of face-to-face conversations. Rather, they are suggested by populations. The **Regional Center** and **Area Wide Medical Center** concepts are driven by "at-large" interest from Portland Area Service Areas, the Portland Area Office and the Northwest Portland Indian Health Board. This represents a "top-down" approach. In short, local PSA delivery plans might benefit from these partnerships.



8

Regional Centers – Final MP

Northwest Regional Center
Level 3 Partnership
User Pop. - 55,186

Service	City/Healthmarkets
Internal Medicine	4,875
Neurology	1,475
Cardiology	1,475
General Surgery	2,975
ENT	1,475
Orthopedics	1,475
Urology	1,475
Obstetrics/Gynecology	1,475
Emergency	1,475
Psychiatry	1,475
Behavioral Health	1,475
Specialty Services	1,475
Medical Laboratory	1,475
Immunization	1,475
Health Services	1,475
Pharmacy	1,475
Other	1,475
Total	32,425

Northwest Regional Center
Level 3 Partnership
User Pop. - 74,888

Service	City/Healthmarkets
Internal Medicine	4,875
Neurology	1,475
Cardiology	1,475
General Surgery	2,975
ENT	1,475
Orthopedics	1,475
Urology	1,475
Obstetrics/Gynecology	1,475
Emergency	1,475
Psychiatry	1,475
Behavioral Health	1,475
Specialty Services	1,475
Medical Laboratory	1,475
Immunization	1,475
Health Services	1,475
Pharmacy	1,475
Other	1,475
Total	32,425

Area Medical Center
Level 4 Partnership
User Population - 130,341

Service	City/Healthmarkets
Internal Medicine	2,475
Neurology	2,475
Cardiology	2,475
General Surgery	4,975
ENT	2,475
Orthopedics	2,475
Urology	2,475
Obstetrics/Gynecology	2,475
Emergency	2,475
Psychiatry	2,475
Behavioral Health	2,475
Specialty Services	2,475
Medical Laboratory	2,475
Immunization	2,475
Health Services	2,475
Pharmacy	2,475
Other	2,475
Total	15,033

The relative approximate potential market for each Regional Center is identified below the Service Population by county for 2015 that might access such care if available.

Regional Center	Projected User Pop.	Projected Market (Service Pop.)
Northwest RC	26,888	32,425
Southwest RC	37,007	66,871
Northwest RC	55,186	99,012

The relative approximate potential market for the Area Wide Medical Center is identified below the Service Population by county for 2015 that might access such care if available.



Area Medical Center	Projected User Pop.	Projected Market (Service Pop.)
Area Medical Center	130,341	207,426

The Portland Area made significant strides toward developing regional concepts from 2003 to 2005


October 2005

9

This Scope of Work

Suggests...



Regional facilities are intended ...

- for smaller Tribes.
- reduce dependency on CHS funding
- opportunity for direct care revenues
- reinvested in the respective regions.
- geographically dispersed/autonomous user populations

The IHS health services preliminary planning process ...

- based upon the user population
- can develop preliminary demand/sizes for PC OP & IP facilities
- cannot determine preliminary demand/size of OP regional referral center

The purpose of this study is to...

- document a different means for determining demand
- useable over a cross-section of IHS areas
- recommendation(s) to modify the existing IHS preliminary process
- validate supportable need for a new category of health service delivery
- identification of additional facilities needs across Indian country
- ensure these facilities are scored and ranked in priority system

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The HFCPS: The Priority List

IHS Health Care Facilities FY 2011 Planned Construction Budget ^{a/}
(\$000)

FACILITY	Prior to FY 09 ^a	FY 09	FY 10 Request	FY 11 Est.	FY 12 Est.	FY 13 Est.	FY 14 Est.	Outyears Est.	Total Cost ^{***}	Could Use FY 10
Planning Studies: ^{b/}	-	-	-	500	500	500	500	500	-	500
Inpatient Facilities: ^{c/}										
PHMC AZ Health Care System:										
SAGE ACC: ¹									70,650	64,000
NIE ACC: ²	2,590	4,000	-	32,000	33,000	-	-	-	70,100	5,000
Central Hosp & ACC: ⁴	100	-	-	35,000	35,000	-	-	-	70,100	5,000
Central Hosp & ACC: ⁴	575	-	-	-	-	-	-	523,925	524,500	1,000
Blaine: AK Hosp: ⁵	33,624	-	15,234	50,000	36,042	-	-	-	154,900	50,000
Whitmore: AZ Hosp: ⁶	200	-	-	-	13,000	73,800	72,000	-	71,000	13,000
Clifton: NM: ⁷	300	-	-	-	-	-	-	556,700	557,000	-
Outpatient Facilities: ^{c/}										
Es Yuma: CA: HC: ⁸	2,208	-	-	35,000	-	-	-	-	37,208	35,000
Kaysville: AZ HC: ⁹	6,318	12,000	7,000	40,000	44,000	40,682	-	-	150,000	40,000
San Carlos: AZ: ¹⁰	8,604	14,000	7,000	40,000	46,306	-	-	-	116,000	40,000
Washita: OK: ¹¹	200	-	-	5,000	35,500	35,300	-	-	76,000	5,000
Dillon: AZ: ¹²	500	-	-	8,500	50,000	50,000	34,000	-	143,000	8,500
Alamo: NM: ¹³	100	-	-	3,000	18,750	18,750	-	-	40,600	3,000
Pueblo: Pueblo: NM: ¹⁴	-	-	-	-	-	2,500	31,500	-	34,000	-
Bostwick: OK: AZ: ¹⁵	-	-	-	-	-	2,500	33,500	-	36,000	-
Ambulatory Health Care System:										
Albuquerque West: NM: ¹⁵	-	-	-	-	5,000	28,000	27,000	-	60,000	-
Albuquerque Central: NM: ¹⁶	-	-	-	-	-	6,000	75,500	-	81,500	-
Sedillo: AZ: ¹⁷	-	-	-	-	-	9,000	118,000	-	127,000	-
North Regional Treatment Centers (Section 704): ^{e/}										
S. California YRTC: ¹⁶	1,300	-	-	19,000	-	-	-	-	20,300	19,000
N. California YRTC: ¹⁷	1,379	-	-	18,000	-	-	-	-	19,379	18,000
Joint Venture Construction Program (Section 818): ^{e/}										
Health Facilities: ¹⁸	17,361	-	-	5,000	5,000	5,000	5,000	5,000	-	5,000
Small Ambulatory Programs (Section 300): ^{e/}										
Small Health Clinics: ¹⁹	39,273	-	-	10,000	10,000	10,000	10,000	-	-	10,000
Dental Facilities Program:										
Dental Units: ²⁰	15,434	-	-	3,000	3,000	3,000	3,000	-	-	-
Non-IHS Funds Renovation Projects (Section 305): ^{e/}										
Equipment Projects:	-	-	-	-	-	-	-	-	-	-
TOTAL	167,845	40,000**	39,234	292,500	321,938	247,032	267,350	1,431,625	3,548,077	317,000
UNFUNDED (FY 2010-Outyears): ^{f/}										2,442,579

A

B

D

C


This complete page is provided as a handout.

Small Ambulatory Care Projects for HFCPS Ranking are not currently shown. Congress recently directed IHS to develop a top 10 list (different than the SA Grant Program shown)

\$\$ Unfunded

Let's Talk...

- What is a "Regional Center"?
- How is a Regional Center different from an...
 - Inpatient Facility
 - Ambulatory Care Facility
 - "Other"?

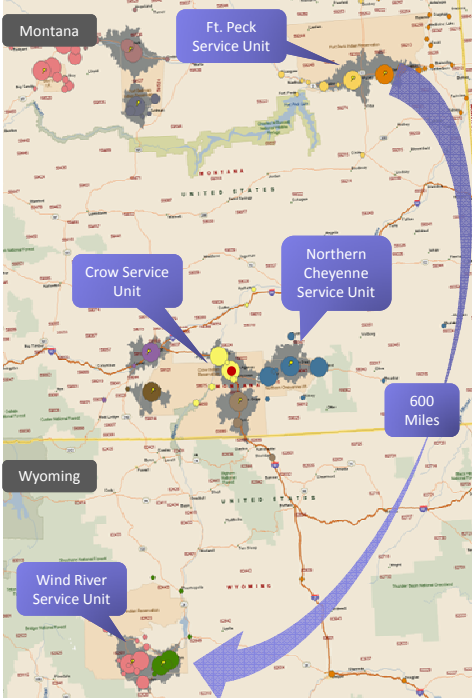


Regional Centers


The Big Idea...

Services based on discreet population assignment

- **One** Primary Service Area (PSA)
- **One or more** Extended Service Areas (ESA)
- **One** Facility
- This example: • Crow/Northern Cheyenne Hospital, Billings Area



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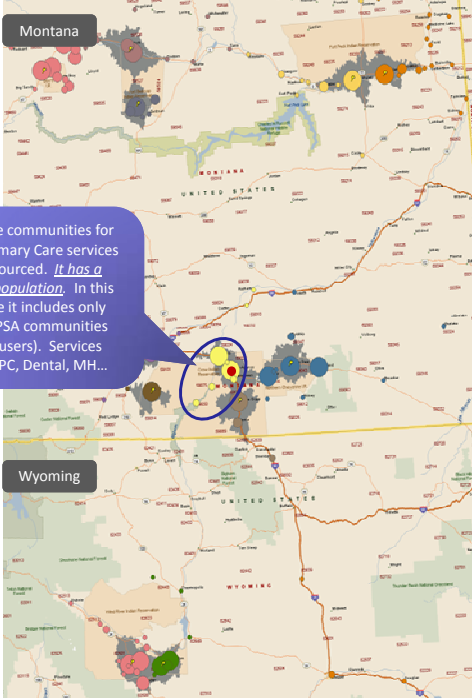


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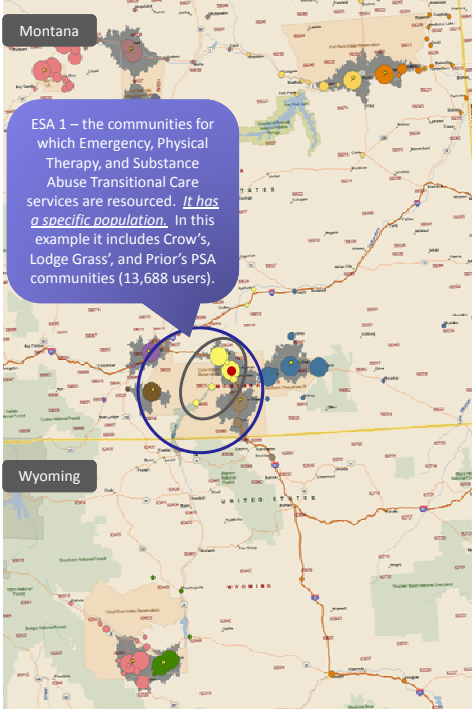


Regional Centers


The Big Idea...


Services based on discreet population assignment

- **One** Primary Service Area (PSA)
- **One or more** Extended Service Areas (ESA)
- **One** Facility
- This example: ● Crow/Northern Cheyenne Hospital, Billings Area



ESA 1 – the communities for which Emergency, Physical Therapy, and Substance Abuse Transitional Care services are resourced. *It has a specific population.* In this example it includes Crow's, Lodge Grass', and Prior's PSA communities (13,688 users).


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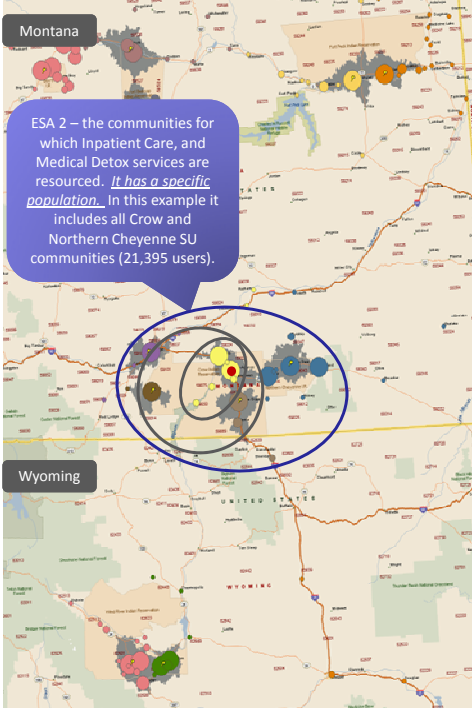


Regional Centers


The Big Idea...

Services based on discreet population assignment

- **One** Primary Service Area (PSA)
- **One or more** Extended Service Areas (ESA)
- **One** Facility
- This example: ● Crow/Northern Cheyenne Hospital, Billings Area



ESA 2 – the communities for which Inpatient Care, and Medical Detox services are resourced. *It has a specific population.* In this example it includes all Crow and Northern Cheyenne SU communities (21,395 users).


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Regional Centers

The Big Idea...

Services based on discreet population assignment

- One Primary Service Area (PSA)
- One or more Extended Service Areas (ESA)
- One Facility
- This example:
 - Crow/Northern Cheyenne Hospital, Billings Area

ESA 3 – the communities for which Orthopedics, General Surgery, Radiologist, Oral Surgery and SA Residential Treatment services are resourced. *It has a specific population.* In this example it includes all Crow, Northern Cheyenne, Wind River and Ft. Peck SU communities (45,963 users).

This Regional Services plan is multi-tribal, multi-SU, multi-state.

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Regional Centers

The Big Idea...

Workload assignments made in the Delivery Plan section of your Master Plan determine the size of the ESA and the services it will offer.

Discipline	Projected Need		Key Characteristics	# Req'd	Summarized in the Direct Care Services Distribution Plan		Considered in the Regional Referral Partnership Plan	
	PSA Direct Care	ESA Direct Care			PSA	ESA		
Dentist Service	248,367	248,367	Dentists	1.5	248,367	1.5		
Optometry Visits	431	431	Optometrists	2.2	431			
Podiatry Visits	455	455	Podiatrists	0.2	455			
Dialysis Patients	18	18	Dialysis Stations	4.8				

Summarized in the Visiting Professional Summary

Summarized in the Contract Health Summary

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Let's Talk...




- *What is a Regional Center's user population?*
- *Because of Extended Service Areas, should Regional Centers be grouped with Inpatient Facilities?*




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Primary Tools – HSP & HFCPS





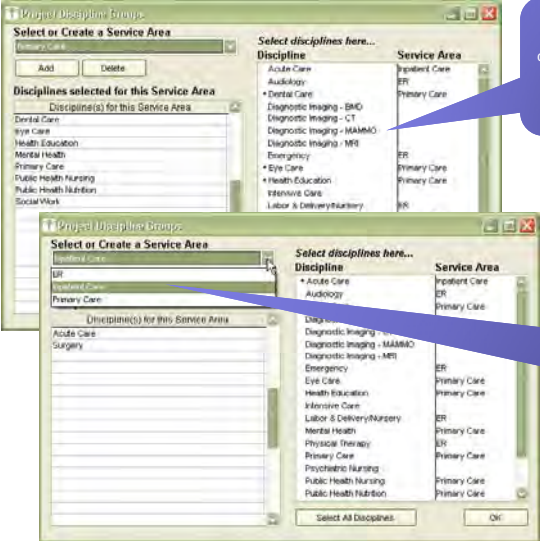
- **Health Systems Planning (HSP)** is a health services planning software that allows the user to “build” a healthcare facility with one or more user defined service areas and manual overrides where appropriate. It projects workloads, staff and space both as summaries and room-by-room. It is the tool by which IHS justifies services for planned facilities. It incorporates the Required Resources Methodology (RRM) as its base staffing projection tool. It typically supports the creation of PJD/POR documentation.
 - Established in 1995
 - Updated with User Pops, Metrics, Design Tools, etc.
- **Healthcare Facilities Construction Priority System (HFCPS)** helps IHS comply with a directive from the Indian Healthcare Improvement Act to provide Congress a list of the 10 highest priority IP & OP facilities construction projects. 6 criteria are applied during 2 phases to determine ranking for 4 facility types or categories.
 - Established in 1991
 - Congress directed IHS to revise the HFCPS in 2000



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The HSP: *Service Area Specific*









Services are selected from a comprehensive list and assigned to the appropriate service area.

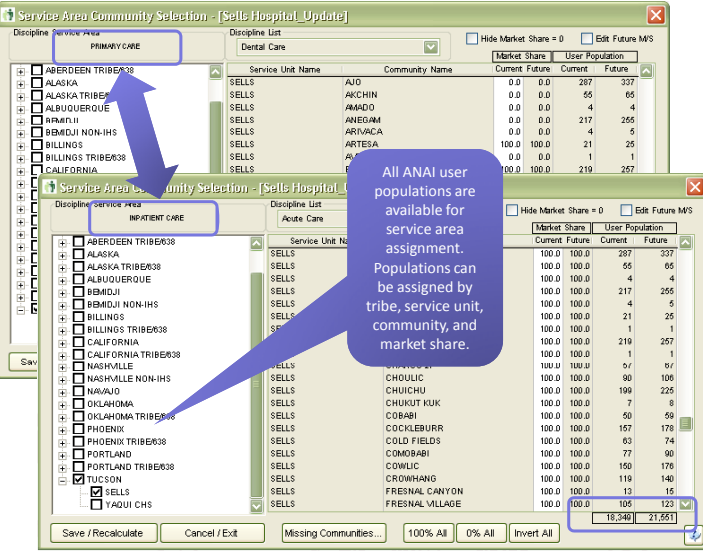
Multiple service areas can be created. For this project 3 distinct service areas are designed for specific services.

HSP Software allows the creation of multiple service areas to which services are assigned in step 1 and populations are assigned in step 2. This example shows a clinic plan with 3 distinct service areas: Primary Care, Inpatient Care, and Emergency Care.


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The HSP: *Community Specific*



All ANAI user populations are available for service area assignment. Populations can be assigned by tribe, service unit, community, and market share.

Populations are assigned to each service area (after its created). This allows each clinical or support service resource to be driven by a specific population. Populations can be selected by tribe, community and market share.


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The HSP: *Population Specific*

Current / Projected User Population, Primary Care - (PC)
(Dental Care, Eye Care, Health Education, Mental Health, Primary Care, Public Health Nursing, Public Health Nutrition, Social Work)

SELLS - ARYESA (PSA)

Male	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	Total
cur 2009			2	1	1	3	4	6	2	1		16
prj 2015			2	1	1	4	6	2	1			17

Current / Projected User Population, Inpatient Care - (AC)
(Medical Care, Surgery)

SELLS - ACH (PSA)

Male	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	Total
cur 2009						1						1
prj 2015						1						1

Current / Projected User Population, Ambulatory Care - (AO)
(Dental Care, Eye Care, Health Education, Mental Health, Primary Care, Public Health Nursing, Public Health Nutrition, Social Work)

SELLS - AJO (PSA)

Male	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	Total
cur 2009	6	15	12	10	10	15	14	20	14	11	5	131
prj 2015	6	19	14	12	12	19	17	24	17	13	6	157

Services such as Dental, Eye Care and Primary Care are driven by "Primary Care" populations

Services such as Acute Care and Surgery are driven by "Inpatient Care" populations

Each department's workload, and therefore space and staff need, is driven by the population (PSA/ESA) it serves.

ESAs Driven

PSAs Driven

Building Area Summary...

Template Or Discipline	Net Square Meters	Conversion Factor	Department Square Meters	
Administration				
Administration	AD	246.00	1.40	344.40
Business Office	BO	122.00	1.40	170.80
Health Information Management	HIM	261.00	1.25	326.25
Information Management	IM	78.00	1.20	93.60
				935.05
Ambulatory				
Audiology	AU2	64.30	N/A	81.00
Dental Care	DCC17	524.40	N/A	787.00
Emergency	ER3	229.70	N/A	389.00
Eye Care	EC1	128.20	N/A	163.00
Primary Care	PCP10	775.00	N/A	1124.00
Specialty Care	SC	157.00	1.40	219.80

Populations assigned to each service area are then used to produce workload projections that drive the creation of resource needs such as staffing and space. Resource needs are then totaled to show comprehensive need.

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The HFCPS: *Four Categories*

4 Facility Types permits IHS to rank each facility's need relative to other similar facilities. There are currently 26 ranked projects totaling an estimated \$2.54 billion in anticipated funding requirements.

- Category A – Comprehensive Health Care Center**
Ambulatory Care Facility, 40 hours per week, basic health team and services for acute and chronic ambulatory problems (could include alternative rural hospital)
- Category B – Comprehensive Inpatient Facility/Medical Facility**
Inpatient and ambulatory care, usually providing general surgery and full service OB/GYN. Meets minimum IHS ADPL>=15
- Category C – Small Health Care Clinic**
Ambulatory Care Facility designed to serve populations generating 4400 PCPVs or less
- Other – Other**
Facilities other than those described above (Youth Regional Treatment Centers, Dental Units, etc.)

35.4% of funding requirements: Ft. Yuma CA, Kayenta AZ, San Carlos AZ, Rapid City SD, Dilkon AZ, Alamo NM, Pueblo Pintado NM, Bodaway Gap, AZ, Albuquerque HCS (2), Sells AZ

63.1% of funding requirements: PIMC (Hosp & 3 ACCs), Barrow AK, Whiteriver AZ, Gallup NM

0.0% of funding requirements: no projects identified

1.6% of funding requirements: Youth RTC (2) CA

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The HFCPS: *Six Criteria/Two Phases*

Health Status (20%) – increases ranking where there are relatively fewer resources for health programs

Isolation (10%) – increases the ranking related to distance from closest ER

Facility Size (15%) – increases the total ranking inversely proportional to the size of the facility

Facility Deficiencies (40%) – indicates space deficiency by comparing existing space, age and condition, with space required to service population

Maximum Point Score = 850


Barriers to Services (15%) – identifies accessibility of healthcare dependant on travel time and other barriers

Innovation (10%) – increases the total ranking where a Tribe has documented innovation in acquiring a facility or delivering health services.

Maximum Point Score = 1,000

Phase 1 - The Facility Needs Assessment Process
permits IHS to develop a categorized, preliminary ranking of all healthcare facilities needs using available data in the IHS services and facilities database

Phase 2 - The Project Prioritization Process
permits IHS to use the categories and preliminary rankings to focus resources on a group of PSA projects for more intensive validation, evaluation and possible selection for funding and prioritization under one of the authorized healthcare facilities construction programs



Phase 1
All Facilities Scored Based on 4 Criteria

Phase 2
Validation on anticipated Congressional Funding

Highest Ranking Facilities Advised to Proceed with Planning

Priority Ranking


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The HFCPS: *Inputs & Impact*

Criteria =>	Phase 1										Phase 2				
	Facility Deficiency (400 Pts)					Health Status (200 Pts)					Isolation (100 Pts)	Facility Size (150 Pts)	Facility Deficiency (400 Pts)	Barriers to Service (50 Pts)	Innovation (100 Pts)
	Required Space		Adjusted Existing Space			Birth Disparities Index	% Pop over 65	Composite Poverty Index	Disease Disparities Index	Distance from ER	Size of Facility (smaller = better)	Required Space	Yes/No	5 Possible Elements	
User Pop	# Days	Facility Age	Condition Adjustment (FEDS)	Cost/\$M to Replace	HSP (Un-deviated)										
Inputs =>															
Regional Center	Could Harm Scoring - Insufficient Entry Capability	Could Harm Scoring - OP/Ancillary Sensitivity Required	Could Help Scoring for a New RC	Irrelevant for New RC	Irrelevant for New RC	Impact Unclear Despite More Appropriate Use of Data	Impact Unclear Despite More Appropriate Use of Data	Impact Unclear Despite More Appropriate Use of Data	Impact Unclear Despite More Appropriate Use of Data	Unclear - rural location could help; urban could harm	Would Likely Harm Scoring Rank	Could Help Scoring for a New RC	Could Help Scoring for a New RC if Population Centric	Could Help Scoring for a New RC	
Outpatient Facility	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Inpatient Facility	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Unclear	Unclear		
Small Ambulatory Care	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	Unclear	Unclear		
Other	Unclear	Unclear	✓	✓	✓	Unclear	Unclear	Unclear	Unclear	✓	✓	Unclear	Unclear		

Phase 2 only shows new or changed criteria



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The HFCPS: *Regional Centers?*



- Facility type categories do not identify a regional facility option.
- User population input does not allow for multiple services areas. This is a critical planning element in accurate regional services forecasting.
- Required Space assumes OP has a single user population input. IP facility size based on single patient day input regardless of the OP service area complexity. More sensitivity appears to be required.
- Health Status disparities calculation is an area-wide number that does not offer appropriate detail of populations that might benefit most from regional services.
- Isolation Status assumes a single population “anchor” from which to determine the distance to an ER. This will not accurately reflect isolation issues dispersed populations face.
- Assuming one used the “other” category to rank Regional Centers, the means of comparing the need (using existing criteria) with a YTC or Dental project is unclear. Some criteria appear irrelevant.
- More...?

In what ways does the HFCPS not support the selection and ranking of regional centers?



Let's Talk...



- *Why is the current system organized around Inpatient, Ambulatory Care, Small Ambulatory Care, and “Other”?*
- *What's wrong with “the system” relative to regional centers?*
- *How should Regional Centers be prioritized against each other?*
- *Is there a separate funding source for Regional Centers?*
- *Should and can one be created?*
- *Why and How?*

Lessons from Real Life "RCs"



- What is their history of service delivery?
- What was their mission and opportunity?
- What challenges do these centers face?
- What are the PSA & ESA structures upon which their healthcare delivery rests?
- Is service delivery truly driven by regional populations they were commissioned to serve or by some other interest?
- What lessons can be learned from them?



1
Alaska Native Medical Center



2
Crow/Northern Cheyenne Hospital



3
Phoenix Indian Medical Center



4
Gallup Indian Medical Center



5
Sioux San Indian Hospital



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Lessons from Real Life RCs

	Alaska Native Medical Center	Crow / Northern Cheyenne Hospital	Phoenix Indian Medical Center	Gallup Indian Medical Center	Sioux San Indian Hospital
Partners	131 Federally Recognized Tribes in the state of Alaska. Entire state BSH contracted.	Crow Service Unit and Northern Cheyenne Service Unit. Hospital at Crow, OP Clinic at N. Cheyenne. IHS facilities.	IHS owned for benefit of all tribes in Phoenix Area. Partners with Service Units in proximity. Partners with 3 states. Tribes don't have a direct say specifically; might disassemble if they did.	IHS facility offering regionally sized services to Navajo, Zuni and Hopi populations without formal partnership.	IHS facility. No one lets a government entity what to do. 3 tribes invited to sit on governing body. Pine Ridge, Rose Bud, Cheyenne (all Sioux).
Board / Management Structure	Alaska Native Tribal Health Consortium; 15 members (13 from tribal health organizations, 2 at large). South Central Foundation; reps from Anchorage and surrounding area. Joint Commission Accredited Campus; 5 members from ANTHC, 3 from SCF.	No formal board structure aside from Governing Body that reviews "score card" and progress. CEO to CEO relationship on coordinated services.	Leadership Board in Hospital (CEO and 3-4 asst. directors). OP services board (Leadership Board plus reps from participating 6 SU tribes). IP service board (Leadership plus rep from each state for Area Services)	Governing Body: IHS employees and executive from SU and Area. Health Board community members selected by hiring practice.	Governing Body is an advisory group to CEO.
Frequency of Meeting	ANTHC: every 2 months. SCF - uncertain/As needed. Joint Operating Board - 5 times a year.	Governing Body meets 6 times a year for each facility.	Quarterly for IP services board; OP groups meets weekly or more or as needed (the lines blur between the OP and Leadership Board).	Governing Body: 2x/year. Health Board: 4x/year.	Governing Body meets 4x/year. Really they are the GR for the Service Unit, not the facility.
Responsible for...	ANTHC: statewide tertiary and secondary care. SCF: SU primary care services. JCAC: medical center day-to-day operations. Complex.	Bodies are combination of CEO, AG, Director of Nursing, executive leadership and executives from Area Office. General coordination.	Leadership Board: day to day hospital operations. OP services: services for immediate participating SUs. IP services: Care affecting entire area. Responsibilities not always clearly distinguished.	Governing Body: executive authority for us, safety issues, disciplinary actions, union issues. Health Board input on programs for SU.	Governing Body makes decisions or recommendations that are largely followed. Day to day responsibilities go to the CEO and leadership team.
Shared Costs?	Multiple level cost sharing based on agreements formed through their 4 tiered system: village clinic, health clinic, regional hospital, ANMHC. Complex.	Billings Area office moves funds according to agreements arranged by CEOs at each facility. Crow manages Hospital, N. Cheyenne the clinic.	All tribal shares are kept at PIMC for Planning, IT, etc. Only shares disbursed from Area Office are PHN, Dental, etc.	IHS facility - don't really "share" costs.	IHS facility - don't really "share" costs. However, SUs/CEOs talking about sharing costs on referrals made to referral center (ie. Rosebud).
Shared Revenues?	For services at JCAC there is a general split of 1/3 to SCF and 2/3 to ANTHC. Complex.	IHS facilities - not an issue	Any profit reinvested in PIMC or distributed by Area Office to tribes. Deeply bothers tribes.	IHS facility - revenues not "shared"	IHS facility - revenues not "shared". However, when there is a legitimate payor for a referral their country go to the private sector. Revenue is lost.
Effective Management	Most things are managed effectively.	Seems to be working adequately.	Facility deeply "in the red".	Works fairly well on the whole.	Happens when partner tribes hear no complaints about service in Rapid City.
Ineffective Management	Behavioral Health because ANMHC doesn't have these services. As a result they are provided by SCF. IP Substance Abuse treatment occurs at regional level.	Could be more proactive in taking advantage of regional services opportunities.	No good leadership group for Regional Services. Many leaders are on both boards. IP leadership makes most decisions. Use of people who don't have insurance. Retain folks for PC that came to us for surgery. Spreading care across tri-state area by visiting professionals.	Complaints from some SUs that we services are scheduled too far out. We are sent IP leadership for PC that came to us for surgery.	When there is a legitimate payor for referral they usually go to the private sector. Revenue is lost.
What would be done differently	Nothing specific identified. Invited to talk with leadership further.	Structure of actual partnership doesn't need much alteration.	More true collaboration. Distinctly staffed Leadership boards. IP & OP serve different populations and needs.	Not enough top-down management. Area comes to us more as a consultant than giving directives.	Separate entity to manage any regional services. Critical piece to consider is BSH process because tribes may take shares and eliminate regional opportunities.

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Regional Centers' Challenge









General Concerns...

- Cooperative Tribal Representation
- Equitable Cost Sharing
- Equitable Revenue Sharing
- Responsive to Regional Needs



Specific HQ Concerns...

- Patient Access
- Operation Concept
- Economic Viability
- Governance Issues


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Portland's Culture





- Do Portland Tribes have a track record of sharing services, costs, and revenue?
- Do Portland Tribes genuinely support regionalization of services?
- Are Portland Tribes ready to hammer out a mutually beneficial concept of operations?
- Who can speak for them?


Portland Area Medical Center
(Site to be Determined)
User Pop – 130,341

PAMC includes Fort Hall – 7,250

Northwest Regional Center <i>(in the Seattle Area)</i>	Southwest Regional Center <i>(in the Portland/Salem Area)</i>	Northeast Regional Center <i>(in the Spokane Area)</i>
User Pop – 59,186	User Pop – 40,469	User Pop – 23,436
Puyallup – 11,335	Klamath – 2,667	Colville – 10,887
Yakama – 14,615	Western Oregon – 13,876	N. Idaho – 4,640
Taholah – 4,974	Warm Springs – 7,231	Wellpinit – 3,312
Puget Sound – 15,131	Umatilla – 3,462	Coeur D'Alene – 4,597
NW Washington – 8,789	Southern Oregon – 7,094	
Neah Bay – 4,342	Cowlitz – 6,139	



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The HFCPS: *Inputs & Impact*




Phase 2 only shows new or changed criteria

Criteria =>	Phase 1										Phase 2				
	Facility Deficiency (400 Pts)					Health Status (200 Pts)					Isolation (100 Pts)	Facility Size (150 Pts)	Quality Deficiency (400 Pts)	Barriers to Service (50 Pts)	Innovation (100 Pts)
	Required Space		Adjusted Existing Space			Birth Disparities Index	% Pop over 55	Composite Poverty Index	Disease Disparities Index	Distance from ER	Size of facility (smaller = better)	Required Space	Yes/No	5 Possible Elements	
User Pop	IP Days	Facility Age	Condition Adjustment (FEDS)	Cost/AM to Replace	Facility Deficiency										
Sub-Categories =>															
Inputs =>															
Regional Center	Could Harm Scoring - Insufficient Entry Capability	Could Harm Scoring - OP/Ancillary Sensitivity Required	Could Help Scoring for a New RC	Irrelevant for New RC	Irrelevant for New RC	Impact Unclear Despite More Appropriate Use of Data	Impact Unclear Despite More Appropriate Use of Data	Impact Unclear Despite More Appropriate Use of Data	Impact Unclear Despite More Appropriate Use of Data	Unclear - rural location could help; urban could harm	Would Likely Harm Scoring Rank	Could Help Scoring for a New RC	Could Help Scoring for a New RC if Population Centric	Could Help Scoring for a New RC	
Outpatient Facility	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Unclear	Unclear	
Inpatient Facility	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Unclear	Unclear	
Small Ambulatory Care	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Unclear	Unclear	
Other	Unclear	Unclear	✓	✓	✓	Unclear	Unclear	Unclear	Unclear	✓	✓	✓	Unclear	Unclear	


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Portland's Response




Of the criteria used in the HFCPS, what should continue to be used for a Regional Center?


- Facility Deficiency
- Health Status
- Isolation
- Facility Size



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HCFPS Square Meter Calculation




- Outpatient = (.8 sm x User Pop) + 200 sm
- Inpatient = (3.5 sm x IP Days) + 5,500 sm
- Regional - ????

What factor complexity should be included in the creation of a Regional Center's square meter calculation?







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Operational Concerns




What are the critical operational questions that you believe have to be addressed to make a working concept of operation?







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Path Forward...




- Phase 1 - Forward
 - Agree on 3 Precepts (this needs definition – what is in the precept)
 - Discuss Precepts with IHS HQ
 - Provide documentation of Problem, Facts, Needs, Identified Precepts and Options for adapting the IHS planning process to PAFAC and PAO
- Phase 2 – Concept Development
 - Develop 3 Concepts from Precepts
 - Develop Concept of Operations Outline
 - Present to PAFAC
 - Revise and review with PAFAC
 - Present to IHS HQ through Conference Call
- Phase 3 – Concept Documentation
 - Develop and document final concept for PAFAC
 - Review by Conference Call
 - Revise and Publish Final Report
- Phase 4 (Optional) – Concept Application & Testing

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Project Schedule



June 10, 2009

- Kick-Off Meeting: *Workgroup Discussion/Precept Identification*
- Concept Development: *Strategic Concept Development, Data Review*
- +4 Weeks ▪ Concept Presentation Meeting: Concepts Presented to PAFAC
- Concept Refinement: Concept Presentation Meeting Follow Up
- +4-6 Weeks ▪ Concept Presentation to HQ: Facilitated by Conference Call
- +4 Weeks ▪ Revise and Publish Final Documentation
- TBA ▪ Optional: Concept Application and Testing

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Thank You for the Opportunity



Planning

Strategy Visioning

Population Assessment

- Demographic Change Profile
- Growth Assessment
- Real Estate Absorption Analysis

Service Area Definition/Validation

- Workload Overview
- Patient Profile
- Competitor Profile
- Population Distribution Overview
- Service Area Decision Facilitation

Market Opportunity Assessment

- Product Line Definitions
- Inpatient Opportunity
- Outpatient Opportunity
- Physician Needs Assessment
- New Competitor Market Carve-in Modeling

Operational Assessment

- Product Line Financial Analysis
- Physician Financial Profile Analysis

Capacity Analysis

- Key Characteristic Productivity Benchmarking
- Bed Utilization & Peaking Evaluation
- IP, OP, Ancillaries Key Characteristic Forecasting

Direction Development

- Executive Team and Board Facilitation

Facility Planning

Master Planning

- Functional Assessment
- Site and Building Analysis
- Financial Capacity Assessment
- Concept Options and Decision Phasing
- Total Project Cost

Medical Equipment Planning

- Existing Equipment Assessment
- Capital Budget Development
- Room by Room Equipment List & Budget
- Procurement Services

Capital Project Scope Definition

- RFP Development
- Space Programming
- Functional Programming

System Standards Development

- Space Planning Criteria
- Room by Room Equipment & Building Criteria
- Capital Project Cost Modeling

System Network Planning

- Multiple Facility Workload and Resource Modeling
- System Priority Criteria Facilitation
- System Capital Program Management

Project Management

Owner Management

- User Coordination
- Leadership & Hospital Project Communication
- Owner-Provided Building System Coordination
- Owner-Provided Building System Procurement
- Budget Management & Maintenance
- Schedule Management & Maintenance
- Transition & Occupancy Services
- Get Ready Project Management

Design Team Management

- AE Selection
- AE Negotiation & Contract Coordination
- Vendor Design Coordination & Management
- Design Process & Schedule Management
- City, State & Code Review Oversight
- Construction Cost Management
- AE Contract Management

Contractor Management

- Contractor Selection
- Contractor Negotiation & Contract Coordination
- Vendor Installation Coordination and Management
- Construction Process & Schedule Management
- City, State & Code Inspection Oversight
- Construction Cost & Change Management
- Contractor Contract Management

Implementation

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Facility Priority System – HFCPS Study Kick-Off Meeting Comments

Portland, Oregon – Marriott City Center, June 10, 2009

PAFAC Members Present: Pearl Capoeman-Baller, Julia Davis-Wheeler, Leslie Dye, Mark Johnston, Angela Mendez, John Stephens

Facilitators Present: Gene Kompkoff (PAO), Mathew Martinson (PAO), John Temple (TIG), Anthony Laird (TIG)

Notes/Comments

Innova needs to acquire the purpose statement from the PAFAC along with their charter and guiding documentation if possible.

What is the motivation for a Regional Center?

- Isolation – some tribes just cannot get critical care that they need
- Cost of care for people that are being referring out
- A lot of unmet need because of the contract health system (day surgery, endoscopy, etc.)
- Health disparities – each of us as Portland Area tribes don't have a set of excellence for treating those (?)
- Limited in specialty providers in our area and the doctors often don't treat the people right
- CHS dependant, forced to refer out to specialty care – non-Indian, insensitive, costly, and there's a feeling that we could do much better than we're currently doing in the existing structure
- Specialty care that is provided in an IHS center is concentrated around a large population.
- We have tribal members that don't live within our CHSDA that can't get specialty services
- We have 3 urban centers with large populations for whom the system does not adequately recognize their needs
- We don't have any hospitals (Julia referred specifically to her treaty which specified a hospital)
- Innova: *what's your sense of how many of your people don't have insurance, what percentage?* They really didn't have a specific answer but they felt it would be high. And it doesn't even deal with the non-CHSDA populations
 - *John Temple made this an assignment for people to find out*
- Mark – we've been in this conversation for 15 years; started as a rerouting of CHS \$ initially, evolved to hospital desires and now has settled in on the need for specialty care
- Reliance out to referrals to non-Indian providers may provide a different level (quality) of care than if we were able to refer to Indian providers
- We have patients in our system that don't come in soon enough and by then it's too late for them. They may be doing this because they hear the "we're on priority one" message all the time. The elders hear they are short of money and think it should go to younger people

Notes taken by Anthony Laird of The Innova Group and reflect his following and understanding of conversations/comments throughout the meeting. Corrections and errors should be submitted within 5 business days.



John and Mark stressed: It's important to define access to care as our patients not having to pay out of pocket. The access is not as much driven by time or distance as by payor.

Innova: **Market Share is a big planning assumption – our RCs are based on 100% and that is not realistic. But be aware that in certain regions the user pop is 120% of the service pop.**

Mark thought the user pop had gone down since the master plan. **This needs to be checked on.**

How does the new IHS director feels about this?

Committee chair – I would frame this as true reform not just tweaking the system. We've been pushing for an area allocation system rather than national scoring system.

What is a Regional Center?

- A place where we have specialty care available, endoscopic, stress, etc. (all the things that wind up in priority 2 CHS). So an orthopedic doing hip, we need surgery, or and OB/Gyn doing tubal ligation, or a cardiologist. It could involve specialties happening on a rotating basis. So, in short, a higher level of care not available at the local level.
- Put in a place where there is also access to inpatient care – as back up for surgical, anesthesia, etc.
- A place where there is no incurring the high cost of maintaining a hospital. (Leslie Dye was quite clear that it doesn't provide 24/7 IP care or "we might as well just call it a hospital")
- Its culturally friendly
- No primary care
- Doesn't currently fit in to the system – its secondary care natives normally don't have access to.
- Do we have the right name? Should it be a referral center, specialty care diagnostic center?
 - Multi-tribal is a big part of it
 - Multi-tribal specialty referral center

Grouped seemed to identify that the population of a specialty care referral center is complex. It's not a single answer.

Lobbying is probably an important effort at this point

Roubideaux is more connected with the White House than others in the past... (innovation, reform, evidence based, cost efficient. A demonstration could cover all of these. In her letter she said her focus was going to be greater access and greater quality.

Could CHS deficiency be one of the critical drivers in ranking this kind of center?

Notes taken by Anthony Laird of The Innova Group and reflect his following and understanding of conversations/comments throughout the meeting. Corrections and errors should be submitted within 5 business days.



Could the carving up of dollars remove the political aspect of facility prioritization? ...send dollars to area offices and let them decide how they want to use it.

One challenge for Regional Centers is folks from the descendency list coming for care and essentially “taking our services”. So the dilution of moneys across larger populations is “hurting us”. This issue was raised later and the chair asserted that the need to count user populations that they feel are larger than reported does not sit in conflict with this concern. The fear is the displacement of care among enrolled tribal members by descendants, because the system is underfunded in the first place, by the addition of direct care in the regional centers...

CHS dollars would solve part of the descendency list issue (not certain how this would work)

Critical strategic question: *Do we adapt the priority system or challenge it?*

Gene suggested another box in Phase 1 defining the number of specialty care visits as a way of ranking regional centers.

How would you ensure you had cooperative tribal representation on a regional center board?

- First, consult with the tribes
- Using SW RC as an example, there would be 9 tribes in Oregon (remember: “as we build one, it’s going to serve everyone until we build another”)
- If the Feds built it and you took it over, would you allow a 638-ed tribe to take it over?
- Could have the existing health board act as the contracting entity on behalf of the tribes
- NWPIHB would manage the equitable cost and revenue sharing (workgroup responded well to this idea)
- Could monies collected be reinvested in the facility itself like a utility? The thought was that this might not work
- Mark: “If it does not pay its own bills then cost sharing is going to be a problem”. Our assumption is the cost would not be a problem because it comes with federal operational funds attached.
- Revenue should just be split up equitably (other suggestions: let it go back to the center or fund travel or other... like the example of gambling machines in Washington)
- Patients without 3rd party insurance will drive by care while those with 3rd party insurance will probably not drive by
 - How do we respond to this in our planning? The methodology could take 33% of visits from a tribe that drives by 2 opportunities versus 67% from a tribe that drives by 1 (Or something like that)

Notes taken by Anthony Laird of The Innova Group and reflect his following and understanding of conversations/comments throughout the meeting. Corrections and errors should be submitted within 5 business days.



Clarification was made by the chair that though we've defined regional centers as not having an inpatient component this does not mean the PAFAC doesn't want to see such care in the Portland Area. The Portland Area Medical Center is "still on the table". The PAFAC simply defined a Regional Center as not being 24/7 care.

In evaluating the relevance of ranking Regional Centers, should we continue to use...?

Should we use Health Status?

- Birth disparities (probably not)
- Age over 55 (could be useful)
- Poverty (yes/no... but more no)
- Disease Disparity (yes)

Should we use Isolation?

- Yes as discussed.
- We've had extensive discussion about this. Isolation for us is about access – no out of pocket care. Maybe here it has to do with distance from an IHS or Tribal hospital. Or... distance from the proposed location to the next IHS or Tribal facility offering comparable services. But access is still a better definition of the problem

Should we use facility size?

- No, because this rewards small facilities.

What other criteria should be considered?

- There has to be some weighted factor related to contracted health dependency (matter of fact, this may be the same issue as the access point)
- Ability to staff (perhaps related to distance from urban center and size of urban center)... perhaps quantity of staff in locale, presence of medical schools

Notes taken by Anthony Laird of The Innova Group and reflect his following and understanding of conversations/comments throughout the meeting. Corrections and errors should be submitted within 5 business days.



What about moving innovation from Phase 2 to Phase 1? And let's put meat on it...

- # of tribal governments participating in a venture
- Phase 2 should actually be before Phase 1... and it should include (*is this list correct?*)
 - CHS Dependency
 - Access to Care (Staff Retention/Recruitment)
 - Facility Deficiency
 - Health Status
 - Innovation

For a calculation or formula, we should ask what the private sector does. They must have a method. One option might simply discount the primary or specialty care visit rate, degrading it by payor and distance.

Regional facilities should have a pharmacy that only fills scripts from visits to that location.

Other critical operational questions that have to be addressed:

- Regional Center would require its own administration
- An EHR would be helpful
- Telemedicine to help with consults back at the home clinic (it helps access issues as well)
- What about CHS? The referral center would send tertiary referrals back to the source tribe for CHS approval

Next Meeting: Concept Presentation Meeting – July 7th in Seattle

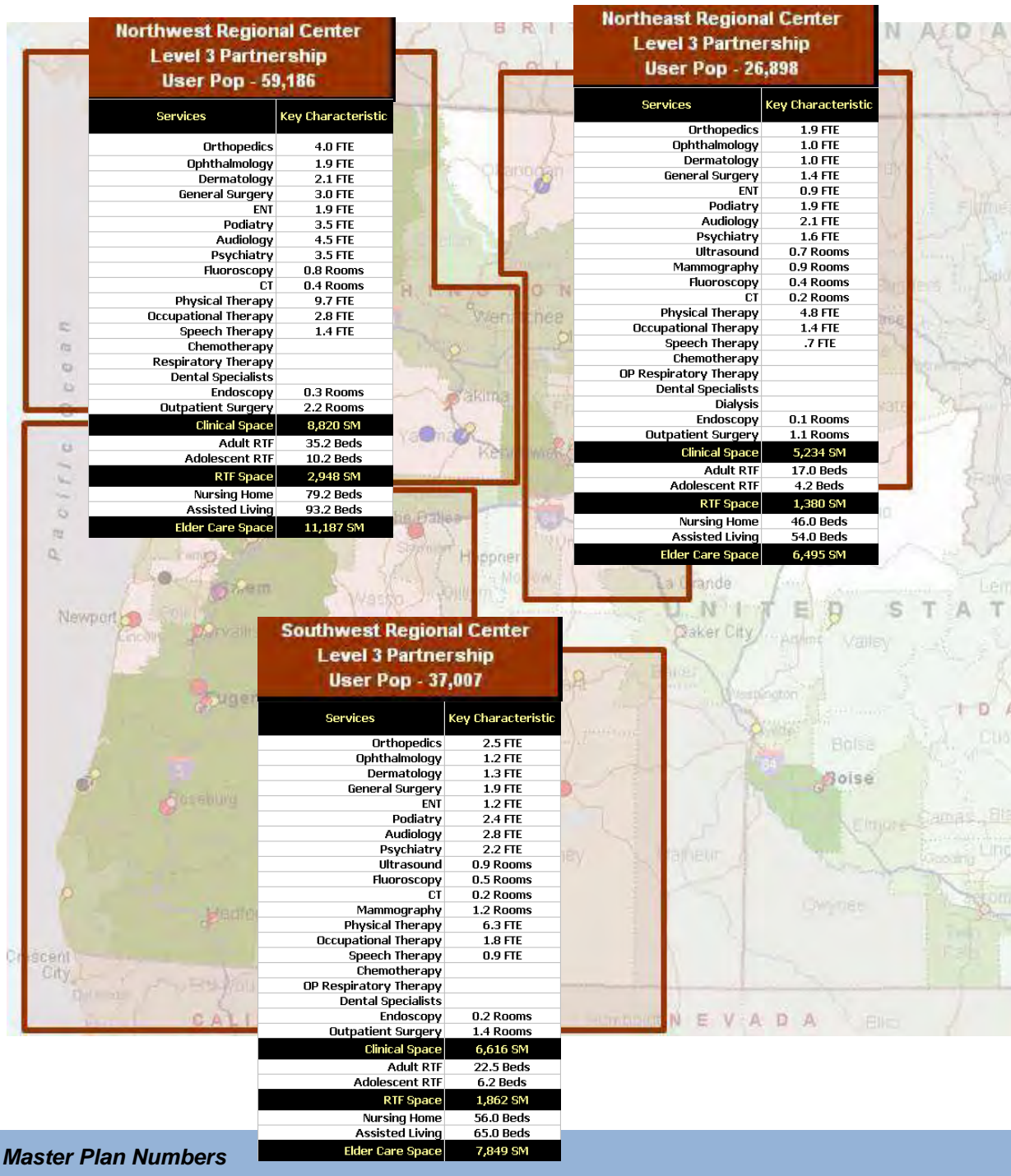
Notes taken by Anthony Laird of The Innova Group and reflect his following and understanding of conversations/comments throughout the meeting. Corrections and errors should be submitted within 5 business days.



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Packet 1 – Scenario Building



Master Plan Numbers

Regional Center	Projected User Pop	Projected Market (Service Pop)
Northeast RC	26,898	32,628
Southwest RC	37,007	66,871
Northwest RC	59,186	98,015



Regional Centers - Service Unit Alignments

Northwest (Seattle) Regional Center

- Puyallup
- Yakama
- Taholah
- Puget Sound
- Northwest Washington
- Neah Bay

Southwest (Portland) Regional Center

- Klamath
- Western Oregon
- Warm Springs
- Southern Oregon
- Umatilla

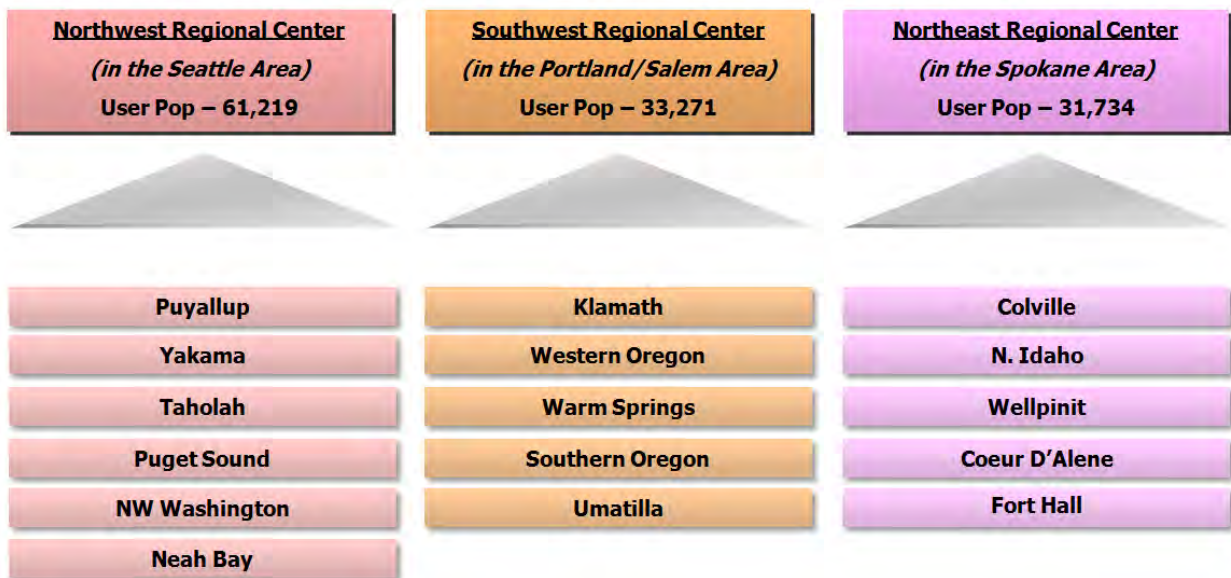
User Pops projected to 2020 differ somewhat from original Master Plan projections.

Northeast (Spokane) Regional Center

- Colville
- North Idaho
- Wellpinit
- Coeur D'Alene
- Fort Hall

User populations shown below reflect projected 2020 users considered for Specialty Care without any Primary Care base.

Modified Alignment from Master Plan





	1		2		3		4	
	Southwest Regional Center - Portland Service Options							
	Scenario 1 - 100% MS				Scenario 2 - Eroded MS (36.7 %)			
	w/out PC		with PC		w/out PC		with PC	
2020 Primary Care Service Area User Pop	-	-	25,213	25,213	-	-	25,213	25,213
2020 Specialty Care Service Area User Pop	33,271	33,271	58,484	58,484	11,583	11,583	36,716	36,716
PCPV's	-	-	98,972	98,972	-	-	98,972	98,972
SCPV's	37,293	37,293	66,612	66,612	12,225	12,225	41,544	41,544
Total Provider Visits (TPV)	37,293	37,293	165,584	165,584	12,225	12,225	140,516	140,516
	KC #	DGSM	KC #	DGSM	KC #	DGSM	KC #	DGSM
Services								
Ambulatory								
Primary Care (Providers)	-	-	24.0	3,087.0	-	-	24.0	3,087.0
Case Management (FTE's)	-	-			-	-		
Eye Care (Optometrist)	-	-	4.6	441.6	-	-	4.6	441.6
Audiology (Audiologist)	3.0	166.0	4.8	309.0	1.7	81.0	3.2	191.4
Dental Care (Dentist)	-	-	30.3	1,102.3	-	-	30.3	1,102.3
Dental Specialists								
Specialty Care								
Medical Specialties								
Cardiologist	1.0		1.8		0.3		1.1	
Dermatologist	0.6		1.1		0.2		0.7	
Neurologist	0.5		0.9		0.1		0.5	
Other Medical Specialist	3.3		5.8		1.1		3.6	
Surgical Specialties		1,225.0		2,204.0		136.3		1,225.3
General Surgeon	1.3		2.4		0.4		1.5	
Ophthalmologist	1.5		2.7		0.5		1.7	
Orthopedist	1.6		2.8		0.5		1.7	
Other Surgical Specialist	0.8		1.4		0.2		0.9	
Otolaryngologist	0.7		1.3		0.2		0.8	
Urologist	0.6		1.1		0.2		0.7	
Preventive								
Public Health Nutrition (FTE's)	-	-	4.1	46.2	-	-	4.1	46.2
Health Education (FTE's)	-	-	5.9	85.4	-	-	5.9	85.4
Public Health Nursing (FTE's)	-	-	36.9	564.2	-	-	36.9	564.2
Wellness Center (FTE's)	-	-	13.0	655.2	-	-	13.0	655.2
Ancillary								
Surgery (OR's)	2.0	625.0	3.0	851.0	-	-	2.0	625.0
Laboratory (FTE's)	4.7	183.0	25.9	330.0	2.2	80.0	22.1	276.0
Diagnostic imaging								
Radiography (Rooms)	1.0		3.0		-		2.0	
Fluoroscopy (Rooms)	-		1.0		-		1.0	
Ultrasound (Rooms)	1.0	504.0	2.0	996.8	-	99.4	1.0	672.0
Mammography (Rooms)	2.0		2.0		1.0		2.0	
CT (Rooms)	1.0		1.0		-		1.0	
MRI (Rooms)	-		1.0		-		-	
Bone Mineral Density (Rooms)	-		-		-		-	
Pharmacy (FTE's)	-	-	50.1	912.5	-	-	42.8	743.1
Physical Rehab Services								
Physical Therapist	-	173.2	9.2	1,290.4	-	125.8	9.0	1,152.6
Occupational Therapist	2.5		4.4		0.8		2.7	
Speech Pathologist	-		1.2		-		0.7	
Behavioral Health (FTE's)	-	-	58.5	1,544.5	-	-	58.5	1,544.5
Administration								
Administration (FTE's)	11.4	268.8	37.7	599.2	7.5	211.4	33.4	544.6
Information Management (FTE's)	4.5	111.6	18.5	316.8	2.3	68.4	16.5	283.2
Business Office (FTE's)	18.0	175.0	77.6	688.8	6.4	81.2	66.1	585.2
Health Information Management (FTE's)	25.7	438.0	86.9	1,008.8	9.9	211.3	74.9	890.0
Security (FTE's)	1.8	15.6	5.0	25.2	0.7	15.6	4.2	25.2
Facility Support								
Clinical Engineering (FTE's)	1.9	42.0	5.0	117.4	0.7	-	4.1	84.0
Facility Management (FTE's)	8.5	99.0	24.2	246.0	4.2	99.0	21.0	246.0
Support Services								
Medical Supply (FTE's)	0.7	122.0	0.7	122.0	0.7	122.0	0.7	122.0
Property & Supply (FTE's)	2.1	331.1	10.5	875.1	0.8	165.0	9.3	1,242.4
Total RRM FTE's	175.0		846.0		66.0		754.0	
BGSM		6,815.8		25,862.6		2,413.5		24,318.2
BGSM/TPV	0.183		0.156		0.197		0.173	
BGSM/SCPV	0.183		0.388		0.197		0.585	



	1		2		3		4	
	Northeast Regional Center - Spokane Service Options							
	Scenario 1 - 100% MS				Scenario 2 - Eroded MS (28.8 %)			
	w/out PC		with PC		w/out PC		with PC	
2020 Primary Care Service Area User Pop	-	-	8,743	8,743	-	-	8,743	8,743
2020 Specialty Care Service Area User Pop	31,734	31,734	40,477	40,477	8,874	8,874	17,613	17,613
PCPV's	-	-	34,014	34,014	-	-	34,014	34,014
SCPV's	36,956	36,956	46,896	46,896	9,842	9,842	19,782	19,782
Total Provider Visits (TPV)	36,956	36,956	80,910	80,910	9,842	9,842	53,796	53,796
	KC #	DGSM	KC #	DGSM	KC #	DGSM	KC #	DGSM
Services								
Ambulatory								
Primary Care (Providers)	-	-	9.0	1,019.0	-	-	9.0	1,019.0
Case Management (FTE's)	-	-			-	-		
Eye Care (Optometrist)	-	-	1.7	163.0	-	-	1.7	163.0
Audiology (Audiologist)	2.8	166.0	3.5	217.1	1.2	81.0	1.8	81.0
Dental Care (Dentist)	-	-	10.5	917.0	-	-	10.5	917.0
Dental Specialists								
Specialty Care								
Medical Specialties								
Cardiologist	1.1		1.3		0.2		0.5	
Dermatologist	0.6		0.8		0.2		0.3	
Neurologist	0.5		0.6		0.1		0.3	
Other Medical Specialist	3.2		4.0		0.9		1.7	
Surgical Specialties								
General Surgeon	1.4	1,225.3	1.7	1,619.7	0.3	136.3	0.7	364.0
Ophthalmologist	1.5		1.9		0.4		0.8	
Orthopedist	1.5		2.0		0.4		0.8	
Other Surgical Specialist	0.8		1.0		0.2		0.4	
Otolaryngologist	0.7		0.9		0.2		0.4	
Urologist	0.6		0.8		0.2		0.3	
Preventive								
Public Health Nutrition (FTE's)	-	-	4.2	46.2	-	-	4.2	46.2
Health Education (FTE's)	-	-	2.2	35.0	-	-	2.2	35.0
Public Health Nursing (FTE's)	-	-	13.5	240.8	-	-	13.5	240.8
Wellness Center (FTE's)	-	-	7.4	447.9	-	-	7.4	447.9
Ancillary								
Surgery (OR's)	2.0	625.0	3.0	851.0	-	-	2.0	625.0
Laboratory (FTE's)	5.8	183.0	12.7	276.0	1.9	80.0	8.5	218.0
Diagnostic imaging								
Radiography (Rooms)	1.0		2.0		-		1.0	
Fluoroscopy (Rooms)	-		-		-		-	
Ultrasound (Rooms)	1.0	425.6	1.0	564.2	-	99.4	1.0	292.6
Mammography (Rooms)	1.0		2.0		1.0		1.0	
CT (Rooms)	1.0		1.0		-		-	
MRI (Rooms)	-		-		-		-	
Bone Mineral Density (Rooms)	-		-		-		-	
Pharmacy (FTE's)	-	-	24.9	569.2	-	-	16.8	425.0
Physical Rehab Services								
Physical Therapist	-	171.1	3.4	489.1	-	-	3.0	450.6
Occupational Therapist	2.4		3.0		-		1.3	
Speech Pathologist	-		0.8		-		-	
Behavioral Health (FTE's)	-	-	22.2	600.0	-	-	22.2	600.0
Administration								
Administration (FTE's)	11.3	260.4	14.5	306.6	7.2	198.8	16.0	333.2
Information Management (FTE's)	4.5	90.0	9.5	145.2	2.0	68.4	17.4	145.2
Business Office (FTE's)	17.9	175.0	38.4	175.0	5.3	81.2	25.7	242.2
Health Information Management (FTE's)	25.3	427.5	43.0	292.5	8.3	182.5	29.8	380.0
Security (FTE's)	1.8	15.6	3.0	15.6	0.6	15.6	2.6	15.6
Facility Support								
Clinical Engineering (FTE's)	1.9	42.0	3.0	42.0	0.6	-	2.0	42.0
Facility Management (FTE's)	8.4	99.0	14.5	176.0	3.8	61.0	12.5	99.0
Support Services								
Medical Supply (FTE's)	0.7	122.0	0.7	122.0	0.7	122.0	0.7	122.0
Property & Supply (FTE's)	2.1	331.0	5.1	715.4	0.6	165.0	3.8	437.0
Total RRM FTE's	173.0		409.0		55.0		315.0	
BGSM		6,574.0		14,727.1		2,124.7		11,642.9
BGSM/TPV	0.130		0.133		0.158		0.158	
BGSM/SCPV	0.130		0.229		0.158		0.430	



	1		2		3		4	
	Northwest Regional Center - Seattle Service Options							
	Scenario 1 - 100% MS				Scenario 2 - Eroded MS (25.7 %)			
	w/out PC		with PC		w/out PC		with PC	
2020 Primary Care Service Area User Pop	-		36,311		-		36,311	
2020 Specialty Care Service Area User Pop	61,219		97,530		27,533		51,869	
PCPV's	-		146,036		-		146,036	
SCPV's	67,580		111,304		29,876		60,077	
Total Provider Visits (TPV)	67,580		257,340		29,876		206,113	
	KC #	DGSM	KC #	DGSM	KC #	DGSM	KC #	DGSM
Services								
Ambulatory								
Primary Care (Providers)	-	-	35.0	3,696.0	-	-	35.0	3,696.0
Case Management (FTE's)								
Eye Care (Optometrist)	-	-	6.6	645.9	-	-	6.6	645.9
Audiology (Audiologist)	5.0	323.1	7.7	519.8	2.5	81.0	4.3	273.9
Dental Care (Dentist)	-	-	43.6	1,601.7	-	-	43.6	1,601.7
Dental Specialists								
Specialty Care								
Medical Specialties								
Cardiologist	1.8		3.0		0.8		1.6	
Dermatologist	1.1		1.8		0.5		1.0	
Neurologist	0.9		1.5		0.4		0.8	
Other Medical Specialist	5.8		9.6		2.6		5.3	
Surgical Specialties								
General Surgeon	2.5	2,204.0	4.1	3,455.4	1.1	545.2	2.2	1,790.8
Ophthalmologist	2.7		4.5		1.2		2.5	
Orthopedist	2.8		4.6		1.2		2.5	
Other Surgical Specialist	1.4		2.3		0.6		1.2	
Otolaryngologist	1.4		2.2		0.6		1.2	
Urologist	1.1		1.8		0.5		1.0	
Preventive								
Public Health Nutrition (FTE's)	-	-	6.7	79.8	-	-	6.7	79.8
Health Education (FTE's)	-	-	7.7	113.4	-	-	7.7	113.4
Public Health Nursing (FTE's)	-	-	52.7	791.0	-	-	52.7	791.0
Wellness Center (FTE's)	-	-	15.1	712.4	-	-	15.1	712.4
Ancillary								
Surgery (OR's)	4.0	979.0	5.0	1,288.0	2.0	625.0	3.0	851.0
Laboratory (FTE's)	10.6	218.0	40.4	502.0	4.7	183.0	32.4	448.0
Diagnostic imaging								
Radiography (Rooms)	2.0		4.0		1.0		3.0	
Fluoroscopy (Rooms)	-		1.0		-		1.0	
Ultrasound (Rooms)	2.0	814.8	2.0	1,457.4	1.0	292.6	2.0	996.8
Mammography (Rooms)	2.0		4.0		1.0		2.0	
CT (Rooms)	1.0		1.0		-		1.0	
MRI (Rooms)	1.0		2.0		-		1.0	
Bone Mineral Density (Rooms)	-		2.0		-		-	
Pharmacy (FTE's)	-	-	77.8	1,821.1	-	-	62.5	1,466.8
Physical Rehab Services								
Physical Therapist	-	451.1	13.7	1,400.4	-	342.7	14.0	1,313.8
Occupational Therapist	4.6		7.3		4.6		3.9	
Speech Pathologist	1.4		2.0		1.3		1.0	
Behavioral Health (FTE's)	-	-	82.9	2,167.5	-	-	82.9	2,167.0
Administration								
Administration (FTE's)	16.3	327.6	53.0	814.8	10.2	224.0	45.2	694.4
Information Management (FTE's)	7.1	145.2	26.9	427.2	3.9	90.0	22.9	372.0
Business Office (FTE's)	32.2	308.0	120.5	1,040.2	14.6	166.6	96.7	831.6
Health Information Management (FTE's)	45.1	745.0	134.0	1,507.5	21.1	385.0	108.8	1,266.3
Security (FTE's)	2.9	15.6	5.2	25.2	1.4	15.6	4.2	25.2
Facility Support								
Clinical Engineering (FTE's)	3.1	42.0	7.8	185.6	1.6	42.0	5.8	137.1
Facility Management (FTE's)	13.7	176.0	27.6	404.2	7.1	99.0	22.9	323.7
Support Services								
Medical Supply (FTE's)	0.7	122.0	0.7	122.0	0.7	122.0	0.7	122.0
Property & Supply (FTE's)	3.7	607.0	15.5	2,275.3	1.7	331.0	13.2	1,822.4
Total RRM FTE's	299.0		905.0		133.0		1,060.0	
BGSM		11,241.0		39,946.7		5,469.7		33,589.8
BGSM/TPV	0.121		0.113		0.134		0.119	
BGSM/SCPV	0.121		0.262		0.134		0.408	



Service & User Pop by State and County - Comparison Markets

State	County	Region	Total 2005 User Pop	2005 Service Pop	2020 Service Pop	Service Pop Growth	Service Pop Growth Rate	User Pop to Service Pop	2020 Proj. User Pop	Unserviced Service Pop
AK	Anchorage	Anchorage	34,048	24,602	33,955	9,353	38.02%	138.4%	46,992	-13,037
AZ	Maricopa	Phoenix	64,634	76,433	109,454	33,021	43.20%	84.6%	92,558	16,896
AZ	Pima	Tucson	23,652	33,453	39,327	5,874	17.56%	70.7%	27,805	11,522
MI	Chippewa	(Sioux St. Marie) Bemidji	6,571	6,341	7,315	974	15.36%	103.6%	7,580	-265
NV	Washoe	(Reno/Sparks) Phoenix	5,347	7,848	10,199	2,351	29.96%	68.1%	6,949	3,250
NM	Bernalillo	Albuquerque	25,654	29,062	39,376	10,314	35.49%	88.3%	34,759	4,617
SD	Pennington	(Rapid City) Aberdeen	11,153	9,018	12,137	3,119	34.59%	123.7%	15,010	-2,873
Totals - All			125,858	153,137	205,671	52,534	34.31%	82.19%	169,650	



Counties within 60 Minute Drive Time of Proposed Regional Center

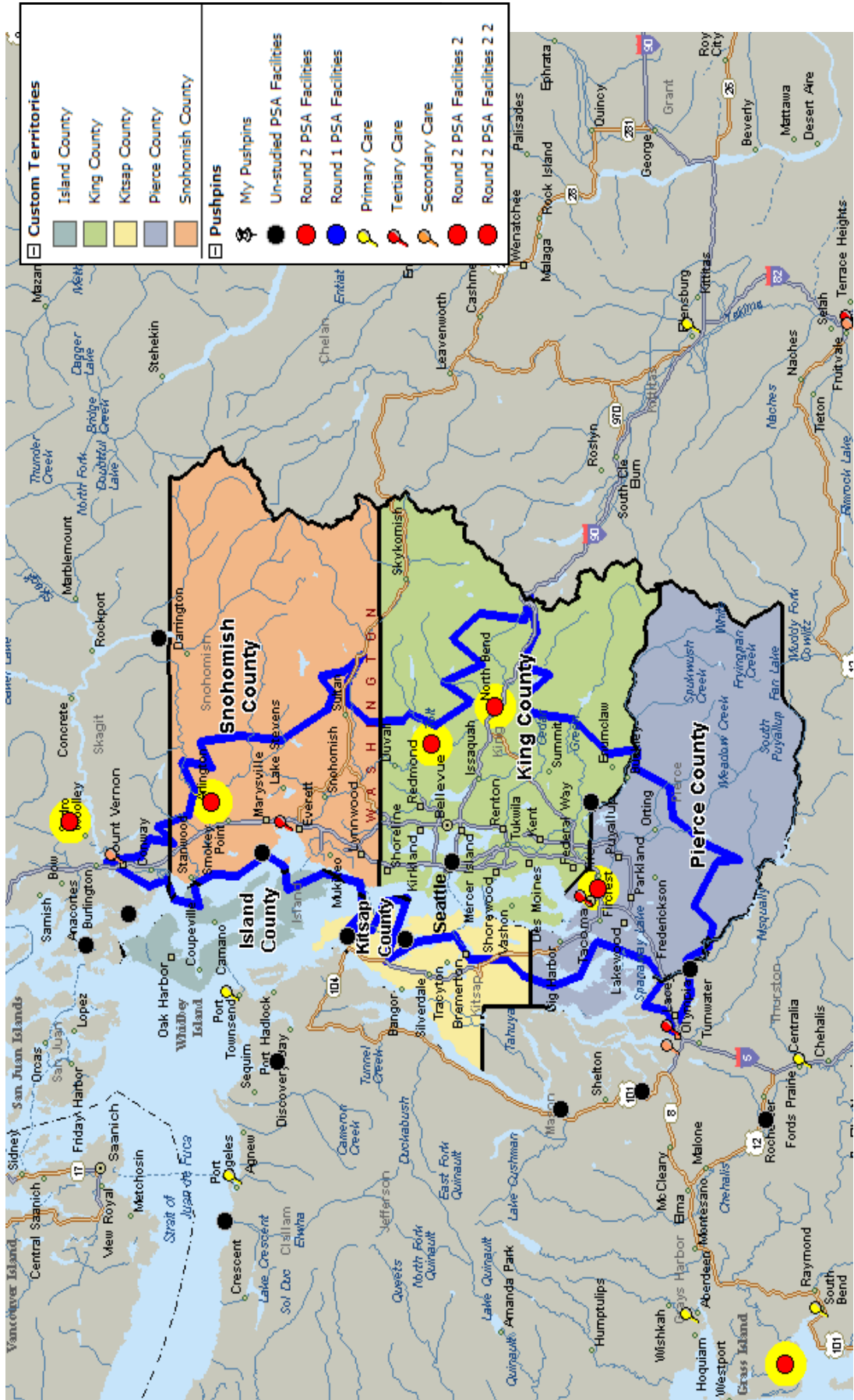
Regional Area	State	Counties w/in 60 minutes	Projected 2020 User Pop w/in 60 minutes	Projected 2020 Service Pop w/in 60 minutes	New PC Potential Market (at 100%)	Projected % User Pop to Service Pop	Tribal or Federal Facility Available for PC	Planned % User to Service Pop	Planned PC Market
Portland - SWRC	Oregon	Clackamas	821	4,277	3,456	19.2%	NO	90%	3,028
Portland - SWRC	Oregon	Columbia	57	828	771	6.9%	NO	90%	688
Portland - SWRC	Oregon	Marion	4,579	8,009	3,430	57.2%	YES	90%	2,629
Portland - SWRC	Oregon	Multnomah	1,504	11,845	10,341	12.7%	NO	90%	9,157
Portland - SWRC	Oregon	Washington	611	5,853	5,242	10.4%	NO	90%	4,657
Portland - SWRC	Washington	Clark	881	5,210	4,329	16.9%	NO	90%	3,808
Portland - SWRC	Washington	Skamania	93	471	378	19.7%	NO	90%	331
Portland - SWRC	Total		8,546	36,493	27,947	23.4%		90%	24,298
Eugene - SWRC	Oregon	Benton	206	981	775	21.0%	NO	90%	677
Eugene - SWRC	Oregon	Douglas	1,105	2,890	1,785	38.2%	YES	90%	1,496
Eugene - SWRC	Oregon	Lane	1,219	5,332	4,113	22.9%	NO	90%	3,580
Eugene - SWRC	Oregon	Linn	935	2,900	1,965	32.2%	NO	90%	1,675
Eugene - SWRC	Total		3,465	12,103	8,638	28.6%		90%	7,428
Seattle - NWRC	Washington	Island	82	1,035	953	7.9%	NO	90%	850
Seattle - NWRC	Washington	King	3,444	25,214	21,770	13.7%	YES	90%	19,249
Seattle - NWRC	Washington	Kitsap	2,557	6,325	3,768	40.4%	YES	90%	3,136
Seattle - NWRC	Washington	Pierce	11,599	20,277	8,678	57.2%	YES	90%	6,650
Seattle - NWRC	Washington	Snohomish	6,803	15,007	8,204	45.3%	YES	90%	6,703
Seattle - NWRC	Total		24,485	67,858	43,373	36.1%		90%	36,587
Spokane - NERC	Idaho	Kootenai	1,479	2,350	871	62.9%	NO	90%	636
Spokane - NERC	Washington	Lincoln	200	393	193	50.9%	NO	90%	154
Spokane - NERC	Washington	Spokane	2,799	12,004	9,205	23.3%	NO	90%	8,005
Spokane - NERC	Total		4,478	14,747	10,269	30.4%		90%	8,794



Facility Priority System
Concept Presentation

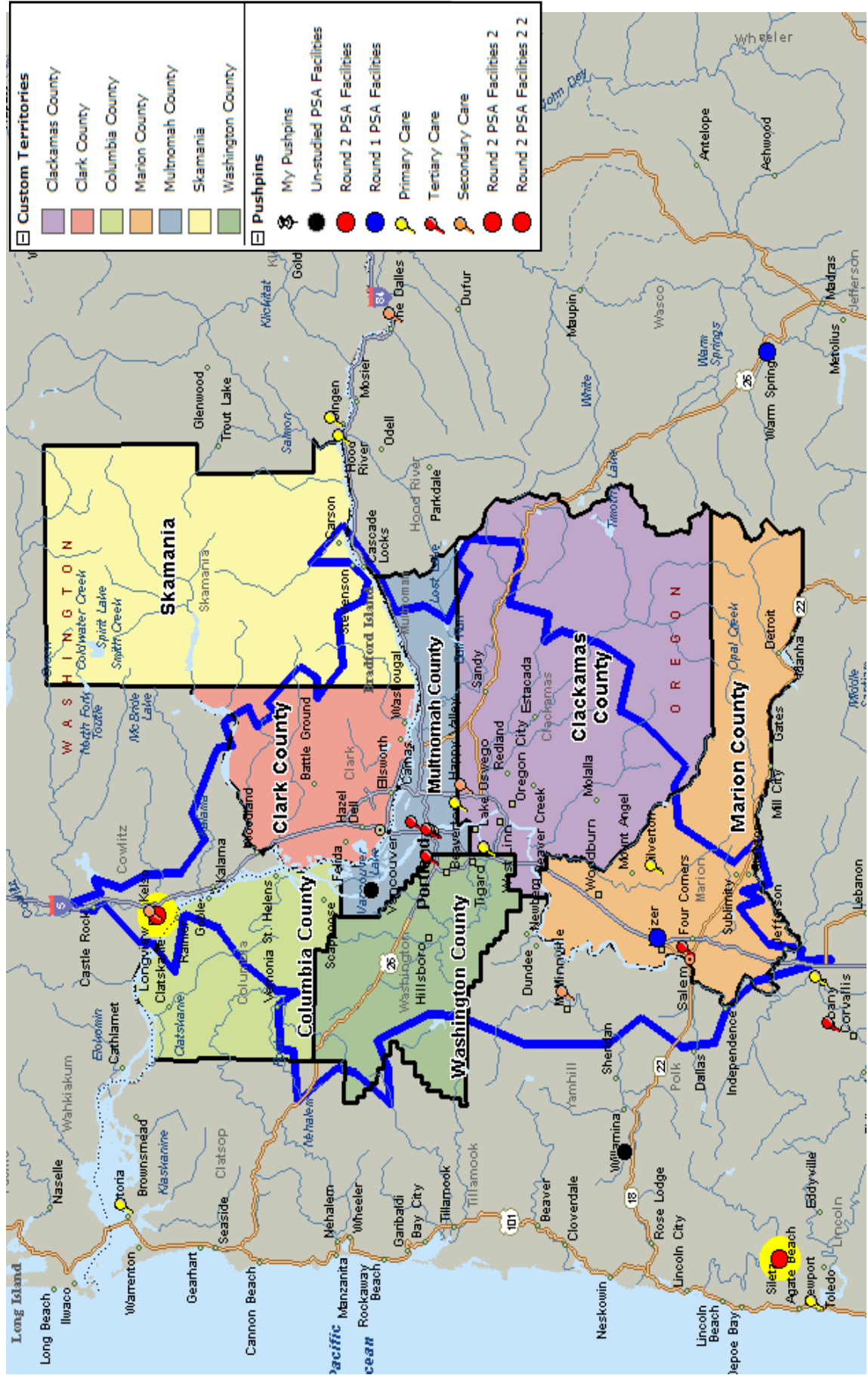
Regional Centers
The Portland Area

Countries within 60 Minute Drive Time of Proposed Seattle Regional Center



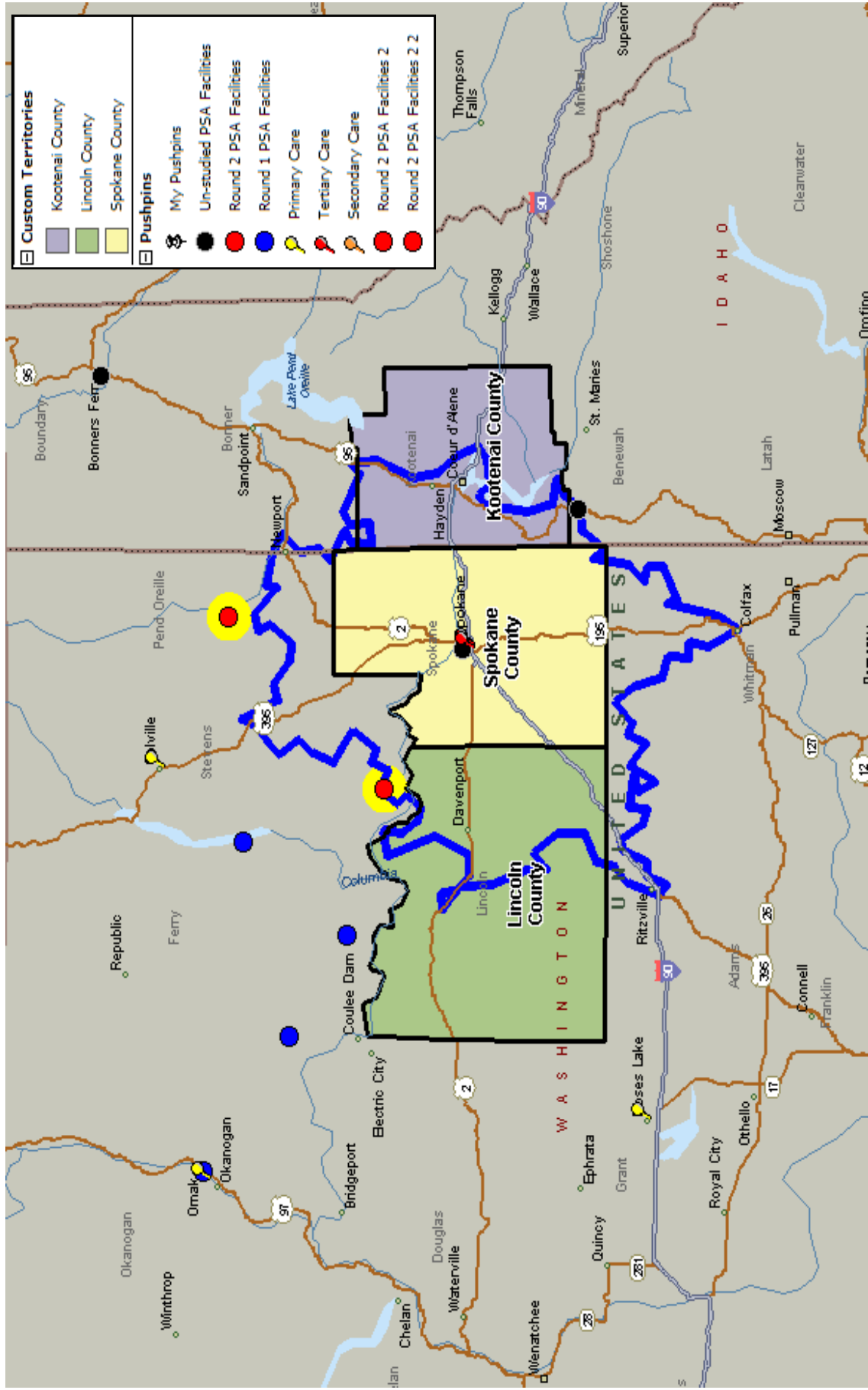


Counties within 60 Minute Drive Time of Proposed Portland Regional Center





Counties within 60 Minute Drive Time of Proposed Spokane Regional Center





Issues and Concerns

1. *Is the alignment of Service Units to Regional Centers appropriate?*
2. *Does the logic applied to reclaiming Urban Service Population as user populations seem sound?*
3. *Are the counties included in Primary Care Service Population consideration appropriate?*
4. *Do you think IHS will support your speculation on reclaiming user population*
5. *In what way does erosion of considered markets concern the workgroup?*
6. *What is the workgroup's desire in relationship to the inclusion of Primary Care at Regional Centers?*
 - a. *What are the positives?*
 - b. *What are the negatives?*



Packet 2 – Access & Eroded Market Share



Payor Profile

Colville	
Medicaid Only	1826
Private Ins Only	1478
Medicare A Only	36
Medicare B Only	1
Medicare Part A & B Only	257
Medicare Part D	204
Medicaid & Medicare	44
Medicaid & Private Ins	298
Medicare & Private Ins	102
Medicaid, Medicare, & Private Ins	2
Total	4248

	No 3P Coverage	W/in CHSDA	w/3P Coverage	W/in CHSDA
Non Indian Active Users	39	26	49	26
CHS Eligible Active Users	1999	1599	3246	2688
Direct Only Active Users	959	535	1000	658
Other Eligibility	12	8	6	4
Totals	2970	2142	4252	3350

7222

5492

PGEN - Third party coverage first NO, then again with Yes, save as a cohort. - take to Qman and search eligibility, visit date since 06-01-06, community (GPRA community tax)

3rd party eligibility stats for patients with eligibility: June 1, 2009 and having a visit in the past 3 years. All patients included in this report. (active/inactive per registration, any community)

*Confirmed by: PGEN-Living Patients-Any 3P Coverage, save as a cohort. In Q-man Cohort with a visit since 06-01-06



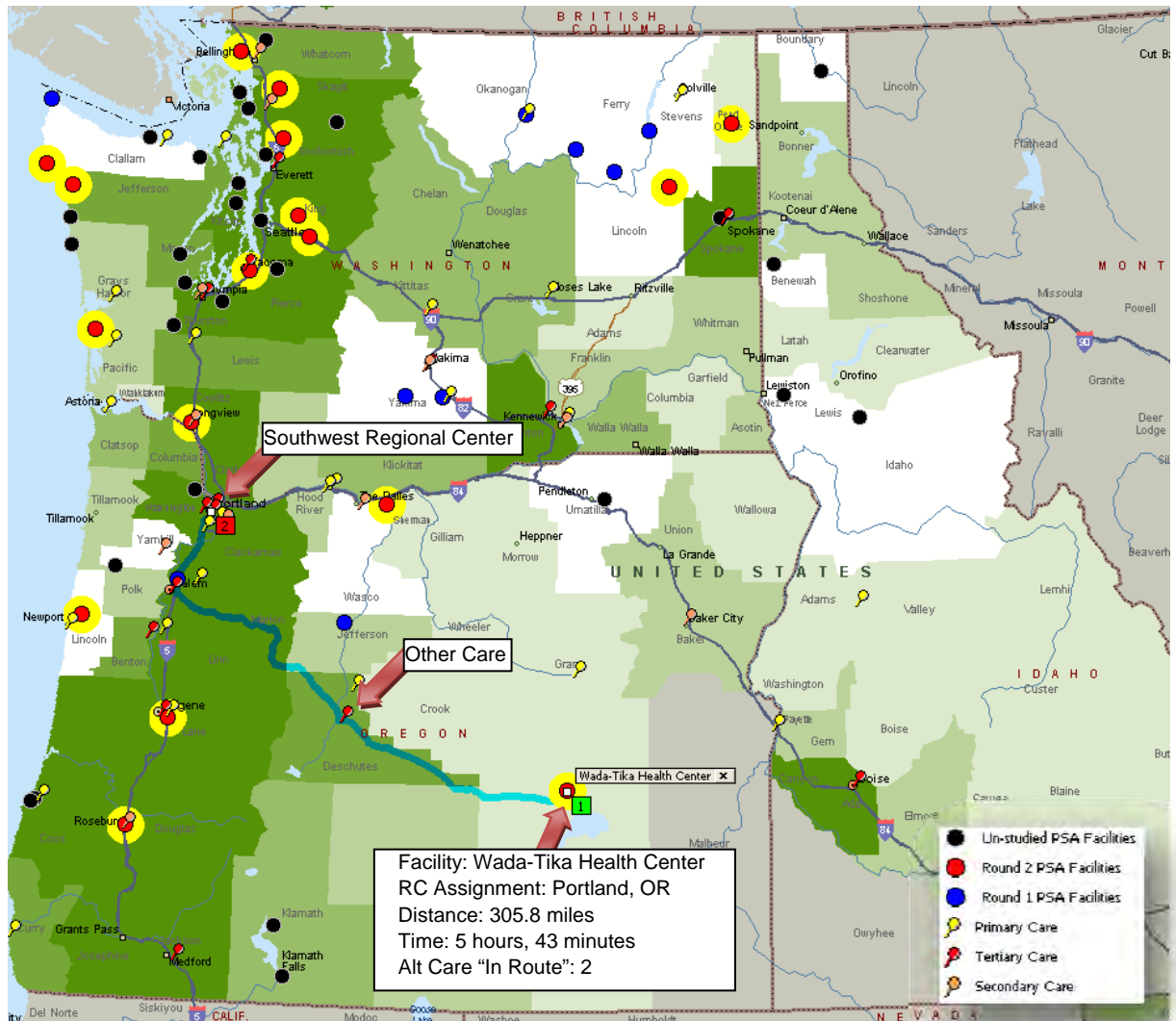
Market Erosion Table

<i>by Distance</i>	High (H) Reliance	Moderate (M) Reliance	Moderate (M) Reliance	Low (L) Reliance
	Direct Care Only No 3P	Direct Care & CHS No Choice	Direct Care & CHS Choice	Direct Care & CHS & 3P
<i>Drive Time (< than in Minutes)</i>	<i>% likely to drive</i>	<i>% likely to drive</i>	<i>% likely to drive</i>	<i>% likely to drive</i>
60	100%	100%	63%	25%
90	100%	100%	58%	15%
120	100%	100%	53%	5%
240	100%	100%	50%	0%
240+	100%	100%	50%	0%

<i>by Alternative Care</i>	High (H) Reliance	Moderate (M) Reliance	Moderate (M) Reliance	Low (L) Reliance
	Direct Care Only No 3P	Direct Care & CHS	Direct Care & CHS	Direct Care & CHS & 3P
<i>Secondary or Tertiary Alternative Care Options "in route"</i>	<i>% likely to drive</i>	<i>% likely to drive</i>	<i>% likely to drive</i>	<i>% likely to drive</i>
1	100%	100%	84%	67%
2	100%	100%	67%	33%
3	100%	100%	55%	10%



Alternative Care Erosion Methodology



Using Microsoft Map Point, The Innova Group was able to identify Indian health clinics and their distance to their particular Regional Center (RC) assignment. The following settings were used to standardize driving time between the health center and the RC assignment:

- no driving breaks were allotted,
- all driving speeds on the various types of roadway were set to “average”,
- and segments were based on preferred roads rather than the quickest route or shortest distance.

If a Service Unit was specified, the distance was calculated using the primary point of care (ex: for the Colville Service Unit, Nespelem was used). If a PSA was specified, the distance was calculated using the PSA.

Map Point made it possible to count the number of alternative secondary and tertiary care options between the health center and the RC assignment. Any alternative care sites that were within 15 miles distance of the planned route were counted as a possible care sites. Any alternative care sites located in a RC assignment were not counted as possible care sites.

The total number passed “in route” was entered on the Market Share projection table. Only secondary and tertiary alternative care was considered.



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Market Erosion Calculation Table

Service Area	Market %			Year	Uneroded Market			Regional Center	SU/PSA Drive Time	Market Erosion by Distance				Sub Market Erosion by Competitors				M Reliance - No Choice		M Reliance - Choice						
	H Reliance	M Reliance	L Reliance		2020	H Reliance	M Reliance			L Reliance	Only No 3P	& CHS (No Choice)	& CHS (Choice)	& CHS & 3P	M Reliance	M Reliance	# of Alt Care in	Only No 3P	& CHS (No Choice)	& CHS (Choice)	& CHS & 3P	Net Combined	% of User Pop	Net Combined	% of User Pop	
	Only No 3P	Direct Care & CHS	& CHS & 3P	HSP User Pop	Only No 3P	Direct Care & CHS	& CHS & 3P			w/out 3rd Party	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage	Combined Sub-	Combined Sub-		w/out 3rd Party	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage						
	All/CHSDA Blended %	All/CHSDA Blended %	All/CHSDA Blended %	CHSDA Users	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage			23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39
Coeur D'Alene Service Unit*								Spokane, WA						0	0					0	0.0%	0	0.0%			
Benewah Medical Center*								Spokane, WA	61					0	0	0				0	0.0%	0	0.0%			
Colville Service Unit	11.5%	28.4%	59.9%	10,614	1,222	3,014	6,353	Spokane, WA	122	1,222	3,014	1,507	0	4,236	2,729	0	1,222	3,014	1,507	0	4,236	39.9%	2,729	25.7%		
Inchelium - Health Clinic								Spokane, WA	130					0	0	0					0	0.0%	0	0.0%		
Nespelem - Colville Health Center								Spokane, WA	122					0	0	0					0	0.0%	0	0.0%		
Omak - Dental Facility								Spokane, WA	166					0	0	0					0	0.0%	0	0.0%		
Keller - Keller Health Station								Spokane, WA	165					0	0	0					0	0.0%	0	0.0%		
Fort Hall Service Unit	20.8%	30.2%	48.7%	7,283	1,511	2,198	3,546	Spokane, WA	471	1,511	2,198	1,099	0	3,709	2,610	1	1,511	2,198	918	0	3,709	50.9%	2,429	33.4%		
NW Band of Shoshone								Spokane, WA	480					0	0	2					0	0.0%	0	0.0%		
Fort Hall - Not-tsoo Gah-nee Health Center								Spokane, WA	471					0	0	1					0	0.0%	0	0.0%		
Klamath Service Unit*	13.4%	22.9%	61.8%	3,086	413	707	1,906	Portland, OR		413	707	442	477	1,597	1,331		413	707	442	477	1,597	51.7%	1,331	43.1%		
Klamath Tribal Health Center - Klamath Falls*								Portland, OR	306					0	0	4					0	0.0%	0	0.0%		
Klamath Tribal Health Center - Chiloquin*								Portland, OR	274					0	0	4					0	0.0%	0	0.0%		
Neah Bay Service Unit								Seattle, WA						0	0						0	0.0%	0	0.0%		
Neah Bay - Neah Bay Indian Health Center	8.3%	23.9%	61.7%	2,004	166	478	1,237	Seattle, WA	246	166	478	239	0	645	406	0	166	478	239	0	645	32.2%	406	20.2%		
Jamestown S'Kallum Tribal Health Clinic*								Seattle, WA	101					0	0	0					0	0.0%	0	0.0%		
Lower Elwha Clinic*								Seattle, WA	145					0	0	0					0	0.0%	0	0.0%		
Quileute Tribal Health Clinic	8.5%	1.6%	47.3%	1,550	132	24	733	Seattle, WA	220	132	24	14	0	156	146	0	132	24	14	0	156	10.1%	146	9.4%		
North Idaho Service Unit*								Spokane, WA						0	0						0	0.0%	0	0.0%		
Kootenai Tribal Clinic*								Spokane, WA	136					0	0	0					0	0.0%	0	0.0%		
Nimiipuu - Kamiah Health Facility*								Spokane, WA	199					0	0	0					0	0.0%	0	0.0%		
Nimiipuu - Lapwai Health Center*								Spokane, WA	139					0	0	0					0	0.0%	0	0.0%		
Northwest Washington Service								Seattle, WA						0	0						0	0.0%	0	0.0%		
Lummi Health Center								Seattle, WA	98					0	0	3					0	0.0%	0	0.0%		
Nooksack Community Clinic*								Seattle, WA	103					0	0	2					0	0.0%	0	0.0%		



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Market Erosion Calculation Table

Service Area	Market %			Year	Uneroded Market			Regional Center	SU/PSA Drive Time	Market Erosion by Distance				M Reliance	M Reliance	# of Alt Care in	Sub Market Erosion by Competitors				M Reliance - No Choice		M Reliance - Choice			
	H Reliance	M Reliance	L Reliance		2020	H Reliance	M Reliance			L Reliance	Only No 3P	& CHS (No Choice)	& CHS (Choice)				& CHS & 3P	Only No 3P	& CHS (No Choice)	& CHS (Choice)	& CHS & 3P	Net Combined	% of User Pop	Net Combined	% of User Pop	
	Only No 3P	Direct Care & CHS	& CHS & 3P	HSP User Pop	Only No 3P	Direct Care & CHS	& CHS & 3P			w/out 3rd Party	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage	Combined Sub-	Combined Sub-	w/out 3rd Party	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage	Net Combined	% of User Pop	Net Combined	% of User Pop			
	All/CHSDA Blended %	All/CHSDA Blended %	All/CHSDA Blended %	CHSDA Users	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage			23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39
Samish Indian Nation*	0.5%	14.2%	84.8%	426	2	61	361	Seattle, WA	83	2	61	35	18	81	55	2	2	61	23	6	69	16.1%	31	7.3%		
Swinomish Health Clinic*								Seattle, WA	80					0	0	1					0	0.0%	0	0.0%		
Upper Skagit Tribal Health Clinic								Seattle, WA	80					0	0	2					0	0.0%	0	0.0%		
Puget Sound Service Unit								Seattle, WA						0	0						0	0.0%	0	0.0%		
Muckleshoot Tribal Clinic*								Seattle, WA	40					0	0	0					0	0.0%	0	0.0%		
Nisqually Health Clinic*								Seattle, WA	65					0	0	1					0	0.0%	0	0.0%		
Port Gamble S'Kallum Clinic*								Seattle, WA	66					0	0	0					0	0.0%	0	0.0%		
Sauk-Suiattle Health Clinic*								Seattle, WA	90					0	0	1					0	0.0%	0	0.0%		
Seattle Indian Health Board*								Seattle, WA	4					0	0	0					0	0.0%	0	0.0%		
Skokomish Health Center*								Seattle, WA	97					0	0	0					0	0.0%	0	0.0%		
Snoqualmie (North Bend/Tolt)								Seattle, WA	34					0	0	0					0	0.0%	0	0.0%		
Squaxin Island Tribal Health Clinic*								Seattle, WA	80					0	0	3					0	0.0%	0	0.0%		
Stillaguamish Tribal Clinic								Seattle, WA	52					0	0	0					0	0.0%	0	0.0%		
Suquamish (Port Madison IR)*								Seattle, WA	53					0	0	0					0	0.0%	0	0.0%		
Tulalip Health Clinic*								Seattle, WA	48					0	0	1					0	0.0%	0	0.0%		
Puyallup Service Unit	25.2%	13.7%	53.9%	11,526	2,910	1,580	6,211	Seattle, WA	35	2,910	1,580	987	1,553	6,043	5,450	1	2,910	1,580	824	1,040	5,530	48.0%	4,775	41.4%		
Puyallup Tribal Health Authority								Seattle, WA	35					0	0	1					0	0.0%	0	0.0%		
Southern Oregon Service Unit								Portland, OR						0	0						0	0.0%	0	0.0%		
Coos Umpqua Health Center*	45.3%	11.3%	41.1%	1,404	635	159	578	Portland, OR	230	635	159	79	0	794	715	4	635	159	44	0	794	56.5%	679	48.4%		
Coquille Community Health Center*								Portland, OR	232					0	0	4					0	0.0%	0	0.0%		
Cow Creek Health Center								Portland, OR	158					0	0	5					0	0.0%	0	0.0%		
Cow Creek South (new)								Portland, OR						0	0						0	0.0%	0	0.0%		
Taholah Service Unit														0	0						0	0.0%	0	0.0%		
Chehalis Community Health Center*	11.9%	17.7%	62.7%	1,477	176	261	926	Seattle, WA	91	176	261	137	46	484	360	3	176	261	75	5	442	29.9%	256	17.3%		
Cowlitz North PSA (Tribal Health Ctr)	22.1%	6.7%	69.2%	671	148	45	465	Portland, OR	54	148	45	28	116	310	293	1	148	45	23	78	271	40.4%	250	37.2%		



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Market Erosion Calculation Table

Service Area	Market %			Year	Uneroded Market			Regional Center	SU/PSA Drive Time	Market Erosion by Distance				M Reliance	M Reliance	# of Alt Care in	Sub Market Erosion by Competitors				M Reliance - No Choice		M Reliance - Choice			
	H Reliance	M Reliance	L Reliance		2020	H Reliance	M Reliance			L Reliance	Only No 3P	& CHS (No Choice)	& CHS (Choice)				& CHS & 3P	Only No 3P	& CHS (No Choice)	& CHS (Choice)	& CHS & 3P	Net Combined	% of User Pop	Net Combined	% of User Pop	
	Only No 3P	Direct Care & CHS	& CHS & 3P	HSP User Pop	Only No 3P	Direct Care & CHS	& CHS & 3P			w/out 3rd Party	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage	Combined Sub-	Combined Sub-	w/out 3rd Party	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage	Net Combined	% of User Pop	Net Combined	% of User Pop			
	All/CHSDA Blended %	All/CHSDA Blended %	All/CHSDA Blended %	CHSDA Users	w/out 3rd Party	w/out 3rd Party	w 3rd party Coverage			23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39
Cowlitz South PSA (New)							Portland, OR					0	0									0	0.0%	0	0.0%	
Hoh Tribe							Seattle, WA	224				0	0	0								0	0.0%	0	0.0%	
Roger Saux Health Center (Quinalt)*	19.6%	7.4%	67.0%	2,721	533	202	1,824	Seattle, WA	178	533	202	101	0	736	634	3	533	202	56	0	736	27.0%	589	21.6%		
Queets Health Center (Quinalt)*								Seattle, WA	200					0	0	3						0	0.0%	0	0.0%	
Shoalwater Bay Tribal Clinic	9.2%	0.3%	27.1%	1,264	117	4	343	Seattle, WA	237	117	4	2	0	120	119	2	117	4	1	0	120	9.5%	118	9.3%		
Umatilla Service Unit*								Seattle, WA						0	0							0	0.0%	0	0.0%	
Yellowhawk Tribal Health Center*								Seattle, WA	261					0	0	2						0	0.0%	0	0.0%	
Warm Springs Service Unit	16.7%	26.3%	55.9%	8,024	1,339	2,107	4,488	Portland, OR	128	1,339	2,107	1,054	0	3,446	2,392	0	1,339	2,107	1,054	0	3,446	42.9%	2,392	29.8%		
Wada-tika Health Center (Burns Paiute)								Portland, OR	343					0	0	2						0	0.0%	0	0.0%	
Warm Springs - Warm Springs Health and								Portland, OR	128					0	0	0						0	0.0%	0	0.0%	
Wellpinit Service Unit								Spokane, WA						0	0							0	0.0%	0	0.0%	
Kalispell								Spokane, WA	72					0	0	0						0	0.0%	0	0.0%	
Wynecoop Memorial Clinic (Spokane Tribe)								Spokane, WA	65					0	0	0						0	0.0%	0	0.0%	
Western Oregon Service Unit								Portland, OR						0	0							0	0.0%	0	0.0%	
Grand Ronde Health Center	17.7%	3.3%	45.9%	5,625	997	188	2,581	Portland, OR	79	997	188	99	129	1,314	1,225	1	997	188	82	86	1,272	22.6%	1,166	20.7%		
Salem - Chemawa Health Center	54.1%	5.1%	40.1%	5,881	3,181	302	2,360	Portland, OR	38	3,181	302	189	590	4,073	3,960	0	3,181	302	189	590	4,073	69.3%	3,960	67.3%		
Siletz Community Health Center	7.1%	32.3%	49.6%	3,741	264	1,209	1,857	Portland, OR	146	264	1,209	605	0	1,473	868	2	264	1,209	402	0	1,473	39.4%	666	17.8%		
Yakama Service Unit	11.5%	23.5%	63.7%	14,662	1,685	3,445	9,344	Seattle, WA	152	1,685	3,445	1,723	0	5,130	3,407	2	1,685	3,445	1,146	0	5,130	35.0%	2,830	19.3%		
Toppenish - Yakama Comprehensive Health								Seattle, WA	152					0	0	2						0	0.0%	0	0.0%	
White Swan - White Swan Health Clinic								Seattle, WA	178					0	0	2						0	0.0%	0	0.0%	
Seattle Reg Ctr	16.0%	16.5%	57.9%	35,630																	12,827	36.0%	9,150	25.7%		
Portland Reg Ctr	25.7%	15.4%	49.4%	28,432																	12,925	45.5%	10,444	36.7%		
Spokane Reg Ctr	16.5%	29.4%	53.8%	17,897																	7,945	44.4%	5,158	28.8%		



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Revisit Impact on Scenarios

1. *Does the payor data seem reliable?*
2. *What aspect of the payor data surprises the workgroup most?*
3. *Can payor data be uniformly gathered for all Portland Service Areas?*
4. *Do the market erosion assumptions by payor appear appropriate?*
5. *In what way do they require refinement?*
6. *Do the market erosion assumptions by distance appear appropriate?*
7. *In what way do they require refinement?*
8. *Do the market erosion assumptions by alternative care appear appropriate?*
9. *In what way do they require refinement?*
10. *Can you remove a patient's choice of where to receive specialty care? Should you?*



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Packet 3 – Healthcare Facility Construction Priority System Proposal



Issues and Concerns

As Is

Schedule =>	Phase 1										Phase 2		
	Facility Deficiency (400 Pts)				Health Status (200 Pts)				Isolation (100 Pts)	Facility Size (150 Pts)	Facility Deficiency (400 Pts)	Barriers to Service (50 Pts)	Innovation (100 Pts)
	Required Space		Adjusted Existing Space		Birth Disparities Index	% Pop over 55	Composite Poverty Index	Disease Disparities Index	Distance from ER	Size of Facility (smaller = better)	Required Space	Yes/No	5 Possible Elements
	User Pop	IP Days	Facility Age	Condition Adjustment (FEDS)									
Criteria =>													
Sub-Criteria =>													
Inputs =>													
Regional Center	Could Harm Scoring - Insufficient Entry Capability	Could Harm Scoring - OP/Ancillary Sensitivity Required	Could Help Scoring for a New RC	Presently Irrelevant for New RC, Will work in future	Presently Irrelevant for New RC, Will work in future	Impact Unclear Despite More Appropriate Use of Data	Impact Unclear Despite More Appropriate Use of Data	Impact Unclear Despite More Appropriate Use of Data	Unclear - rural location could help; urban could harm	Would Likely Harm Scoring Rank	Could Help Scoring for a New RC	Could Help Scoring for a New RC if Population Centric	Could Help Scoring for a New RC
Outpatient Facility	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	Unclear	Unclear
Inpatient Facility	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Unclear	Unclear
Small Ambulatory Care	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	Unclear	Unclear
Other	Unclear	Unclear	✓	✓	Unclear	Unclear	Unclear	Unclear	✓	✓	✓	Unclear	Unclear

Feedback

Schedule =>	Phase 1										Phase 2		
	Facility Deficiency (400 Pts)				Health Status (200 Pts)			Isolation (100 Pts)	Facility Size (150 Pts)	Facility Deficiency (400 Pts)	Barriers to Service (50 Pts)	Innovation (100 Pts)	
	Required Space		Adjusted Existing Space		% Pop over 55	Composite Poverty Index	Disease Disparities Index	Distance from ER	Size of Facility (smaller = better)	Required Space	Yes/No	5 Possible Elements	
	User Pop	IP Days	Facility Age	Condition Adjustment (FEDS)									Cost/SM to Replace
Criteria =>													
Sub-Criteria =>													
Inputs =>													
Multi-Tribal Specialty Referral Center	Baseline SM needs to be established based on eroded marketshare specialty care visits	✓	✓	✓	No, Poverty does not necessarily coincide with a poor health status. Lack of poverty doesn't change the governments treaty obligation to a tribe.	✓	No, not applicable to referral center	Not applicable, specifically hurts regional center which is likely in urban area, should be changed to access	Not applicable. Works well for our SACs. Specifically hurts regional centers	Should be moved to Phase 1, applicable to all categories, simplified SM formulas of Phase 1 is not a true statement for OP or IP facilities	Could Help Scoring for a New RC if Population Centric	Could Help Scoring for a New RC - Needs to be given more definition, priority and moved to Phase 1	
Outpatient Facility	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	Unclear	Unclear	
Inpatient Facility	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	Unclear	Unclear	
Small Ambulatory Care	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	Unclear	Unclear	

	bgsm/scpv				bgsm/tpv				
	% MS	SCPVs	without PC	with pc	% MS	without PC	TPVs	with pc	TPVs
southwest	100	37293	0.183	0.388	100	0.183	37293	0.156	165584
	36.7	12225	0.197	0.585	36.7	0.197	12225	0.173	140516
northeast	100	36956	0.13	0.229	100	0.13	36956	0.182	80910
	28.8	9842	0.158	0.43	28.8	0.158	9842	0.216	53796
northwest	100	67580	0.121					0.113	257340
	25.7	29876	0.134					0.119	206113
Average			0.154	0.408	Average	0.167		0.160	

Add a new facility category within the existing funding system, A multi-tribal specialty referral center. Use existing system as best as possible. Comparisons to other facility types is irrelevant as soon as grouped as multi-tribal referral centers.

Solution #1

	Phase 1						Phase 2			
	Facility Deficiency (400 Pts)		Health Status (200 Pts)			Isolation (100 Pts)	Facility Size (150 Pts)	Facility Deficiency (400 Pts)	Barriers to Service (50 Pts)	Innovation (100 Pts)
Schedule =>	Adjusted Existing Space							Required Space		
Criteria =>	Required Space	Condition Adjustment (FEDS)	Birth Disparities Index	% Pop over 55	Composite Poverty Index	Disease Disparities Index	Distance from ER	Size of Facility (smaller = better)	Facility Deficiency (400 Pts)	Innovation (100 Pts)
Sub-Criteria =>	User Pop	Facility Age							Required Space	Yes/No
Inputs =>	IP Days	Cost/SM to Replace							HSP (Un-deviated)	5 Possible Elements
Multi-Tribal Specialty Referral Center	Without PC = .154 * SCPVs = BGSIM; With PC = .160* TPVs = BGSIM	New Facilities score better than existing facility as all space is new. A new Portland facility will score better than an existing facility being newly categorized as a referral center.	Health Status scores are regional scores. Will not likely differentiate Portland or Spokane, but will differentiate Portland from Aberdeen.	All referral centers are likely to be built in close proximity to an existing emergency room. No differentiation likely with criteria	Smaller referral centers like Spokane will score better than Seattle-like Centers	Same as Phase 1, just using HSP for space calculation.	All Referral centers are likely to score well in these vague categories. The number of small tribes collaborating in the Portland Area for a referral center could be interpreted positively in both of these categories.			

Solution #2 Reinvent HFCPS to reflect a single comparison of facility priority regardless of facility type. Eliminate advantage that small facilities presently have with system. Balance staff retention and isolation criteria.

Phase 1										Phase 2						
Facility Deficiency (400 Pts)				Health Status (200 Pts)			Access to Care (200 Pts)			Innovation (200 points)						
Required Space		Adjusted Existing Space		Birth Disparities Index (50 points)	Disease Disparities Index (150 points)	CHS Dependency (100 points)	Distance to Emergency Department (50 points)	Distance to IHS facility with comparable services (50 points)	# of tribes in long term governance partnership (50 points)	Staff Retention Ability (50 points)	Cost & Revenue Sharing Agreement (50 points)	Cost Effectiveness (50 points)				
Baseline HSP	Facility Age	Condition Adjustment (FEDS)	Cost/SM to Replace													
<p>Multi-Tribal Specialty Referral Center</p> <p>Establish Policy on definition of baseline RRM. Correct HSP and RRM non compatibility issues relative to regional planning, specialty care and staffing. Points same as today, consistent use of HSP to commence exercise.</p>													<p>Accessibility to Secondary, Tertiary, or Medical School = (if all three available within 40 KM than 1, if two than .67, if one .33, of 0 than 0)*50</p>		<p>Demonstrate proposed operational saving as compared to IHS authorized operating budget. Operating savings \$/capital expenditure</p>	
				<p>Birth disparity index x .5</p>			<p>(Less than 40 KM from an ED, 0, 40 KM to 90 KM/90, > than 90,1) * 50</p>			<p>(No tribal governance or tribal partnership, * years of partnership, x=max 25, x/25*50)</p>			<p>(No agreement, 0, 2-5 tribal government agreement, tribe #/5,>5 tribal governments, 1)*50</p>			



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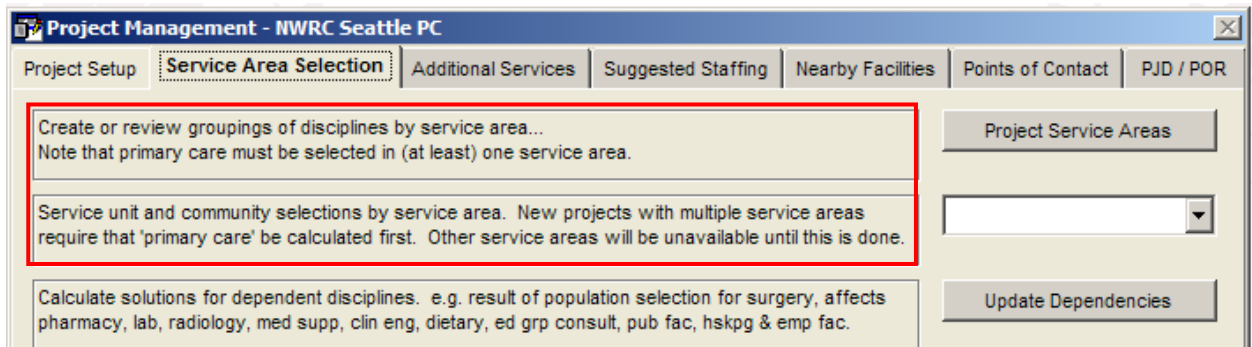


HSP Regional Center Difficulties

Though the HSP is typically used for facility planning by IHS and Tribal planners, and is the primary means by which space needs are justified in PJD/PORs and Joint Ventures, it presently possesses limitations in planning specialty care for a regional center. These limitations can be overcome by appropriate modifications to the HSP. Therefore the following recommendations should be considered to allow the HSP to facilitate appropriate and reliable regional/specialty care forecasting.

1. **Modify the HSP to support Specialty Care planning independent of Primary Care.**

Existing Problem: The HSP cannot currently plan for Specialty care apart and separate from Primary Care. Primary Care must be selected in order for space and staff to be calculated for Specialty Care. As a result, HSP user populations must currently be modified in order to produce workloads that are appropriate solely for a specialty care center. Additionally, the HSP does not take into account ancillary and support services/staff dependencies required unless Primary Care is selected.



2. **Enhance compatibility and accuracy between the HSP and the RRM.**

Existing Problem: There are no Specialty Care, Occupational Therapy, and Speech Pathology staff positions presently accounted for in the RRM. The HSP allows for manual entry of numbers for those positions but it would be preferred if the RRM directly accounted for these positions, allowing the HSP and RRM staffing numbers to be identical. Behavioral Health staff might also be stratified beyond what the RRM currently allows.

3. **Amend the RRM to forecast support staff such as Business Office, Health Information Management, and Information Management in response to Specialty Care visits as well as Primary Care visits.**

Existing Problem: Currently, such staff are forecasted based solely on Primary Care provider visits.

4. **Modify the HSP to consider manually created services when calculating support services.**

Existing Problem: The HSP does not currently consider space requirements for disciplines that are over/ under template thresholds. As a result, planning the required space must be done



manually. The HSP will provide the workload and staffing required but the planner must then manually calculate the space required. Consequently, the HSP is not calculating the appropriate support services staff and space required to manage these disciplines, ultimately leading to the HSP underestimating the required building size..

5. *Modify the HSP to allow for discreet selection of Laboratory, Pharmacy and Diagnostic Imaging services.*

Existing Problem: Pharmacy is one of several disciplines that cannot be discreetly selected or deselected. It is automatically calculated based on other services. If the planner needs to amend Pharmacy services in response to planning requirements or populations served, this must be performed manually. This is also true for Diagnostic Imaging Rad/Fluoro Rooms and Laboratory services.