



NOV 6 2007

Indian Health Service
Rockville MD 20852

TO: Acting Director

FROM: Director
Office of Environmental Health and Engineering

SUBJECT: Revision to the Healthcare Facilities Construction Priority System -- ACTION

ISSUE

In language accompanying the fiscal year (FY) 2000 appropriations, the Congress directed the Indian Health Service (IHS), in consultation with the Administration and the Tribes, to review and revise the Healthcare Facilities Construction Priority System (HFCPS). The IHS HFCPS (attached) has been revised and should be forwarded for administrative review before being forwarded to the Congress.

BACKGROUND

The Congress indicated that the review should address specific issues related to projects "funded primarily by Tribes; anomalies such as extremely remote locations; recognition of projects that involve minimal increases in operational costs; and options for alternative funding and modular construction." In response to this directive, the IHS Director established the Facilities Needs Assessment Workgroup to review the existing HFCPS. This Workgroup was charged to provide input and to make recommendations to the IHS Facilities Appropriation Advisory Board (FAAB), which would advise the Office of Environmental Health and Engineering (OEHE) regarding revising the HFCPS.

The Facilities Needs Assessment Workgroup (hereafter referred to as Workgroup) reported its findings to the OEHE and the FAAB in February 2002. In June 2004, after extensive discussion of this Report among the FAAB and IHS staff, the IHS prepared a draft revision to the HFCPS and sent it to all Tribes for review and comment. Following this review, in which over 1200 individual comments were received from 80 Tribes and Tribal organizations, the OEHE sought further FAAB input.

The FAAB made initial recommendations in July 2005 (see attached dated July 21, 2005). However, because the OEHE did not believe some of these recommendations could be supported, the FAAB and the OEHE were asked to review the issues and develop consensus on them. In March 2006, following a series of meetings, the FAAB responded with a letter that addressed most of the concerns (see attached dated March 10, 2006), but retained FAAB proposals on Criteria Weighting and on adjusting the formula for some tribally leased space and for facilities constructed using Tribal loans. At a subsequent FAAB meeting, the OEHE

presented information illustrating that the recommendations related to Tribal loans and leased space would not significantly change scoring, and that statistical data was not available in the detail required to justify a heavier weighting for “Health Status.” As a result, the FAAB indicated that the revision to the HFCPS should be finalized without these recommendations (see attached dated February 2, 2007).

DISCUSSION

The HFCPS, as revised, is implemented in two phases. During Phase I, the total need for facilities in Indian Country is ranked using available statistical and facilities information. Where these data require analysis, simple formulae requiring few resources to implement are used. These data are applied against four criteria (“Facilities Deficiency,” “Health Status,” “Isolation,” and “Facility Size”) to develop a Comprehensive National Listing of Facility Need. During Phase II, high ranking facilities are selected from the Comprehensive National Listing of Facility Need for more detailed review. Data requiring analysis is subjected to thorough planning review and is applied against six criteria (“Facilities Deficiency,” “Health Status,” “Isolation,” “Barriers to Service,” “Facility Size,” and “Innovation”) to prioritize the need of the selected facilities. The weighting of these factors are shown in the table below:

Evaluation Criteria		Phase I Criteria Weighting		Phase II Criteria Weighting	Ranking Score
Facility Resources Deficiency		X 400	Or	400	=
Health Status		X 200	Or	200	=
Isolation/ Barriers to Care	Isolation	X 100	Or	100	=
	Barriers to Care	X 0	Or	50	=
Facility Size		X 150	Or	150	=
Innovation		X 0	Or	100	=
Maximum Possible Score		850	Or	1000	(850 or 1000 = Maximum)

In revising the HFCPS, the IHS has sought to place the highest priority on funding facilities where there is not adequate space to provide access to health services to American Indians and Alaska Natives. However, developing a process that assesses and prioritizes the need for Indian healthcare facilities is a complex issue. That complexity is exacerbated because funding is extremely limited relative to the need and because some Tribes and Area Offices believe their need for healthcare facilities has not received fair assessment in the past. The existing HFCPS does prioritize healthcare facilities construction funding where there are concentrations of American Indians or Alaska Natives. Thus, regions of the country where Indian populations are

geographically dispersed have generally not had their facilities ranked highly enough to be considered for funding. However, facilities in these regions have received some funding through programs other than the HFCPS, e.g., the Small Ambulatory Program and the Joint Venture Program, which are also awarded competitively. Since few of these other programs receive consistent attention during the appropriations cycle, there remains a sense that some regions of the country are outside the funding cycle.

Much of the discussion during the review process and many of the proposed revisions to HFCPS arose out of a frustration resulting from some Tribe's and Area's sense of exclusion from the limited facilities construction appropriations. Several criteria, including "Facility Size" and the "Health Status" were introduced to the revision as a means of addressing this concern. To further alleviate concerns that some Areas are excluded from the prioritization process, the revision also incorporates a process to address funding for an IHS Area distribution. This funding, to be determined by the Congress, would be distributed among the IHS Areas for priority projects identified with the revised HFCPS methodology; thereby allowing funding of the highest priority Area projects, even if these projects do not have a priority ranking on the National list. Discussion of the weighting of the criteria also centered on whether the methodology should focus priorities where facility need is the greatest or disperse funding to more Tribes based on other factors, e.g., "Health Status," "Innovation," etc. Discussions on all issues were thorough and intense; however, as noted in the attached letters these differences on the methodology to be used for facility assessment and prioritization have been resolved.

Because the revision provides a mechanism for ranking the full universe of need during Phase I, it is flexible enough to permit selection of the most significant needs for detailed review during Phase II based on any program standard that the Congress mandates. Thus, during Phase II the highest ranking facilities may be selected for prioritization and presentation to the Congress for funding as authorized by Section 301 of the Indian Health Care Improvement Act, Public Law 94-437. In addition, projects may also be selected for prioritization from those projects in Phase I that meet criteria of any other congressionally mandated programs, including the Joint Venture Program, the Small Ambulatory Program, etc. The revision to the HFPCS specifically addresses the congressional directive in the FY 2000 appropriations language because:

- It incorporates a factor to increase ranking for Tribal innovation which could include alternative or Tribal funding to decrease IHS operational or construction costs; and
- It incorporates a factor to increase ranking based on isolation.

During the process of developing this revision, the IHS and the Tribes have engaged in extensive master planning that provides an estimate of the need for facilities in Indian Country. The total cost to acquire space for all locations with facilities over 20 years old identified in the Area Master Plans, including those with populations as small as 138 users, is approximately \$6.5 billion. Below is a break out of these costs based on population size:

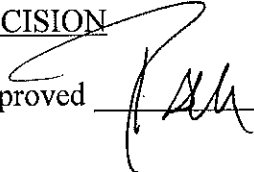
Cost To Acquire Facilities Identified In Health Services and Facilities Master Plans For Locations Over 20 Years By Population Size			
User Population	Number of Facilities	Expected Hours Of Operation Per Week	Estimated Total Construction Cost
Less than 500	51	Less than 15	\$167 Million
500 – 1,320	57	20-40	\$317 Million
1,320 or larger ¹	146	40 or more	\$6 Billion
Totals	254		\$6.5 Billion

The attached “Healthcare Facilities Construction Priority System” reflects the results of a robust Tribal consultation process that included a request for input from all federally recognized Tribes and reviews and discussions by several Tribal and the IHS workgroups, including the FAAB. The HFCPS methodology described in this document provides opportunity for all Tribes with needs for health care facilities to have projects identified and prioritized.

RECOMMENDATION

I recommend that you indicate your approval with forwarding the revision to the HFCPS to the Department of Health and Human Services for review by initialing on the approved line below.

DECISION

Approved  Disapproved _____ Date 11/27/07


Gary J. Hartz, R.E.

Attachments (4)

¹ A population of approximately 1,320 users would generate the minimum workload (approximately 4,400 primary care provider visits) sufficient to support a full medical team.