

# **Facilities Appropriation Advisory Board (FAAB)**

## **Resource Notebook 2014**

Office of Environmental Health and Engineering,  
Indian Health Service

## Table of Contents

Brief on Programs in the Office of Environmental Health and Engineering	3
IHS Health Care Facilities FY 2015 Planned Construction Budget	67
Report to Congress on Estimated Need for Tribal and IHS Health Care Facilities March 2011	69
Response to Congress on Healthcare Facilities Construction Priority System February 2008	86
OEHE Overview PowerPoint	
Dr. Roubideaux's July 3, 2012 letter, Summarized Questions and Responses, tribal Letters	150
Past FAAB Correspondence	180

## **An Introduction for Facilities Appropriation Advisory Board Members**

A Brief on Programs in the Office of Environmental Health and Engineering,  
Indian Health Service

February 2014

## Table of Contents

CONTACT INFORMATION .....	3
PURPOSE AND BACKGROUND OF THE FAAB.....	5
FACILITIES APPROPRIATION ADVISORY BOARD .....	6
INDIAN HEALTH SERVICE.....	6
PLAN OF OPERATION .....	6
I. Introduction .....	6
II. Purpose .....	7
III. Membership .....	7
IV. Logistics and Organization .....	8
V. Board Actions.....	9
VI. Term of the FAAB .....	9
THE OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING .....	11
OEHE Mission: .....	12
OEHE Scope: .....	12
Division of Facilities Planning and Construction .....	12
Division of Engineering Services .....	13
Division of Facilities Operations .....	13
Division of Sanitation Facilities Construction .....	14
Division of Environmental Health Services .....	14
ENVIRONMENTAL HEALTH AND FACILITIES APPROPRIATION HISTORY CHARTS .....	15
Facilities and Environmental Health Support.....	23
<i>Facilities Support Account.....</i>	23
<i>OEHE Support Account.....</i>	24
<i>Environmental Health Support Account.....</i>	24
Health Facilities Construction Priority System .....	24
Other Health Care Facilities Funding.....	25
<i>Dental Facilities Program .....</i>	26
<i>Joint Venture Program .....</i>	28
<i>Small Ambulatory Grants Program.....</i>	31
Use of Medicare and Medicaid Funds for Construction .....	34
Maintenance and Improvement .....	34
<i>Routine Maintenance .....</i>	34
<i>Environmental Remediation .....</i>	35
<i>Demolition Funds .....</i>	35
Medical Equipment Allocation .....	35
<i>Methodology For Tribal Replacement Facilities .....</i>	36
<i>Methodology For Existing IHS and Tribal Facilities .....</i>	37
SANITATION FACILITIES CONSTRUCTION PROGRAM FUNDING .....	38
<i>Project Funding Methodology and Priority Criteria .....</i>	38
<i>SFC Program Funding Criteria and Allocation Methodology .....</i>	45
Injury Prevention .....	59
Potential Areas of Impact Due to IHCRIEA .....	61

## Contact Information

INDIAN HEALTH SERVICE FACILITIES APPROPRIATION ADVISORY BOARD MEMBERS						
AREA	NOMINATIONS	REPRESENTING	Elected Tribal Official	DST, Title I, Title V	Address	Phone Number
Great Plains	Charlee Archambault Charleearchambault@gwtc.net	Area and Tribes Nomination (Rosebud Sioux Tribe)	Health Administrator	DST	PO Box 719 Rosebud, SD 57570	605-747-5100
Alaska	Lincoln Bean lbean@anhb.org	Area and Alaska Native Health Board Nomination (ANTHC and SEARCH)	Chairman	Title V	4000 Ambassador Dr., Ste 101 Anchorage, Alaska 99508	907-562-6006 O 907-947-5016 C 907-563-2001 F
Albuquerque	Leonard Montoya Leonardmontoya@yahoo.com	Area and Tribes Nomination (San Juan Pueblo)	Tribal Representative	DST	PO Box 993 San Juan Pueblo, NM 87566	505-231-5834
Bemidji	Carol Rollins Carol.Rollins@ho-chunk.com	Area and Tribes Nomination (Ho-Chunk Tribe)	Environmental Health Director	Title I	Box 636 Black River Falls, WI	715-284-9851 O 608-797-0207 C 715-284-9592 F
Billings	Charles Headdress ckheaddress@yahoo.com	Area and Tribes Nomination (Fort Peck Tribe)	Council Member	DST	Poplar, MT 59255	406-768-2300
California	Peter Masten Jr. phmasten@gmail.com	Area and Tribes Nomination (Hoopa Valley Tribe)	Board of Directors, Chairperson	Title V	PO Box 1291 Hoopa, CA 95546	707-499-6171
Nashville	Casey Cooper	Area and Tribes Nomination (USET- Oneida Indian Nation of NY) Eastern Band of Cherokee Indians	CEO, Health Systems Administrator	Title I	Caller Box C268 Cherokee, NC 28719	828-497-9163, 4, 3 828-497-7459 F
Navajo	Rex Lee Jim rexleejim@yahoo.com	Area and Tribe Nomination (Navajo Nation)	Tribal Vice-President	DST, Title I, Title V	100 Parkway - PO Box 7440 Window Rock AZ 86515	928-871-7000 928-871-4025 F
Oklahoma City	Charles Grim Charles-Grim@cherokee.org	Area and Tribes Nomination (Cherokee Nation)	Sr. Director of Health Services	Title V	PO box 948 Tahlequah, OK 74465-0948	918-453-5680 O 918-708-2088 C 918-458-6174 F
Phoenix	Terry Rambler Trambler@scatui.net	Area and Tribes Nomination (San Carlos Apache Tribe)	Tribal Chairman	DST	One San Carlos Ave, San Carlos, AZ 85550	928-475-2361 O 928-475-258 F
Portland	Pearl Capoeman-Baller pballer@quinault.org	Area and Tribes Nomination (Quinault Nation)	Vice Chairman	Title V	PO Box 218 Taholah, WA 98587	360-276-8215 O 360-276-4661 F
Tucson	Jennie Becenti jennie.becenti@tonation-nsn.gov	Area and Tribes Nomination (Tohono O'Odham Nation)	Executive Director, Health	DST	PO Box 810 Sells, AZ 85634	520-383-6000 O 520-471-6490 C 520-383-3930 F

Name	Title	Phone Number	email
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## **Purpose and Background of the Facilities Appropriation Advisory Board**

On July 3, 2012, Dr. Roubideaux, Director, Indian Health Service (IHS) sent a survey letter to all American Indian/Alaska Native (AI/AN) tribes requesting counsel on facility related issues and methodology for tribal consultation. In 2013, the Director, IHS, re-established a Facilities Appropriation Advisory Board (FAAB) in answer to the tribal recommendations. The IHS utilizes the FAAB to ensure that there is input from the American Indian/Alaska Native AI/AN communities with programs associated with the Office of Environmental Health and Engineering (OEHE). In 1997, the OEHE obtained the approval of the Director, IHS, to establish the FAAB for the IHS. The FAAB advises IHS regarding a wide variety of environmental health and facilities construction and maintenance issues, including its various funding allocation formulae. The FAAB first met in January of 1998 where a draft charter for the FAAB operations was modified and approved. (See existing charter entitled "Plan of Operation" below). The FAAB has reviewed and advised the IHS on such issues as:

- Revision of the Healthcare Facilities Construction Priority System,
- Base budgeting for environmental health services,
- Reauthorization of the Indian Health Care Improvement Act,
- Use of equipment funds to participate in a Department of Defense (DOD) program that permits IHS and tribes to obtain surplus equipment and supplies,
- A variety of funding allocation policies and formulae including:
  - The Joint Venture Program,
  - Small Ambulatory Program, and
  - Sanitation Facilities Construction Regular Homes Projects Prioritization.

In the past, the FAAB consisted of 14 members, including 12 tribal representatives and 2 IHS representatives who served 3 years each with half the membership being replaced by new members every January. In addition to the members, each IHS Area Office identified an alternate to take part in FAAB activities if the Member was unable to do so.

Heretofore, Tribal representatives were selected by the Director, IHS, from nominations submitted by IHS Area Offices in consultation with tribes. The IHS representatives were selected by the Director, Office of Environmental Health and Engineering. The FAAB met once or twice a year and addresses an agenda developed by the OEHE based on FAAB input. Chairpersons for the FAAB were selected from membership by the FAAB each year at the first meeting during the calendar year.

## **FACILITIES APPROPRIATION ADVISORY BOARD**

### **INDIAN HEALTH SERVICE**

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## **PLAN OF OPERATION**

### **I. Introduction**

The Indian Health Service (IHS) Office of Environmental Health and Engineering (OEHE) operates comprehensive programs that are funded under the Facilities Appropriation portion of the IHS budget. The Congress appropriates funding for these programs, based on need/workload, on an annual basis. Funds are identified for comprehensive environmental health services, maintenance of existing buildings, and construction programs for new health care and sanitation facilities. The OEHE headquarters office is responsible for establishing overall policy for the operation of these programs and for the distribution of resources.

It is the IHS policy to consult with tribal governments to the extent practicable, and to the extent permitted by law, prior to taking actions that affect federally recognized tribes. The IHS Facilities Appropriation Advisory Board (FAAB) is established in accordance with IHS Circular 06-01, Tribal Consultation Policy, to provide for tribal participation in the review, development, and implementation of policies, procedures, guidelines, and priorities which govern the operation of OEHE programs. Additionally, in section 141, Health Care Facility Priority System, of the Indian Health Care Improvement Act, as amended, reinforces the Consultation process “to provide advice and recommendations for policies and procedures of the programs funded pursuant to facilities appropriations and to address other facilities issues.” The Facilities Appropriation Advisory Board (FAAB) is created at the discretion of the Director, IHS.



## II. Purpose

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The FAAB is charged with:

- Evaluating existing facilities policies, procedures, and guidelines and recommending changes if necessary.
- Participating in the development and evaluation of any proposed new policies, procedures, guidelines or priorities. In addition, should any of the recommendations necessitate changes in law; this group may recommend desired legislative changes.
- Determining when it is necessary and appropriate to seek additional consultation from all tribes.
- Providing advice and recommendations for other related issues.
- Recommending modifications to operational guidelines of the FAAB.

## III. Membership

The FAAB is established as a standing committee of tribal and IHS representatives. It shall be composed of twelve tribal members nominated by the Areas in consultation with tribes and two IHS members for a total committee size of fourteen. The Director, IHS, will select the FAAB tribal members from the names submitted by the tribes and tribal organizations and will ensure that representation from all three health delivery systems exists. The Director, Indian Health Service will select the IHS members and at least one of them will be from an Area or field office. As vacancies on the FAAB occur, they will be filled in a similar manner. During the first 3 years (2014-2017) half of the members will serve for 2 years and the other half will serve for 3 years. Thereafter, members will serve two year staggered terms.

The FAAB will select a Chairperson and a Vice Chairperson annually from the membership. In the absence of the Chairperson, the Vice Chairperson will act as Chairperson.

#### IV. Logistics and Organization

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Meetings will be held semi-annually. All meetings will be open to visitors. Additional meetings and conference calls will be held on an “as needed” basis.

The IHS will provide support for all meetings and conference calls.

The Chairperson will chair all meetings and conference calls. In addition, the Chairperson will sign the transmittal forwarding recommendations approved by the FAAB.

Following each meeting, the IHS will prepare a written summary of the meeting proceedings that will be distributed to all Board members for their review. Once comments have been incorporated into the summary, it will be finalized and distributed.

Members will not receive compensation for serving on the FAAB; however, members will be reimbursed for travel expenses in accordance with Federal travel regulations for attending FAAB meetings. The local IHS Area Office will assist with travel arrangements.

No decision on FAAB recommendations will be made unless at least eight of the Board members are present. The FAAB will work to seek consensus on all decisions. Should consensus not be achievable, action by the FAAB will require a simple majority of the votes of the members present at the time of the vote.

Members may not designate substitutes to act on their behalf at FAAB meetings; however, they may authorize another FAAB member to serve as a proxy on any voting matter. Such proxies must be designated in writing prior to the meeting date and must be signed by the FAAB member who is authorizing the proxy.

## **V. Board Actions**

All recommendations from the FAAB should be submitted to the Director, IHS in writing under a dated cover sheet approved by the FAAB members and signed by their chairperson. Each recommendation should include background information that helps to clarify the rationale for the recommendation (this may include pros and cons of discussion points, issues of agreement and disagreement, and dissenting viewpoints).

For those recommendations that are to be adopted, the Director, IHS shall outline a written plan for instituting the recommendations and a timetable for implementation. For those recommendations not accepted, the Director, IHS, can request a written clarification of the recommendation or the Director can deny the recommendation stating in detail, the reasons for the denial, citing laws, agency regulations, agency policies, etc., which support the decision. If the Director, IHS, denies a recommendation, the FAAB may accept that decision or appeal the decision with an amended or clarified recommendation to the Director, IHS.

The Director, IHS will respond to the FAAB recommendations within two weeks of their receipt.

## **VI. Term of the FAAB**

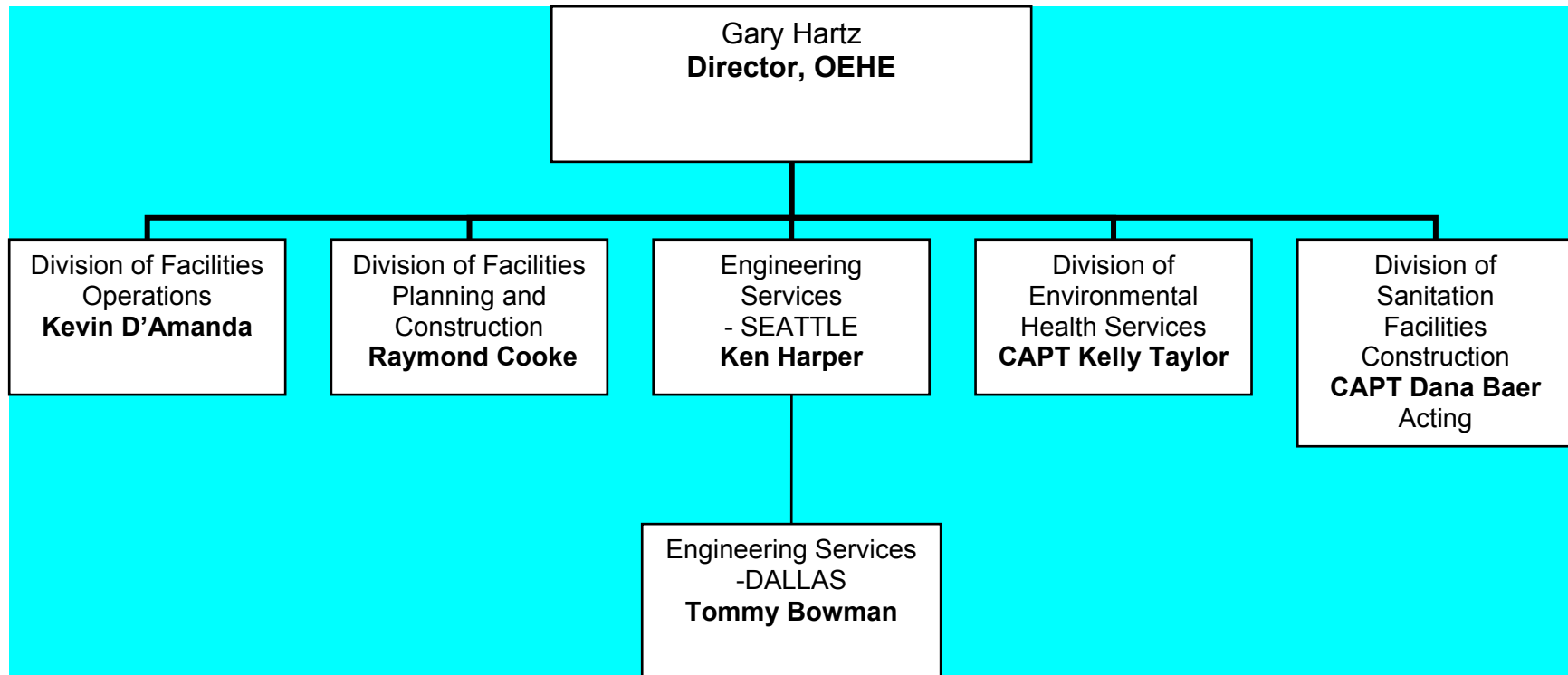
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The FAAB will remain active until the Director, IHS, in consultation with all tribes, determines it should be disbanded.



## The Office of Environmental Health and Engineering

Indian Health Service  
Department of Health and Human Services



**OEHE Mission:**

The mission of the Indian Health Service (IHS) is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. The mission of the Office of Environmental Health and Engineering (OEHE) is to support that mission by:

- Providing optimum availability of functional, well maintained tribal and federal health care facilities and staff housing;
- Providing technical and financial assistance to Indian tribes and Alaska Native communities (tribes) to promote a healthy environment through the cooperative development and continuing operation of safe water, wastewater, and solid waste systems and related support facilities;
- Providing a wide range of environmental health, institutional, and injury prevention services for Indian tribes and Alaska Native communities through training, technical advice and assistance, and monitoring and inspection of facilities and institutions; and
- Assisting each American Indian tribe and Alaska Native community to achieve its unique goals for obtaining health care facilities and establishing and maintaining a healthy environment.

**OEHE Scope:**

The OEHE is composed of five divisions that provide support for IHS Headquarters, each of the 12 IHS Areas, all IHS service units and many tribal programs in the following areas:

- Health care facilities engineering and construction and program management (Division of Facilities Planning and Construction);
- Health care facilities engineering, project management, and construction contracting (Division of Engineering Services—Dallas/Seattle);
- Health care facilities operations, maintenance, clinical engineering, real property management, and realty (Division of Facilities Operations);
- Sanitation facilities construction and environmental engineering (Division of Sanitation Facilities Construction); and
- Environmental health services including injury prevention and institutional environmental health (Division of Environmental Health Services).

Specific responsibilities of each Division are outlined below:

**Division of Facilities Planning and Construction**

- Manages the planning, design, and construction of new health care delivery space and major modernization and renovation of existing space;
- Manages implementation and maintenance of the new IHS Health Systems Planning Project;
- Develops and maintains new health care facilities construction priority lists for use by IHS and the Congress;

- Manages the planning, design, and construction of personnel quarters where needed to ensure that adequate housing is available for IHS staff;
- Provides guidance to tribal organizations seeking to construct facilities that will provide access to health care delivery services for American Indians and Alaska Natives;
- Allocates funds appropriated for construction of health care facilities;
- Provides engineering assistance in development of health care facilities master plans;
- Manages renovation and modernization of existing facilities to meet needs of changing health care delivery program;
- Advocates for tribes during the development of policies, regulations, and programs.

### **Division of Engineering Services**

- Provides technical consultation to tribes and Area Offices regarding planning, design and construction of health care facilities;
- Provides professional architectural and engineering services for health care facilities design and construction; and
- Administers and manages design of health care facilities construction projects;
- Administers and manages construction projects to build, renovate, and/or modernize health care facilities and personnel quarters;
- Advocates for tribes during the development of policies, regulations, and programs.

### **Division of Facilities Operations**

- Programming, budgeting, and policy at the national level for the maintenance, repair and operations of health care facilities;
- Develops and maintains an inventory of maintenance deficiencies in IHS and Indian and Alaska Native health care facilities;
- Maintains data for allocation of funds appropriated for health care facilities management;
- Manages maintenance of existing facilities in a safe, usable condition;
- Manages IHS facilities environmental program;
- Manages IHS historic program;
- Manages IHS energy management program;
- Manages IHS real property asset management program responsibilities;
- Maintains IHS Federal facilities energy usage data;
- Coordinates IHS Clinical Engineering Program;
- Maintains an inventory of IHS real property;
- Manages IHS realty program;
- Manages IHS quarters program; and
- Advocates for tribes during the development of policies, regulations, and programs.

## **Division of Sanitation Facilities Construction**

- Develops and maintains an inventory of sanitation deficiencies in Indian and Alaska native communities for use by the IHS and the Congress;
- Provides environmental engineering assistance with utility master plans and sanitary surveys;
- Plans and coordinates multi-agency funded sanitation projects and assists with grant applications to leverage IHS funds;
- Allocates funds appropriated for water supply and waste disposal facilities;
- Provides professional engineering design and/or construction services for water supply and waste disposal facilities;
- Provides technical consultation and training to improve the operation and maintenance of tribally owned water supply and waste disposal systems;
- Advocates for tribes during the development of policies, regulations, and programs; and
- Assists tribes during sanitation facilities emergencies.

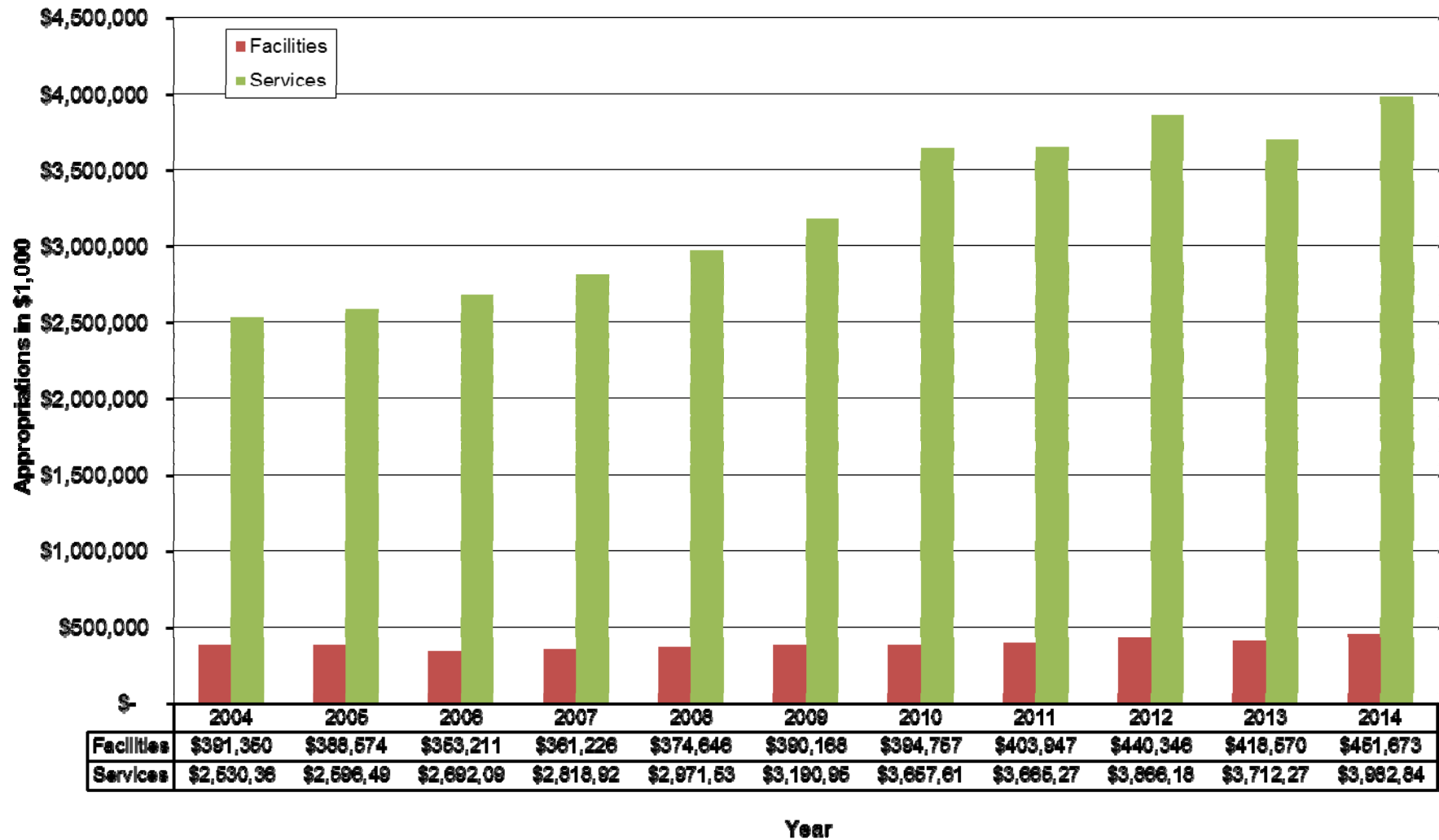
## **Division of Environmental Health Services (DEHS)**

- Delivers a comprehensive EH program to more than 1.9 million American Indian/Alaska Native (AI/AN) people in 35 states;
- Consults with and provides technical assistance to tribes in an effort to provide safe, healthy environments;
- Has five national focus areas: children's environment, safe water, food safety, vector-borne and communicable diseases, healthy homes;
- Four key activities for each of the focus areas: conduct inspections that identify EH risk factors, suggest corrective actions to reduce or eliminate risk factors, conduct investigations of disease and injury incidents, provide EH training classes to federal, tribal, and community members;
- Provides program support and guidance to Area and Tribal Environmental Health Services programs including Area Institutional Environmental Health programs and Area Injury Prevention programs;
- Maintains national environmental health databases for the following:
  - Area and Tribal inventory of public, commercial, and governmental facilities and services provided by EHS staff and programs;
  - An incident reporting system used by any IHS affiliated facility for collecting occupational injuries and illnesses, visitor injuries, patient safety errors and adverse events, security events, property damage, and hazardous conditions;
- Coordinates inter- and intra-agency agreements among various federal and non-federal agencies;
- Allocates funds appropriated for environmental health services activities;
- Coordinates career development opportunities for IHS and Tribal environmental health services staff;
- Advocates for tribes during the development of policies, regulations, and programs; and
- Assists tribes in responding to emergency situations.

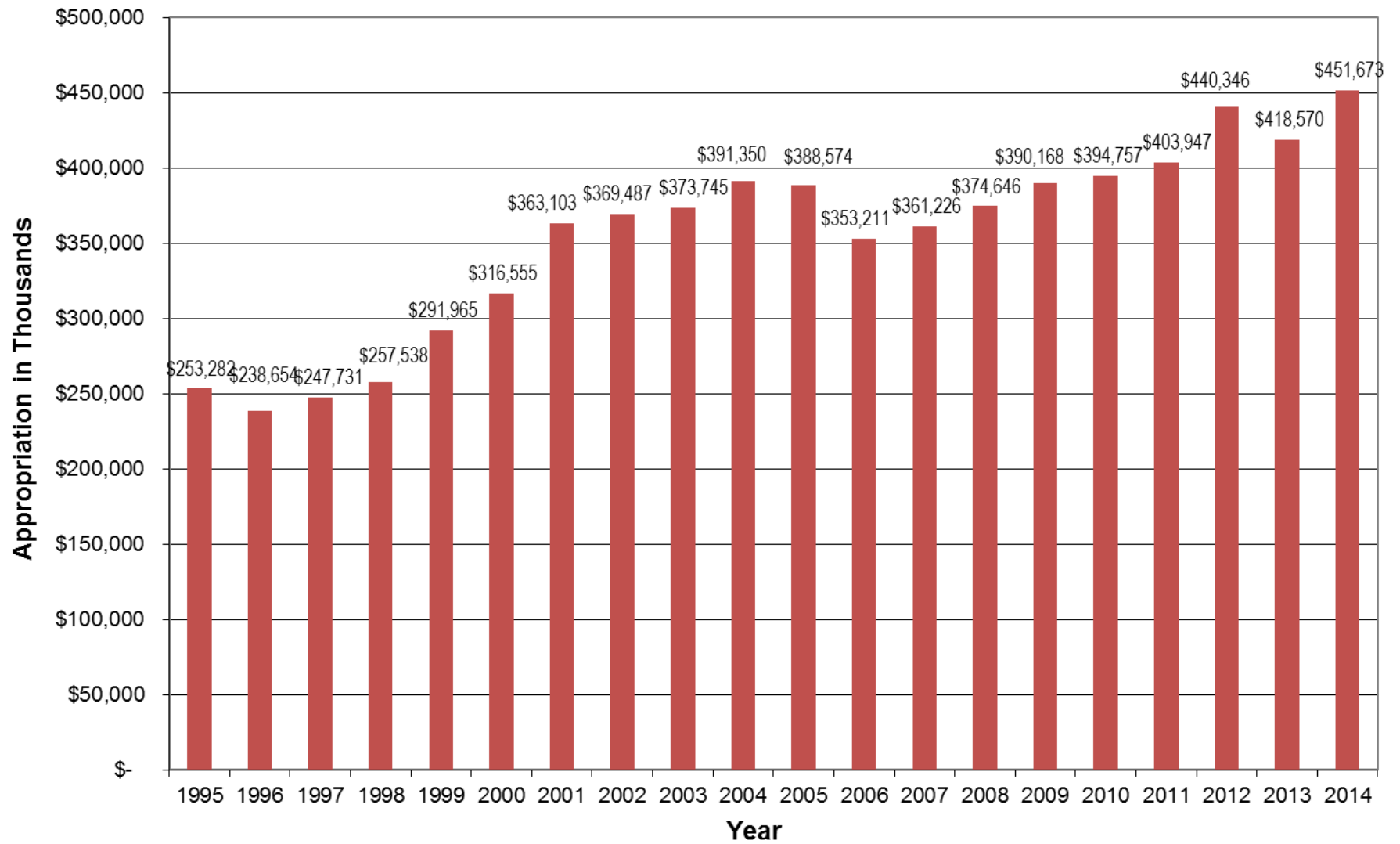


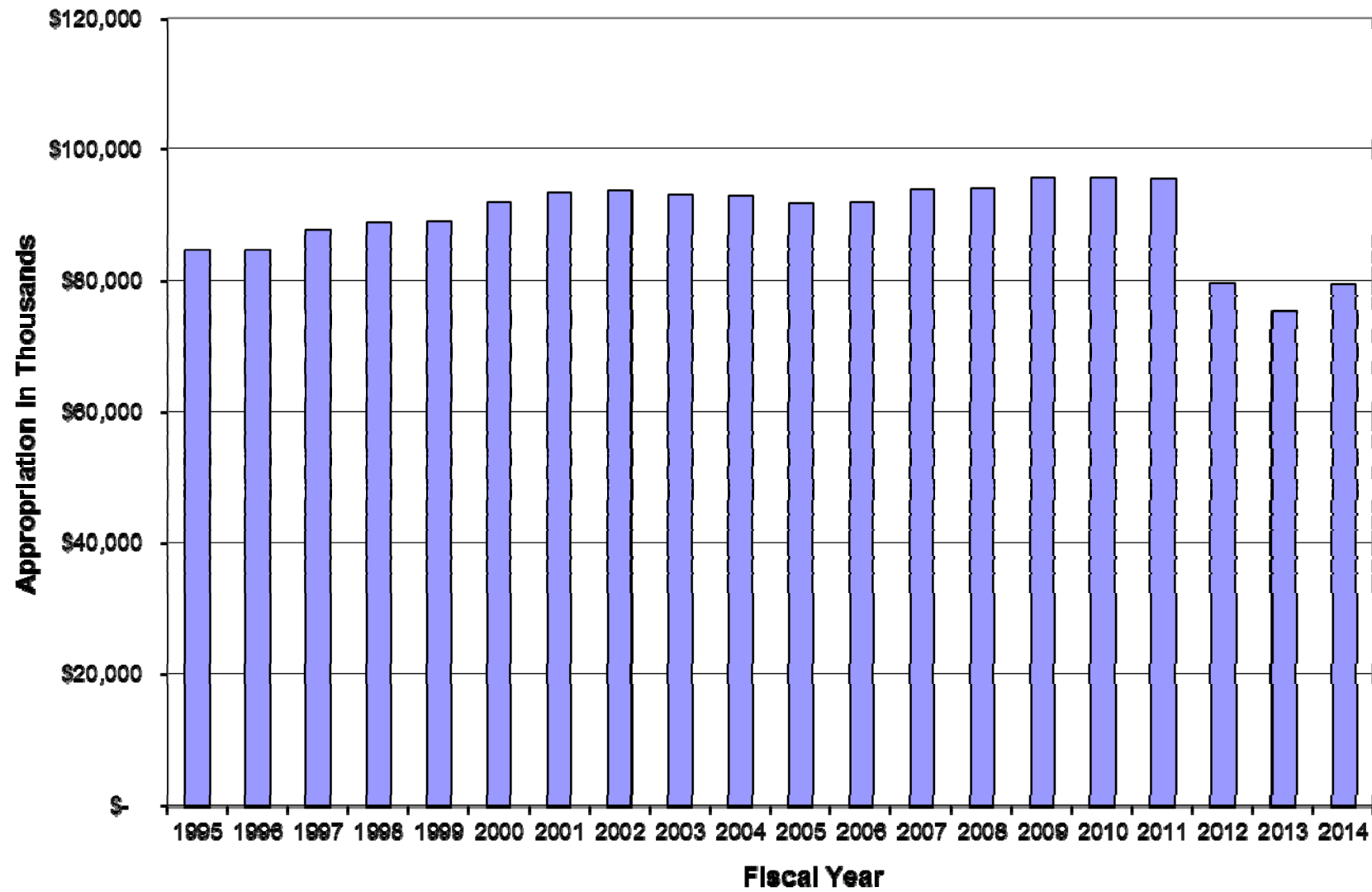
## **Environmental Health and Facilities Appropriation History Charts**

### Services and Facilities Appropriations FY2004-FY2014



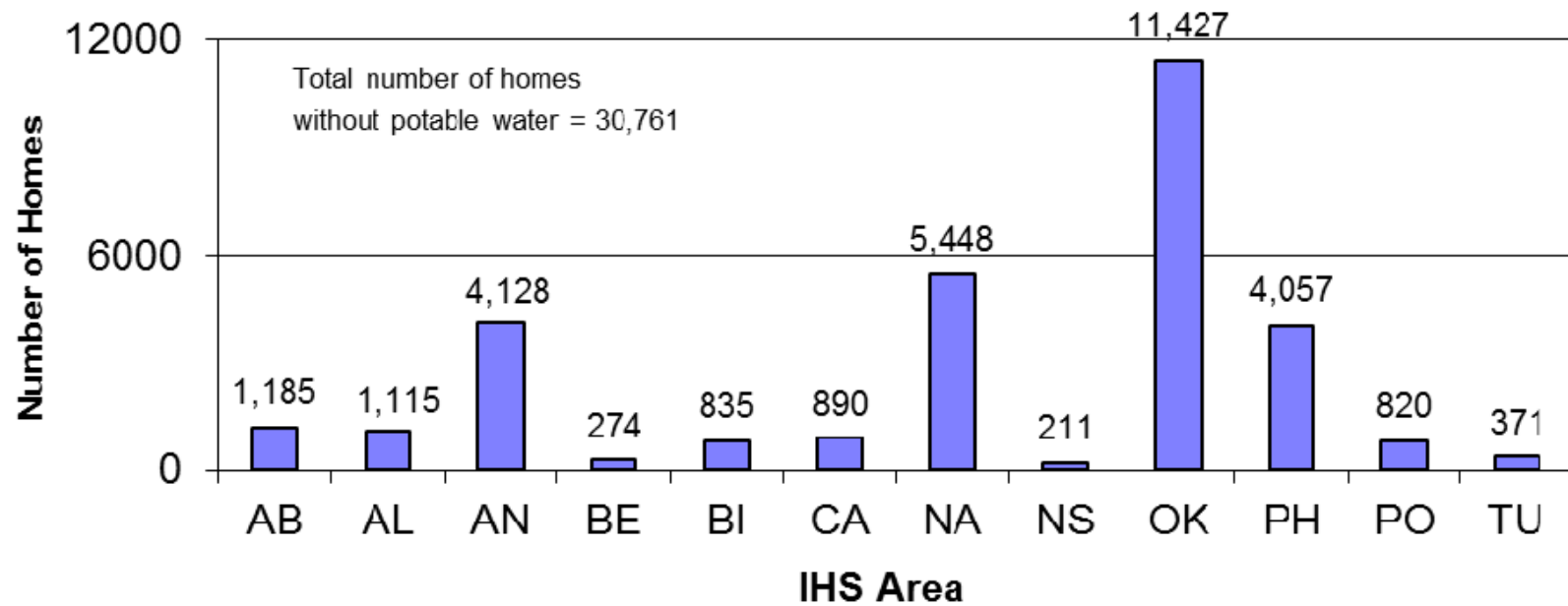
### Total Facilities Appropriation

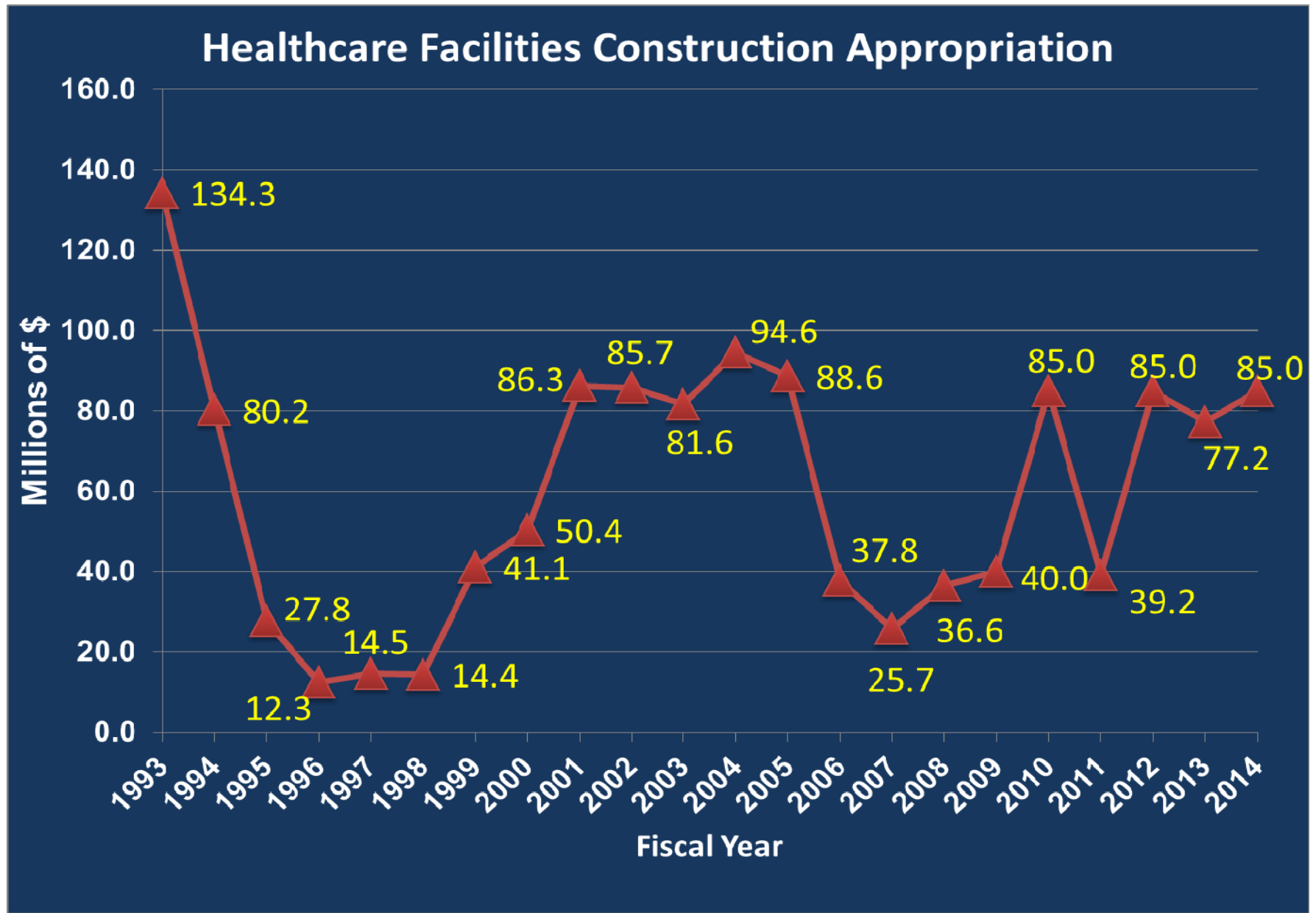


**Sanitation Facilities Construction (SFC)**

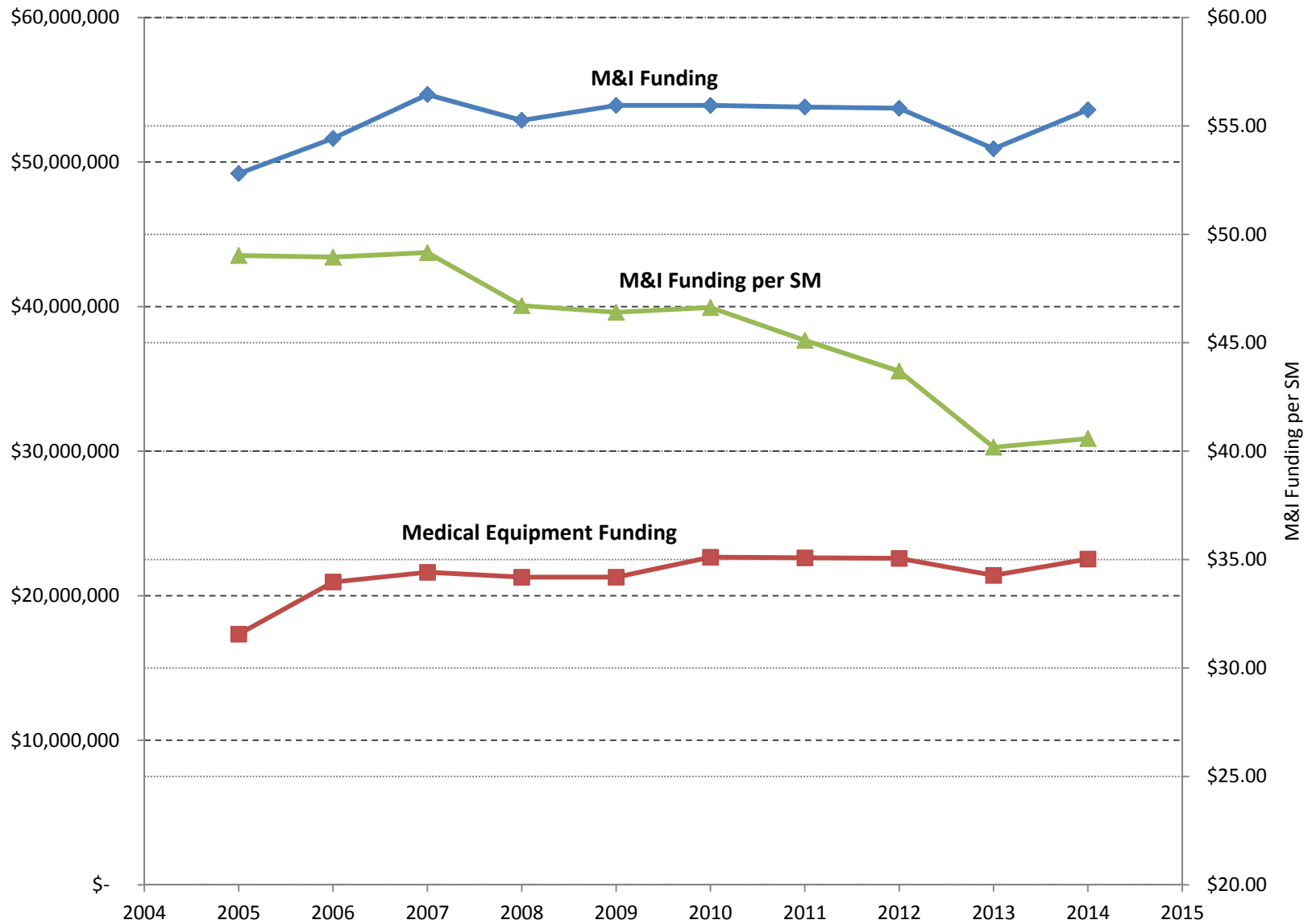
## Indian Sanitation Deficiencies

### Number of Homes Without Potable Water EOY 2013 Data

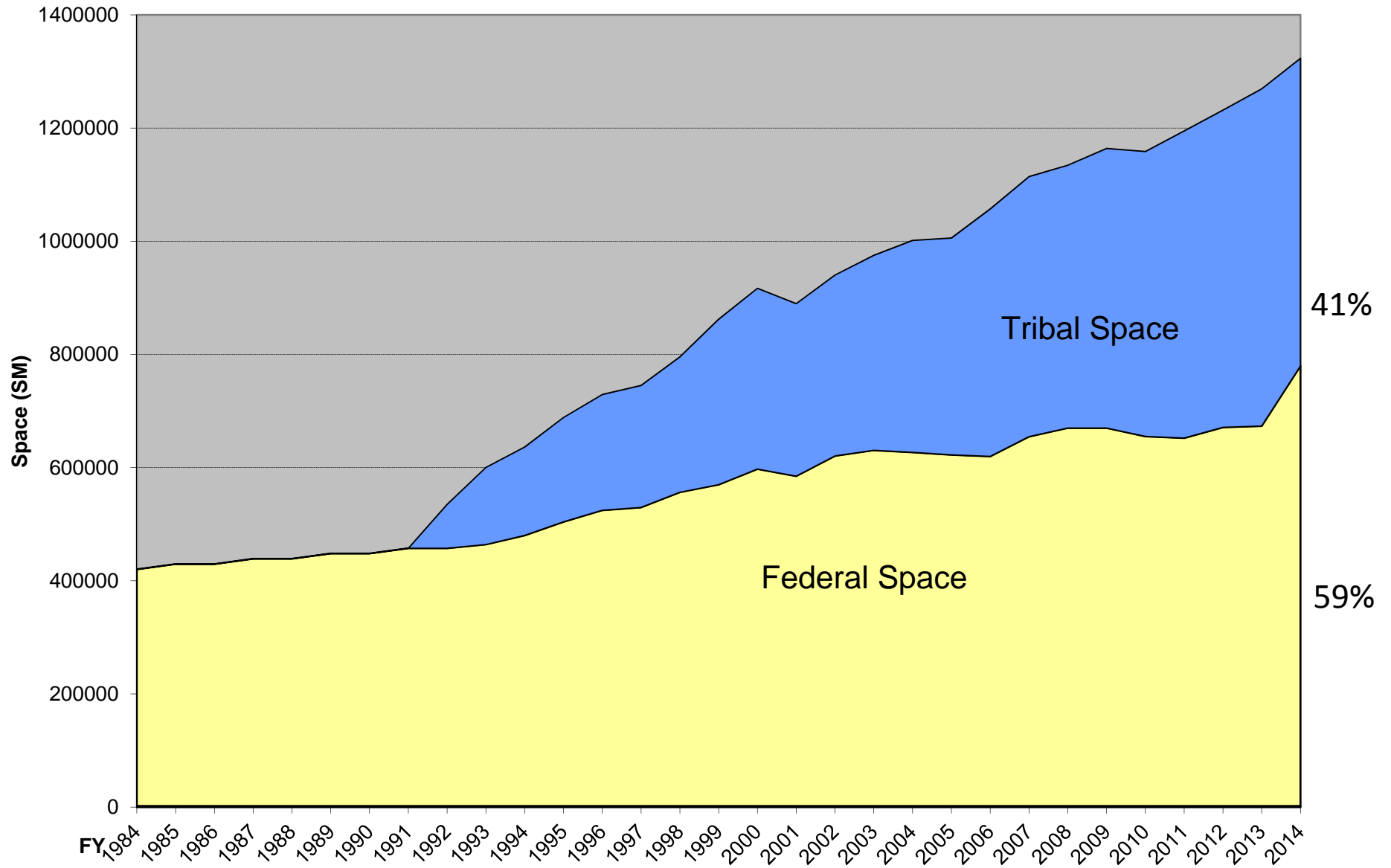




# M&I-E Funding Levels



# Federal-Tribal Supported Space





## Facilities and Environmental Health Support

The Facilities and Environmental Health Support (FEHS) budget line item provides resources that IHS uses to staff and support its headquarters, regional, Area, district, and service unit activities. In order to maintain a clear distinction between the three major categories of costs included in this activity, the IHS has established three sub-activities: 1) Facilities Support; 2) Environmental Health Support, and 3) Office of Environmental Health and Engineering Support. Allocation of the appropriated funds to the sub-activity accounts is based on workload.

### Facilities Support Account

The Facilities Support Account sub-activity provides resources that IHS uses to pay certain personnel and operating costs at the Area and Service Unit Levels. Personnel paid from this account operate and maintain health care facilities and staff quarters. Also, related Area and Service Unit operating costs, such as utilities, building operation supplies, facilities related real and personal property, and biomedical equipment repair and maintenance are paid from this account.

Funds in the Facilities Support Account are dispersed based on historical distribution. This account was established in the early 1990s when recurring appropriations supporting utilities and salaries for the health care facilities program were transferred from the Hospitals and Clinics line item to the Facilities and Environmental Health Support line item. At the time of the transfer, Area offices were asked to identify those funds supporting these activities. However, there was no consistency among the various Area Offices in identifying which types of funds were to be transferred to the Facilities and Environmental Support Line Item from the Services Line Item. As a result some Areas retained some types of funds in the Hospitals and Clinics Account that other Areas identified for transfer to the Facilities and Environmental Support Line. Allocation of funds identified for the Facilities Support Account each year is based on the amount transferred. The following formula is used as a basis for determining the allocation of the Facilities support Account funds, including mandatory increases, but exclusive of program increases.

$$\text{Area's FY Allocation} = \frac{\text{Previous Year's Area Allocation}}{\text{Previous Year's Total FSA}} * \text{This Year's Total FSA}$$

From time to time there may be program increases to the Facilities Support Account (FSA). The first such program increase, totaling \$590,000 in FSA, occurred in fiscal year (FY) 2000. These funds were allocated on a non-recurring basis in FY2000 while a more permanent methodology was developed. The proposed new methodology for FY2001 was discussed with the Area Associate Directors and presented to the FAAB, and has been implemented. This methodology allocated 50% of the funds to all Areas

in proportion to their calculated Facilities Resource Requirements Methodology (RRM) need. The balance was allocated to the four Areas which were otherwise unable to support a core level or Area office staff.

This allocation applies only to the (ongoing) FY 2000 program increase and locks in the distribution of that increase for subsequent years. However, if there are further increases, IHS will revisit how they would be allocated. It is expected that the Facilities RRM will be the basis for future allocations; however, the issue of disparities among the Areas may require some adjustments similar to those identified for the FY 2000 increase.

### **OEHE Support Account**

The Office of Environmental Health and Engineering Support Account funds permanent personnel costs at IHS Headquarters OEHE and in two public health Service Regional Offices of Engineering Services (OES), for direct support/management of the full array of services and activities funded by the Facilities appropriation. These funds are allocated based on workload.

### **Environmental Health Support Account**

The Environmental Health Support Account funds are used to pay for personnel who accomplish environmental health services, injury prevention, institutional environmental health, and sanitation facilities construction activities at the IHS Area, district, and service unit levels. These funds also are used for operating costs associated with provision of these services and activities. These funds are allocated using the Resource Requirements Methodology.

### **Health Facilities Construction Priority System**

In the Indian Health Care Improvement Act, Public Law (P.L.) 94-437, the Congress directs that IHS submit a list of the 10 highest priority inpatient and the 10 highest priority outpatient facilities construction projects annually. To maintain these lists the IHS adds new projects periodically using the Health Facilities Construction Priority System (HFCPS).

In the language accompanying the FY 2000 appropriations the Congress directed the IHS, in consultation with the Tribes to review the existing Healthcare Facilities Construction Priority System (HFCPS). In response to this directive, the IHS formed a workgroup comprised of tribal leaders and health directors to review and advise on revising the HFCPS. This group met five times in 2001 and 2002 and reported to the IHS Facilities Appropriation Advisory Board (FAAB) in February 2002. The FAAB reviewed the workgroup report and advised the IHS on developing a draft document for tribal review. In June 2004, the IHS asked all Tribes to review this document. In response, the IHS received 80 letters providing approximately 1,200 comments. Over

the next 2 years, the FAAB and IHS met several times to discuss the issues identified during tribal review. During that time as work progressed, the FAAB forwarded three letters IHS on these issues. The first letter made the initial recommendation for finalizing the revision to the HFCPS, and subsequent letters modified those recommendations based on discussions with IHS. The goal of the IHS in these discussions with the FAAB was to work toward a document that would be acceptable within the administration and that would also have FAAB support. In their final letter, the FAAB recommended that the HFCPS be finalized essentially as it was presented for tribal consultation in 2004 and forwarded to Congress. The FAAB did recommend that the document be modified to include an Area Distribution Program, and that the HFCPS not consider prioritization of any facilities providing services to fewer than 138 users.

The IHS and Tribes have completed the review of the HFCPS, and a draft revision has been completed. A report to Congress on the review process and the draft revision is being reviewed for clearance. The IHS will implement the HFCPS when it has been determined that the health facilities projects on the current priority list have been substantially funded or when directed by the Congress, who requested this revision. Based upon the health services and facilities master planning effort that was incorporated into the development of the revised HFCPS, a determination has been made that there is an extremely large need for health facilities to ensure access to health services throughout Indian Country.

#### Completed Construction of Facilities off the 1992 Priority List

##### Hospitals

Nome, AK 11/2012  
Barrow, AK 8/2013  
Talihina, OK 6/1999

##### Health Centers

Pawnee, OK 3/2004  
Dulce, NM 3/2005  
St. Paul, AK 1/2006  
Metlakatla, AK 3/2006  
Red Mesa, AZ 9/2006  
Clinton, OK 12/2006  
Sisseton, SD 1/2007  
Eagle Butte, SD 12/2011  
Tohono O'odham Nation (San Simon, AZ) 7/2007  
(via Joint Venture)

#### **Other Health Care Facilities Funding**

The allocation formulas for the health care facility programs list below including the Dental Facilities program, Joint Venture Program, Small Ambulatory Grants Program, Maintenance and Improvement, Medical Equipment, and Sanitation Facilities Construction were established by direction of Congress and/or through tribal consultation via the FAAB or other formal tribal workgroups.

## **Dental Facilities Program**

In the past, dental funds were allocated by the IHS dental services program. However, In the FY 1994 appropriations act, the Congress transferred the responsibility to the IHS facilities program. Appropriations for this program have been typically \$1 million. Since FY1994, approximately \$15.4M has been appropriated to provide for 39 dental units. These units provided a total of 159 dental operatories.

The dental facilities program is a competitive program. When funds are available, applications are solicited, scored, and ranked based on several factors including but not limited to need, user population, isolation, the cost to repair deficiencies, and the availability of staffing funds at the Service Unit. A dental priority list is then established and is used until the funds are depleted. More detailed information on the allocation formulas are shown below the list of facilities.

The program's goal is to maximize the funds received from Congress and therefore limits the funding of dental units to 3, 4, or 5 dental operatories. The funds can be used to either replace old existing units, provide for needed additional operatories, or both or for dental equipment only. The funds are for the design and construction, and to equip the unit. There are no staffing or operational funds that are provided specifically for the units once they are completed. Applications can be from federal or tribal facilities.

The following locations have received funds for dental units.

<u>Location</u>	<u>No. of Chairs</u>	<u>Location</u>	<u>No. of Chairs</u>
Kingston, Wa	4	Mariposa, CA	4
Jeditto, AZ	3	Unalakleet, AK	4
Winslow/Holbrook	5	Schurz, NV	3
Lower Brule, SD	3	Toksook Bay, AK	3
Dillingham, AK	3	Santa Rosa, AZ	4
LaPush, WA	3	Cameron, AZ	4
Heart Butte, MT	3	Horton, KS	3
San Carlos, AZ	5	Many Farms, AZ	5
LaConner, WA	5	PIMC, AZ	5
Round Valley, CA	3	Bylas, AZ	3
Sisseton, SD	5	San Xavier, AZ	5
Wellpinit, WA	5	Whiteriver, AZ	5
Pryor, MT	3	Red Lake, MN	5
Wanblee, SD	3	Thoreau, NM	5
San Simon, AZ	5	Bellingham, WA	5
Eagle Butte, SD	5	Colville, WA	5
Cass Lake, MN	5	Catawba, SC	4
Happy Camp, CA	4	Micmac, ME	3
Dulce, NM	3	Albuquerque, NM	5
Hooper Bay, AK	4		

## Allocation Formula

A freestanding, three-operator dental unit is considered more cost effective than a two-operator unit and so is the minimum size that will be considered under the Free Standing Dental Clinic Facilities Priority System. Projected dental workloads must justify a minimum three-operator dental unit using the criteria of the Health Facilities Planning Manual (HFPN) or the Health Systems Planning program (HSP). In addition, funding will be provided under this program for no more than five operatories. Locations that require more than 5 operatories may receive funding for 5 operatories **In One Year And Apply Under This Program For Funding For Expansion In Subsequent Years**. Applications with workloads not able to justify a three-operator dental unit based on the HFPN or HSP will not be ranked or scored.

As in the HFCPS, three factors are multiplied to obtain a priority score. These factors are the Relative Need Factor, the Absolute Need Factor, and the Isolation/Alternatives Factor.

Priority Score	=	Isolation/Alternatives Factor	X	Absolute Need Factor	X	Relative Need Factor
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**The Isolation/Alternatives Factor:** This factor is a function of the distance to the nearest alternative source of dental health care. In the evaluation formula, this factor is between 1 and 1.6. For proposed dental health facilities in locations where the only access to other dental facilities is by air (i.e., where there are no roads), 1.6 is used as the Isolation/Availability Factor.

**The Relative Need Factor:** This factor is a function of the ratio of the required space to the adjusted existing space, if any. This factor is the most significant in the evaluation formula and will have a value between 1 and 4. If there is no existing space, the relative need factor is 2. Sites that are very old and/or in poor condition can have a negative existing space and would generate a relative need factor value greater than 2. If the adjusted existing space is greater than the required space, as determined by the calculations, the relative need factor is set at 1.

**The Absolute Need Factor:** This factor is a function of the required space minus the (adjusted) existing space, if any. This factor will have a value between 0 and 1.5 in the evaluation formula. If the Adjusted Existing Space is greater than the Required Space, as calculated in the formula, the Absolute Need Factor is set at 0.

## **Joint Venture Program**

**Program Authorization:** Section 818(e) of the Indian Health Care Improvement Act, Public Law (P.L.) 94-437, as amended by languages in the fiscal year (FY) 2001 appropriation, P.L. 106-291, and the FY 2002 appropriation, P.L. 107-63, authorizes the Indian Health Service (IHS) Joint Venture Construction Program (JVCP) for establishing projects where American Indian and Alaska Natives tribes can acquire a tribally owned outpatient health care facility, in exchange for the IHS providing the initial equipment, then operating and maintaining the health care facility for 20 years.

### **Conditions of Authorizing Legislation:**

- The tribe must have the administrative and financial capabilities necessary to complete the acquisition in a timely manner.
- The tribe must expend tribal, private, or other available non-IHS funds for the acquisition.
- The tribe is to lease the tribally owned health care facility to the IHS for 20 years under a no-cost Government lease.
- In exchange, the IHS is to provide the initial equipment<sup>1</sup>, then the supplies and staffing for the operation and maintenance of the health care facility for the lease period.
- A tribe, who has entered into an agreement with the IHS under this program, who breaches or terminates without cause such agreement, will be liable to the U.S. Government for the amount paid by the Government.

### **Program Implementation Criteria:**

- **Project Funding:** Tribes are invited to apply for participation in the JVCP whenever appropriations are received from the Congress for the initial equipment. As joint venture projects are established, subsequent appropriations requests will address the funding needs for staffing, operations, and maintenance of the tribally owned health care facility being leased by the IHS.
- **Type Of Health Care Facility:** The program applies to ambulatory (outpatient) health centers, meeting the current minimum IHS standards of 1,100 user population and a workload of 4,400 primary care provider visits.<sup>2</sup>

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<sup>1</sup> FY2007 appropriation language directed IHS to include hospital facilities and to give preference to Tribal projects funding 100% of the project including initial equipment.

<sup>2</sup> The Congress has, in appropriations language, instructed the IHS to permit acquisition of hospitals through the Joint Venture Program.

- **No Retroactive Projects:** Projects that have been acquired already by a tribe will not be considered retroactively. Where new construction is involved, only projects that have not entered into a construction phase and that have not issued a notice to proceed with construction will be considered, including a design-build contract.
- **Facility Need:** The need for space at the location is verifiable when evaluated based upon existing user population, facility size, age, and deficiency level
- **Tribal Abilities:** The tribe must be able to manage and fund the acquisition of the proposed project in a timely manner.
- **Conformance with IHS Area Master Health Plan and IHS Design Requirements:** The proposed project is to be consistent with the applicable IHS Area Health Services-Facilities Master Plan, in order to maximize the efficient use of the funding. Additionally the project is consistent with the IHS Health Systems Planning Process (HSP) and the design will be in compliance with the *IHS Architect/Engineer Design Guide*.
- **PJD and POR Requirements:** Since IHS funding can support only space and staffing needs that can be verified under the existing IHS Health Facilities Construction Priority System methodology, a Program Justification Document (PJD), a Program of Requirements (POR), a combined Phases I and II Site Selection and Evaluation Report (SSER), which includes full compliance with the National Environmental Policy Act (NEPA) requirements, and a Government cost estimate prepared in accordance with the IHS Facilities Budget Estimating System (FBES), are required to be prepared in accordance with the planning criteria specified in the IHS health facilities planning process. The projected workload must be able to be validated by the IHS data system. The IHS supported staffing requirements will be determined in accordance with the IHS Resource Requirements Methodology. These approved planning documents are the basis for providing the initial equipment funding and for space, staffing, and the operation of the health care facility under the lease.
- **Staff Quarters:** Staff quarters needed to support the health care facility are to be a part of the project and are to be a part of the planning documents. All staff quarters approved in the planning documents are to be constructed and are to be available for use by the non-local staff when the health care facility is ready for operation. The tribe will be the owner of the staff quarters and responsible for all costs for their construction and the subsequent operation and maintenance. Once constructed, staff quarters should be self-supporting from revenues generated from the rental fees.
- **Brief History:** Previously and not under the current program authorization, two joint venture demonstration projects (health centers in Poteau, Oklahoma, and Warm Springs, Oregon) were accomplished, with the IHS providing the initial equipment with funds appropriated in FYs 1991 and 1993. Currently, under no-

cost 20-year leases, the IHS is staffing, operating and maintaining these health centers. Since then, under authorization of the Indian Health Care Improvement Act, in fiscal years (FY) 2001, 2002 and 2005 Congress appropriated approximately \$5,000,000 to equip facilities acquired by Tribes under this program. The FY 2007 appropriation included specific instructions to include hospitals and to give preference to Tribes funding 100% of the project, including equipment. The ongoing Tribal equipment funding has allowed the program to continue without any additional equipment money at least through FY 2011.

Since 2001, when the Congress first appropriated funds for this program, the IHS has entered into agreements to lease and staff 17 tribally constructed facilities. Two of these facilities were on the Healthcare Facilities Construction Priority List. In FY 2009, the Congress directed the IHS to solicit additional proposals from tribes. The result of this solicitation is that 10 proposals were identified for potential Joint Venture Construction Program participation, and in FY 2010 the four highest-ranking of these proposals were notified to begin working with the IHS Area Offices to develop planning documents and a Joint Venture Agreement. Three more were notified in FY 2011. These seven agreements were signed in FY 2011 and FY 2012. Five of these have been completed, and the other two are under construction. The final three projects from the FY 2009 list were notified in March 2014 to begin working with the IHS Area Offices to develop planning documents and a Joint Venture Agreement.

Below is a list of the 17 Projects and facilities that IHS has provided support through the Joint Venture Construction Program:

- Project No. 401 AQ - Dulce, NM, Health Center
- Project No. 402 TU - San Simon, AZ, (Westside) Health Ctr.
- Project No. 403 OK - Idabel, OK Choctaw Health Center
- Project No. 404 OK - Coweta, OK, Health Center
- Project No. 405 OK - Cherokee Muskogee (Three Rivers) Healthcare Center
- Project No. 406 CA - Lake County Health Center
- Project No. 407 OK - Chickasaw Ada Hospital (Carl Albert)
- Project No. 408 OK - Little Axe, Absentee Shawnee Clinic
- Project No. 409 AB - Santee Sioux Health Center
- Project No. 410 OK - Vinita Cherokee Health Center
- Project No. 411 AB - Flandreau Santee Health Center
- Project No. 412 AK - Copper River - Glennallen Health Center
- Project No. 413 AK - Fairbanks AK - Chief Andrew Isaac Health Center
- Project No. 414 AK - Southcentral Foundation Valley Native Primary Care Center
- Project No. 415 OK - Ardmore OK -- Chickasaw Health Center
- Project No. 416 OK - Tishomingo OK -- Chickasaw Health Center
- Project No. 417 NS - Pearl River Mississippi -- Mississippi Choctaw Health Center
- Project No. 418 AK - Kenai AK -- Dena'ina Health Clinic

**Program Management:** The JVCP is managed by the Division of Facilities Planning and Construction, Office of Environmental Health and Engineering (OEHE), at the IHS Headquarters in Rockville, MD. The IHS Facilities Managers in the respective



IHS Areas provide JVCP assistance to the Tribes, with technical assistance being provided by of the Division of Engineering Services, OEHE, IHS, from offices in Dallas, TX, and Seattle, WA. Whenever additional funding is appropriated by the Congress, information about the JVCP will be available on the IHS, OEHE web site at <http://www.oehe.ihs.gov>.

### **Small Ambulatory Grants Program**

**Program Authorization:** The Indian Health Service (IHS) Small Ambulatory Program (SAP) is authorized by Section 306 of the Indian Health Care Improvement Act, Title III, Public Law (P.L.) 94-437; as amended by the fiscal year (FY) 2001 appropriation, P.L. 106-291; the FY 2002 appropriation, P.L. 107-063; the FY 2003 appropriation, P.L. 108-007; the FY 2005 appropriation, P.L. 108-447; and the FY 2006 appropriation, P.L. 109-54. The SAP is available for American Indian and Alaska Native tribes or tribal organizations to competitively obtain funding for the construction, expansion, or modernization of tribally owned small ambulatory health care facilities.

**Legislative Requirements:** Funding can be provided only to eligible applicants who meet the program criteria and can demonstrate compliance with the following:

- Funding, under this authority, may be provided **Only** to a Federally recognized Indian tribe or tribal organization, who **Operates An Indian Health Care Facility Pursuant to a Health Care Services Contract** entered into **Under The Indian Self-Determination and Education Assistance Act, P.L. 93-638**, when:
  - the facility is not owned or constructed by the IHS; or
  - the facility was not originally owned or constructed by the IHS and transferred to the tribe.
- The ambulatory health care facility in the proposed project is located apart from a hospital, and is not contiguous or immediately adjacent to a hospital.
- The proposed project has not received any funding already under Section 301 or Section 307 of P.L. 94-437.
- Upon completion of the proposed project, the health care facility will
  - have a total capacity appropriate for its projected service population;
  - serve no less than 500 eligible Indians annually; and
  - provide ambulatory care in a service area (specified in the services contract entered into under the P.L. 93-638) having not less than 2,000 eligible Indians.

For the purposes of carrying out the SAP, the condition containing the phrase "no less than 500" is defined to mean that the proposed facility will serve no less

than 500 active users as determined by the IHS User Population. Likewise, the phrase "not less than 2,000" relates to the IHS Service Population. The IHS Service Population is an approximate measure of the potential eligible Indians in a service area. These requirements are not applicable to a tribe or tribal organization, whose **Tribal Government Offices** are located on an island.

- Be competitively selected from applications submitted in accordance with published selection criteria.
- Must be able to provide reasonable assurances, that upon completion of the proposed project, the applicant will:
  - have adequate financial support available for providing the services at the health care facility;
  - make the health care facility available to eligible Indians without regard to ability to pay or source of payment; and
  - provide services to non-eligible persons on a cost basis, in accordance with Federal Law, without diminishing the quality or quantity of services provided to eligible Indians.
- A need exists for increased ambulatory health care services.
- Currently, there is insufficient capacity to deliver needed services.

**FY 2001 Selection Process:** Using a two-step application process, applications were reviewed, rated and ranked, using an objective review process, and selections were made in accordance with the criteria provided in the Application Kit.

**FY 2002 and FY 2003 Selection Process:** Pursuant to languages accompanying the respective FY 2002 and 2003 appropriations, the rank-order list established in the FY 2001 process was used for making selections for FYs 2002 and 2003.

**FY 2005 and FY 2006 Selection Process:** Pursuant to the language accompanying the FY 2005 appropriation, the IHS evaluated the lessons learned from the FY 2001 application process and developed a new application process which included the streamlining initiatives provided in the Federal Financial Assistance Management Improvement Act of 1999, P.L. 106-107. Complying with the FY 2005 appropriation language, this proposed new application process was sent for 30-day Tribal Consultation. All comments were individually addressed and the process was revised accordingly. On November 9, 2005, the Application Kit for the FYs 2005-2006 SAP was issued along with the Program Announcement.

**FY 2008 SELECTION PROCESS:** The rank order list established in the FY 2005 – 2006 SAP was used for making selections for FY 2008.

**Award Process:** Adapted Subpart J construction contracts, administered pursuant to the conditions of The Indian Self-Determination and Education Assistance Act, P.L. 93-638, and applicable (as determined by the IHS) sections of 25 CFR Part 900, are being used for providing the SAP Federal assistance.

**History:** SAP Awards have ranged from \$190 K to \$2 million and have included 17 replacement facilities, 7 additions, 4 new satellite facilities and one renovation. The last appropriated funds for the SAP Program were in FY 2008. Below is a list of the 29 Projects and facilities that IHS has provided funding through the Small Ambulatory Program:

Project No. 501 OK - Purcell Outpatient Clinic  
 Project No. 516 AK - YKHC Toksook Bay Regional Clinic  
 Project No. 502 CA - Mariposa Indian Health Clinic  
 Project No. 517 CA - Campo Satellite Clinic –Southern Indian Health Council  
 Project No. 503 PO - Tribal Medical & Dental Clinic-The Klamath Tribes  
 Project No. 518 AK - Chenega Bay Health Clinic – Chugachmiut Village  
 Project No. 504 AQ - Pueblo Jemez Health and Dental Clinic  
 Project No. 505 OK - Stigler Clinic –Choctaw Nation of Oklahoma  
 Project No. 520 BI - Chippewa Cree Health Center – Rocky Boy Indian Reservation  
 Project No. 506 CA - Yreka Clinic – Karuk Tribe of California  
 Project No. 521 PO - Cowlitz health Center – Cowlitz Tribe  
 Project No. 507 BE - Ho-Chunk Health Care Center  
 Project No. 522 PO - Cow Creek Satellite Clinic  
 Project No. 508 PO - White Swan Health Clinic – Yakama Nation  
 Project No. 523 PO - Siletz Clinic Expansion – Conf. Tribes of Siletz Indians  
 Project No. 509 CA - Santa Ysabel Health Care Facility  
 Project No. 524 PO – Makah Tribal Health Administration and Wellness Center  
 Project No. 510 PO - Inchelium Health Care Facility – Colville Tribe  
 Project No. 525 AK - Hooper Bay Sub-Regional Clinic - YKHC  
 Project No. 511 PH - Reno-Sparks Indian Colony Clinic  
 Project No. 526 AK - Kake Clinic Expansion – SEARCH Village Kake  
 Project No. 512 PH - Las Vegas Paiute Colony Health Care Facility  
 Project No. 527 CA - Shingle Springs Rancheria Health Clinic  
 Project No. 513 PO - Roger Saux Health Center – Quinault Indian Nation  
 Project No. 528 BE - Lac du Flambeau – Health Clinic replacement  
 Project No. 529 BE - Bad River Replacement Clinic  
 Project No. 515 BE - Bois Forte Health Clinic of Minnesota Chippewa Tribe  
 Project No. 530 PO - Warm Springs Clinic Renovation  
 Project No. 519 NS - Narragansett Indian Health Center (Not completed)

**Program Management:** The SAP is managed by the Division of Facilities Planning and Construction, Office of Environmental Health and Engineering (OEHE), at the IHS Headquarters in Rockville, MD. The IHS Facilities Managers in the respective IHS Areas are providing project administration with the assistance of the Division of Engineering Services, OEHE, IHS, offices in Dallas, TX and Seattle, WA. Whenever additional funding is appropriated by the Congress, information about the SAP will be available on the IHS, OEHE web site at <http://www.oehe.ihs.gov>.

## **Use of Medicare and Medicaid Funds for Construction**

The Congress allows IHS to use Medicare/ Medicaid (M/M) collections for healthcare facilities construction to correct accreditation deficiencies in IHS facilities.

The House/Senate conference report on fiscal year 1993 appropriations for the Department of the Interior and Related Agencies contains language that changes how IHS may use M/M collections for construction as follows:

- Increases the amount that may be spent on a project from \$250,000 to \$1,000,000,
- Provides authority to construct temporary or permanent space, and
- Permits IHS to undertake projects without first obtaining congressional approval. (The IHS will notify the Congress annually of projects approved and completed.)

Congressional intent in authorizing use of M/M funds for construction primarily is to correct JC deficiencies. The IHS has established guidelines to ensure that these projects are in accord with this intent, that funds are used appropriately, and that proposed projects are consistent with IHS planning criteria and guidelines.

Funds expended for this program come from M/M collections and do not impact the IHS budget appropriations

## **Maintenance and Improvement**

Maintenance and improvement (M&I) funds are allocated for facilities which house IHS funded programs, whether provided directly or through P.L. 93-638 contracts/compacts. Funds are allocated for three general purposes:

Routine maintenance for each facility  
Area major M&I  
Environmental audits and remediation

### **Routine Maintenance**

The allocation of M&I funds for routine maintenance is calculated for each facility using a formula based the following factors:

Building replacement cost  
Class of building, i.e., type of construction  
Intensity of building use

Routine maintenance allocation for any specific IHS Area is equal to the summation of the routine maintenance allocation of the individual facilities in that Area.

## **Environmental Remediation**

The House and Senate Conference Report on IHS Appropriations for FY 1993 states that \$3 million appropriated that year should be included in the IHS base budget for Maintenance and Improvement (M&I) for the purpose of conducting an environmental management program for IHS and tribal health care facilities.

As a result of this direction from the Congress, IHS implemented a comprehensive environmental management program for assessment and remediation of damage to the environment. Assessment consists of formal environmental evaluations at IHS and, upon request, tribal facilities to determine the nature and scope of environmentally related deficiencies. Remediation consists of construction and other activities to alleviate identified environmental threats and hazards.

Environmental compliance and remediation funds are available for all IHS and tribal health care facilities on a competitive basis, with the most acute environmental threats and hazards having the highest priority. These funds are allocated based on a priority of need and are not distributed as tribal shares.

## **Demolition Funds**

The Interior Appropriations Bill contains Congressional language that funds not to exceed \$500,000 shall be placed in a Demolition Fund, available until expended, to be used by IHS for demolition of Federal buildings.

These funds are allocated based on a priority of need and are not distributed as tribal shares. At least once per year, IHS Headquarters will solicit projects from the Area Offices.

## **Medical Equipment Allocation**

In fiscal year (FY) 1995, the Congress established a new "Equipment" budget activity in the Indian Health Facilities Appropriation. Equipment funds were made available for two specific purposes: 1) to provide an equipment funding source for tribes that construct replacement health care facilities using non-IHS funds; and 2) to provide a clearly defined funding source to purchase medical equipment needed by existing IHS and tribal health care facilities. Two methodologies (Equipment Funds Allocation Methodology for Tribal Replacement Facilities and Medical Equipment Funds Allocation Methodology for Existing IHS and Tribal Health Care Facilities) were developed to ensure that the equipment funding is allocated fairly and in accordance with congressional intent.

These methodologies are applied after funding is allocated to address congressionally mandated action. In most years the Interior Appropriations Committee has indicated that a portion of the appropriated funds (usually approximately \$500,000) should be used to acquire excess medical equipment from the Department of Defense. The IHS acquires this equipment from Department of Defense through their reutilization process or from other sources (at no or minimal cost), and pays for transportation and storage. After obtaining the equipment, the IHS inventories it and makes lists available to IHS and tribal health care programs. These funds are not distributed as tribal shares. The Congress also provides instruction that a portion of the equipment funds (usually approximately \$500,000) should be used to purchase ambulances.

These funds are used to subsidize the General Services Administration (GSA) rental rates for IHS and Tribal EMS programs. Ambulances are provided on a priority basis and greatest replacement need. These funds are not distributed as tribal shares.

The remainder of appropriated Equipment funds are allocated to tribal replacement facilities or to exiting IHS and Tribal facilities as described below.

### **Methodology For Tribal Replacement Facilities**

The Tribal General Equipment Funds Distribution (TEFD) methodology provides funds to programs based upon replacement clinic construction costs. Under the TEFD methodology, IHS evaluates information reported by tribal applicants and verifies submitted information. Funds are then made available only when a copy of a fully executed construction contract has been received by IHS Area staff.

Tribes replacing either a leased or owned facility are eligible to request tribal general equipment funds. Tribes not constructing new replacement facilities, but renovating, remodeling or rehabilitating existing space, are not eligible for these funds. The TEFD methodology awards tribal general equipment funds to all eligible tribes. Eligible applicants will be funded on a modified pro rata basis for building new space through replacement, addition, or expansion. Eligible applicants will be funded on a fair share basis up to each program's maximum eligible amount (up to \$300,000). Award amounts are based upon the total funds appropriated for equipping tribal replacement facilities and the total of all equipment requests.

Awards are calculated using the following formula:

Eligible Tribal Equipment Need	=	% of Space Eligible	X	% Non-IHS Funds	X	Building Type (Hospital - 17%, Clinics - 20%)	X	Construction Amount
Up to \$300,000								
Tribal Award	=	<u>Congressional Appropriation</u> Total Of All Equipment Needs				X	Eligible Tribal Equipment Need	

Before funds are released to any facility, a proposed equipment plan containing equipment descriptions, anticipated manufacturer, quantities, and unit and total costs must be submitted to the appropriate IHS Area Clinical Engineer. The Area Clinical Engineer will review the equipment plan to ensure that the items are consistent with program needs. Following this review, the Area Clinical Engineer will ask IHS Headquarters to release the funds.

### **Methodology For Existing IHS and Tribal Facilities**

Funds appropriated for existing facilities are allocated to IHS Areas in proportion to the need, as determined by the Equipment Funds Allocation Methodology. Each Area is responsible for ensuring that the funds are allocated to facilities in accordance with congressional intent. Under the Equipment Funds Allocation Methodology, IHS estimates the relative need for equipment by evaluating basic data on clinical workload and facility size, as reported by each facility, using the following formula:

$$\frac{\text{Share of Equipment Funds}}{\text{Funds Appropriated}} = \left( \frac{0.5 \times \text{Clinical Workload Factor}}{\text{0.5 X Clinical Workload Factor}} + \frac{0.5 \times \text{Space Factor}}{\text{0.5 X Space Factor}} \right)$$

The Clinical Workload is calculated as follows:

$$\begin{aligned} \text{Clinical Workload} &= \frac{\text{Hospital Admissions}}{\text{X 4}} + \frac{\text{Inpatient Days}}{\text{X 2}} + \text{Outpatient Visits} + \frac{\text{CHAPs}}{\text{X .25}} \\ \text{Clinical Workload Factor} &= \frac{\text{Facility Clinical Workload}}{\text{Sum of all Facility Clinical Workloads}} \\ \text{Space Factor} &= \frac{\text{Facility Supportable Space}}{\text{Sum of all Facility Supportable Space}} \end{aligned}$$

## **SANITATION FACILITIES CONSTRUCTION PROGRAM FUNDING**

### **Project Funding Methodology and Priority Criteria**

#### **Funding Methodology**

SFC resource allocation methodologies are based on two fundamental principles: (1) the unmet needs principle and (2) the project based funding principle. Knowledge of these guiding principles is helpful for understanding the SFC Program resource distribution methodologies.

##### **1. Unmet Needs Principle**

The IHS is charged by Congress to prepare and submit an annual report to Congress on the sanitation needs of Indians by degree of need and to prioritize those needs. In accordance with the intent of Congress, IHS funding and services are allocated based on needs. In practice, this has generally meant providing resources first and in greater degree to those homes and communities with the greatest needs. Therefore, equity is achieved in terms of equivalent outcomes rather than equal shares of any allocation. More funds will go where the need is greatest to bring sanitation facilities to an acceptable level of service.

Sanitation needs of different reservations, different IHS service units, and different IHS Areas vary considerably. In addition, sanitation needs at the same location can change over time. Needs can be met (through funding of a project) by any one of several non-IHS sources. Or, they can be created gradually as a result of population growth or suddenly, as a result of a natural disaster, equipment failure, or a change in Federal regulations. Specific sanitation facilities needs are not ongoing or continuous. Needs are defined in terms of a project to meet those needs. A project is defined in terms of total cost and number of homes to be served. IHS reassesses these needs every year and with tribal input updates the priority list of projects to meet those needs. IHS then proceeds to fund projects on the list with resources appropriated by Congress.

##### **2. Project-Based Funding Principle**

The fundamental premise for conducting all aspects of the P.L. 86-121 Sanitation Facilities Construction Program is the concept of the "project", which is used to define and to meet needs. The Congress appropriates the total amount of sanitation facilities construction funds to IHS. Those funds are allocated at the local level based on well-defined projects (scopes of work) and an executed Memorandum of Agreement (MOA), which spells out responsibilities of the parties in carrying out the cooperative project, or by P.L. 93-638 contract or compact.

SFC Program funds (both program and project) are allocated based on a project concept, for which workload and accomplishments can be measured.



There is a legal basis for using projects:

- P.L. 94-437, as amended, Section 302 (g)(1)(C) requires "the level of sanitation deficiency for each sanitation facilities project of each Indian tribe or community;"
- P.L. 94-437, as amended, Section 302 (g) (1) (A) requires the Secretary to report "the current Indian sanitation facilities priority system of the Service." The intent is to prioritize projects.
- IHS budget justification language clearly states that work will be accomplished through projects in priority order.
- The appropriations language uses the term "project" and requires IHS to use its sanitation deficiency priority system, which defines deficiencies in terms of projects.
- IHS is responsible for the NEPA determination of all construction work performed by or with IHS appropriations; i.e., NEPA determinations are a residual IHS function.
- NEPA determinations are based on environmental reviews of well-defined project scopes of work.
- Usually, funds for construction (not including funds for project pre-design) are expended only after NEPA approval.
- If something other than what is in the original scope of work is to be constructed, the NEPA review must be redone and approved by IHS.

The construction work must be well defined in a project scope of work with enough information to verify that the requirements of NEPA and related environmental laws and regulations are met.

The requests for sanitation facilities projects generally exceed the number that can be funded with available appropriations. The large number of requests requires that there be an orderly method of determining the priority order for funding and approving projects

### **Prioritizing Projects for New or Like-New Houses**

Housing support funds are allocated based on needs using the methodology described in this section. The intent of the Housing Priority System (HPS) is to prioritize housing support projects. This requires clear and consistent national as well as Area-specific criteria. The HPS is used by all Areas. Those tribes that manage their own Sanitation Facilities Construction (SFC) Program under Title I or V of P.L. 93-638 (as amended) participate in their Area HPS. New and like-new homes needing sanitation facilities must at least comply with the national eligibility requirements.

The national priority classification for eligible new and like-new homes for sanitation facilities funded by the IHS is provided in Table 6-1. Needed facilities for homes not meeting HPS eligibility criteria should be included in the Sanitation Deficiency System

(SDS) and addressed in priority order as regular projects (see Section V), if they meet SDS eligibility criteria.

Each Area shall establish an Area-specific HPS consistent with national SFC Program policies in consultation with the tribes in the Area. The Area HPS guidance shall describe in detail (a) eligibility requirements and (b) the method of prioritizing projects for funding. Other information and/or requirements can be added to the HPS as needed to meet the unique aspects of each Area. In this manner the HPS can be tailored to better meet regional priorities. Each Area HPS will be reviewed by the Director, Division of Sanitation Facilities Construction, OEHE, IHS Headquarters (HQ), for consistency with this section.

Area-Specific Priority Criteria: The SFC Program recognizes that there are unique Area factors that will affect prioritizing Area projects within each Group in Table 6-1. Table 6-2 shows a list of possible Area specific factors.

Every Area should review these and other applicable criteria in consultation with the Area Tribal Advisory Committee and add appropriate criteria to the national criteria.

Area Unit Cost Caps: Each Area must establish a unit cost cap for housing support projects, which is a maximum average funding amount per house for each housing support project within the Area. For all projects using housing support funds, the project cost divided by the number of homes served will not exceed this predetermined unit cost cap. This cost cap will be set by the IHS Area Office, in consultation with Area tribes and IHS Headquarters. The cost cap shall be comparable to actual historical unit costs for the Area and shall be less than the total allowable unit cost as established by the SDS guidelines. The need for an exception to the Area's unit cost cap must be approved at the HQ level. The unit cost cap will help to limit large capital expenditures using housing support funds (regular funds are available for serious capital deficiencies) and allow housing support funds to be used to serve more new and like-new houses. Areas also may wish to establish a maximum cost for any single house served under a project, and/or, an Area may wish to have cost caps for different types of services (e.g., cost caps for septic tank/drainfields would differ from those for sewer service lines).

**Table 6-1**  
**IHS SFC Program**  
**Housing Priority System**

The priority of service for new or like-new homes determined eligible for housing support projects is as presented in this table, with the highest priority listed first:

HOUSING CLASSIFICATION	GROUP PRIORITY	HSP PRIORITY DESIGNATION
BIA HIP new home and eligible like-new home projects.	I.	<b>A</b>
New homes completed in the previous fiscal years.	II.	<b>B</b>
New homes to be completed during the funding year.		<b>C</b>
Existing eligible "like-new" homes.	III.	<b>D</b>

1. A new home is one that is newly constructed or newly manufactured.
2. Eligibility is established by each Area; however, an eligible like-new home must meet the eligibility criteria in Chapter 5, Section III (including a plumbed kitchen, one bathroom with toilet, insulation, heat, etc.). If a home is considered to be substandard after a BIA-HIP renovation, it is ineligible for service.
3. This housing classification system is to be used in Project Data System (PDS) Housing Reports.
4. Homes of patients with certified medical conditions may be provided with sanitation facilities using housing support funds under any housing support project if the home meets the criteria specified in Chapter 5, Section III, on eligible homes for housing support projects.

**Table 6.2**  
**Potential Area-Specific Priority Criteria**

Documented health issues

Date of application

Timing of house/renovation construction

Date of occupancy

Tribal population or population changes

Percentage of DL 4 or DL 5 homes (homes without water and/or sewer) in the in the project

Tribal operation and maintenance (O&M) criteria/performance history

Home construction or renovation funding source

Relative unit cost (within the constraints of Appendix A of the SDS manual)

Availability of local contributions

## **Establishing Area Housing Support Project Priority Lists**

Congress appropriates funds to serve new Indian homes, often called "Housing Support Funds" that are allocated as follows:

Prior to the beginning of each fiscal year, the IHS Area office contacts each tribe in the Area, preferably in writing, to request the number of homes that are eligible to be served with IHS housing support funds. Self-Governance/Self-Determination (SG/SD) tribes that assumed the responsibility for the SFC Program would develop project cost estimates using their own engineering staff. IHS would develop the project cost estimates for direct service tribes.

At the time tribes and IHS staff develop the estimated needs for new housing support funds, they shall also provide a project status report which identifies how previously distributed housing support funds were spent. At a minimum, this report shall show house identification numbers or homeowner names and location information for each home committed for service from the project. The report shall be submitted to the IHS Area Office and made available to the Area Tribal Advisory Committee (TAC) and to IHS Headquarters, if requested. The purpose of the report is to inform the IHS Area Office and the Area TAC of how previously distributed funds were committed and spent, and to record specifically which homes were served with IHS funding. This information is needed to justify the new funding requests, and may be used to assist the TAC in recommending Area specific project funding policies. The TAC may wish to request that additional information be provided in the report to better enable the TAC to form these recommendations.

The Area SFC Program Director reviews the estimated needs for new housing support projects, and the status reports for previously funded projects.

At the Area office level, the SFC Program Director presents the projected needs and estimated costs for new housing support projects to the Area TAC, if requested. The SFC Program Director also provides comments and recommendations to the TAC. The SFC Program Director, with any feedback from the TAC, reviews the tribal needs and cost estimates and may elect to solicit additional supporting information prior to preparing an aggregate project funding request to Headquarters. The TAC may evaluate each proposed project using the Housing Priority System (HPS) criteria for that Area and recommend a preliminary priority listing for the Area.

Each Area provides its projects and cost estimates to IHS Headquarters using the summary report in the HPS.

The Areas will allocate the IHS funds received using their Area specific priority system based on HPS and Area specific priority criteria developed in consultation with the Area TAC. Throughout the year, the Area SFC Program managers will have the latitude to adjust a project's priority for funding and amount of funding to meet changing tribal needs, fairly and equitably. All Group I projects shall be ranked higher than all Group II projects. All Group II projects shall be ranked higher than all Group III projects. Projects shall be funded in priority order except that an Area may elect not to "reserve"

funds for tribes beyond the end of each FY, either because the tribes did not approve the project documents or the projects are not ready to be constructed.

*Exceeding the Area's unit cost.* If a housing support project to serve new/like-new homes with IHS funding (or partial funding) exceeds the Area's unit cost cap, the projects will be considered infeasible and cannot be prioritized for funding.

Projects fully funded with non-IHS funds that serve new/like-new homes are not subject to the HPS. Projects to serve unfunded future new homes and renovations will not be considered for funding.

Needs for homes not meeting HPS eligibility or feasibility criteria may be included in the Sanitation Deficiency System (SDS) and addressed in priority order as regular projects (see SDS Guide), if they meet SDS eligibility criteria.

### **Headquarters Distribution of Housing Support Funds To Areas**

The amount of funds available for housing support projects to serve new or like-new homes will be identified by the Director, Division of Sanitation Facilities Construction, Headquarters, from the Sanitation Facilities Construction appropriation.

- Headquarters summarizes the Area's request for all projects and compares the total requested amount with previous allocations. If an Area's request increases by more than 10 percent, it must be accompanied by written supporting documentation.

Headquarters consults with the SFC Program Directors both individually and collectively prior to making the final allocation of the appropriated housing support funds. Whenever possible, the allocation amounts shall be established during the first quarter of the fiscal year for the full appropriation amount.

If the total of funds requested by all Areas exceeds the amount appropriated, each Area's allocation will be reduced as follows:

- Each Area will be allocated 90 percent of its previous year's funding level. If appropriations are not sufficient to fund each Area at 90 percent of its previous year's funding level, the new appropriation will be allocated proportionate to the previous year's allocation. In no case will an Area be allocated funds in excess of its identified funding need.
- Any remaining appropriation amount will be allocated according to each Area's current unfunded need. The determination of the final allocation amounts shall be made by IHS Headquarters.

## Projects for Existing Houses

Congress appropriates funds to serve existing Indian homes, often called "regular funds". Funding for this purpose has varied considerably over the last decade. The sanitation deficiencies of existing Indian homes and communities are determined and reported annually by IHS in terms of projects to meet these needs. These projects form the basis of the SDS inventory. The IHS annually prioritizes these needed projects by Area with tribal input. As Congress appropriates money, IHS funds these projects in priority order.

The 1988 Indian Health Care Amendments (P.L. 100-713) amended the Indian Health Care Improvement Act (P.L. 94-437) and requires the IHS to submit to the Congress an annual report on Indian sanitation deficiencies. Congress requires that IHS have and use a priority system, the Sanitation Deficiency System (SDS). This priority setting procedure has been used since 1989. The SDS was established to ensure comparable Area criteria and procedures for identifying deficiencies, and in planning and prioritizing projects. Priority shall be established in accordance with the latest issuance of "Guide to Reporting Sanitation Deficiencies for Indian Homes and Communities," and will be entered into the SDS. Any deviation from these practices must be approved by IHS Headquarters. See Chapter 10 in *Criteria for the Sanitation Facilities Construction Program* on reporting systems and the SDS guide for information on how to submit a project for inclusion in SDS.

Regular Funding Allocation Formula. Funding is distributed in bulk, quarterly, from Headquarters to the Areas based upon an allocation formula that takes into account the relative needs identified for each Area's SDS inventory. The allocation formula uses two factors calculated from information in the SDS—project cost factor and homes factor. The project cost factor is the total estimated cost of feasible projects at deficiency levels (DL) 3 through 5 (by dollar amount) of each Area's priority list. DL 3, 4 and 5 includes homes without a safe water supply or sewer facilities, or without both. The homes factor is the total number of Area homes at DL 3 through 5 listed in the SDS community deficiency profile. In each Area, each project is funded in the order of their priority on the Area SDS inventory.

Prior to FY 1998, feasible projects at DL 2, 3, 4, and 5 were used to compute the dollar limit for the project cost factor. In 1996, an Allocation Workgroup of tribal and federal representatives concluded that the inclusion of DL 2 projects in the allocation formula can exaggerate the degree of need for those Areas which have identified large numbers of DL 2 projects in the SDS. Beginning in FY 1998, only feasible projects at DL 3, 4 and 5 were used to determine that dollar limit. The net result of the change was to allocate a greater share of the "regular" funds to those Areas with large numbers of DL 3, 4, and 5 (greater) needs, and a smaller proportion to those Areas with large DL 2 needs. The change does not affect the funding of DL 2 projects that rise to the top the Area's SDS priority list.

## Special Projects and Emergency Projects

All emergency projects and special project funds are allocated by the Director, Division of Sanitation Facilities Construction, in Headquarters on a project-by-project basis. To request emergency and special project funds from Headquarters, the Area will prepare an one-page report verifying how a proposed project meets the appropriate criteria, what the Area/tribe intends to do (scope), and the cost.

If a tribe makes a solicitation for special or emergency funds, the Area shall prepare and make a written recommendation as to the appropriateness of the project.

The Area will assign the proposal a project number and forward the solicitation, report, and recommendation to Headquarters.

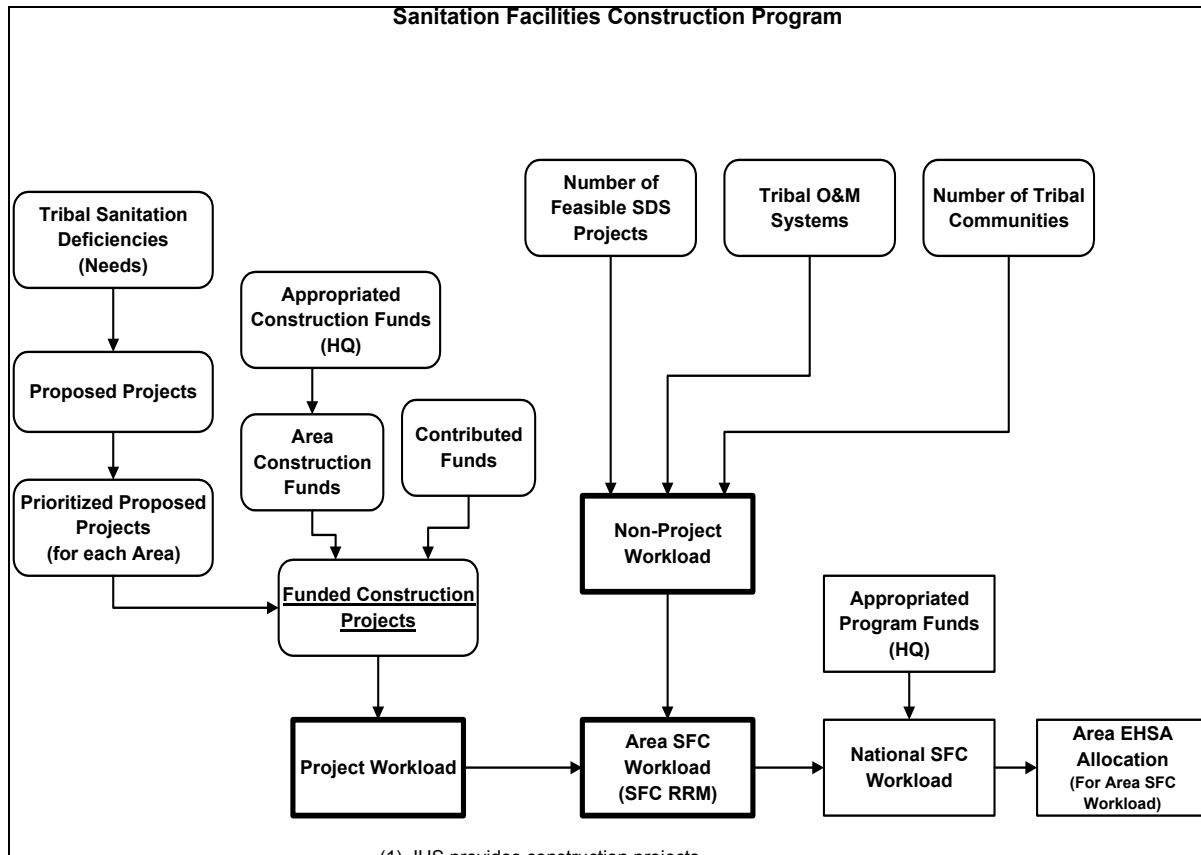
Headquarters will review the project report together with the Area, prioritize the project(s), and provide funding, if available. Since funds for emergency and special projects are limited and requests for emergency and special projects occur throughout the year, Headquarters will use its discretion in approving these projects for funding.

All special and emergency projects shall follow standard project document requirements. Headquarters may request copies. The current status of these projects shall be provided in the Area's year-end report to Headquarters. Upon completion of the project, the Area shall prepare a brief final report which states the reasons the emergency situation developed, what was accomplished, and the contributions of all participants in bringing about a temporary or permanent solution to the emergency. A copy of the report shall be forwarded to Headquarters.

## SFC Program Funding Criteria and Allocation Methodology

SFC funds (both program and project) are allocated based on a project concept, for which workload and accomplishments can be measured. The two principles described in Chapter 6 in *Criteria for the Sanitation Facilities Construction Program (SFC Criteria Document)*, the unmet needs principle and the project based principle, set the foundation for allocating funds for both projects and Area-level programs within the national SFC Program. Program staffing requirements are related to the number and size of projects developed and administered. Project funds are allocated proportional to need, and needs are not always proportional to population size. Therefore, the staff workload for an Area is proportional to need, not population size. As a result of these principles, SFC staff workload allocations to any one Area, district, or service unit are a function of the number and size of SFC projects in that geographic location, as well as the number of communities, O&M systems, and sanitation deficiencies. Diagrams and tables below are from the SFC Criteria Document and retain their original numbering.

Program funds generally are for salary, benefits, travel, training, and related costs of permanent staff in the SFC Program and Environmental Health Services Program at the Area Office level and below. Program funds are appropriated and allocated to the Environmental Health Support Account (EHSA). Headquarters OEHE distributes EHSA funds to each Area OEHE based on a workload model, known as the Environmental Health Application of the Resources Requirement Methodology (RRM). The RRM is



**Figure 7-1.** Relation of SFC Workload to Area EHSA program funding.

used to distribute program funds after the project funds are distributed to Areas. The relationship of workload to Area EHSA program funding for only the SFC program, only, is shown in Figure 7-1.

### **SFC Resources Requirement Methodology (RRM)**

The SFC Program RRM originally was developed in the early 1980's as an in-house staff-workload-estimate model and has since been used successfully to determine the relative SFC Program staff workload among all the IHS Areas. The results of the annual RRM calculations are used to allocate Environmental Health Support Account funds to the Areas. The Area managers then in turn allocate the funds as needed within the Area. More recently, the RRM has been used to calculate the relative workload for tribes that have elected to manage their portion of the SFC Program at the local level under the Self-Determination or Self-Governance provisions of the Indian Self



**Table 7-1****Typical Functions and Services Associated With Field-Level Project Workload**

- Project site review, surveying, pre-design
- Archeological and other environmental review activities at the site
- Obtaining construction and environmental permits
- Engineering designs including, data collection, and preparing specifications and drawings
- Preparation of contract documents
- Coordination with all funding and regulatory agencies
- Attending tribal meetings; meeting individual homeowners
- Construction project management and inspection services
- Project start-up and training (operators and homeowners)
- Transfer documents and final reports
- Project Data System inputting and reports
- Clerical support, project employee training, and project related travel time
- Administrative and supervision/support for project related employees
- Preparation of as-builts and O&M manuals

Determination and Assistance Act (P.L. 93-638, as amended). Therefore, all tribes are interested in the RRM formulas because of the funding implications.

The RRM includes a project and non-project workload component. The non-project workload accounts for functions and services provided by the SFC Program that are not directly project related, such as providing technical assistance to tribal water system operators.

**Scope of the RRM**

The RRM essentially provides a relative measure of the staff time necessary to plan, implement, and complete a construction project and provide other essential non-project activities at the field level. The RRM does not calculate workload by a specific position but is an aggregate of the workload required by several types of positions to perform a set of generally described functions and services associated with direct work on projects, non-project workload at the field level, and providing training and technical assistance. RRM is a measure of the workload by staff that may include engineers, surveyors, draftspersons, and inspectors. It does

not include the workload of those who actually construct the project (laborers, foremen, carpenters, etc.,) and does not include the workload necessary for program administration at the Area office level and above. The workload can be divided into project (Table 7-1) and non-project (Table 7-2) workloads, and into the functions and services associated with them. Note that many of the functions and services listed under the “Other” category in Table 7-2 are provided only when local resources are available.

**Determining the Total SFC Project Workload**

The workload for any project is defined in terms of staff-days of relative staff time needed to complete the functions and services, listed in Table 7-1, associated with the project. A figure of 220 staff-days is used to determine one staff-year (accounts for

weekends, sick leave, and vacations). The total workload for any SFC project is a function of the total project construction cost and is determined using the piece-wise linear curve shown in Figure 7-2. For example, from Figure 7-2, a \$3 million construction project requires approximately 1,340 staff-days (or 6.1 staff-years) of relative effort to complete. Note that all projects start with 40 staff-days, and the maximum number of 1,540 staff-days is used for all SFC projects costing \$5 million or more. Smaller projects require a proportionally higher amount of time and effort because of the proportionally higher amount of time traveling to and from remote scattered sites, attending meetings, and preparing documents. The precise SFC Project Workload Formula is provided in Table 7-3.

### **Distributing Project Workload Over Time**

On the average, once funded, sanitation facilities construction projects take four years from preliminary planning to completion. For the SFC Program, the RRM project workload credit associated with any project is spread over a 3-year period. Also, the workload for a specific project is not assumed to be spread evenly, as shown in Table 7-4.

### **Project Phases**

As shown in the distribution of project workload in Table 7-4, a project is divided into four distinct phases: Pre-planning, planning, pre-design, design, and construction. Each phase is defined in general terms by its activities and products as described below:

- **Pre-Planning.** These are SFC Program functions that are non-project workload activities such as gathering data for the SDS and Housing Support databases and preliminary site evaluations, prior to project funding.
- **Planning.** Prior to a project being funded, products include preparation of a Project Summary or Project Scope (also called a Program of Requirements or POR). Note that under Title I of the Indian Self-Determination Act (PL 93-638), planning functions are treated differently than construction functions.
- **Pre-Design.** Pre-design phase activities typically include community meetings, project site testing such as soils testing, and surveys such as a land survey and archeological survey. Products include conceptual drawings, cost estimates, right-of-way identification, and NEPA reviews and environmental assessments. Note that projects that do not fall under a NEPA categorical exclusion shall only be funded through the pre-design or design phases until the NEPA determination is made by the IHS.
- **Design.** Design phase activities include design calculations, preparing drawings and specifications, applying for permits, filing legal documents (e.g., easements), obtaining design approvals. Products include complete contract documents and bid packages, including plans and specifications, detailed engineering cost estimates, and permits.

**Table 7-2****Typical Functions and Services Associated With Field-Level Non-Project Workload****1. Determining Sanitation Deficiencies/ Project Planning**

- Field data collection for the IHS Sanitation Deficiency System (SDS), Housing Support Project database, and Community Deficiency Profiles
- Preparation of project summary/scope documents
- Community planning and site evaluation (that may lead to a future IHS project)

**2. Operation and Maintenance (O&M) Assistance to Tribes**

- O&M training
- O&M annual surveys
- Technical assistance for O&M organizations
- Local response to emergencies; providing assistance
- Safety training and safety inspections
- The number of O&M systems is reported annually in the Operation and Maintenance Data System (OMDS).
- A Tribal O&M system is a tribally operated and maintained water or sewer system. They are reported annually in the IHS OMDS.

**3. Other Non-Project Services and Functions**

- Local program coordination with other Federal, State and local programs
- Locating non-IHS project funding sources for tribes
- Staying current of new developments in laws, regulations, and programs
- Ongoing technical assistance to tribes on environmentally related public health issues
- Review of engineering plans and specifications for non-IHS funded sanitation facilities construction projects
- Preparation and technical review of non-IHS sanitation grant proposals and feasibility studies
- Administration, supervision, support, and training for non-project related employees
- Non-Project related travel time

Minimal engineer involvement, such as plan reviews and comments alone, will not receive partial or pro-rated RRM credit. However, if contract engineering services, purchased with project funds, are used to actively design and manage the project, no RRM credit is needed and therefore cannot be obtained.

- **Construction.** Construction phase activities include project construction management, quality control activities such as testing and inspections, and training. Products include as-built drawings, operation and maintenance manuals, cost accounting, warranty protection, and trained operators.

**Determining the Project Workload at Any Location**

The workload for any location for any given year is determined by the number and size of projects funded in the first three of the four previous fiscal years at that location. An example RRM calculation is shown in Section II of this chapter.

**How the Source/Type of Project Funds Affects Project Workload RRM Credit**

The RRM formula for total workload associated with a construction project is based on a single variable, the total cost to construct the project (generally considered to be labor, materials, and equipment) plus the cost of project support services, such as drafting and inspection. For the purposes of RRM credit, the costs in Table 7-5, which are normally IHS eligible costs, will not be considered for RRM credit.

These projects are reviewed on a case-by-case basis. There must be engineering involvement to obtain project RRM credit. The project, or portion thereof eligible for RRM credit, must be actively designed and managed by IHS or the tribe to obtain RRM credit.

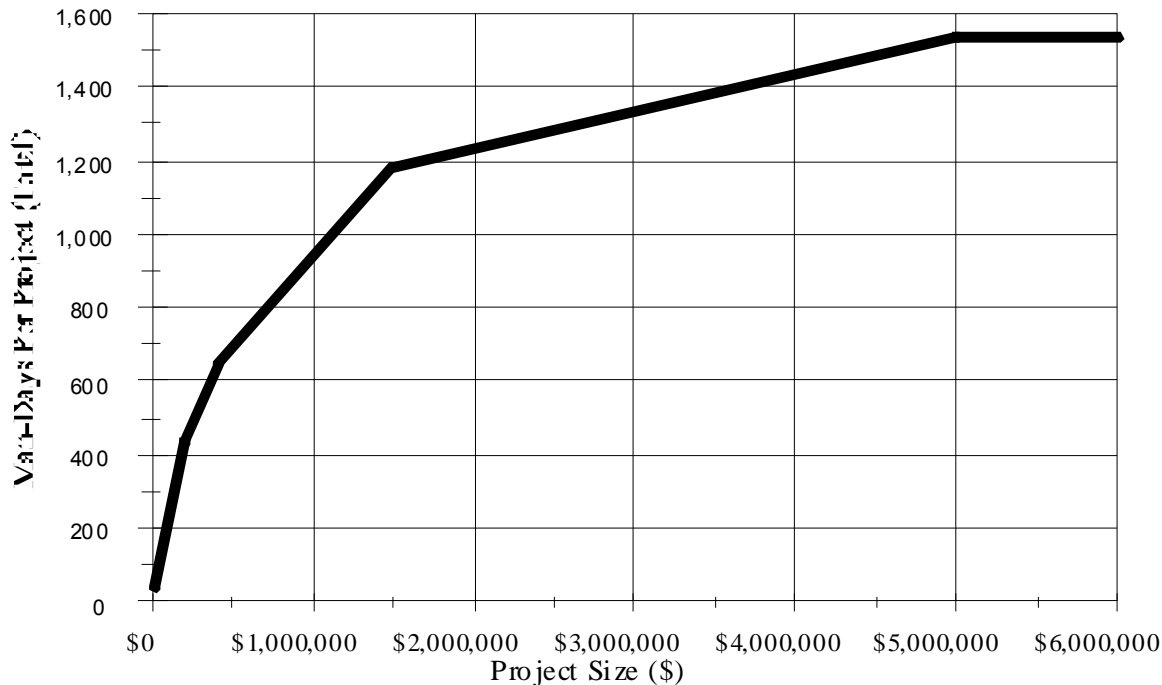
**Table 7-3. SFC Project Workload Formula (RRM)**

<b>Project Funding Ranges</b>	<b>Funding Range Workload Rate</b>	<b>Total Project Workload (relative to other projects)</b>
(\$)	(staff-days per \$1,000)	(staff-days)
\$0	Minimum staff-days per eligible project	40
first \$0 - 200,000	2 staff-days per \$1,000	40 - 440
next \$200,000 – 400,000	add 1 staff-day per \$1,000	440 - 640
next \$400,000 - 1.5 million	add 0.5 staff-day per \$1,000	640 - 1,190
next \$1.5 million - 5 million	add 0.1 staff-day per \$1,000	1,190 - 1,540
greater than \$5 million	add 0 staff-day per \$1,000	1,540 (maximum)

**Table 7-4. Distribution of Project Workload by Year**

If FY98 is "Current Year, then this → is the distribution of project workload	94	95	96	97	98	←Fiscal Year of Projects
	↓	↓	↓	↓	↓	
	4	3	2	1	0*	←RRM Year
	30	50	20	0	0	←Percent Of Project Workload
	Construction/ Project Close out	Design/ Construction	Pre-Design	Planning	Pre-Planning	←Project Phase
* begins the year when the project is funded						
** considered to be a portion of the Non-Project Workload						

Figure 7 - 2

**SFC Project Workload Formula****Table 7-5**

Costs **not** eligible for RRM credit:

- Cost of land.
- Funds passed through to other agencies, rural water districts, etc. where the IHS/tribe does not perform engineering services.
- Funds passed through to other agencies, rural water districts, municipalities, etc. for capitalization costs, such as system connection fees or development charges.
- Project funds used to purchase professional engineering services such as general planning, design, and construction management. (Note: Projects of this type may not receive any RRM credit.) Specialty engineering services incidental to the cost of the project are exempt (e.g., electrical controls, seismic design).
- All costs that would otherwise be ineligible for IHS funding.

Project technical support services may be a RRM-eligible cost. Project technical support services can include some specialty engineering services (usually contracted with project funds). They also include functions/services directly related to the specific project performed by some non-permanent technicians, clerical, inspectors, and other technicians. These project technical support costs are eligible for RRM consideration if less than 15 percent of the total project cost. Typical specialty engineering services are for unusual situations and might include seismic design, complex land surveying, or sophisticated soils investigations. Thus, professional engineering services are a RRM-eligible cost only to the extent they are project technical support services as described above.

**Table 7-6**  
**Criteria to Obtain RRM Credit for**  
**Non-IHS Funded Projects**

- The project or portion thereof must meet all the IHS eligibility criteria, (e.g., the project is not for economic development, fire protection, etc.)
- The tribe cannot obtain RRM credit unless it is actively involved in the management of the project (either in-house or by subcontract). For example, no RRM credit will be given for construction funds passed through to a rural water district.
- Since RRM credit is for distribution of program funds, if project funds are available to fund the professional engineering services, then RRM credit is not necessary and will not be given.
- No RRM credit will be given for projects to make O&M repairs or fund Deficiency Level 1 needs.
- The tribe must describe the project in sufficient detail for the IHS Area to determine if it is eligible.
- Projects must be consolidated to the maximum extent feasible. For example, a tribe should only submit a maximum of one project per community per year.
- The Area office must review the project to evaluate/verify what portions are eligible.
- The tribes must follow the IHS NEPA requirements; IHS must make a NEPA determination. (Note: A NEPA determination by IHS may be needed even if IHS contributes only engineering funds towards the project.)

### **How Multi-Year Funding Affects Project Workload RRM Credit**

Funding for some projects is received over a period of two or more years. For example, a \$1 million project may only be funded for \$50,000 at first to gather necessary design data and the remaining funds (\$950,000) will come later when the project is ready to be constructed. If a project is phase-funded, that is, funding is provided over more than one fiscal year, the project obtains RRM credit as follows:

- RRM credit is tied to the year of the appropriated IHS funds or the year that IHS receives the contributed funds (it is no longer tied to the project number). The RRM credit sequence will start separately for each set of funds (a set is all funds received in one fiscal year) placed into the project. No project will obtain more total RRM credit by piecemealing the funds over several years than they would if the funds were all received in one year.

All projects of the same total cost will receive the same total amount of RRM credit over time no matter when the funds are appropriated/received. The only difference will be the years they receive the incremental credit.

### **How Non-IHS Funds Affect Project Workload RRM Credit**

RRM credit may be allowed for a sanitation facilities construction project

funded with non-IHS appropriated funds. The funding source can be another Federal agency, a state, or the tribe's own funds. The funds do not necessarily have to be deposited in the IHS finance system. However, the project(s) must be identified in the IHS Project Data System (PDS). Full RRM credit is received only if the project is within the scope of the IHS legislative authorizations and the homes served would otherwise be eligible for IHS-provided engineering services. For example, the project must serve IHS-eligible Indian homes (and HUD housing program homes) with appropriate

sanitation facilities. Combined projects, such as those that provide water service to non-Indians or commercial establishments, or that construct more than sanitation facilities, such as roads and houses, receive only a proportional RRM credit. Construction funds that come with dedicated funds for necessary engineering services also should not be given RRM credit.

Any tribe that obtains non-IHS funds for sanitation facilities construction projects to serve Indian homes, may be eligible to receive RRM credit (and hence obtain EHSA funds) if IHS does not participate in the project. This is most applicable to self-determination and self-governance (SD/SG) tribes. The project, however, must meet certain criteria.

The criteria necessary for a tribe to obtain RRM credit (and hence program funds for professional engineering services) for a non-IHS funded project are shown in Table 7-6. The criteria assumes that the Area review of non-IHS funded SD/SG projects, needed to determine tribal RRM credit, normally would be covered by the Area's existing resources, if resources are available. For unusual or complex projects requiring considerable effort to review, the Area should retain an appropriate amount of project RRM credit to cover the workload associated with reviewing and verifying non-IHS funded projects (to be negotiated up front).

Non-IHS funded projects administered by the tribes (no funds come to IHS) must be included and tracked in PDS to obtain RRM credit. Funds must be coded appropriately to indicate if they are eligible for RRM credit.

### **The Non-Project RRM Workload Formula**

The SFC Program staff non-project workload occurs when providing the services and functions described previously in Table 7-2. These services and functions are provided or available to all tribes whether or not they have funded SFC projects (subject to available resources). The non-project workload is divided into three categories: (1) SDS/Project Planning workload, (2) O&M workload, and (3) other workload as shown in Table 7-2. Because this workload is independent of funded projects, a different type of formula is used. The non-project workload formula for any geographical location is shown in Table 7-7.

All of the variables for the non-project workload are available from existing SFC Program data systems. The number of feasible SDS projects is reported annually in the SDS (Sanitation Deficiency System). The number of O&M (operation and maintenance) systems is reported annually in the Operation and Maintenance Data System (OMDS). The number of tribal communities is reported in the community deficiencies profile portion of the SDS. Full RRM credit for non-project workload is provided annually based on information within the data systems cited. In general, the non-project workload will not vary greatly from year to year.

The factors used in the non-project workload formula are extracted as follows:

- Number of SDS Projects. The number of SDS projects counted is the number of economically feasible SDS projects and project phases reported annually in the SDS. Each phase is a stand-alone project that results in an operational facility that improves community environmental health. O&M projects and Deficiency Level 1 projects are not included in this number.
- Tribal O&M Systems. A Tribal O&M system is a tribally operated and maintained water or sewer system. They are reported annually in the IHS OMDS. Systems are counted and not O&M organizations, because some tribes have one organization to cover many systems.
- Tribal Communities. Tribal communities are reported in the SDS under the community deficiency profile section. Homes by deficiency level are counted for each tribal community. In some cases, they are not actual communities but other designated geographic areas, such as counties.

### Application of the RRM

The RRM workload for the SFC Program is a component of the entire RRM workload for the IHS Environmental Health Program. The SFC RRM is designed for allocating bulk funding to the Areas based on an aggregate of many different-sized projects. Figure 7-1, at the beginning of this Chapter, showed the relationship between funded projects to Area SFC program funding (EHSA) allocations, using the RRM. The RRM is used to relate funded projects to Area SFC program funding (EHSA) allocations. SFC projects vary in size and complexity, which affects actual workload. Since the project RRM uses only project cost as a driving variable, and projects of similar construction cost can require vastly different amounts of engineering, the RRM is not a good measure of the absolute workload of an individual project. From experience, the actual workload for a single project will fall to one side or the other side of the RRM formula prediction. This means that on a project by project basis, some projects would be allocated more or less staff-days than needed.

However, if many projects that vary in type, size, and complexity are grouped together, the total RRM staff-days needed for the group of projects more accurately reflects the total workload predicted. If RRM is calculated for each of several groups of mixed projects (e.g., all projects for one Area), the RRM can be used to determine the “relative” workload among the groups of projects.

Environmental Health Support Account (EHSA) funds are appropriated each fiscal year and are distributed to the Areas to pay for the permanent staff necessary to carry out the projects, training, and technical assistance. The appropriated EHSA funds historically have never been adequate to meet the needs predicted by RRM. In recent years, the gap has widened. The SFC RRM is used to allocate limited resources on a proportional basis with all Areas receiving approximately the same level of need funded (LNF).



## **How does the application of RRM relate to residual workload?**

The Title V residual staffing level determined for each Area office is based on 100 percent of the tribes in the Area compacting. The SFC Program RRM is a measure of the project and non-project workload at the field/project level. It is not a direct measure of Area-level administrative functions and services, which is what remains, in part, with the residual. Therefore, the Area Title V residual functions and the RRM services and functions listed in Tables 7-1 and 7-2 do not overlap. However, the Title I contracting “add-on” residual functions and the RRM services and functions do overlap somewhat. This is described in more detail in other SFC Program guidance documents.

Since RRM is used on a relative basis to distribute all EHSA funds to each Area, in effect the RRM has been used to fund the administrative services and functions for an Area office in direct proportion to the Area’s field/project level workload. It is important to keep in mind that the residual staffing formula developed by and for the SFC Program is an “absolute” measure of needed administrative staff whereas the RRM formula is a measure of “relative” workload for non-administrative staff. Therefore, they are not directly related. Also, Area office staff often perform many field and project level services and functions.

## **Alternative (Discretionary) Accelerated Distribution of Program Funds to Self-Determination and Self-Governance Tribes for Small Intermittent SFC Projects**

There are occasions when SD/SG tribes, typically very small ones, obtain SFC project funds infrequently (e.g., one small project every three years). Under the RRM, they would receive RRM credit and corresponding program funds over the 4-5 years following the project funds transfer. For small projects, the amount of program funds received in any one year would be small. When an IHS-managed Area program is of sufficient size to accommodate such advanced payments, it is practical and more efficient to allow for an accelerated distribution of EHSA program funds for specified SFC projects in this situation.

The relationship between RRM credit and distributed EHSA program funds is not exact. The RRM credit, in terms of staff-years, is constant based on project size and is independent of how the EHSA funds are appropriated or distributed. EHSA funds are appropriated annually, at varying amounts and are distributed to Areas on the basis of relative RRM credit; therefore the amount of EHSA funds an Area will receive in future years is not exactly predictable. Consequently, the exact monetary “value” of the RRM credit if spread over multiple years is unknown, but it can be reasonably estimated if it is assumed Congress will continue to appropriate EHSA funds at the same funding level. Thus, an alternative accelerated EHSA payment is an approximation of the total amount to be received if the EHSA payments were made over multiple years as assumed in the RRM model.

<b>Table 7-7. SFC Non-Project Workload Formula (RRM)</b>		
<b>Non-Project Services and Functions (from Table 7-2)</b>	<b>Data Source</b>	<b>Non-Project Workload Factor</b>
Determining Sanitation Deficiencies/Project Planning	SDS	3 staff-days per feasible SDS Project
O&M Assistance to the Tribes	OMDS	4 staff-days per tribal O&M system
Other Non-Project Services and Functions	SDS Community Deficiency Profiles	7 staff-days per tribal community

Tribes are not entitled to an accelerated payment of EHSA program funds. Accelerated payments must be negotiated between the Area and the tribe. The tribe and the IHS agree to an accelerated payment process and the terms and conditions of the process are included in the SFC Project Funding Agreement (PFA)/AFAA or Title I Subpart J contract IHS Areas may make an accelerated payment (ahead of RRM credit) of EHSA program funds for specified SFC projects under the following criteria:

1. The Headquarters distribution of EHSA program funds to an Area will continue to follow the RRM process and will not be adjusted or accelerated if an Area elects to make an accelerated EHSA payment to a tribe.
2. The tribe can receive an accelerated EHSA payment only if the tribe received no funded project in the prior fiscal year and the sum total of all projects to be funded for that tribe in the current fiscal year does not exceed \$250,000.
3. The Area must have the additional funds available to make the accelerated payment. An accelerated payment cannot result in an adverse affect upon any other tribe in the Area.
4. The total amount of RRM credit does not exceed what would have otherwise been received over the 5-year period. The actual EHSA payment is made on the basis of the current year allocation of EHSA funds to the Area. No subsequent adjustments will be made based on actual appropriations and EHSA allocations to the Areas in future years.
5. When an SD/SG tribe assumes program responsibility for projects started under IHS program administration, the EHSA payment amount to the SD/SG tribe for specified projects will be adjusted downward proportional to the amount of actual work remaining regardless of the remaining RRM credit.
6. The Areas have the ability to keep track of the payments and RRM credit using appropriate accounting processes.

### Example RRM Calculation for a Specific Geographic Location

In Table 7-8, for a given geographic location (e.g., Area, district, reservation, service unit), the total RRM workload for FY 1998 is determined by adding 20 percent of the workload associated with projects funded in FY 1996 plus 50 percent of the workload associated with projects funded in FY 1995 plus 30 percent of the workload associated with projects funded in FY 1994. Note that no RRM workload "credit" is given for any projects at that location funded in FY 1997. Any "credit" is used for obtaining program (EHSA) funds.

Table 7-8. Example FY 1998 RRM Calculation					
Year Funded	No. of Projects	Total Project Cost	RRM Formula (from Fig 7-2 or Table 7-3)	Annual Distribution Factor (Table 7-4)	FY 98 Project Workload (staff-days)
FY 98	1	\$40,000	120 staff-days	0	120x 0 = 0 staff-days
FY 97	1	\$50,000	140 staff-days	0	140x 0 = 0 staff-days
FY 96	1	\$650,000	765 staff-days	0.20	765 x 0.2 = 153 staff-days
FY 95	1	\$390,000	630 staff-days	0.50	630 x 0.5 = 315 staff-days
FY 94	1	\$125,000	290 staff-days	0.30	290 x 0.3 = 87 staff-days
FY 93	1	\$350,000	590 staff-days	0	590 x 0 = 0 staff-days
Sub- total for Project Workload					555 staff-days (2.52 staff-years)
Non-Project Workload Element			RRM Formula (Table 7-7)		Non-Project Workload (staff-days)
9 Feasible Projects in SDS			9 x 3 staff-days/project =		27 staff-days
2 Tribal O&M Systems			2 x 4 staff-days/system =		8 staff-days
15 Tribal Communities			15 x 7 staff-days/community =		105 staff-days
Sub-total for Non-Project Workload					140 staff-days (0.64 staff-years)
TOTAL RRM WORKLOAD AT LOCATION = 3.16 staff-years					

## **Injury Prevention**

The Injury Prevention program is funded through the Facilities and Environmental Support Line Item under the Environmental Health Services Account. These funds provide administrative support to the program, but do not fund specific initiatives. In FY 2000, Congress appropriated an increase to the Facilities and Environmental Support Account Line with allocations for injury prevention initiatives and specifically for assisting tribes in building core programmatic capacity in injury prevention. These funds were distributed to tribes through three types of competitive cooperative agreements as part of an ongoing aggressive public health campaign to prevent unintentional injuries. The initiative was titled the IHS Injury Prevention Cooperative Agreement Program (TIPCAP) and has become the premier funding mechanism to support tribal injury prevention.

### **FY 2000-2005**

Part 1: \$1.25 million (84% of the funds) was awarded to tribes for Basic Core Capacity Injury Prevention Program Development or Enhanced Injury Prevention Program Development. Individual awards were up to \$50,000 and could be continued for 5 years. 43 applications from tribes were received and 25 awards were made.

Part II: \$180,000 (12% of the funds) was awarded to tribes to implement proven or promising injury intervention projects that are based on addressing local injury problems. Individual awards were up to \$15,000 and could continue for 3 years. 21 applications from tribes were received and 12 awards were made.

Part III: \$15,000 (1% of the funds) was awarded to tribes to provide training to address local injury prevention issues and concerns. Individual awards were for \$5,000 for one year. Three applications were received and 3 awards were made.

All applications were evaluated and rated on the basis of the criteria published in the Cooperative Agreement Application Kit including background/need/capacity, goals/objectives, methods/staffing, evaluation, collaboration, and budget/justification.

### **FY 2005-2010**

In FY 2005, the Injury Prevention program announced funding opportunities to continue funding of Part I and Part II interventions. Approximately 80% of the funds were available for cooperative agreements, with the remaining 20% used for program support. 62 applications were reviewed and 32 were funded.

Part I - Basic programs: \$650,000 was awarded to 13 new tribal injury prevention programs for five years.

Part I - Advanced programs: \$675,000 was awarded to 9 existing, previously funded tribal injury prevention programs for five years.

Part II Injury Prevention interventions: \$80,000 was awarded to tribes for three years to implement proven or promising interventions that addressed local injury problems. 10 applications from tribes were received and 8 awards were made.

## **2010-2015**

TIPCAP continued for a new funding cycle in FY 2010 with a focus on two injury prevention priorities - motor vehicle safety and elder fall prevention (+65 years old). However, tribes were given the opportunity to submit applications that address local injury prevention concerns including suicide prevention, bullying, fire prevention, drowning prevention, helmet use, and others. More than \$2 million was awarded to 40 tribal injury prevention programs each year.

Part I(a) - Basic programs: \$1.04 million was awarded to 16 new tribal injury prevention programs for five years.

Part I(b) - Advanced programs: \$1.36 million was awarded to 17 existing, previously funded tribal injury prevention programs for five years.

Part II - Effective strategy projects: \$70,000 was awarded to tribes for three years to implement effective injury prevention interventions that addressed local injury problems. 7 awards were made.

## Potential Areas of Impact Due to the Indian Health Care Improvement Reauthorization and Extension Act

### The Indian Health Care Improvement Reauthorization and Extension Act S. 1790 as Reported & included in H.R. 3590

Section	Description of Section	Summary
<b>Title I – Indian Health Care Improvement Act Reauthorization and Amendments</b>		
Sec. 111. Community Health Aide Program.	Amends Sec. 119 in current law to continue the authority for operation of the community health aide program in Alaska. Directs that a study be conducted on the dental health aid therapist services provided by the community health aid program to ensure that the quality of care provided through those services is adequate. Authorizes the Secretary to establish a national community health aid program under this provision. In establishing a national program, the Secretary shall not reduce the amounts provided for the Alaska Community Health Aid Program, and shall exclude dental health aid therapists services covered under the program. An amendment in H.R. 3590 authorizes the use of dental health aid therapist where such services are authorized under State law.	Authorizes the Secretary to establish a national community health aid program as long as the Secretary does not reduce the amounts of funding providing for the Alaska Community Health Aid Program, and shall exclude dental health aid therapist services from services covered under program, except in those states that authorize such dental health aid therapists.
<b>Subtitle B – Health Services</b>		
Sec. 123. Diabetes Prevention, Treatment and Control	Amends Sec. 204 of current law to revise the wording of the section, and to clarify that diabetes screening will be done with informed consent. Adds the Medical Vanguard program to diabetes projects the Secretary shall continue to maintain, along with the model diabetes projects in existence on the date of enactment of the Act. Also, the Secretary is authorized to provide through the Service, Indian tribes, and tribal organizations, dialysis programs. To the extent funding is available; the Secretary is directed to consult with Indian tribes and tribal organizations regarding programs for the prevention, treatment, and control of diabetes. Authorizes the Secretary to establish and maintain in each area office a position of diabetes control officer. Further, provides that any activity carried out by the diabetes control officer carried out under an ISDEAA contract/compact shall not be divisible.	Clarifies and expands authorities/requirements for diabetes programs.

Sec. 124. Other authority for provision of services	Amends Sec. 205 of current law to authorize the sharing of facilities and staff between IHS and tribally-operated long-term care programs. Also, provides authorization for hospice care, assisted living, long-term care and home-and community-based care. Also, authorizes "Convenient Care Services" through the Service, Indian tribes, and tribal organizations. Also, repeals Sec. 821 of current law which authorized home/community based demonstration projects; and amends Sec. 822 in current law to authorize the provision of long-term care services (including health care services associated with long-term care) provided in a facility to Indians. Further, authorizes sharing of staff or other services or a tribal health program and a long-term care facility owned/operated directly or through a contract/compact under the ISDEAA. Provides for the content of the agreements to provide long-term services.	Provides authority for new programs in Indian communities.
Sec. 121. Indian Health Care Improvement Fund	Amends Sec.201 of current law to authorize use of funds for Clinical care, including inpatient care, outpatient care (including audiology, clinical eye, and vision care), secondary and tertiary care, and long-term care. <b>For Injury prevention, adds:</b> "including data collection and evaluation, demonstration projects, training, and capacity building" Updates to include tribal organization, where tribes are mentioned. Expands the type of information that should be included in the report on the "fund", including in addition to the number of Indians using the Service resources, and to the extent available to each Service unit, Indian tribe or tribal organization, information on the waiting lists and number of Indians turned away for services due to lack of resources.	Authorizes additional uses and services paid by the "fund" and expands the requirements for information to be included in the report due 3 years after enactment. Sec. 201 (c) (2) requires Tribal Consultation on apportionment of funds.
<b>Subtitle C – Health Facilities</b>		
Sec. 141. Health Care Facility Priority System	Amends sec. 301 of current law to direct the Secretary, through IHS, to maintain a health care facilities priority system which shall be developed in consultation with tribes and tribal organizations; with opportunity for nomination to the priority list at least once every three years or other appropriate frequency; the Service/non-Service facilities operated under contracts/compacts pursuant to ISDEAA are fully and equitable integrated into the health care facilities priority system. Includes reporting requirements to Congressional authorizing committees no later than 1 year after the date of enactment of this Act describing the comprehensive, national, ranked list of all health care facilities.	Amends current law by directing the Secretary to maintain a facilities priority system and sets certain requirements for the priority system. Also amends current law to include new report requirements.
Sec. 142. Priority of Certain Projects Protected	Sec. 301 in current law is amended to protect certain projects on the priority list on the date of enactment of this Act.	Stipulates the priority status of projects on the facilities construction priority list on the date of enactment (March 23, 2010) is not affected by any changes made to the priority system thereafter.

Sec. 143. Indian Health Care Delivery Demonstration Projects	Amends Sec. 307 of current law to authorize the development of new health programs offering care outside of regular clinic operational hours and/or in alternative settings, and to use alternate or innovative methods of delivering health care services to Indians (including primary care services, CHS, or any other program or services authorized by this Act, through convenient care services.	Authorizes the Secretary to carry out or enter into contracts or compacts with Tribes and Tribal Organizations pursuant to ISDEAA to test new models/means of health care delivery. Permits the use of other Federal funds, third party collections, and non-Federal funds to support these programs.
Sec. 144. Tribal Management of Federally Owned Quarters	Amends Title III of the current law to add new authority authorizing tribes and tribal organizations that operate a health facility and Federally-owned quarters associated with such facility under the Indian Self-Determination and Education Assistance Act to set rental rates and collect rents/collect from occupants of the quarters.	Tribes and Tribal Organizations operating programs under ISDEAA are authorized to manage their staff quarters including setting and collecting rents from occupants of staff quarters.
Section 145. Other - Funding, Equipment and Supplies for Facilities.	Amends Title III of the current law to allow for the transfer of funds, equipment or other supplies from any source, including federal or state agencies, to HHS for use in construction or operation of Indian health care or sanitation facilities. Secretary is authorized to accept from any source, including Federal and State agencies, funds, equipment or supplies that are available for the construction or operations of health care or sanitation facilities.	New authority to allow transfer, acceptance of funds, equipment, and supplies for facilities for planning, design, construction, or operation of health care or sanitation facilities. Receipt of funds under this section shall not affect any priority established under Sec. 301.
Section 146. Indian Country Modular Component Facilities Demonstration Program	Directs IHS to establish a demonstration program for construction of health care facilities using modular component construction. Once funds are appropriated for this program, a report is required on the implementation of the program one year later, then annually afterwards.	Expands authorities for construction of new types of health care facilities.
Section 147. Mobile Health Stations Demonstration Program	Requires IHS to establish a demonstration program to provide funding to consortia of two or more service units to purchase a mobile health station to provide specialty health care services such as dentistry, mammography and dialysis. The Secretary is directed to establish at least 3 mobile health station demonstration projects. No later than 1 year after the date of the establishment of the demonstration program, and annually thereafter, a report is required on the implementation of the program and potential benefits of increased use of mobile health stations to provide specialty health care services in Indian communities.	Authorizes program to fund new ways to provide health care to Indian communities.
<b>Subtitle E -Health Services for Urban Indians</b>		
Sec. 161. Facilities Renovation	Amends sec. 509 of current law to add "or construction or expansion of facilities" as an allowable renovation facilities option. Current law authorizes minor renovations to allow urban program recipients to maintain accreditation.	Title V, urban Indian organizations are authorized to receive funding from IHS for minor renovations and to construct or expand urban Indian health facilities.



<b>Subtitle G -Behavioral Health Programs</b>		
Section 702. Behavioral Health Prevention and Treatment Services	Amends sec. 702 in current law by authorizing a comprehensive continuum of behavioral health care to include community-based care, detoxification, hospitalization, intensive out-patient treatment, residential treatment, transitional living, emergency shelter, case management, and diagnostic services. The Secretary, acting through the Service, shall coordinate behavioral health planning, to the extent feasible with other Federal agencies and with State agencies to encourage comprehensive behavioral health services for Indians regardless of their place of residence. No later than 1 year after date of enactment of this Act, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians, and the availability and cost of inpatient mental health facilities to meet such needs, including conversion of existing, underused Service hospital beds into psychiatric units to meet such needs.	
Sec. 704. Comprehensive Behavioral Health Prevention and Treatment Program	Amends sec. 704 in current law, which directs the IHS to establish comprehensive behavioral health, prevention and treatment programs for Indians.	
Sec. 708. Indian Youth Program involvement.	Amends sec. 708 in current law authorizing the establishment of a program for acute detoxification and treatment for Indian youth, including behavioral health services and family involvement.	
Sec. 709. Inpatient and Community-Based Mental Health Facilities Design, Construction and Staffing	Authorizes the establishment, in each IHS area, of not less than one inpatient mental health care facility, or equivalent, to serve Indians with behavioral health problems.	
<b>Subtitle H – Miscellaneous</b>		
Sec. 198. Disease and Injury Prevention Report	Amends Title VIII of current law adding a new requirement that no later than 18 months after date of enactment of this Act, the Secretary shall submit to the Senate Committee on Indian Affairs, the Committee on Natural Resources, and the Committee on Energy and Commerce a report describing all disease and injury prevention activities conducted by the Service, independently or in conjunction with other Federal departments and agencies and Indian tribes, and the effectiveness of such activities, including the reductions of injury or disease conditions achieved by such activities.	



April 18, 2014

**IHS Health Care Facilities FY 2015 Planned Construction Budget a/  
(Dollars in Thousands)**

<b>FACILITY</b>	<b>Prior to FY 2015*</b>	<b>FY 2015</b>	<b>Total Required Post 2015 To Complete</b>	<b>Total Cost **</b>
<b>Inpatient Facilities b/ c/</b>				
PIMC, AZ, Health Care System 1/				
Gila River PIMC SE ACC 2/	6,590	2,726	63,684	73,000
Salt River PIMC NE ACC 3/	90	-	79,400	79,490
Central - Hosp & ACC 4/	228	-	579,000	579,228
Whiteriver, AZ, Hosp 5/	-	-	222,000	222,000
Gallup, NM 6/	173	-	490,000	490,173
<b>Outpatient Facilities b/ c/</b>				
Ft. Yuma, CA, HC 7/	2,208	46,292	-	48,500
Kayenta, AZ HC 8/	131,131	18,869	-	150,000
Rapid City, SD	-	-	86,000	86,000
Dilkon, AZ	454	-	152,500	152,954
Alamo, NM	-	-	37,400	37,400
Pueblo Pintado, NM	-	-	32,000	32,000
Bodaway Gap, AZ	-	-	32,500	32,500
Albuquerque Health Care System	-	-	-	-
Albuquerque West, NM	-	-	62,000	62,000
Albuquerque Central, NM	-	-	82,000	82,000
Sells, AZ	-	-	126,000	126,000
<b>Youth Regional Treatment Centers (Section 704) d/</b>				
N. California YRTC 9/	339	17,161	-	17,500
<b>Joint Venture Construction Program (Section 818e) d/</b>				
Health Facilities 10/	-	-	-	-
<b>TOTAL</b>	<b>141,213</b>	<b>85,048</b>	<b>2,044,484</b>	<b>2,270,745</b>

**NOTES:**

\* Amounts appropriated and reprogrammed for active projects. All funds appropriated prior to FY 2015 are consolidated.

\*\* Cost estimate based on mid-point of construction using current year dollars.

a/ Subject to the availability of funds and does not include Maintenance & Improvement, Environmental Remediation, Environmental Assessment, Biomedical Equipment, or staff support, which are budgeted separately.

b/ This project list includes all PJD approved projects from the existing IHS Facilities Construction Priority List implemented in 1992.

c/ Projects which require staff quarters to support the health care delivery program have the quarters included in the total cost of the project.

d/ The Section cited is the appropriate section of P.L. 94-437 that authorizes the program.

1/ The PIMC Hospital system is proposed to be located at four sites in the Phoenix area: southeast, southwest (completed), northeast and central.

2/ The Gila River Ambulatory Care Center (PIMC SE) design was completed Nov 2010; Construction funds completed infrastructure.

3/ The Salt River Ambulatory Care Center (PIMC NE) Phase 2 Site Selection documents are complete.

4/ PIMC Central may include inpatient, outpatient, and a hostel. PJD is in development.

5/ Total cost includes an estimate of \$55,600,000 for planned 144 staff quarters. The quarters estimate is based upon design-build.

6/ Planning money provided.

7/ Planning and design completed Apr 2010.

8/ Total cost includes an estimate of \$45,000,000 for planned 129 staff quarters based upon design-build.

9/ Planning complete; Funds appropriated for design in FY 2012.

10/ 19 prior year JVCPs signed. Three approved to move forward in FY 2014. New round of applications anticipated in FY 2014.



**SUMMARY REPORT**  
**INDIAN HEALTH SERVICE, HEALTH CARE FACILITIES CONSTRUCTION PROGRAM**

April 2014

**COMPLETED CONSTRUCTION (FY 1992 -Present)**

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

**PRIORITY LISTS**

**Health Care Facilities Construction**

**Quarters**

**Youth Regional Treatment Centers**

**Inpatient:**

PIMC Health System, AZ,  
PIMC Southeast ACC  
PIMC Northeast ACC  
PIMC Central Hosp & ACC  
Whiteriver, AZ  
Gallup, NM

**Outpatient:**

Ft. Yuma, AZ  
Kayenta, AZ  
San Carlos, AZ  
Rapid City, SD  
Winslow-Dilkon, AZ  
Alamo Navajo, NM  
Pueblo Pintado, NM  
Bodaway-Coppermine, AZ  
Albuquerque Heath System, NM,  
    Albuquerque West  
    Albuquerque Central  
Sells, AZ

California, Central-Southern  
California, Northern

**IHS PARTNERSHIPS WITH TRIBES (1992- Present)**

**Completed Projects**

**Joint Venture**

Warm Springs, OR 1993  
Poteau, OK 1994  
Jicarilla (Dulce, NM) 2005  
Choctaw Nation (Idabel, OK) 2005  
Muscogee Creek (Coweta, OK) 2006  
Tohono O'odham Nation (San Simon, AZ) 2007  
Cherokee Nation (Muskogee, OK) 2007  
Absentee Shawnee (Little Axe, OK) 2010  
Chickasaw Nation (Ada, OK) 2010  
Lake County, CA (Lakeport, CA) 2010  
Santee Sioux (Santee, NE) 2011  
Tanana Chiefs Conference (Fairbanks, AK) 2012  
Chickasaw Nation (Ardmore, OK) 2013  
Southcentral Foundation (Wasilla, AK) 2013  
Cherokee Nation (Vinita, OK) 2012  
Chickasaw Nation (Tishomingo, OK) 2013  
Copper River Native Assoc. (Tazlina, AK) 2013  
Kenaitze Indian Tribe (Kenai, AK) 2014

**Small Ambulatory Program**

Black River Falls, WI 2002  
Jemez Pueblo (Jemez Pueblo, NM) 2003  
Karuk Tribe (Yreka, CA) 2003  
Chippewa Tribe (Nett Lake, MN) 2003  
Southern Indian Health Council (Campo, CA) 2003  
Diegueño Indians (Santa Ysabel, CA) 2003  
Confederated Tribes of Colville (Inchelium, WA) 2004  
Paiute Colony (Las Vegas, NV) 2004  
Choctaw Nation (Stigler, OK) 2004  
Chickasaw Nation (Purcell, OK) 2004  
MACT (Mariposa, CA) 2005  
Toksook Bay, AK 2005  
Quinault Indian Nation (Taholah, WA) 2006  
Chenega Bay, AK 2006  
Chippewa Cree Tribe (Bonneau Village, MT) 2007  
Yakama Nation (White Swan, WA) 2008  
Reno-Sparks Indian Colony (Reno, NV) 2008  
Kake, AK 2009  
Hooper Bay, AK 2009  
Lake Superior Chippewa Indians (Lac du Flambeau, WI) 2009  
Klamath Tribes (Chiloquin, OR) 2009  
Siletz Indians (Siletz, OR) 2010  
Cowlitz Tribe (Longview, WA) 2010  
Bad River Band (Odanah, WI) 2010  
Miwok Indians (El Dorado County, CA) 2011  
Confederated Tribes of Warm Springs (Warm Springs, OR) 2012  
Shingle Springs, CA 2011  
Bad River, WI 2011  
Canyonville, OR 2012



**REPORT TO CONGRESS**

**ON**

**ESTIMATED NEED FOR TRIBAL AND INDIAN HEALTH SERVICE  
HEALTH CARE FACILITIES**

**Contents**

Executive Summary .....	2
Purpose for this Report .....	4
Background on the IHS Health Facilities Planning Process .....	4
Process for Developing Report Required by the IHCA .....	6
Report.....	10
Summary .....	12

**Exhibits**

Exhibit 1 Estimated Cost Formula.....	9
Exhibit 2 Estimated Space for Health Centers and Health Stations .....	10
Exhibit 3 Estimated Space for Inpatient Facility .....	10

## Executive Summary

The Indian Health Care Improvement Act (IHCIA) directs the Indian Health Service (IHS) to provide to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives, by March 23, 2011, a report that describes the comprehensive, national, ranked list of all health care facilities, including specialized health care facilities (such as long-term care and alcohol and drug abuse treatment), wellness centers, and staff quarters.

This initial report provides an estimate of need based on the information that is currently available and that could be summarized with existing resources within the time frame specified. This report provides the total estimated cost to complete unfunded projects on the existing Health Care Facilities Construction Priority List (Priority List) plus the total estimated cost to construct, renovate, and/or expand tribal and IHS inpatient and outpatient facilities not on the Priority List but identified in Area Health Services and Facilities Master Plans developed five years ago. Costs for facilities on the Priority List, were developed using the IHS Facilities Budget Estimating System (FBES). Costs for all other Tribal and IHS facilities were estimated by determining space requirement for each facility and multiplying this times the historical average unit cost to construct comparable health care space. Estimates for all facilities are summed to derive the total estimate. Space was estimated using the IHS Health System Planning (HSP) process software for smaller facilities (less than 1,319 user population) and using formulas to determine the average space per user population for larger health centers and the average space per patient bed days for inpatient facilities.

The top 10 priority inpatient, outpatient, staff quarters and youth regional treatment center projects on the current Priority List are not affected by any change in the priority system; therefore, the 17 projects on the existing Priority List are the highest ranked in this IHS estimate of need. The cost to complete facilities on the Priority List is approximately \$2.5 billion. The estimated cost to address the construction needs (whether through new construction, renovation and/or expansion) of additional facilities identified in Area Health Services and Facilities Master Plans, developed in 2005-2006, is approximately \$5.9 billion. Estimated costs may change significantly when the planning is completed for these facilities and the FBES is applied.

The IHS planning methodologies do not incorporate processes to develop space or cost estimates for wellness centers or specialized facilities as noted above (which could include types of facilities not mentioned as examples in the legislation, i.e., dialysis facilities, psychiatric facilities, etc.). IHS has not yet developed these methodologies, which are needed to update IHS Area Health Services and Facilities Master Plans. The accomplishment of these items will be done in collaboration and consultation with the Tribes.

Developing a ranked list of need requires a ranking methodology that has been reviewed by the tribes and approved by the Administration and the Congress. In addition, before the ranking methodology can be implemented, the IHS must complete two planning activities for which resources have yet to be identified:

1. Develop descriptions of need for all services (including specialized services) for which facilities are to be planned.
2. Develop an IHS master plan that incorporates a full description of need for inpatient, outpatient, and specialized services, including the facilities required to provide access to these services.

When resources become available to develop definitions for specialized services and space and to update the IHS master plans to incorporate these definitions, the IHS could use the proposed recent revision to the Healthcare Facilities Construction Priority System (HFCPS) to generate the ranked list of all facilities, including specialized facilities.



**Purpose for this Report**

On March 23, 2010, the Indian Health Care Improvement Reauthorization and Extension Act of 2009, S. 1790, 111th Cong. (2010) (IHCIREA), was enacted into law as section 10221(a) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (PPACA). IHCIREA reauthorized and amended the Indian Health Care Improvement Act, Pub. L. No. 94-437 (IHCIA). Section 301 directs the Secretary to provide to the House and Senate committees no later than one year after the date of enactment, a report that:

describes the comprehensive, national, ranked list of all health care facilities needs for the Service, Indian tribes, and tribal organizations (including inpatient health care facilities, outpatient health care facilities, specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, and staff quarters, and the renovation and expansion needs, if any, of such facilities).

25 U.S.C. 1631(c)(2)(A)(ii)(1).

**Background on the IHS Health Facilities Planning Process**

The IHS planning process stipulates the assumptions, criteria, and thresholds for planning health programs that effectively and efficiently deliver access to services through hospitals and health centers. Tools used in this planning process include service delivery guidelines, Area Health Services and Facilities Master Plans (Master Plans), the IHS Health System Planning (HSP) software, and the Health Care Facilities Construction Priority System (HFCPS). The general process that IHS has used to plan how, where, and what kind of facilities the IHS will construct is as follows:

- IHS planning guidelines are used to instruct Areas and Tribes on the development of Area Health Services and Facilities Master Plans.
- Areas and Tribes assess health services need and develop plans for providing services by contract or through constructed facilities; most of these plans incorporate the HSP to provide planning assumptions for delivery of services throughout the Area and to provide conceptual facility plans for each location at which a need is identified.
- The existing HFCPS is a methodology used to identify and rank need for facilities, using the Master Plans as a source for information and local priorities. The HFCPS uses Phase I and Phase II to screen projects and to provide a draft ranking of a limited number of facilities. These rankings are then fully validated through statistical and planning analysis of each proposed project being considered in Phase III. Some projects may be removed from consideration if validated and verified information would generate a lower ranking.
- When these Phase III analyses are completed, a Program Justification Document (PJD) and Program of Requirements (POR) are prepared for each project for which information

has been validated and verified. The PJD/POR describes the facility health delivery program, including services to be provided and the staffing and space requirements for those services.

- When these project PJDs and PORs are approved, they are added to the IHS Health Care Facilities Construction Priority List (Priority List) below all other projects.

In 1991, Area offices submitted proposals for 149 health facilities construction projects for review in the HFCPS. These proposals represented the Area offices' highest priority needs; however, they did not reflect the total need for health facilities construction in Indian Country. All proposals submitted were evaluated using the HFCPS methodology for Phase I, resulting in about 30 being selected for Phase II review. In 1992, following the completion of the Phase II evaluation, Area offices were asked to work with Tribes and local communities to prepare a detailed Program Justification Document (PJD) for each project advancing for Phase III review. After a PJD was approved, each project was placed on the IHS Priority List in the order of its approval. The last of these projects was added to the Priority List in 2008.

When the Priority List was developed (1991-1994), annual appropriations were between \$80 million and \$125 million, and it was expected that the needs identified would be addressed in a few years. However, funding levels (1995-2010) averaged less than \$45 million per year; and as a result many of those projects still remain to be completed (see Appendix A, "The IHS Health Care Facilities FY 2012 Planned Construction Budget"). Ensuring that these 17 facilities on the Priority List rank highest in the IHS report of need is consistent with the recent instruction in the amendments to the IHCIA that the priority of facilities identified under the existing HFCPS be protected.

Of the 17 inpatient and outpatient facilities on the existing Priority List, all but two, which were grandfathered onto the list, were added using this process. The two California Youth Regional Treatment Centers (YRTC) on the current list were not added as part of this process, but were added to comply with Section 708 of the IHCIA. Section 708 directs IHS to construct one YRTC in each Area except California, which is to receive two facilities.

In 2005-2006, the IHS Areas were asked to update Master Plans in consultation with the Tribes. All Areas completed these by the end of 2006. These plans, with supporting statistical information, describe the tribal and IHS inpatient and outpatient health services and facilities need in each Area (Appendix B). Areas did not document a need for specialized care facilities because authorizations did not exist prior to enactment of the reauthorized IHCIA. Furthermore, IHS has not developed methodologies or assumptions to govern how these services would be delivered or how staffing and facility size would be determined.

Although the IHS maintenance and improvement (M&I) program is not directly part of the overall facility planning process, the two activities are not mutually exclusive. Efficient and effective buildings and infrastructure are necessary to deliver healthcare in direct support of the

IHS mission. An active and aggressive new construction program is essential to address the backlog of maintenance and repair. When IHS replaces an older, obsolete hospital or clinic with a new facility, all the deficiencies associated with the old facility are removed from the backlog.

Maintaining reliable and efficient buildings is increasingly challenging as existing facilities age and the demands of providing modern healthcare services strain the infrastructure. Many of IHS and Tribal facilities are old, overcrowded, and not designed to be utilized efficiently in the context of modern healthcare delivery. As existing health care facilities continue to age, the healthcare delivery system tends to become less efficient and the operational and maintenance costs for the facility increase. The average age for IHS-owned healthcare facilities is 31 years. Fourteen of the 35 IHS hospitals and 22 of the 61 IHS health centers are older than 40 years; whereas, the average age of private-sector hospital plant is 9 to 10 years.

The physical condition of the existing IHS-owned and many Tribally-owned facilities is evaluated through a series of condition surveys. These surveys, together with routine observations by facilities personnel, identify deficiencies that are included in the Backlog of Essential Maintenance, Alterations, and Repair (BEMAR). The current BEMAR for IHS and reporting Tribal facilities as of October 1, 2010, is \$472.9 million (Appendix C). In the commercial (non-government) healthcare sector, hospitals spend an average of approximately five percent of a facility's value each year on restoration and modernization to maintain a reasonable backlog of maintenance and repair. Applying this industry level would establish a maximum BEMAR of no more than \$173 million if IHS had enough appropriations to apply that standard. The \$173 million is based upon the industry standard that the BEMAR should not exceed 5 percent of the asset value of the healthcare facilities.

Closely associated with BEMAR is the Condition Index (CI), which is a measure of the condition of facilities. In 2005, the Federal Real Property Council approved the CI as the measure of a constructed asset's condition at a specific point in time. The CI is calculated as the ratio of Repair Needs (i.e., BEMAR) to Replacement Value. The CI is reported as a "percent condition" on a scale of 0 to 100%. The higher the CI, the better the condition the constructed asset is in. The average CI of all IHS-owned facilities is 81, which is significantly below the Department of Health and Human Services goal of 90 (Appendix C).

### **Process for Developing Report Required by the IHCIA**

Section 301 of IHCIA directs that the priority of projects on the current Priority List be protected, as follows:

The priority of any project established under the construction priority system in effect on the date of enactment of the IHCIA shall not be affected by any change in the construction priority system taking place after that date if the project—

- (i) was identified in the fiscal year 2008 Service budget justification as—
  - (I) 1 of the 10 top-priority inpatient projects;
  - (II) 1 of the 10 top-priority outpatient projects;
  - (III) 1 of the 10 top-priority staff quarters developments; or
  - (IV) 1 of the 10 top-priority Youth Regional Treatment Centers;
- (ii) had completed both Phase I and Phase II of the construction priority system in effect on the date of enactment of such Act; or
- (iii) is not included in clause (i) or (ii) and is selected, as determined by the Secretary—
  - (I) on the initiative of the Secretary; or
  - (II) pursuant to a request of an Indian tribe or tribal organization.

25 U.S.C. § 1631(c)(1)(D).

Therefore, the 17 projects on the existing Priority List are the highest ranked in this IHS estimate of need and are included in Appendix A.

This report estimates the cost to address the health care facilities need for which IHS has developed planning criteria and assumptions, that is, for traditional outpatient and inpatient medical care facilities using the recent updates of the Master Plans in consultation with Tribes in 2006. The IHS planning methodologies do not incorporate processes to develop space or cost estimates for wellness centers or specialized facilities (which could include types of facilities not mentioned as examples in the legislation, i.e., dialysis, psychiatric, etc.) because these were not required prior to the reauthorization of IHCA in 2010.

A more complete estimate incorporating the cost for these specialized facilities, including long term care facilities, wellness centers, etc., noted in the congressional directive, will be provided when planning criteria and assumptions are developed for these services and facilities.

Developing planning methodologies that incorporate planning assumptions for wellness centers, specialized facilities, etc., will need to include delivery modes, demographic studies, workload thresholds, and concepts of operation to ensure that facilities are well planned to deliver the appropriate access to services for the population served. The complexity of issues related to developing planning assumptions are such that they need full IHS and Tribal review before beginning the equally complex task of updating Master Plans that define the type of services and facilities to plan, where to build them, and how they should be sized, designed, and staffed.

Developing methodologies for newly authorized specialty facilities, obtaining and reviewing data, and incorporating these specialty facilities into Area Master Plans will require three activities.

**#1 - Criteria Development** – The development of demand, staff and space operational metrics, staff and space allocation formulas for all newly directed services.

**#2 - Operational Principles** – The review and development of guiding principles related to the integration of existing and new services. IHS and Tribes will discuss issues specific to regional specialty centers including long term care, medical home, chronic care initiative, telemedicine among other technological advancements relative to the future of Indian Health and its delivery system.

**#3 - Update of Indian Health Master Plans** – The synthesis of the existing criteria, new criteria, operational principles, and interfaces nationwide to describe the IHS/Tribal healthcare delivery system, and identifying the required services, staff and space requirements for these newly authorized specialty centers.

These activities will require resources and consultation with the Tribes.

When planning has been completed, a ranked listing of all facility need can be developed using the HFCPS revision when it is submitted to the Congress.

The total estimate of facilities need (\$8.4 billion), provided in this report, was developed by adding the cost to complete facilities on the existing Priority List (\$2.5 billion) to the estimated cost to address all other need for inpatient and outpatient facilities that includes the Priority List Need (\$5.9 billion).

The estimated cost for facilities on the existing Priority List was determined by using the HSP and the Facility Budget Estimating System (FBES). The HSP uses IHS User Population as an input to assist planners in developing a basic description of program services and a module-based facility plan. The IHS User Population consists of registered American Indian and Alaska Native patients who have had direct encounters with IHS inpatient, outpatient, or dental services—or received IHS referrals for these services—during the most recent three years. The HSP output provides a generic estimate of facility size and layout that can sometimes be used as a rough estimate of need, but is more usefully employed as a guide by IHS planners as they develop a detailed program description, staffing plan, facility plan, and medical equipment list that effectively and efficiently meet the requirements of the community for which the facility is planned.

Once the facility size, staffing, and equipment requirements are established, these are then entered into the FBES to develop a budget cost. The FBES uses construction cost data from industry standard publications (such as the R. S. Means Company, Marshall Swift, etc.). The FBES incorporates all costs associated with construction, including design, material, wages, medical and non-medical equipment, site development, construction scheduling and administration, and local taxes and fees. Because of the wide diversity in locations where IHS builds facilities, estimated costs include adjustments based on the location of the facility.

The estimated cost for facilities not on the Priority List was generated by multiplying the average cost per square meter to construct health care space times the estimated required space of each facility times a location factor (See Exhibit 1, “Estimated Cost Formula. The formula is a

standard for estimating building construction costs when using industry cost estimating methodologies of R.S. Means Company, Marshall Swift, and locality factors.

### **Exhibit 1 - Estimated Cost Formula**

$$\text{Estimated Cost} = (\text{Average Cost Per Square Meter}) \times (\text{Required Space}) \times (\text{Locality Factor})$$

The population for a facility is the current user population of the Service Area described in Area Health Services and Facilities Master Plans. The cost factor is the average cost per square meter to construct a comprehensive IHS health care facility. Because inpatient facilities have more specialty space and also cost more per square meter to build, compared to outpatient facilities, a different cost factor is used for each type of facility. The location factor accounts for differences in costs to construct facilities at the wide diversity of locations where IHS builds facilities.

The required space value used in the Estimated Cost Formula was determined in one of three ways. For smaller populations<sup>1</sup> (between 138 and 1,319 IHS user population) the IHS has established criteria in the existing HSP that determines the size of these facilities (Exhibit 2, “Estimated Space for Health Centers and Health Stations”). Determining or estimating facility size for larger populations, requires a more complex analysis of the data and an application of the HSP and often involves adjustments to HSP output. Since IHS does not have resources to complete these analyses for all the facilities identified, required space has been estimated for these facilities using one of two formulas. For outpatient facilities providing access to services for a user population greater than 1,319 users, required space is estimated by multiplying the average space per user population times the user population (See Exhibit 2, “Estimated Space for Health Centers and Health Stations. For inpatient facilities the required space is estimated by multiplying the average space per bed day times the bed days (See Exhibit 3, “Estimated Space for Inpatient Facility”).

<sup>1</sup> The estimate provided in this report, only addresses need for user populations greater than 138, which is about the minimum population that can support a small 1-day-a-week medical clinic and a 2-day-a-week dental clinic.

### Exhibit 2 - Estimated Space for Health Centers and Health Stations

IHS User Population	Required Space	Medical Clinic Days-per-Week	Dental Clinic Days-per-Week
138 to 275	221 Square Meters	1	2
276 -587	305 Square Meters	2.5	2.75
588- 900	494 Square Meters	3	5
901 – 1,319	1,022 Square Meters <sup>2</sup>	5	5
=> 1,320	IHS User Population X 0.8 Meters	5	5

### Exhibit 3 - Estimated Space for Inpatient Facility

Inpatient Facility Estimated Space = (Patient Bed Days) X (5,500 Meters)
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Assessing the need for programs and services that would be provided in specialized health care facilities requires that significant resources be identified to modify the tools listed above or to develop similar tools. Also, resources are needed to update Area Health Services and Facilities Master Plans, developed in 2005 and 2006, to ensure they contain current data and incorporate the need for specialized services and facilities. These resources need to be identified before the IHS can develop a ranked list of all facility need. Finally, because Tribes must be consulted on issues such as facility ranking that potentially affect funds allocation, both the IHS and Tribes will need to identify resources for the consultation process.

#### Report

This report is based on existing information that could be efficiently analyzed and summarized within existing resources and the time frame specified. This initial report provides the total cost to complete unfunded projects on the existing Priority List plus the estimated total cost to address the construction, renovation, and expansion need for other inpatient and outpatient facilities in Indian Country where none currently exists or where a facility exists but is over 10 years old. A ranked list that includes these facilities, as well as specialized facilities for which planning information is not currently available, will be prepared and forwarded to the Congress,

<sup>2</sup> This facility, which is open 5 days a week, differs from a health center offering access for more than 1,319 users because it provides space for more limited services and because mission support and administration responsibilities would be shared.

as an addendum to a follow up report, as resources become available to develop definitions for specialized services space and to update the IHS Area Master Plans. Developing this list will require that planning information be applied to a ranking system similar to the proposed revision of the HFCPS. This report provides an estimate of facility need in Indian Country based upon Area Health Services and Facilities Master Plans developed in 2005 and 2006, a description of how the estimate was derived, and a discussion of the HFCPS, which includes the reason for using the revised HFCPS to rank facilities need.

Tribes were extensively consulted in 2006 on the concept of Area Master Plans and the HFCPS guidelines. More than 1,200 comments were received and considered in revising the HFCPS. Based on that process, space needs and costs were incorporated into the master planning guidelines. In the numerous meetings with Tribes since then, health facilities has remained a top issue of discussions. The Tribes have given no indication in these discussions for a major overhaul of the approach developed in 2006. Tribal consultation would be initiated if appropriations are received to incorporate new types of facilities not consulted on in 2006, such as long-term care and alcohol and drug abuse treatment and wellness centers.

To provide for Tribal participation in the review, development and implementation of policies, procedures, guidelines, and priorities of facilities construction programs, IHS established the Facilities Appropriation Advisory Board (FAAB). The FAAB included 12 Tribal representatives that advised the IHS Director on related health facility construction planning guidelines. The FAAB collaborated with the IHS during the consultation process and provided advisory input related to the concept of developing an interim report with available data from the 2005-2006 Master Plans.

The recent amendments to the IHClA direct that the priority of projects on the current Priority List be protected; therefore, the 17 projects on the existing Priority List are the highest ranked in this IHS estimate of need. These 17 priority facilities on the existing Priority List will cost approximately \$2.5 billion to complete (see Appendix A, "The IHS Health Care Facilities FY 2012 Planned Construction Budget"). It is estimated that an additional \$5.9 billion is required to address the construction, renovation, and expansion needs for not-yet-prioritized inpatient and outpatient health care facilities identified in Area Health Services and Facilities Master Plans developed in 2005-2006 (see Appendix B, "Summary by Area of the Estimated Cost to Construct Indian Health Facilities"). The IHS existing Backlog of Essential Maintenance, Alteration, and Repair costs (See Appendix C, "Condition Index and Backlog of Essential Alteration Maintenance and Repair") are part of the \$5.9 billion estimate. On-going and consistent health care facilities construction and maintenance and improvement programs that address this need will improve the IHS condition index and reduce the BEMAR. The Area Health Services and Facilities Master Plans, originally intended to be updated every 5 years, are approximately 6 years old and will be updated when funds become available for this purpose.



## Summary

The 17 facilities on the existing Priority List remain the highest ranked need. This report provides an estimate of the cost for health care facility need in Indian Country. The estimated cost to complete the facilities on the Priority List of approximately \$2.5 billion was developed using the IHS FBES. However, the estimated cost to address those facilities needs not on the Priority List, whether through new construction, renovation, and/or expansion of approximately \$5.9 billion was generated using formulas. Costs generated by the FBES and based on a more accurate definition of the needed facility, could be significantly different than the estimated \$8.4 billion needed for health care facilities throughout Indian Country. However, this more extensive assessment of need will require significant additional resources.

Developing a ranked list of need requires a ranking methodology that has been reviewed by the Tribes and approved by the Administration and submitted to the Congress. In order for the ranking methodology to be implemented, the IHS must complete two planning activities for which resources have yet to be identified:

1. Develop descriptions of need for all services (including newly authorized specialized services) for which facilities are to be planned; and
2. Develop an IHS master plan that incorporates a full description of need for inpatient, outpatient, and specialized services; including the facilities required to provide access to these services.

The existing HFCPS was first used nearly 20 years ago and with the new authorization contained in IHCIA, the IHS must consult with Tribes. This consultation must include health services need, facility type, staffing methodology, priorities, and budget allocation proposals. Finally, Tribes must be consulted on issues such as facility ranking that potentially affect funds allocation, and both the IHS and Tribes will need to identify resources to successfully carry out this important consultation process.

**Appendices: Summary of Inpatient and Outpatient Need**

Appendix A shows a need of \$2.5 billion for projects on the Priority List; Appendix B shows a need of approximately \$5.9 billion for other inpatient and outpatient facilities in Indian Country. The total health care facilities need of \$8.4 billion excluding special facilities described in the IHCIA. Appendix B also separates inpatient and outpatient need, pages 2 and 3, respectively. Appendix C shows the IHS Condition Index and Backlog of Essential Maintenance, Alteration and Repair.

5 February 2010

**IHS Health Care Facilities FY 2012 Planned Construction Budget a/  
(\$000)**

FACILITY	Prior to FY 10 *	FY 10	FY 11 Request	FY 12 Est.	FY 13 Est.	FY 14 Est.	FY 15 Est.	Outyears Est.	Total Cost ***
<b>Planning Studies b/</b>	-	-	-	500	500	500	500	500	
<b>Inpatient Facilities c/ d/</b>									
PIMC, AZ, Health Care System 1/									
SE ACC 2/	6,590	-	-	32,000	32,000	-	-	-	70,590
NE ACC 3/	100	-	-	6,000	36,000	36,600	-	-	78,700
Central - Hosp & ACC 4/	575	-	-	-	-	-	-	524,000	524,575
Barrow, AK, Hosp 5/	53,624	15,234	40,192	45,850	-	-	-	-	154,900
Whiteriver, AZ, Hosp 6/	200	-	-	-	13,000	73,800	73,000	73,000	233,000
Gallup, NM 7/	300	-	-	-	-	-	-	556,700	557,000
<b>Outpatient Facilities c/ d/</b>									
Ft. Yuma, CA, HC 8/	2,208	-	-	36,600	-	-	-	-	38,808
Kayenta, AZ HC 9/	18,318	7,000	10,000	40,000	44,000	30,682	-	-	150,000
San Carlos, AZ 10/	22,604	7,000	16,000	40,000	30,396	-	-	-	116,000
Rapid City, SD 11/	200	-	-	5,800	36,000	36,000	-	-	78,000
Dilkon, AZ 12/	500	-	-	10,000	50,000	50,000	43,500	-	154,000
Alamo, NM 13/	100	-	-	3,200	19,000	19,000	-	-	41,300
Pueblo Pintado, NM 14/	-	-	-	-	2,700	32,000	-	-	34,700
Bodaway Gap, AZ 14/	-	-	-	-	3,000	33,200	-	-	36,200
Albuquerque Health Care System									
Albuquerque West, NM 15/	-	-	-	-	-	5,000	28,000	28,000	61,000
Albuquerque Central, NM 15/	-	-	-	-	-	6,000	40,000	37,500	83,500
Sells, AZ 15/	-	-	-	-	-	10,000	40,000	88,000	138,000
<b>Youth Regional Treatment Centers (Section 704) e/</b>									
S. California YRTC 16/	1,300	-	-	-	19,000	-	-	-	20,300
N. California YRTC 17/	1,379	-	-	18,000	-	-	-	-	19,379
<b>Joint Venture Construction Program (Section 818e) e/</b>									
<b>Health Facilities 18/</b>	17,361	-	-	-	5,000	5,000	5,000	-	-
<b>Small Ambulatory Program (Section 306) e/</b>									
<b>Small Health Clinics 19/</b>	39,273	-	-	40,000	50,000	50,000	50,000	-	-
<b>Dental Facilities Program</b>									
<b>Dental Units 20/</b>	15,434	-	-	-	3,000	3,000	3,000	-	-
<b>Non-IHS Funds Renovation Projects (Section 305) e/</b>									
<b>Equipment for Projects</b>									
<b>TOTAL</b>	167,845	29,234	66,192	277,950	343,596	390,782	283,000	1,307,700	2,589,952
<b>UNFUNDED (FY 2011-Outyears) f/</b>									

**NOTES:**

\* Amounts appropriated and reprogrammed for active projects. All funds appropriated prior to FY 2009 are consolidated.

\*\* In FY 2009 CR and prior to ARRA, \$10,000,000 was provided for the Nome, AK project; the total FY 2009 omnibus appropriation was \$40,000,000.

\*\*\* Based on mid-point of construction using current year dollars.

a/ Subject to the availability of funds and does not include Maintenance & Improvement, Environmental Remediation, Environmental Assessment, Biomedical Equipment, or staff support, which are budgeted separately.

b/ Funding for Phase II Site Selection and Evaluation Reports, and other planning needs for proposed projects.

c/ This project list includes all PJD approved projects from the existing IHS Facilities Construction Priority List which was implemented in 1992. It also includes two projects from the previous priority system.

d/ Proposed projects which require staff quarters to support the health care delivery program have the quarters included in the total cost of the project.

e/ The Section cited is the appropriate section of P.L. 94-437 that authorizes the program.

f/ The funding required to complete line item projects from FY 2010 through Outyears.

1/ Appropriated: It is anticipated that PIMC Hospital system will be located at four sites in the Phoenix area: southeast, southwest, northeast and central. Central includes inpatient, outpatient, and a hostel. The other three sites will be ambulatory care centers (ACC).

2/ Appropriated: \$2,590,070 planning and to begin design (FY 2005);\$4,000,000 (FY 2009) to begin utility work.

3/ Reprogrammed: \$100,000 planning (FY 2007).

4/ Appropriated: \$150,000 planning (FY 1989); Reprogrammed: \$74,405 planning (FY 1994); \$350,000 (FY 2007) planning. PIMC Central includes inpatient, outpatient, and a hostel. PJD in development.

5/ Reprogrammed: \$120,000 planning (FY 2003), \$15,000,000 construction (FY 2007); Appropriated: \$2,958,322 site acquisition (FY 2005);\$7,882,300 for design and construction (FY2006); \$12,664,000 construction (FY 2008);\$15,234,000 construction(FY2010). Total cost includes \$15,000,00 from the Denali Commission for planning and design.

6/ Reprogrammed: \$200,000 planning (FY 2007); Appropriated: \$-0-; Total cost includes \$55,600,000 for 144 staff quarters units. The quarters estimate is based on the design-build method.

7/ Reprogrammed: \$300,000 planning (FY 2007); Appropriated: \$-0-.

8/ Appropriated: \$667,000 planning and design (FY 1989); withdrew <\$ 667,000> (FY 1996); \$2,208,000 (FY2008) for planning and design.

9/ Reprogrammed: \$66,000 planning (FY 2004). Appropriated: \$430,929 design (FY 2005), \$3,820,946 design (FY 2006), \$2,000,000 (FY 2007) construction; \$12,000,000 (FY 2009) construction;\$7,000,000 (FY 2010) construction. Total Cost includes \$45,000,000 for 129 staff quarters units based

10/ Appropriated: \$555,178 planning and design (FY 2005); \$6,049,000 design (FY2006), \$2,000,000 (FY 2007) complete design and begin construction; \$14,000,000 (FY 2009) construction;\$7,000,000 (FY 2010) construction. Total Cost includes \$17,200,000 for 43 additional staff quarters units.

11/ Reprogrammed: \$200,000 planning (FY 2007); Appropriated: \$-0-.

12/ method.

13/ Reprogrammed: \$100,000 planning (FY 2007);Appropriated: \$-0-. Total cost includes \$12,800,000 for 33 staff quarters using the design-build method.

14/ Appropriated: \$-0-; Determination of need, and cost estimate for quarters will be established during the development of the PJDQ.

15/ Appropriated: \$-0-

16/ Reprogrammed: \$1,300,000 planning and land purchase (FY 2007);Appropriated: \$-0-.

17/ Reprogrammed: \$1,300,000 land purchase (FY 2007), Reprogrammed: \$79,140 planning (FY 1991);Appropriated: \$-0-.

18/ 8 prior year JVCPs signed.

19/ Prior appropriations have funded 27 SAP health center projects.

20/ Prior appropriations have funded 39 dental facilities.

# Summary by Area of the Estimated Cost to Construct Indian Health Facilities

8 February 2011

Area	Number of Facilities	Repair/Replacement Cost
Aberdeen	33	354,635,749
Alaska	104	1,616,903,010
Albuquerque	18	172,754,134
Bemidji	38	283,085,587
Billings	18	326,844,131
California	48	233,992,603
Navajo	21	818,613,085
Nashville	30	195,220,764
Oklahoma City	44	972,840,550
Phoenix	25	246,766,424
Portland	51	596,601,491
Tucson	5	44,883,587
<b>Total</b>	<b>435</b>	<b>\$5,863,141,115</b>

Note: Cost estimates are generated based on the average cost-per-estimated-square-meter for construction. Actual estimates to replace these facilities will be developed as IHS completes and approves planning documents that detail actual facility space and other requirements.

Estimates include only those proposed projects that would provide access to health services for populations greater than 138 users and that are either not-yet-existing, not yet in the IHS Construction Priority System, or greater than ten years in age.

## APPENDIX C

**Condition Index and Backlog of Essential Alteration Maintenance and Repair****Condition Index (CI) and Age of IHS Owned Facilities**

<b>Building Type</b>	<b>Number</b>	<b>Gross SF</b>	<b>Average Age</b>	<b>CI</b>
Hospital Buildings	35	3,502,853	36	78
Health Center Buildings	61	1,508,367	34	89
Health Station Buildings	27	66,361	40	83
Institutional Buildings	84	395,772	27	92
Youth Regional Treatment Centers	11	113,160	23	94
Institutional Field Health Office	6	28,089	39	89
Alcohol Substance Abuse Program	6	43,203	62	83
Office Buildings	141	476,421	48	53
Other Buildings	229	401,514	40	75
Residential Building	1,478	3,242,085	34	100

The Federal Real Property Council approved Condition Index (CI) as the measure of a constructed asset's condition. The higher the CI, the better the condition the constructed asset is in.

**Backlog of Essential Maintenance, Alterations, and Repairs (BEMAR)**  
**IHS Owned and Reporting Tribal Facilities as of 1 October 2010**  
(\$ thousands)

<b>Deficiency Description</b>	<b>AB</b>	<b>AK</b>	<b>AQ</b>	<b>BE</b>	<b>BI</b>	<b>CA</b>	<b>NV</b>	<b>NS</b>	<b>OK</b>	<b>PH</b>	<b>PO</b>	<b>TU</b>	<b>Total</b>
<b>Public Law</b>													
Life Safety	2,930	14,299	499	453	110	327	2,498	1,037	581	3,305	106	270	26,415
General Safety	2,958	3,907	56	73	196	1,459	900	141	38	872	717	64	11,379
Environmental	1,053	5,201	-	84	-	-	144	-	262	3	50	3	6,808
Other Compliance	10,803	20,670	6,470	1,562	747	1,558	28,861	6,983	5,423	9,499	1,043	841	94,460
Sub Total	17,744	44,077	7,024	2,172	1,053	3,344	32,403	8,161	6,304	13,679	1,916	1,177	139,054
<b>Improvements</b>													
Patient Care	1,816	18,539	10,225	1,412	169	920	70,209	110	1,740	1	336	124	105,601
Program	8,715	12,033	1,553	235	2,227	20	1,364	2,308	147	1,292	2,391	2	32,287
Sub Total	10,531	30,572	11,778	1,647	2,396	940	71,573	2,418	1,887	1,293	2,727	127	137,888
<b>Maintenance &amp; Repair</b>													
Sub Total	36,981	51,042	13,153	5,643	6,832	7,329	27,131	2,557	16,396	18,138	2,579	8,198	195,979
<b>Grand Total</b>													
Total	65,256	125,691	31,955	9,462	10,281	11,613	131,107	13,136	24,587	33,110	7,222	9,501	472,921



## DEPARTMENT OF HEALTH AND HUMAN SERVICES

## INDIAN HEALTH SERVICE

Response to Congress  
on

**Indian Health Service  
Healthcare Facilities Construction Priority System**

## Table of Contents

INTRODUCTION .....	3
BACKGROUND .....	4
The Existing HFCPS .....	4
The Review and Revision Process .....	4
DISCUSSION .....	5
The Revised HFCPS .....	5
The Revised HFCPS Compared with the Existing HFCPS .....	6
Addressing the FY 2000 Congressional Request .....	8
CONCLUSION .....	9
Table 1, The Existing HFCPS Compared with the Revised HFCPS .....	7
Table 2, Responsiveness to the Congressional Request .....	8
Attachment 1, The Revised Indian Health Service Health Care Facilities Construction Priority System .....	11
Attachment 2, Summary Report, Indian Health Service Health Care Facilities Construction Program .....	12

## ***EXECUTIVE SUMMARY***

The Indian Health Care Improvement Act (IHCIA) authorizes the Indian Health Service (IHS) to fund several healthcare facilities construction programs. Under Section 301 of the IHCIA, the IHS is directed to submit to the Congress a list of the highest priority inpatient and the highest priority outpatient projects. Other authorizations in the IHCIA establish basic criteria for other construction programs such as the Joint Venture Construction Program (JVCP), and the Small Ambulatory Program. Since 1991, IHS has used the existing IHS Healthcare Facilities Construction Priority System (HFCPS) to prioritize projects for the Priority List authorized under Section 301, and has selected construction projects for other authorized programs by applying an HFCPS-type formula to evaluate and select projects from proposals submitted by Tribes.

In the FY 2000 Conference Report on the appropriations bill for The Department Of The Interior And Related Agencies For The Fiscal Year Ending September 30, 2000, the Congress instructed IHS to work closely with Tribes and the Administration to review the HFCPS. In response, the IHS involved tribal workgroups, including the Facilities Appropriation Advisory Board (FAAB)<sup>1</sup>, in the preparation of a revised draft methodology, which was then distributed to all Federally recognized Tribes for their review and comment. The IHS and the FAAB reviewed comments generated by this tribal consultation to develop the revised methodology for assessing and prioritizing healthcare facilities construction projects.

The existing methodology consists of three phases and is a proposal/review process in which Area Offices submit proposals based on consultation with Tribes. These proposals are reviewed at IHS Headquarters, using the criteria of facility deficiency and isolation under the existing HFCPS methodology to determine need. Successful proposals then undergo a detailed planning review.

The revised methodology differs most significantly from the existing methodology because it would incorporate additional criteria such as health resource indicators, facility size, documented barriers to care, and innovation. In addition, it starts with a review of the total need for healthcare facilities, rather than reviewing a few selected proposals. The revised methodology also would include a provision for allocating funds to Area Offices to address high priority local projects. In the existing version, IHS does not limit the number of facilities reviewed for prioritization. This has resulted in a large backlog of potential projects for the IHCIA Section 301 Priority List. While this backlog reflects a large need for healthcare facilities, identifying so many for priority evaluation has created a large backlog that does not permit flexibility in addressing changing requirements. Under the revision, this would change because only a limited number of facilities would be reviewed for prioritization, based on the number of projects already on the Priority List and the number of projects likely to be funded within 3-5 years.

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<sup>1</sup> The FAAB is established as a standing committee of tribal and IHS representatives. It shall be composed of twelve (12) tribal representatives, nominated by the Area Offices in consultation with tribes, and two (2) IHS members for a total committee size of 14. In addition, for each tribal representative there is one alternative tribal member who attends meetings when the appointed member cannot.



This revised methodology responds to the Congressional request and includes the input of workgroups and tribes generated during the consultation review. It is consistent with Federal law, and can be administered consistent with current regulation and policy.

## ***INTRODUCTION***

The Indian Health Care Improvement Act (IHCIA) authorizes the Indian Health Service (IHS) to fund several healthcare facilities construction programs. Under Section 301 of the IHCIA, the IHS is directed to submit to the Congress a list of the highest priority inpatient and the highest priority outpatient projects. Other authorizations in the IHCIA establish basic criteria for other construction programs such as the Joint Venture Construction Program (JVCP), and the Small Ambulatory Program. Since 1991, IHS has used the IHS Healthcare Facilities Construction Priority System (HFCPS) to prioritize projects for the Priority List authorized under Section 301 and has selected projects to allocate funding under other authorized construction programs by applying HFCPS-type formula to evaluate qualifying facilities.

The FY 2000 Conference Report (No. 106-479) on the bill for The Department Of The Interior And Related Agencies For The Fiscal Year Ending September 30, 2000 included a request for IHS to revise its methodology for developing the Healthcare Facilities Construction Priority List:

“The managers expect the Service to work closely with the tribes and the Administration to make needed revisions to the facilities construction priority system. Given the extreme need for new and replacement hospitals and clinics, there should be a base funding amount, which serves as a minimum annual amount in the budget request. Issues which need to be examined in revising the current system include, but are not limited to, projects funded primarily by the tribes, anomalies such as extremely remote locations like Havasupai, recognition of projects that involve no or minimal increases in operational costs such as the Portland Area pilot project, and alternative financing and modular construction options. It is the managers' intent that in asking the Service to re-examine the current system for construction of health facilities, a more flexible and responsive program can be developed that will more readily accommodate the wide variances in tribal needs and capabilities.” (pages 496-97)

This report describes the existing HFCPS; the process used to review the existing HFCPS; the revised HFCPS; and the difference between the existing and the revised methodologies.

## **BACKGROUND**

### **The Existing HFCPS**

The existing version of the HFCPS was developed in the late 1980s when the IHS began to review how projects were being prioritized and to develop a prioritization process that incorporated a planning pipeline. This review of the priority system was conducted by IHS Area and Headquarters staff, who developed a draft document describing a proposed Healthcare Facilities Construction Priority System (HFCPS) methodology. This document was presented to Area Offices for comment. The document was revised to address Area Office comments, and was implemented in 1991.

The existing HFCPS methodology, which has been in place since 1991, is a three phase process in which IHS asks Area Offices to submit proposals for their highest priority projects. In Phase I and II, projects showing the greatest need (based on a formulaic analysis of the data) are selected for further analysis in Phase III. The criteria used in this analysis are Facilities Deficiency and Isolation; facility deficiency is defined by population and existing facility size and condition, and isolation is defined as the distance to alternative sources of care. During Phase III, the IHS and Tribes conduct a comprehensive planning review and develop a Program Justification Document (PJD).<sup>2</sup> The PJD is submitted for approval to the Director, Office of Environmental Health and Engineering. After the PJD is approved, the project is placed on the IHS Priority List.

In 1991, Area Offices submitted proposals for 149 facilities construction projects<sup>3</sup>. These proposals represent the Area Offices' highest priority needs, but do not reflect the total need for facilities construction in Indian Country. In 1992, Area Offices were asked to work with Tribes and local communities to prepare PJDs for the 22 projects selected from the 1991 submissions for review in Phase III. The last of these PJDs were approved by the Director of the Office of Environmental Health and Engineering in February 2008, and these facilities have been placed on the IHS Priority List.

### **The Review and Revision Process**

In response to the FY 2000 the Conference Report, the Director of IHS established a tribal 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)<sup>4</sup>, which then provided recommendations to the Office of Environmental Health and Engineering (OEHE) regarding revising the HFCPS.

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<sup>2</sup> A PJD is a planning document that describes the program, and the staffing, and other health delivery requirements for a population, including but not limited to the facilities needs.

<sup>3</sup> In February 1991, the Director, IHS, directed all Area Directors to submit proposals for review under the HFCPS. At that time consultation policy was not as comprehensive as it is now and, while some Area Offices consulted with tribes regarding development of these proposals; some may not have. Area submittals were based priorities identified in Area Master Plans.

<sup>4</sup> The IHS Facilities Appropriation Advisory Board (FAAB) was established in accordance with the current IHS policy on tribal consultation, to provide for tribal participation in the review, development, and implementation of policies, procedures, guidelines, and priorities which govern the operation of OEHE programs.

The tribal workgroup reported its findings to the OEHE and the FAAB in February 2002. The IHS drafted a revised HFCPS and, in June 2004, sent it to all Tribes for review and comment. Following this review, in which over 1,200 individual comments were received from 80 Tribes and Tribal organizations, the IHS and the FAAB met several times to discuss how these comments might be incorporated into the proposed revision. In February 2007, the FAAB recommended that the version of the revised HFCPS that was presented for tribal consultation in 2004 should be finalized with one significant change. They recommended that the revised HFCPS incorporate a provision for distributing some funds to each of the Area Offices for distribution to local high priority projects.

## ***DISCUSSION***

### **The Revised HFCPS**

The revised HFCPS consists of two phases, which would permit the IHS and the Tribes to focus available resources by conducting a limited review of all healthcare facilities needs in Phase I, while concentrating more detailed analysis on a limited number of facilities in Phase II. Phase I would be applied every 5 years. The process would include documenting all health care facilities in IHS Area Healthcare Services and Facilities Master Plans<sup>5</sup>, evaluating and scoring them using the HFCPS formula, categorizing them according to proposed facility type (inpatient, health center, clinic, etc.), and ranking them on a comprehensive national list. Phase II of the HCFPS would be applied as needed, to identify projects for the Priority List.

During Phase II, the highest ranking facilities from Phase I would be evaluated in a comprehensive planning process that includes validating and verifying information by the IHS health care Facilities Validation Committee<sup>6</sup>. To ensure that the Validation Committee could assess information fairly and consistently, the IHS would provide an orientation for Committee members at the beginning of each meeting. This orientation would include instruction on written guidelines, developed based on recommendations of the IHS Facilities Appropriation Advisory Board (FAAB). For the Priority List authorized under Section 301 of the IHCIA, the selection factors for participation in Phase II are the Phase I score and the category. For other authorized programs, the highest ranking facilities from Phase I that meet the criteria defined in the program will be selected for Phase II. After the PJD has been approved, the facility would be ranked and placed on the Priority List following all other projects already on the list.

For a complete description of the revised HFCPS see Attachment 1, “The Revised Indian Health Service Health Care Facilities Construction Priority System,” The Indian Health Service Health Care Facilities Construction Priority System.

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<sup>5</sup> Area Services and Facilities Master Plans are comprehensive assessments of program and services needs that include a description of how those needs could be addressed, including through facilities as well as other means, such as Contract Health Services. For this reason these Plans describe and review the capability of all existing facilities regardless of age, whether they are currently addressing the full need or not.

<sup>6</sup> The Healthcare Facilities Validation Committee or Validation Committee consists of seven individuals appointed by the Director of IHS. Membership may include but not be limited to IHS Headquarters and Area Offices, Tribal, and other health oriented professionals.

**The Revised HFCPS Compared with the Existing HFCPS**

The revised methodology differs from the existing methodology because it would incorporate additional criteria and because Phase I would review the total need for healthcare facilities. The revision will also change the HFCPS from a three-phase process to a two-phase process. In the existing HFCPS, IHS does not limit the number of facilities reviewed for prioritization in Phase III. This has resulted in a large backlog of potential projects, which hinders flexibility in addressing changing requirements. Under the revision, this will change because it is structured to limit the number of facilities reviewed in prioritization phase (Phase II), based on projects already on the Priority List and the number of projects likely to be funded within 3-5 years. This would minimize the potential for a large backlog, permitting flexibility in adjusting changes in appropriations levels.

Finally, a new Area Distribution Program is incorporated into the revised process. This program would provide a methodology for allocating funds to each of the Area Offices to address a portion of the highest priority projects within the Area. It would be implemented only if and when the Congress appropriates construction funds specifically for this purpose. These funds would be distributed to Area Offices to address their highest priority facilities (identified during Phase II) where the Area and Tribes agree that only limited new staffing is required. If a facility were completed under the Area Distribution Program, IHS would request funding for 50% of the Resource Requirements Methodology (RRM) staffing for the facility at its opening.

Table 1, “The Existing HFCPS Compared with the Revised HFCPS,” summarizes the differences between the existing HFCPS and the revision.

**Table 1, The Existing HFCPS Compared with the Revised HFCPS**

Existing Process	Revision																								
<p>The HFCPS is a three-phase process.</p> <p>Phase I: Area Offices submit proposals and IHS used the unvalidated and unverified data in these proposals to apply a formulaic analysis to obtain a short list of proposals for more systematic review.</p> <p>Phase II: Area Offices review and update data for proposals identified in Phase I. These data are validated and then reviewed based on formulaic analysis of Facility Deficiency and Isolation criteria.</p> <p>Phase III: Proposals showing greatest need are evaluated in a detailed planning process that involves development and approval of a PJD.</p>	<p>The HFCPS would be a two-phase process, incorporating the existing HFCPS processes for Phase I and Phase II as a single Phase.</p> <p>Phase I: All facilities identified on Area Health Services and Facilities Master Plans are reviewed and ranked based on Facility Deficiency, Isolation, Health Resources Indicators, and Facility Size.</p> <p>Phase II: Highest need facilities selected from Phase I are prioritized using the same criteria<sup>7</sup> as Phase I as well as Documented Barriers to Care and Innovation.</p>																								
The HFCPS identifies only top priorities, based on review of proposals selected by the Area Offices.	The HFCPS would assess and identify the total need for construction and use this description of need to determine priorities for construction.																								
The HFCPS prioritizes the need for the top 10 inpatient and the top 10 outpatient facilities.	The HFCPS would develop a ranked list of all facilities in Indian Country and use this list to prioritize the few facilities with the greatest need.																								
The HFCPS does not limit the number of projects to be evaluated for prioritization in Phase III.	The HFCPS would limit the number of projects evaluated for prioritization in Phase II, based on what would be likely to be funded within 3 to 5 years.																								
The HFCPS establishes one national list for funding. Projects for other authorized programs are identified in separate processes.	The HFCPS Phase I rankings would be used as a basis for identifying projects for all authorized programs. During Phase II, specific program requirements, as authorized and funded by Congress, would be used to prioritize projects.																								
<table><tr><td>Criteria</td></tr><tr><td>Facility Deficiency<sup>8</sup></td></tr><tr><td>Isolation<sup>9</sup></td></tr></table>	Criteria	Facility Deficiency <sup>8</sup>	Isolation <sup>9</sup>	<table><tr><td>Criteria</td><td>Phase I Points</td><td>Phase II Points</td></tr><tr><td>Facility Deficiency</td><td>400</td><td>400</td></tr><tr><td>Isolation</td><td>100</td><td>100</td></tr><tr><td>Health Resources Indicators</td><td>200</td><td>200</td></tr><tr><td>Facility Size</td><td>150</td><td>150</td></tr><tr><td>Barriers Documented</td><td>0</td><td>50</td></tr><tr><td>Innovation</td><td>0</td><td>100</td></tr></table>	Criteria	Phase I Points	Phase II Points	Facility Deficiency	400	400	Isolation	100	100	Health Resources Indicators	200	200	Facility Size	150	150	Barriers Documented	0	50	Innovation	0	100
Criteria																									
Facility Deficiency <sup>8</sup>																									
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Criteria	Phase I Points	Phase II Points																							
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Facility Size	150	150																							
Barriers Documented	0	50																							
Innovation	0	100																							

<sup>7</sup> The criteria in Phase II may use a more complex analysis of the data than Phase I; the facilities deficiency criterion, for example, would use data obtained from the approved PJD, which may differ from the data used in Phase I.

<sup>8</sup> Facility Deficiency in the existing system is determined using both the difference between the required space and the existing space (absolute need) and the ratio of the existing space/required space (relative need). Since the required space is determined by population and the workload to serve that population, the existing HFCPS is driven strongly by population. Existing space is the space available to support the provision of health care services. This space is adjusted for its condition and age.

<sup>9</sup> Isolation is determined using the distance to alternative sources of care.

Existing Process	Revision
Facility Deficiency is determined using both the difference between the required space and the existing space (absolute need) and the ratio of the existing space/required space (relative need). Since the required space is determined by population and the workload to serve that population, the existing HFCPS is driven strongly by population.	Facility Deficiency is determined using ratio of existing space divided by required space. The formula in the proposed revision is also driven by population, but not as strongly as the existing system.
Allocates funds to national priorities only	Includes an option to allocate funds to Area Offices to address high priority needs, if and when the Congress specifically appropriates funds for this purpose. Also can be used for competitive selection for programs such as the Joint Venture Program which may not always address the highest priorities.

### Addressing the FY 2000 Congressional Request

All elements of the FY 2000 Congressional request were addressed during consultation and review. As indicated, the IHS has worked closely with the Tribes to review and make revisions to the facilities construction priority system to ensure that this system could be administered effectively and efficiently. IHS also sought to ensure that the final document was consistent with existing authorizations and federal policy. During review, the IHS, the workgroups, and the Tribes, examined and commented on all issues identified in the Congressional request. Comments that were consistent with Federal Law and regulations and that were appropriate to the Congressional request were incorporated into the revised HCFPS. Table 2, “Responsiveness to the Congressional Request” describes how the review process and the resulting revision to the HFCPS address the request.

**Table 2, Responsiveness to the Congressional Request**

Congressional Request	Response in the Review and Revision
Work with Tribes and the Administration	The IHS consulted with Tribes to develop a revision that could be effectively administered in accordance with all Federal laws and policies.
Projects funded by tribes/Alternative financing	The revision would incorporate an Innovation Factor, which increases priority for Tribes that can fund projects or identify alternative financing.
Remote locations	Isolation is a part of the existing HFCPS, and overall it was not found necessary to expand its influence significantly.
Recognition of projects that involve no or minimal increases in operational costs	The Area Distribution Program, if implemented, would fund projects that have reduced operational support. In addition, other IHCIA authorizations that involve minimal increase in operation support are incorporated into the revision. <sup>10</sup>

<sup>10</sup> The existing HFCPS is designed only to address the IHS authorization, under Section 301, of the IHCIA, to provide Congress with a list of priority projects. The proposed revision would be utilized for all construction programs, including the small Ambulatory Program which involves no or minimal increases to staffing and operational support.

Modular Construction	Modular construction would remain an option under the HFCPS. There was some discussion, during the review process, regarding double-wide-type modular construction; but general consensus was that facilities acquired through this method usually did not meet the rigorous life-cycle requirement that IHS facilities should have a useful life approaching 60 years.
The revised HFCPS should accommodate wide variances in needs and capabilities	The revised HFCPS would provide the flexibility for Tribes to participate in a number of ways that accommodate their needs and capabilities.
The revised HFCPS should be more flexible and responsive than the existing system.	As discussed above, the revision is structured to be more responsive and flexible.

## ***CONCLUSION***

Following consultation with tribes and extensive review by the FAAB and other workgroups, the IHS has revised the HFCPS. This review and the revision of the HFCPS is consistent with the Congressional request:

- The IHS worked closely with the Tribes to make needed revisions to the facilities construction priority system, and to ensure that this system could be administered effectively and efficiently.
- During the process the IHS consistently sought to ensure that the final document was consistent with existing authorizations and policy.
- The review examined issues and the revision incorporates elements related to:
  - Projects funded primarily by the tribes,
  - Anomalies such as extremely remote locations,
  - Recognition of projects that involve no or minimal increases in operational costs, and
  - Alternative financing and modular construction options.

As a result of this process the IHS has developed a revision that incorporates many features of the existing system, but which is very different in scope and process. The proposed revision would provide a complete assessment of facilities need in Indian Country that can be used to prioritize and/or allocate funding for all IHS healthcare facilities construction programs. This assessment, which occurs in Phase I, would evaluate facility deficiency, isolation, health resources indicators, and facility size to determine the facilities with the greatest relative need. In Phase II, the results of the Phase I assessment would be used to select a few projects for an in-depth facility planning review to determine priority for construction. The Phase II review would be documented in a PJD that, when approved, would provide the data applied to the methodology to establish the priority of these selected facilities. The proposed revision also identifies a new area distribution program.

The revised HFCPS addresses the Congressional intent by accommodating wide variances in needs and capabilities and because it is structured to be more flexible and more responsive than the existing system.



**Attachment 1, The Revised Indian Health Service Health Care Facilities  
Construction Priority System**

## The Indian Health Service Revised Health Care Facilities Construction Priority System

### Table of Contents

I)	Introduction	1
A)	Overview .....	1
B)	Background .....	1
C)	Scope of the Revised HFCPS Methodology .....	2
II)	Definitions	2
III)	HFCPS Process .....	2
A)	Explanation of Phasing .....	3
B)	The Revised HFCPS Criteria .....	4
1)	The Facility Resources Deficiency Criterion .....	4
2)	Health Status Criterion .....	6
3)	Isolation Criterion.....	6
4)	Barriers to Service Criterion.....	7
5)	Facility Size Criterion.....	7
6)	Innovation Criterion .....	8
IV)	Implementation .....	9
A)	The HFCPS Formula.....	9
B)	Phase I.....	9
1.	Time Line .....	9
2.	Facilities Evaluated in Phase I.....	10
3.	Data Used .....	10
4.	Validation.....	10
5.	Application of Data .....	10
6.	Scoring .....	10
7.	Uses of Scoring .....	11
C)	Phase II.....	11
1.	Time Line .....	11
2.	Facilities Evaluated in Phase II .....	11
3.	Data Used .....	12
4.	Validation: .....	12
5.	Application of Data .....	13
6.	Ranking in Phase II .....	13
D)	Area Distribution Program.....	13

### Tables

Table 1, HFCPS Evaluation Criteria and Weighting .....	4
Table 2, Phase I Required Space Formula .....	5
Table 3, Calculating the Facility Deficiency Criterion Value,.....	5
Table 4, Calculating the Health Status Criterion Value.....	6
Table 5, Calculating Isolation.....	6
Table 6, Phase II Determining Barriers to Service .....	7
Table 7, Facility Size Criterion Value Look up Table.....	7
Table 8, Facility Size Criterion.....	8
Table 9, Innovation Criterion .....	9
Table 10, Facilities Categories .....	11
Table 11, Area Distribution Formula.....	14

### Appendices

Appendix I. Glossary .....	I—15
Appendix II. The Revised Healthcare Facilities Construction Priority System Methodology.....	II—17

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

**I) Introduction****A) Overview**

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

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

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

**B) Background**

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

- The Joint Venture Program. Under this program, the IHS is authorized into enter into agreements with Tribes under which the Tribes agree to construct a facility and IHS agrees to provide staffing and operating funds using the same allocation process as is used for facilities constructed under Section 301 of the IHCIA.
- The Small Ambulatory Program. Under this program the IHS is authorized to provide funds to Tribes for construction, expansion, or modernization of outpatient facilities that meet certain requirements:
  - The facility must provide access for a population of at least 500 eligible Indians in a service area with at least 2,000 eligible Indians;
  - The facility may not be part of a hospital campus; and
  - The facility must meet other specified requirements
- Other programs that have been authorized but not funded.

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

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

when Congress specifically appropriates them for this purpose, to Area Offices to address high priority projects within the Area.

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

### **C) Scope of the Revised HFCPS Methodology**

The revised HFCPS methodology does two things:

- It provides a Comprehensive National Listing of Facility Need by identifying the total need for construction of IHS and Tribal healthcare facilities<sup>1</sup>, and
- It provides a process for prioritizing that need for the authorized facilities construction programs.

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

The revised HFCPS does not prioritize the need for staff quarters; however, this need is evaluated and addressed prior to requesting construction funding for a facility. If staff quarters are needed at a facility and if Congress appropriates funds for them, they are planned, designed, and constructed at the same time as the facility.

The revised HFCPS can only evaluate, identify, and prioritize facilities that are part of an Area Health Services and Facilities Master Plan and that are reporting statistical data to the IHS National Patient Information Reporting System (NPIRS).

## **II) Definitions**

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

## **III) HFCPS Process**

The revised HFCPS consists of two phases. In Phase I, all health care facilities documented in IHS Area Healthcare Services and Facilities Master Plans, are evaluated and scored by IHS Headquarters using the HFCPS formula. This scored listing is referred to as the Comprehensive National Listing of Facility Need. Facilities on this list are categorized according to Table 10, “Facilities Categories,” on page 11 of this document. This list is used to identify facilities for the more comprehensive Phase II planning analysis and prioritization that generates a comprehensive description of a required program and the facility required to support it.

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<sup>1</sup> Construction includes replacing, expanding and/or modernizing existing facilities and constructing or otherwise acquiring new facilities.

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

In Phase II, facilities selected from the Comprehensive National Listing of Facility Need are reviewed by the HFCPS Validation Committee. Data for these facilities, obtained from approved Program Justification Documents (PJD), are applied to the HFCPS Phase II formula by IHS Headquarters to develop the Priority List.

The method for selecting facilities for Phase II review differs based on the different facilities construction funding programs and the requirements of each such program. For example, facilities selected for review for potential placement on the Section 301 program Priority List will be the highest scoring Phase I facilities on the Comprehensive National Listing of Facility Need. However, those selected for the Joint Venture Program will be the highest scoring facilities on Comprehensive National Listing of Facility Need where the Tribe(s) is capable of and willing to construct a facility in return for operation assistance from IHS<sup>2</sup>. (See “Facilities Evaluated in Phase II” on page 11 for details on selection criteria for these and other construction programs.)

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

### **A) Explanation of Phasing**

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

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

- The “Required Space” element of the “Facility Deficiency Factor” is estimated using a simple formula (see Table 2, “Phase I Required Space Formula” on page 5) in Phase I, while a full application of the IHS Health System Planning Process (HSP) is used in Phase II.
- The “Innovation” Factor, which requires extensive resources to validate, is used in Phase II only, and
- The “Barriers to Services” element, which requires extensive resources to validate, is used in Phase II only.

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

In Phase II, the HFCPS methodology is applied to determine actual need for the highest scoring facilities selected from Phase I and to establish the priority of those facilities. This is done by comparing the space available with the actual space required for the population. Actual space requirements are determined through a comprehensive facilities planning process that includes development and approval of the PJD. Facilities identified as priority projects in Phase II are

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<sup>2</sup> The IHS would request funds for equipment, staffing and operation for the tribally constructed facility.

## The Indian Health Service Revised Health Care Facilities Construction Priority System

incorporated into the IHS 5-Year Planned Construction Budget which is used to request appropriations for construction funding.

### B) The Revised HFCPS Criteria

The HFCPS Methodology uses four criteria in Phase I and six criteria in Phase II (See Table 1, “HFCPS Evaluation Criteria and Weighting”). The weighting shown in Table 1 is the maximum that each criterion may add to the score. Weightings indicate the relative influence on the final score.<sup>3</sup>

**Table 1, HFCPS Evaluation Criteria and Weighting**

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

### 1) The Facility Resources Deficiency Criterion

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

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

The existing facility size, age and condition are used to calculate the “*Adjusted Existing Space*” for a facility. These data are obtained from the IHS Healthcare Facilities Data System (HFDS) data base. Tribes that do not participate in the IHS HFDS data base must provide this data, with

<sup>3</sup> The “Barriers to Service” and “Innovation” factors are not considered in Phase I because these criteria require significant resources to validate. They are included only in Phase II, when a limited number of facilities are evaluated.

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

documentation verified by a licensed professional (engineer, architect, etc.) For Tribes not participating in the IHS HFDS, size, age and condition data would be used as submitted in Phase I, but would be validated before used in Phase II. If there is a significant difference between data used during Phase I and the data validated during Phase II, a facility could be disqualified from Phase II. It would be re-ranked in Phase I based on the validated data.

The cost to replace a facility is determined using the existing facility size and two factors in the IHS Cost Estimating System<sup>4</sup>:

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

The value of each of the factors varies from facility to facility. It may also change from year to year based on economic conditions. The value used for each facility in a specific application of the HFPCS would be shown in the formula posted at [www.dfpc.ihs.gov](http://www.dfpc.ihs.gov).

User population is used to estimate a facility's "Required Space" and is obtained from the IHS National Patient Information Reporting System (NPIRS). User population for Tribes that are not currently participating in NPIRS will be verified, if possible; otherwise the latest statistically validated data available to IHS will be used. In Phase I, required space is estimated using the formula in Table 2, "Phase I Required Space Formula," on page 5. In Phase II, required space is determined using the IHS HSP.

**Table 2, Phase I Required Space Formula**

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

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

**Table 3, Calculating the Facility Deficiency Criterion Value,**

	Calculate the Facilities Resource Deficiency	Facility Resource Deficiency Value
Facility Resource Deficiency <sup>5</sup>	= 1 - ( $\frac{\text{Adjusted Existing Space}}{\text{Required Space}}$ )	=

<sup>4</sup> The IHS Cost Estimating System unit cost is based on facility type and may change from year to year based on economic conditions. The locality factor is obtained from the Federal Budget Estimating System and may also vary from year to year based the economy. Both the unit cost value and the locality factor are determined using the historical record and data from nationally recognized, private sector construction estimating organizations, such as R.S. Means, Marshall and Swift, and the McGraw Hill Engineering News Record.

<sup>5</sup> See, Appendix II, "The Healthcare Facilities Construction Priority System Methodology," on II—17," for details on developing the different elements of this formula.

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

## 2) Health Status Criterion

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

- Birth Disparities Indicator (BDI),
- Percent of the population over 55 years old (Pop>55),
- Composite Poverty Indicator (CPI)
- Disease Disparity Indicator (DDI).<sup>6</sup>

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

**Table 4, Calculating the Health Status Criterion Value**

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

## 3) Isolation Criterion

The Isolation Criterion provides an advantage to those facilities where the population is geographically isolated and does not have access to nearby healthcare services of any kind. It refers specifically to the amount of time it takes most people to get to a place where they can receive healthcare services. In the HFCPS, time is estimated using the distance from the Indian health facility or proposed facility to the nearest Level I, II, or III emergency room (Federal, Tribal or private sector)<sup>7</sup>. Facilities not on a road connecting to a Federal or State highway are assumed to be isolated. Table 5, “Calculating Isolation,” illustrates how the Isolation Criterion value is calculated:

**Table 5, Calculating Isolation**

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

<sup>6</sup> These four indices are those indicators related to health status used in the IHS Level of Need Funded calculations to allocate funds appropriated to the Indian Health Care Improvement Fund. These indices provide a comparison of the American Indian/Alaska Native population with the U.S. general population.

<sup>7</sup> The nearness of an emergency room does not mean that this emergency room would be the primary access to services for IHS and Tribal patients. The availability of an emergency room is used as a measure of isolation because it is assumed that any place supporting an emergency room would have healthcare services available.



## The Indian Health Service Revised Health Care Facilities Construction Priority System

### 4) Barriers to Service Criterion

The ability to access health care may be difficult for reasons besides the geographic distance to available services. Some IHS patients may find other hindrances to obtaining services in hospitals and clinics available to them. The Barriers-to-Care Criterion attempts to capture these situations by increasing the Priority Score by up to 50 points in Phase II. Information required to support Barriers-to-Service is documentation showing that IHS clients have been consistently turned away or not provided services at the available facilities. The documentation must show that there is a pattern of IHS clients not receiving services at the same level and with the same consistency as other patients at the available facilities.

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

**Table 6, Phase II Determining Barriers to Service**

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

### 5) Facility Size Criterion

The Facility Size Criterion increases the total Priority Score for smaller facilities<sup>8</sup>. Facilities serving smaller populations receive up to 150 points, while facilities serving larger populations receive proportionally fewer points. The Facility Size Criterion is based on the IHS User Population for the facility Service Area. This information is obtained from the IHS National Patient Information Reporting System (NPIRS). Table 7, "Facility Size Criterion Value Look up Table," provides an approximate Facility Size Criterion Value for all facilities up to 25 200 m<sup>2</sup>. The actual value can be calculated using the formula in Table 8, "Facility Size Criterion." This table can also be used to calculate The Facility Size Criterion Value for the three or four IHS and Tribal facilities larger than 25 200m<sup>2</sup>.

**Table 7, Facility Size Criterion Value Look up Table**

Facility Required Space In Square Meters (m <sup>2</sup> )				Facility Size Value	Facility Required Space In Square Meters (m <sup>2</sup> )				Facility Size Value	Facility Required Space In Square Meters (m <sup>2</sup> )				Facility Size Value
Up to 1 200				1										
1 201	to	1 600		0.976	9 601	to	10 000		0.541	18 001	to	18 400		0.345
1 601	to	2 000		0.952	10 001	to	10 400		0.524	18 401	to	18 800		0.340
2 001	to	2 400		0.928	10 401	to	10 800		0.507	18 801	to	19 200		0.335
2 401	to	2 800		0.904	10 801	to	11 200		0.489	19 201	to	19 600		0.329
2 801	to	3 200		0.880	11 201	to	11 600		0.472	19 601	to	20 000		0.324
3 201	to	3 600		0.856	11 601	to	12 000		0.455	20 001	to	20 400		0.318
3 601	to	4 000		0.832	12 001	to	12 400		0.438	20 401	to	20 800		0.313
4 001	to	4 400		0.808	12 401	to	12 800		0.421	20 801	to	21 200		0.308
4 401	to	4 800		0.784	12 801	to	13 200		0.416	21 201	to	21 600		0.302

<sup>8</sup> The facility size is the required space. In Phase I required space is based on population for outpatient facilities and on workload (ADPL) for inpatient facilities. In phase II required space is determined using the HSP.

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

Facility Required Space In Square Meters (m <sup>2</sup> )				Facility Size Value	Facility Required Space In Square Meters (m <sup>2</sup> )				Facility Size Value	Facility Required Space In Square Meters (m <sup>2</sup> )				Facility Size Value
4 801	to	5 200		0.760	13 201	to	13 600		0.410	21 601	to	22 000		0.297
5 201	to	5 600		0.736	13 601	to	14 000		0.405	22 001	to	22 400		0.291
5 601	to	6 000		0.712	14 001	to	14 400		0.399	22 401	to	22 800		0.286
6 001	to	6 400		0.695	14 401	to	14 800		0.394	22 801	to	23 200		0.281
6 401	to	6 800		0.678	14 801	to	15 200		0.389	23 201	to	23 600		0.275
6 801	to	7 200		0.661	15 201	to	15 600		0.383	23 601	to	24 000		0.270
6 801 or more				Calculated using the same formula used for Table 8, Facility Size Criterion										

**Table 8, Facility Size Criterion**

If Required Space is	Use	Facility Size Value
0 to 1 200m <sup>2</sup>	1	1
1 201m <sup>2</sup> – 6 000m <sup>2</sup>	(1 - [(Required Space - 1 200 m2) X 0.00006])	
6 000 m <sup>2</sup> than 12 800m <sup>2</sup>	(.712 - [(Required Space - 6000 m2) X 0.0000428])	
More than 12 800 m <sup>2</sup>	(.416 - [(Required Space - 6000 m2) X 0.0000135])	

### 6) Innovation Criterion

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

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

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

- Planning/Coordination with another Tribe or Primary Service Area (PSA) for sharing major Health Delivery programs with written use agreements.
- Developing a written shared use agreement with private or other non-IHS health delivery organizations involving major diagnostic or treatment departments, e.g. one health program providing diagnostic imaging while the other would establish and maintain a burn unit.
- Developing other health delivery innovations that involve major medical departments or programs and partnering with State or Local Health Programs.
- Providing a portion of the cost of construction or operation (at least 15% of the total acquisition cost, or at least 15% of the annual recurring costs for the life of the facility; i.e., operation, maintenance, and staffing. A proportionally fewer number of points are assigned for lesser contributions. Greater contributions do not generate more points.

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

- Reducing the new construction costs by 25% (capital investment) by reusing parts of the existing facility. Proportionally fewer points are assigned for lesser construction savings. Greater savings do not affect scoring.
- Developing, administering, and funding a public health initiative or program.
- Other types of innovative approaches.

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

**Table 9, Innovation Criterion**

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

#### **IV) Implementation**

##### **A) The HFCPS Formula**

For each facility considered, the HFCPS Formula incorporates the weighting for each factor and sums the factors to obtain the score (see Table 1, “HFCPS Evaluation Criteria and Weighting”). In Phase I only Facility Resource Deficiency, Health Status, Isolation, and Facility Size are summed. In Phase II, these factors as well as Barriers to Service and Innovation are summed. Table 1, “HFCPS Evaluation Criteria and Weighting,” on page 4 shows the weightings and how the factors are summed in both Phase I and Phase II.

##### **B) Phase I**

###### **1. Time Line**

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

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

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

**2. Facilities Evaluated in Phase I**

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

**3. Data Used**

The data required for completion of Phase I are:

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

**4. Validation**

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

**5. Application of Data**

For Phase I, the IHS Headquarters Staff uses an internet based database to apply the data to the HFCPS formula shown on page 4 in Table 1, “HFCPS Evaluation Criteria and Weighting,” using weighting factors in the column headed “Phase I Criteria Weighting.” The “Innovation” and “Access-to-Care” criterion are not evaluated during Phase I.

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

**6. Scoring**

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

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

**Table 10, Facilities Categories**

Following Phase I scoring, all facilities are placed in an initial category by type of facility. Each facility category is then [describe how] further evaluated during the selection process for Phase II.	Category	Category Abbreviation	Description
	Comprehensive Health Care Center	Category A	An ambulatory care facility operating a minimum of 40 hours per week, staffed with a basic health team offering services for acute and chronic ambulatory problems and which may act as a referral center to other levels (higher acuity and specialty) of care. A Comprehensive Health Care Center could include an alternative rural hospital for purposes of the IHS construction priority system.
	Comprehensive Inpatient Facility	Category B	A facility providing inpatient services, ambulatory care, and a range of inpatient and ambulatory specialty care. The facility must meet IHS average daily patient load ( ADPL ) > 15 policy and usually provides general surgery and full service OB/GYN. Patients for these facilities are routinely referred from Health Centers.
	Small Health Care Clinic	Category C	An ambulatory care facility designed to serve populations less than 1320.
	Other	Other	Facilities other than those described above, e.g. Youth Regional Treatment Centers, Dental Units, etc.

**7. Uses of Scoring**

The Phase I scoring would be used by all funded healthcare facilities construction programs to identify facilities for review in Phase II. These programs include the line-item program authorized under Section 301 of the IHCA, Public Law (P.L) 93-437, the Small Ambulatory Program, authorized under Section 316, the Joint Venture Program authorized under Section 818, etc. These will also be used within each Area to identify the projects for the “Area Distribution Program” described on page 13.

**C) Phase II****1. Time Line**

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

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

**2. Facilities Evaluated in Phase II**

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

The number and type of facilities evaluated in Phase II will depend on the program for which Phase II is being applied. For the budget line-item program authorized in Section 301 of the IHCA, the facilities selected will depend primarily on the scoring in the Phase I “Comprehensive National Listing of Facility Need.” However, because some types of facilities are funded more

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

quickly than others, selection may be limited to certain categories of facilities (see Table 10 “Facilities Categories”). The actual number of facilities selected for Phase II depends on the number of facilities already on the Priority List, on the cost to complete these projects, and on what is expected to be appropriated over the subsequent years.

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

- Before a facility may be considered in Phase II for the Small Ambulatory Program funding, it must meet specific ownership, size, and population criteria and must not be connected to a hospital. It should be noted that in the past, when funds are appropriated, the Congress has specified the amount that can be expended on each project;
- Before a facility may be considered in Phase II for the Joint Venture Program, a Tribe must show a capability and willingness to enter into an agreement with the IHS. Under the Joint Venture agreement the Tribe will acquire the facility and lease it, at no cost for 20 years, to the IHS; in return, the IHS will equip the facility and provide resources for its staffing and operation using the same allocation process as is used for facilities constructed under Section 301 of the IHCIA.
- Other authorized programs have never been funded by the Congress, but these, too, have requirements that may restrict selection for Phase II.

### **3. Data Used**

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

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

- Innovation
- Barriers to Service

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

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

### **4. Validation:**

Each PJD must be approved by the Director, Office of Environmental Health and Engineering, IHS, to ensure consistency with Master Plans and IHS planning guidelines. The HFCPS Validation Committee (see the Glossary page I—16) will review the documentation supporting Innovation and Barriers to Service proposals. The Validation Committee will also review any

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

Tribal facilities information that is not included in the FDS (i.e., existing space, facility condition, and facility age).

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

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

### **5. Application of Data**

The IHS Headquarters Staff applies approved and validated data to the HFCPS formula shown on page 4 in Table 1, “HFCPS Evaluation Criteria and Weighting.”

### **6. Ranking in Phase II**

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

### **D) Area Distribution Program**

The Area Distribution Program provides a methodology for allocating funds to Area Offices to address the highest priority projects within the Area. It is initiated only if and when the Congress appropriates construction funds specifically for this purpose. These funds must be distributed to the highest priority Area Office facilities where the Area and Tribes agree that only limited new staffing is required. The reason for this is that, upon completion of Area Distribution Program projects, the IHS requests funding for 50%<sup>9</sup> of the Resource Requirements Methodology (RRM) staffing for the facility at its opening. The Area Distribution Program funds would be allocated as follows:

In a given year, the Area Offices where the congressionally appropriated line-item amount in the Facilities Appropriation exceeds 20% of the total appropriations for facilities construction may not participate in the Area Distribution Program. For those Areas that receive 20% or less of the annual line-item facilities appropriation, the Area Distribution Program funds are initially calculated as follows:

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<sup>9</sup> In their recommendation to finalize the HFCPS, the IHS Facilities Appropriation Advisory Board (FAAB) recommended that staffing for Area Distribution Program, if and when it is implemented, should not exceed 50% of RRM at opening of the facility.

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

**Table 11, Area Distribution Formula**

Area Allocation	=	Total Area Distribution Funds appropriated	X	Area User population X Avg. Area locality factor Sum all the participating Area's (Area User population X Avg. Area locality factor)
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Actual allocation to the Areas would be based on the capability for completing the highest priority projects with the funding available. Area Distribution allocations are distributed, so that at least one Area can complete its highest priority project with the funds appropriated. If sufficient funds are appropriated to fund projects in two Areas, these Areas would receive their allocation. After an Area receives an Area Distribution allocation, it would not be eligible for another Area Distribution Allocation until the highest priority in all Areas had been addressed. This means that there may be some adjustment of allocations among Areas from year-to-year in order to ensure that projects are fully funded.

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



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

*Appendix I. Glossary*

**Area Distribution Program** – A program under which the Congress would appropriate funds to be allocated to IHS Area Offices using a pro-rata formula.

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

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

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

**HFCS (Healthcare Facilities Construction Priority System)** – The IHS process for evaluating and scoring the need for healthcare facilities to provide access to health services for American Indians and Alaska Natives.

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

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

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

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

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

**Priority List** – A list authorized in Section 301 of the Indian Health Care Improvement Act, that IHS uses to request funding from Congress

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

**Required Space** – The space necessary to provide access to healthcare services for a given population.

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

**Validation Committee (Healthcare Facilities Validation Committee)** – The Healthcare Facilities Validation Committee or Validation Committee is a standing committee consisting of seven individuals appointed by the Director of IHS. Membership may include but not be limited to IHS Headquarters and Area Offices, Tribal, and other health oriented professionals. Members would be asked to serve on the Validation Committee for at least 5 years initially, with no other limit on terms of service.

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

*Appendix II. The Healthcare Facilities Construction Priority System Methodology*

**Table of Figures**

Figure 1, Calculating the Phase I Score.....	II—18
Figure 2, Facilities Categories.....	II—18
Figure 3, Calculating the Phase II Score .....	II—19
Figure 4, Calculating the Facility Deficiency Criterion Value .....	II—19
Figure 5, Estimating Required Space for Phase I.....	II—20
Figure 6, Calculating Adjusted Existing Space .....	II—20
Figure 7, Look-Up: Age Factor .....	II—21
Figure 8, Calculate Weighted Age for Multi Building Facilities.....	II—21
Figure 9, Calculate Condition Adjustment Factor for Existing Facilities.....	II—21
Figure 10, Calculating the Health Status Criterion Value .....	II—22
Figure 11, Calculating the Isolation Criterion Value.....	II—22
Figure 12, Calculating the Barriers to Service Criterion Value.....	II—22
Figure 13, Facility Size Criterion Value Look up Table .....	II—23
Figure 14, Facility Size Criterion Formula.....	II—24
Figure 15, Innovation Criterion Value.....	II—24
Figure 16, Facility Condition Factor Lookup Table .....	II—25

**Overview**

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

**HFCPS Methodology Formula**

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

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

**Figure 1, Calculating the Phase I Score**

Enter the Facility Deficiency, Health Status, Isolation, and Facility Size criterion values on the appropriate line under the column headed "Evaluation Criteria Value."  Complete the calculation for lines A, B, C, and D, as indicated. Enter each result on the appropriate line in the column headed Score.  Add the scores for lines A, B, C, D and enter the result in line E under Score.  The Evaluation Criteria values used on this table can be determined as follows: For Line A see Figure 4, "Calculating the Facility Deficiency Criterion Value" Calculating this value is fairly complex and will also require the use of Figure 5, "Estimating Required Space for Phase;" Figure 6, "Calculating Adjusted Existing Space;" Figure 7, "Look-Up: Age Factor;" Figure 8, "Calculate Weighted Age for Multi Building Facilities;" and Figure 9, "Calculate Condition Adjustment Factor for Existing Facilities." For Line B see Figure 10, "Calculating the Health Status Criterion Value." For Line C see Figure 11, "Calculating the Isolation Criterion Value." For Line D see Figure 13, "Facility Size Criterion Value Look up Table."	Line	Evaluation Criteria	Evaluation Criteria Value	Criteria Weighting	Score
	A	Facility Deficiency	x	400	=
	B	Health Status	x	200	=
	C	Isolation	x	100	=
	D	Facility Size	x	150	=
	E	Phase I Total Score The Total Score is the sum of the scores on lines A, B, C, and D. (850Maximum)			

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

**Figure 2, Facilities Categories**

Following Phase I scoring, all facilities are placed in an initial category. This initial placement is used as a part of the selection process for Phase II.	Category	Category Abbreviation	Description
	Comprehensive Health Care Center	Category A	An ambulatory care facility operating a minimum of 40 hours per week, staffed with a basic health team offering services for acute and chronic ambulatory problems and which may act as a referral center to other levels (higher acuity and specialty) of care. A Comprehensive Health Care Center could include an alternative rural hospital for purposes of the IHS construction priority system.
	Comprehensive Inpatient Facility	Category B	A facility providing inpatient services, ambulatory care, and a range of inpatient and ambulatory specialty care. The facility must meet IHS ADPL ≥ 15 policy and usually provides general surgery and full service OB/GYN. Patients for these facilities are routinely referred from Health Centers.
	Small Health Care Clinic	Category C	An ambulatory care facility designed to serve populations generating 4400 primary care provider visits or less.
	Other	Other	Facilities other than those described above, e.g. Youth Regional Treatment Centers, Dental Units, etc.

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

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

**Figure 3, Calculating the Phase II Score**

<p>Enter the Facility Deficiency, Health Status, Isolation, Barriers to Service Facility Size and Innovation criterion values in column headed "Evaluation Criteria Value" for lines A, B, C, D, E, and F respectively.</p> <p>Complete the calculation for lines A, B, C, D, E, and F as indicated. Enter each result on the appropriate line in the column headed Score.</p> <p>Add the scores for lines A, B, C, D, E, and F and enter the result in line G under Score.</p>	Line	Evaluation Criteria	Evaluation Criteria Value	Criteria Weighting	Score
	A	Facility Deficiency		x 400	=
	B	Health Status		x 200	=
	C	Isolation		x 100	=
	D	Barriers to Service		x 50	=
	E	Facility Size		x 150	=
	F	Innovation		x 100	=
	G	Phase II Total Score			(1000 Maximum)

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

**Facility Deficiency Criterion Calculations****Figure 4, Calculating the Facility Deficiency Criterion Value**

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

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

**Figure 5, Estimating Required Space for Phase I**

<p><b>Outpatient:</b> During Phase I the estimated size for any outpatient facility will be at least 200m<sup>2</sup>, with and additional .8m<sup>2</sup> per user population. The IHS user population for a facility is the IHS User Population obtained from the IHS National Patient Information Reporting System. Enter the IHS user population for the facility on line B. Multiply Line A (0.8 m<sup>2</sup>) times Line B and enter the result on line C. Add line D (200 m<sup>2</sup>) to line C and enter the result on line E.</p>	Line		
	A		IHS Average Space per User Population
	B	x	User Population
	C		User Population Space
	D	+	Base Facility Size
	E		Estimated Required Space for an outpatient facility
<p><b>Inpatient:</b> During Phase I the estimated size for any inpatient facility will be at least 5 500m<sup>2</sup>, with and additional 3.5m<sup>2</sup> per annual inpatient bed days (ID). The estimated space for the outpatient component of an inpatient facility has been included as part of the calculations F-J. The IHS ABD for a facility is the ID obtained from the IHS National Patient Information Reporting System. Enter the IHS ID for the facility on line G. Multiply Line F (3.5 m<sup>2</sup>) times Line G and enter the result on line H. Add line I (5 500 m<sup>2</sup>) to line G and enter the result on line J.</p>	Line		
	F		IHS Average Space per ID
	G	x	ID
	H		IDL Space
	I	+	Base Facility Size
	J		Estimated Required Space for an inpatient facility

**Figure 6, Calculating Adjusted Existing Space**

<p>If there is no existing facility, enter 0 as the Adjusted Existing Space on Line E.</p> <p>If there is an existing facility:</p> <ul style="list-style-type: none"> <li>Refer to Figure 7, "Look-Up: Age Factor" and Figure 8, "Calculate Weighted Age for Multi Building Facilities," to obtain the Age Adjustment Factor for Line A.</li> <li>Refer to Figure 9, "Calculate Condition Adjustment Factor for Existing Facilities" to obtain the Condition Adjustment Factor for line B.</li> <li>Add lines A and B. If the result is 1 or less, enter the result in line C. If the result is greater than 1, enter 1 on line C.</li> <li>Enter 1 on line D.</li> <li>Subtract Line D from Line C and enter the result on line E</li> <li>Enter the Existing Space on Line F. Existing space is obtained from the IHS FDS data base or, for Tribal facilities, is the documented gross size in square meters.</li> <li>Multiply line E times Line F and enter the result on line G.</li> </ul>	Line		
	A		Age Adjustment Factor
	B	+	Condition Adjustment Factor
	C	=	Space Adjustment Factor
	D	-	1
	E	=	Space adjustment
	F	*	Existing Space
	G	=	Adjusted Existing Space

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

**Figure 7, Look-Up: Age Factor**

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

**Figure 8, Calculate Weighted Age for Multi Building Facilities**

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

**Figure 9, Calculate Condition Adjustment Factor for Existing Facilities**

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

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

**Health Status Criterion Calculations**

**Figure 10, Calculating the Health Status Criterion Value**

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

**Isolation Criterion Calculations**

**Figure 11, Calculating the Isolation Criterion Value**

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

**Figure 12, Calculating the Barriers to Service Criterion Value**

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



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

**Facility Size Criterion Calculations**

**Figure 13, Facility Size Criterion Value Look up Table**

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

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

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

**Figure 14, Facility Size Criterion Formula**

If Required Space is	Use	Facility Size Value
0 to 1 200m <sup>2</sup>	1	1
1 201m <sup>2</sup> – 6 000m <sup>2</sup>	$(1 - [( \text{Required Space} - 1\,200\text{ m}^2) \times 0.00006])$	
6 000 m <sup>2</sup> than 12 800m <sup>2</sup>	$(.712 - [( \text{Required Space} - 6000\text{ m}^2) \times 0.0000428])$	
More than 12 800 m <sup>2</sup>	$(.416 - [( \text{Required Space} - 6000\text{ m}^2) \times 0.0000135])$	

**Innovation Criterion Calculations****Figure 15, Innovation Criterion Value**

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

## Attachment A

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

Figure 16, Facility Condition Factor Lookup Table

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

## Attachment A

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

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

**Attachment 2, Summary Report, Indian Health Service Health Care Facilities  
Construction Program**



**SUMMARY REPORT**  
**INDIAN HEALTH SERVICE, HEALTH CARE FACILITIES CONSTRUCTION PROGRAM**      February 11, 2008

**COMPLETED CONSTRUCTION (FY 1998 -Present)**

<b>HOSPITALS</b>	<b>HEALTH CENTERS</b>	<b>QUARTERS</b>	<b>YOUTH REG. TREAT. CTRS.</b>
Ft. Defiance, AZ 2/2004 Winnebago, NE 4/2004	White Earth, MN 4/1998 Lame Deer, MT 7/1999 Hopi (Polacca), AZ 5/2000 Parker, AZ 10/2001 Pawnee, OK 3/2004 Pinon, AZ 8/2005 St. Paul, AK 1/2006 Metlakatla, AK 3/2006 Red Mesa, AZ 9/2006 Clinton, OK 12/2006 Sisseton, SD 1/2007	Bethel, AK 3/2005 Zuni, NM 6/2006	Wadsworth, NV 7/2007

**PRIORITY LISTS**

<b><u>Health Care Facilities Construction</u></b>		<b><u>Quarters</u></b>	<b><u>Youth Regional Treatment Centers</u></b>
<b><u>Inpatient:</u></b>	<b><u>Outpatient:</u></b>		
PIMC Health System, AZ, PIMC Southeast ACC PIMC Southwest ACC PIMC Northeast ACC PIMC Central Hosp & ACC Barrow, AK Nome, AK Whiteriver, AZ Gallup, NM	Ft. Yuma, AZ Eagle Butte, SD Kayenta, AZ San Carlos, AZ Pueblo, CO Winslow-Dilko, AZ Alamo Navajo, NM Pueblo Pintado NM Bodaway-Coppermine, AZ Albuquerque Heath System, NM, Albuquerque West Albuquerque Central Sells, AZ	Wagner, SD Fort Belknap, MT	California, Central-Southern California, Northern

**PHASE III (PJD Preparation)**

No projects remain in Phase III of the current priority system

**IHS PARTNERSHIPS WITH TRIBES (1998- Present)**

<b><u>Joint Venture</u></b>	<b><u>Small Ambulatory</u></b>
Jicarilla (Dulce, NM) Choctaw Nation (Idabel, OK) Muscogee Creek (Coweta, OK) Tohono O'odham Nation (San Simon, AZ) Cherokee Nation (Muskogee, OK) Lake County, CA Chickasaw Nation (Ada, OK)	Chickasaw Nation (Purcell, OK) MACT Health Board, Inc (Mariposa, CA) Klamath Tribes (Chiloquin, OR) Jemez Pueblo (Jemez Pueblo, NM) Choctaw Nation (Stigler, OK) Karuk Tribe (Yreka, CA) Ho-Chunk Nation (Black River Falls, WI) Yakama Nation (White Swan, WA) Diegueño Indians (Santa Ysabel, CA) Confederated Tribes of Colville (Inchelium, WA) Reno-Sparks Indian Colony (Reno, NV) Paiute Colony (Las Vegas, NV) Quinault Indian Nation (Taholah, WA) Chippewa Tribe (Nett Lake, MN) Southern Indian Health Council (Campo, CA)
	Chenega Bay, AK Narragansett Indian Tribe (Charlestown, RI) Chippewa Cree Tribe (Bonneau Village, MT) Toksook Bay, AK Cowlitz Tribe (Longview, WA) Umpqua Tribe of Indians (Canyonville, OR) Siletz Indians (Siletz, OR) Makah Indian Tribe (Neah Bay, WA) Hooper Bay, AK Kake, AK Miwok Indians (El Dorado County, CA) Lake Superior Chippewa Indians (Lac du Flambeau, WI)

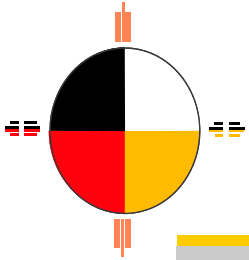
Distribution: **All IHS Area:** AD, OEHE; Directors, DFMs; Facilities Planners

**IHS/HQ:** Director, IHS; Deputy Director, IHS; Director OEHE; Deputy Director, OEHE; Director, DFPC, OEHE; Deputy Director, DFPC, OEHE; Director, ES-Seattle, DES, OEHE; Director, ES-Dallas, DES, OEHE; Director, DFO, OEHE; Deputy Director, DFO, OEHE; Director, DSFC, OEHE; Director, OCPS; Director, DBH, OCPS; Director, DCCS, OCPS; Director, DNS, OCPS; Director, DOH, OCPS; Director, DDPC, OCPS; Director, DPS, OPHS; Director, DPS, OPHS; Director, CLAS, PFCG, OD; Director, OFA; Director, DA, OFA; Director, DBF, OFA; Director, DBE, OFA; Director, DPER, OPHS; Program Analyst, DPER, OPHS; Director, DRA, OMS.

FEB 11, 2008







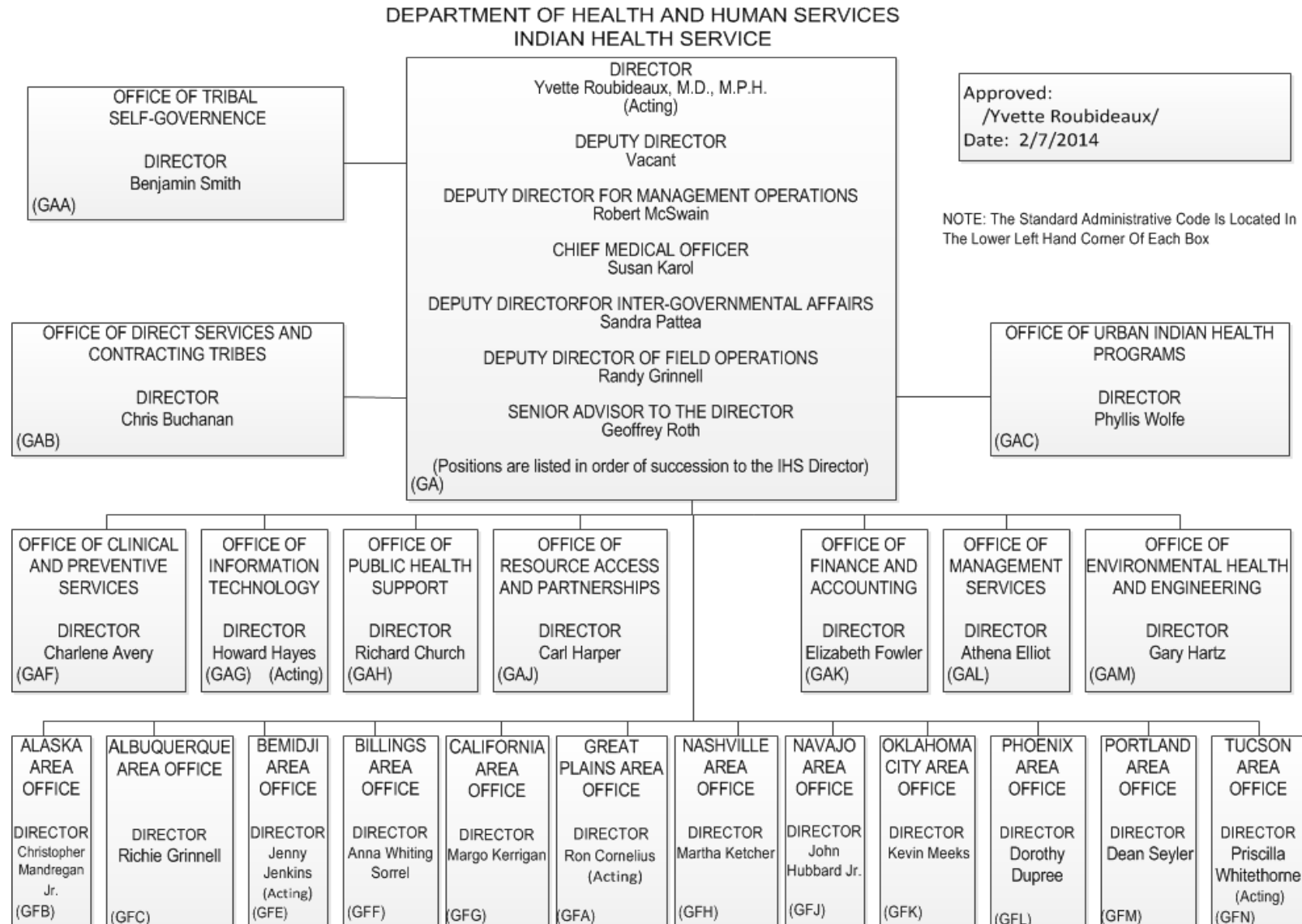
# Office of Environmental Health and Engineering

Health Care Facilities  
Sanitation Facilities  
Environmental Health

OEHE Overview  
February 2014

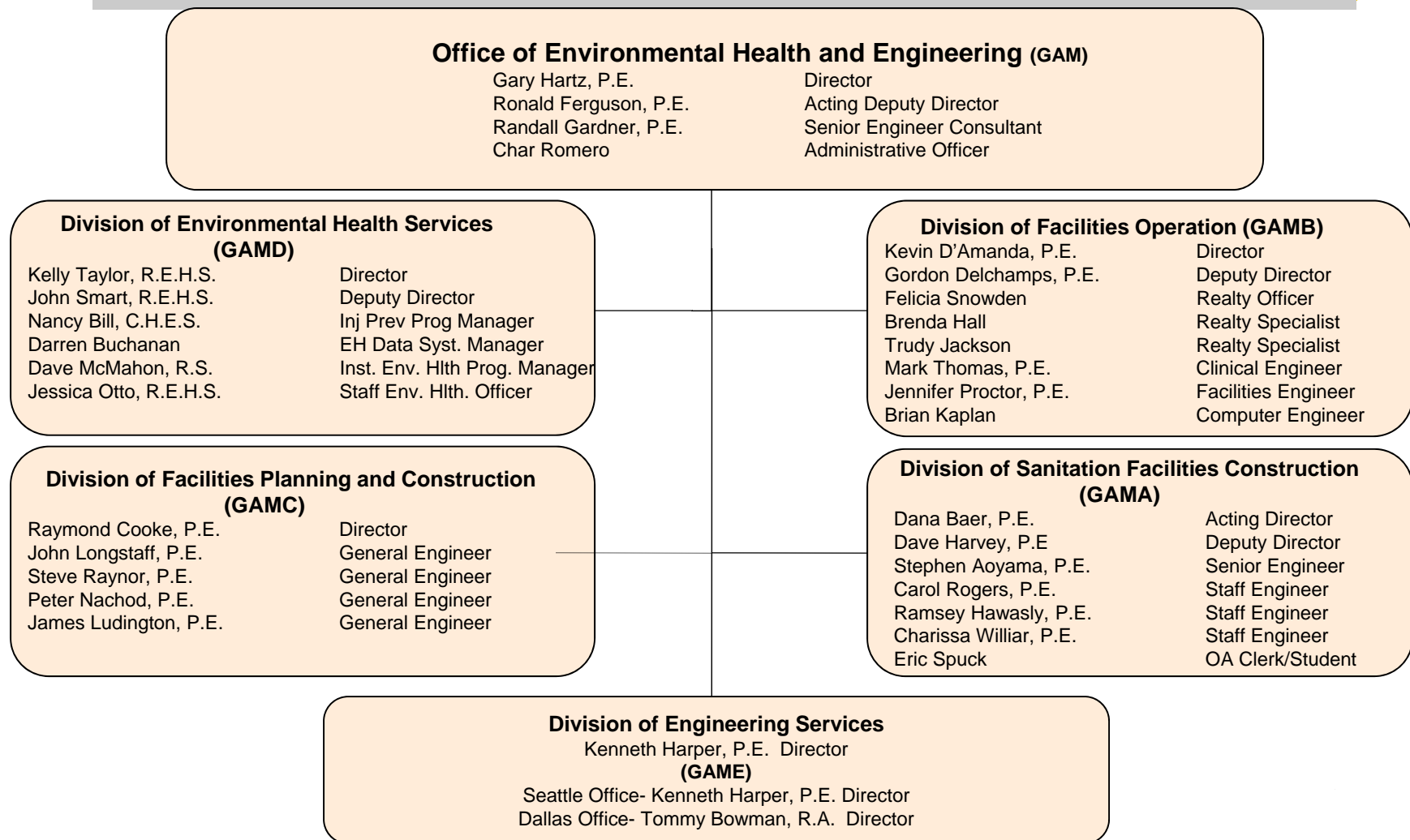


## INDIAN HEALTH SERVICE ORGANIZATIONAL CHART Feb 2014





# OEHE Organization Chart





# Environmental Health and Engineering

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- Facilities and Environmental Health Goals
  - OEHE Programs
  - Facilities Appropriation Budget Activities
    - Overview on funds distribution and allocation
-



# Facilities and Environmental Health Goals

---

- Improve public health in Indian Country
    - Reduce the incidence of environmentally-related disease and injury by:
      - Determining and addressing causes of injury
      - Advocating for improved environmental conditions
      - Constructing sanitation facilities for Indian homes and communities
  - Provide optimum availability of functional, well maintained health care facilities.
-



# Office Environmental Health and Engineering



## Program Activities

### Environmental Health

-  Injury Prevention
-  Institutional Environmental Health

### Construction

-  Sanitation Facilities
-  Health Care Facilities

### Facilities Operations

-  Maintenance and Improvement
-  Equipment and Clinical Engineering
-  Facilities Management
-  Real Property Management



# Budget Activities Funding OEHE Programs

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- Facilities and Environmental Health Support
  - Sanitation Facilities Construction
  - Health Care Facilities Construction
  - Maintenance and Improvement
  - Equipment
  - Quarters Return (Collections)
-



Budget Activities Continued

# Facilities and Environmental Health Support



- Funds Personnel and certain facilities operating expenses
    - Personnel to
      - Manage and implement programs and activities at IHS and Tribal health care facilities and communities
    - Facilities Operations for
      - Utilities,
      - Non-medical building operations supplies and equipment, and
      - Biomedical equipment repair/maintenance
  - Includes three sub-activities:
    - Facilities Support (\$124.1 million in 2014)
    - Environmental Health Support (\$70.9 million, in 2014)
    - Office of Environmental Health and Engineering Support (\$16.1 million in 2014)
-





# Environmental Health Services

---



Work with Tribal communities to prevent disease and injury:

- Conduct inspections to identify environmental health risk factors
  - Suggest corrective actions to reduce or eliminate risk factors
  - Conduct investigations of disease and injury incidents
  - Provide training to Federal, Tribal, and community members
  - Enhance capability of Tribal Injury Prevention Programs
-



## Environmental Health Services Includes Two Specialty Areas



### Injury Prevention

- Work with Tribes and other partners to prevent injuries and fatalities

### Institutional Environmental Health

- Work with Tribes and IHS to ensure safety of community members and staff





# Environmental Health Services

## Five Focus Areas



Children's Environment



Food Safety



Safe Drinking Water



Vectorborne &  
Communicable Disease



Healthy Homes









## Budget Activities Continued



# Sanitation Facilities Construction

---

- ✦ Funds sanitation facilities design and construction for new and existing homes.
  - ✦ Total cost to correct sanitation deficiencies:
    - ✦ Approximately \$3.1 billion
  - ✦ Cost to correct feasible sanitation deficiencies:
    - ✦ Approximately \$1.46 billion
  - ✦ FY 2014 appropriations of \$79.4 million
    - ✦ Complemented with contributed funds.
  - ✦ Appropriations are not project specific.
    - ✦ Projects funded from Area priority lists.
-





# Round Rock Waterline Extension

## Round Rock, AZ





## Budget Activities Continued



# Health Care Facilities Construction

---

- Funds planning, design, construction and equipment of facilities and staff quarters
  - Total cost to fund IHS Health Facilities Construction Priority System is \$2.5 Billion
  - FY 2014 Appropriation is \$85 million
  - Healthcare Facilities Construction Programs
    - Priority List, Replacement modular dental facilities,
    - Joint Venture, Youth regional treatment centers,
    - Small Ambulatory Program, Quarters
  - Funding of Priority List is project specific.
    - Projects identified and ranked as part of long term planning and prioritization process
    - Requests for resources consistent with priority rank of projects
  - Other Programs (Joint Venture, Small Ambulatory, etc.)
    - Appropriations are not project specific.
-



# Present Health Care Facilities Construction Priority Rankings

March 2014



<u>Inpatient</u>	<u>Outpatient</u>
Phoenix, AZ, Health System*	Fort Yuma, CA*
South East*	Kayenta, AZ*
North East	Rapid City, SD
Central - Hospital *	Winslow/Dilkon, AZ
Whiteriver, AZ	Alamo Navajo, AZ
Gallup, NM	Pueblo Pintado, NM
	Bodaway-Coppermine, AZ
	Albuquerque, NM
	Albuquerque West
	Albuquerque Central
	Sells, AZ
<u>Youth Regional Treatment Centers</u>	
Northern California	
* Partially funded through Direct Appropriations to IHS	





# Construction of the Kayenta Health Center

Kayenta, AZ





# Construction of the San Carlos Main Hospital Building

San Carlos, AZ





## Budget Activities Continued



# Maintenance and Improvement

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- Fund maintenance and repair of facilities
    - Routine general/preventive maintenance and repair
    - Projects for larger maintenance and improvement items
  - BEMAR is approximately \$427million.
  - FY 2014 Appropriation is \$53.6 million
    - Continued funding ensures functional health care facilities that
      - Meet building/life safety codes,
      - Conform with laws/regulations, and
      - Satisfy accreditation standards.
  - Appropriations are not project specific.
    - M&I Projects are funded from Area priority lists.
-



## Budget Activities Continued



# Equipment

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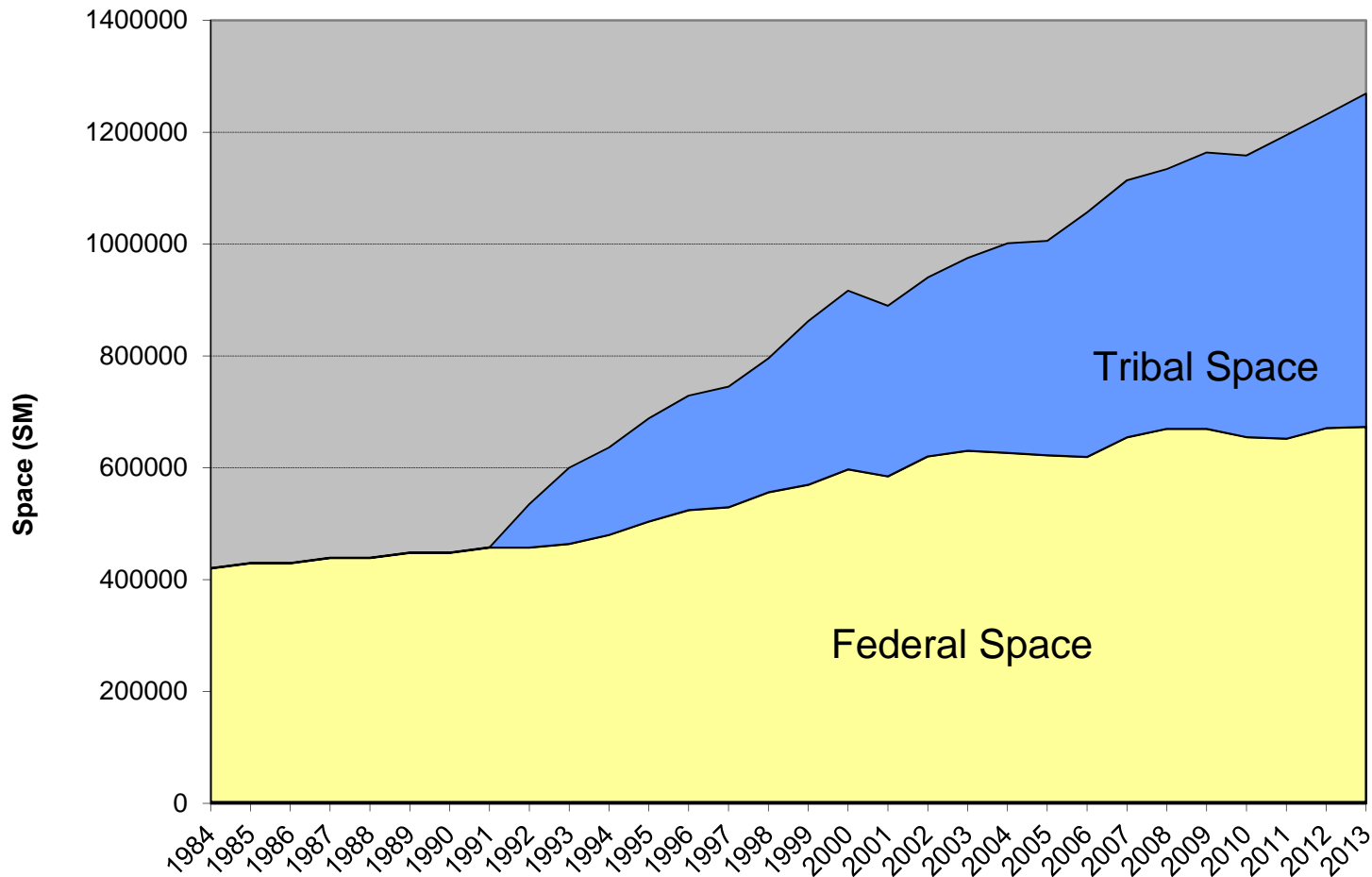
- ❖ Funds medical equipment
    - ❖ Replacement equipment for existing facilities
    - ❖ Equipment for replacement facilities constructed by Tribes using non-IHS resources.
  - ❖ IHS' medical equipment inventory approximately \$320 million
  - ❖ FY 2014 Appropriation is \$22.5 million
    - ❖ \$5 million of medical equipment supports tribally constructed facilities
    - ❖ \$1 million for TRANSAM and ambulances
  - ❖ Average equipment life is approximately 6 years
  - ❖ All funding allocated to IHS Areas/Service Units
-



## Budget Activities Continued

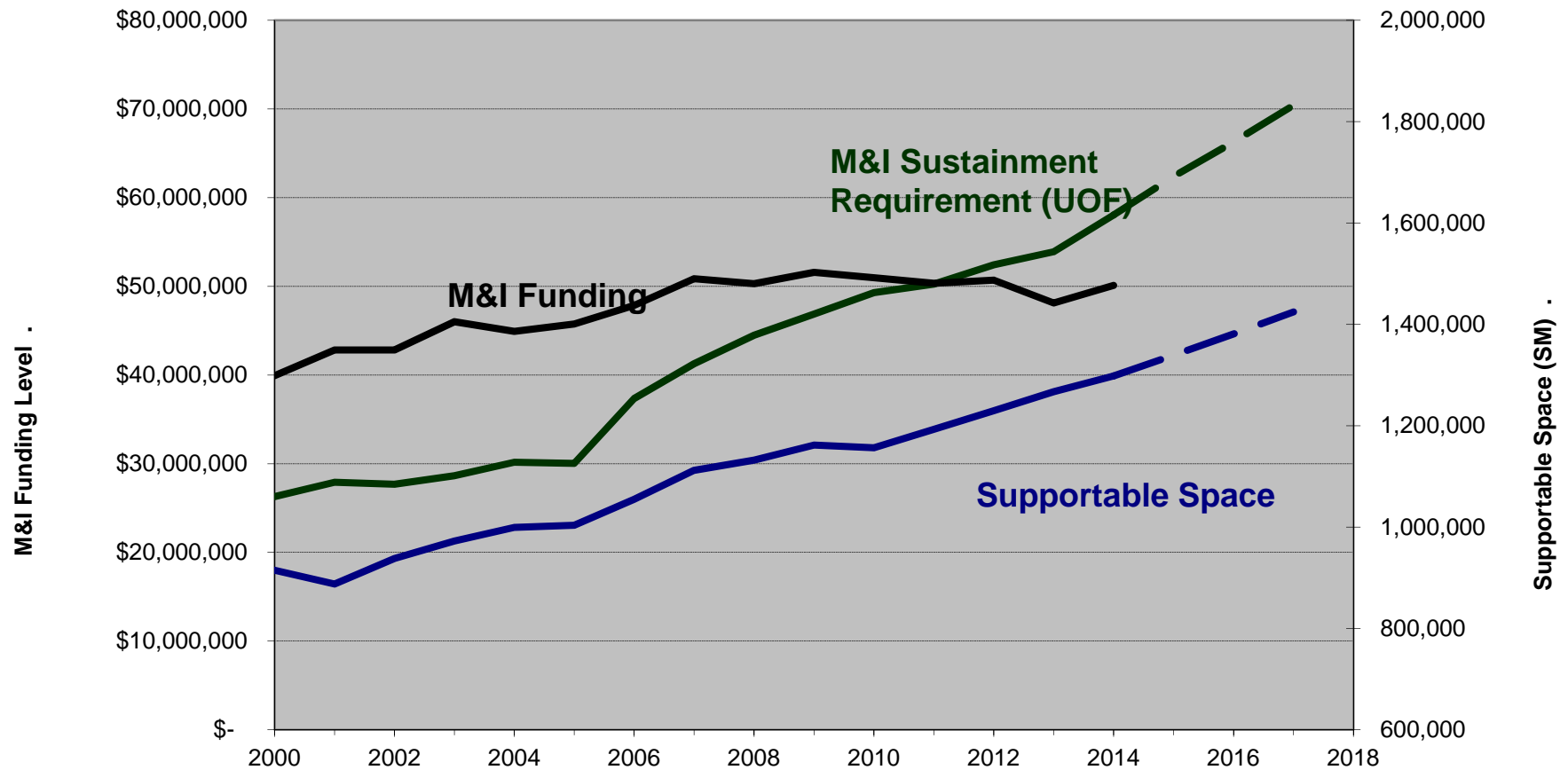


# Federal-Tribal Supported Space





# M&I TRENDS



+ One Time ARRA M&I Funding of  
\$100M Appropriated in FY 2009





JUL 3 2012

Dear Tribal Leader:

As part of the Affordable Care Act, the Indian Health Care Improvement Act (IHCIA) was permanently reauthorized and contains new provisions on health care facility construction priorities, methodology, innovation, and demonstrations. I am writing to request your input on **how to improve the Indian Health Service (IHS) health care facilities construction process.**

Since I have been the IHS Director, the topic of health care facilities construction and the associated staffing and operational needs is mentioned very frequently in my meetings with Tribes. As you may know, the IHS has a priority list for health care facilities construction that has been in place for many years. The ongoing challenge related to this list is that the amount of annual funding for construction, staffing, and operations of new health care facilities is greater than available resources in the IHS budget. In recent years (excluding the Recovery Act), appropriated health care facility construction funding has been between \$29 million and \$85 million each year.

The IHCIA's Subtitle C, "Health Facilities," authorizes a new Facilities Appropriation Advisory Board (FAAB) to review and revise the IHS Health Care Facilities Construction Priority System and to be "comprised of 12 members representing Indian tribes and 2 members representing the Service, established at the discretion of the Director."

The IHCIA Health Care Facility provisions provide new authorities that:

- Expand the types of health care facilities that must be assessed and prioritized in a report to Congress; in addition to inpatient and outpatient facilities, the IHS must report the priority need for "specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, and staff quarters."
- Ensure projects on the current priority list will not be affected by any changes in the Priority System.
- Require a report by March 23, 2011 that ranked facility need. A Report to Congress on Estimated Need for Tribal and IHS Health Facilities was submitted on time and described the current priority list and Tribal consultation needed on the new IHCIA authorities.
- Require IHS to establish, by regulation, standards for the planning, design, construction, and operation of health care or sanitation facilities serving Indians.
- Include the authority for other agencies to contribute to the IHS and for IHS to accept contributions for facility planning, design, construction and maintenance. These funds may be placed into Public Law 93-638 accounts and contracts.
- Direct the IHS to establish a demonstration program for modular component construction. IHS requested and received \$1 million in the FY 2012 budget to conduct a feasibility study on this provision.



## Page 2 – Tribal Leader

- Authorize a demonstration program “for consortia of two or more service units to access funding to purchase a mobile health station to provide specialty health care services such as dentistry, mammography and dialysis.”
- Authorize Indian Tribes to set rental rates and collect rents at federally-owned quarters operated under the ISDEAA.
- Reauthorize the demonstration to test or use alternative means of delivering health care through health facilities to Indians. This authorization includes specific direction to develop new health programs offering care outside of regular clinic operational hours and/or in alternative settings, and to use alternate or innovative methods of delivering health care services to Indians.

I am requesting your input and recommendations on how the IHS should move forward with health care facilities construction in light of the new health facilities construction language in the IHCIA. I have listed some questions for your consideration below and have also enclosed a summary of IHS health care facility construction programs for your reference.

1. IHS plans to proceed with establishing the **FAAB** as authorized by Section 141 of the IHCIA. The IHCIA establishes it as advisory to the IHS Director. Do you have any recommendations on the structure, focus, or composition of the Board? Please also submit nominations for members to your IHS Area Director by July 31, 2012.
2. How should the IHS proceed with establishing the **Facilities Needs Assessment Workgroup** as authorized by Section 141 of the IHCIA? Should this be a separate group from #1?
3. How should the IHS improve our overall **health care facilities planning and construction process** and the way we do business related to health care facility construction?
4. How could the IHS improve our approach to health care facilities construction within the **Budget Formulation process**?
5. Do you have suggestions for **innovative strategies** for health care facilities construction?
6. How could the IHS improve the overall process for determining **staffing and operational costs** related to specific types of health care facilities?
7. Do you have suggestions about how the IHS could change and improve our **small ambulatory program**?
8. Do you have suggestions about how the IHS could change and improve our **joint venture construction program**?

Page 3 – Tribal Leader

**Please submit your health care facilities construction recommendations in writing to me by August 31, 2012, at either of the following addresses:**

By e-mail at [consultation@ihs.gov](mailto:consultation@ihs.gov); or by postal mail at:

Yvette Roubideaux, M.D., M.P.H.  
Director, Indian Health Service  
801 Thompson Avenue, Suite 440  
Rockville, MD 20852

Thank you for your input on this very important program.

Sincerely,

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.  
Director

Enclosure

IHS Health Care Facilities Construction Programs (Summary Description)

## Summarized Questions and Responses to Dr. Roubibeaux's July 3, 2012 letter

The eight questions and responses are summarized in Appendix A. The letters are included in Appendix B. There were nine responses, two from the Oklahoma Area, two from the Alaska Area (Identical letters, both from ANTHC with different signatories), and one each from the Aberdeen Area, the California Area, the Bemidji Area, the Phoenix Area, and the Nashville Area. The United South and Eastern Tribes (USET) from the Nashville Area nominated Meg Parsons to the Facilities Appropriation Advisory Board (FAAB), there were no other nominations. The Sisseton-Wahpeton Oyate of the Lake Traverse Reservation from the Aberdeen Area suggested that IHS Area Facilities personnel represent the Area on the FAAB. In general there is: support for the FAAB; one recommendation that the Facilities Needs Assessment Workgroup be separate from the FAAB and one recommendation that it be the same as the FAAB; concerns and suggestions about IHS facilities funding; disagreement on the priority system and fund distribution; and requests to improve communication.

### 1. Do you have any nominations or recommendations on the structure, focus, or composition of the FAAB Board?

- Strongly support decision to establish the FAAB. Membership comprised of one tribal leader from each IHS Area seems appropriate; this was the composition of the original FAAB, and it worked well.
- Because of the very complex formulaic nature of the HFCS methodology and the required steep learning curve, retaining the participation of Tribal Leaders from the Aberdeen Area is problematic. Tribal Leaders are intensely interested in this process but may not be able to neglect their other duties to give participation in the FAAB due diligence. Several Tribes in our Area have assumed operation of their Facilities Management Programs; however, we feel the burden of representing our Area on the FAAB that would take them away from their onsite duties might cause hardship. Therefore, we feel the Tribes in our Area can best be represented on the FAAB through Federal Office of Engineering Services staff participating via videoconference and web-ex. We believe there should be one representative from each Area with at least two alternates, and the alternates should participate actively in the FAAB meetings even if the primary is able to attend.
- Structure - Upon initial formation of the FAAB it would be necessary for at least quarterly meetings and then move to annually after first year. The chairperson would need to be filled by one of the two IHS staff members for accountability. Focus - policy review and development that covers the process for submitting requests for construction, needs assessment, selection criteria and setting of construction project priorities. Composition -- 12 tribal members and two IHS staff. The tribal members should be selected from various disciplines to include Administrative, Medical and support staff/personnel.
- USET recommend Ms. Meg Parsons as the Nashville Area representative on the FAAB. USET insists that the FAAB continue its work on revising the Health Care Facilities Construction priority list and its methodology. USET stresses the importance of studying and implementing ways in which both those Areas on the priority list and those who have never benefited from the priority list are able to address facilities-related needs.

### 2. How should the IHS proceed with establishing the Facilities Needs Assessment Workgroup as authorized by Section 141 of the IHCIA? Should this be a separate group from the FAAB?

- The development of the Facilities Needs Assessment Workgroup should be comprised of a balance between tribal staff and IHS staff and in a way that allows all vested parties to have a voice in the decision process. It would be best if the Facilities Needs Assessment Workgroup were a separate group from the

## Summarized Questions and Responses to Dr. Roubibeaux's July 3, 2012 letter

FAAB and their focus were to take policy and apply it to requests for construction and submit to the Director for review.

- As the topic of need is relevant to the work of the FAAB, the Facilities Needs Assessment Workgroup need not be a separate entity, but should include enough technical advisors to address this complex issue.

### 3. **How should the IHS improve our overall health care facilities planning and construction process and the way we do business related to health care facility construction?**

- IHS Facilities Appropriation includes three main responsibilities: New health care facilities prioritization and construction; Existing health care facilities operations; and Sanitation Facilities Construction and utility operations/training. Together, these provide the platform for our health care system to function and deliver critically needed services, and each of these responsibilities needs significant improvement. We strongly recommend that the FAAB be involved in all three program planning and development arenas.
- Integrate Health Care Facilities Master Planning with Phase I of the IHS Facilities Construction Priority System and more fully assess each Tribe's need for co-occurring disorder capable Behavioral Health.
- With the development of the FAAB and the Facilities Needs Assessment Workgroup the overall facilities planning and construction process will improve. The only other item for improvement would be the communication between the IHS and the tribal entities that are on the priority list.
- USET will continue to advocate for the development of an Area Distribution Fund. While USET Tribes have supported increased funding for Health Care Facilities Construction in the past, the Nashville Area (along with the Bemidji, California and Portland Areas) has not historically benefitted from the program in its current form. An Area Distribution Fund would allow the Areas currently underserved by the IHS Health Care Facilities Construction program and the out-of-date Priority List to address major facility needs. USET supports the Fund as a more equitable dissemination of Health Care Facilities Construction dollars.

### 4. **How could the IHS improve our approach to health care facilities construction within the Budget Formulation process?**

- Regarding new health care facilities prioritization and construction, the original FAAB expended significant effort to formulate a new prioritization methodology, which was reviewed by IHS and vetted through a formal consultation process with the Tribes. Over 1,200 comments from 80 Tribes were received. This process resulted in a draft IHS Health Care Facilities Construction Priority System, which in November 2007 the IHS Director recommended to replace the 1991 Priority System. Much of the reasoning behind the original effort is still relevant and would provide a valuable starting point for improving the IHS approach to health care facilities construction within the budget formulation process. It is also a potential source of innovative project funding strategies and opportunities. We recommend the new FAAB review and build on this effort to establish an updated priority system better aligned with today's health care best practices.
- Question: Would the total unmet need, as identified in the Area Health Care Facilities Master Plan, be embargoed information? Tribal Leaders really need this information, particularly for their own Tribes and for the Area. If memory serves, the only amount reported to Congress or provided during the Budget Formulation process is the cost of the constructing the facilities on the IHS Facilities Construction Priority List, which as we know is the very small tip of the iceberg.
- The IHS Budget Formulation process has become a proactive tool for tribal leaders input. The process is highly developed and beneficial for making recommendations. The Indian Health Service needs to develop an informational/educational piece for tribal leaders to be used at the Area Office level Budget Planning.

## Summarized Questions and Responses to Dr. Roubibeaux's July 3, 2012 letter

This educational tool should describe the backlog and provide a historic review of Budget Recommendations and Budget Appropriations.

- Following a protracted (and ultimately unproductive) discussion between the Areas during this year's meeting of the National Tribal Budget Formulation Workgroup regarding Health Care Facilities Construction, the Priority List, and the possibility of an Area Distribution Fund, USET recommends that the topic be addressed at a dedicated pre-meeting prior to Budget Formulation each year. Devoting the day before Budget Formulation to the issue will allow the Areas to explore it fully without detracting from the overall task at hand.

### 5. Do you have suggestions for innovative strategies for health care facilities construction?

- Protecting and maintaining the current inventory of health care facilities must receive serious attention. In Alaska during the 10-year period between 2003 and 2012, the average M&I program space/square foot funding decreased by 28 percent while the price of energy simultaneously increased by more than 75 percent. The same story can be found across Indian Country. The FAAB is an opportunity to create a central clearinghouse of facility program best practices and technological innovation to begin to address this rapidly expanding problem.
- Given the paltry level of appropriations and inadequate status of IHS facility infrastructure, we believe the Indian Health Service has little alternative other than to study private sector models for construction financing, such as setting aside a percentage of third party collections for a capital improvement fund or utilizing private investors through tax credits.
- The rapid design/modular component construction method is a process that can help tribal entities provide health care to its members at a faster pace over traditional construction. It would be good to see IHS take a lead role in the evaluation of this methodology and make recommendations on appropriate usage.

### 6. How could the IHS improve the overall process for determining staffing and operational costs related to specific types of health care facilities?

- Sanitation facilities have long been the cornerstone of an effective public health program; yet, in the last three years, the Sanitation Facilities Construction Program is the only sub activity in the IHS budget which has suffered a reduction (16.7 %). As of 2010, the IHS estimates the unmet sanitation need at \$3 billion and rising. A recently completed study shows huge disparities between communities with piped water service and communities without piped water service.
- "In order to assess the need for long-term care facilities, the Indian Health Service MUST aggressively initiate documentation of limitations in activities of daily living and instrumental activities of daily living for patients in the medical record. There is a process for documenting this information, but when we queried records at the Sisseton Indian Health Service recently we found only one assessment documented! Documentation of ADLs and IADLs needs to commence as soon as possible."
- A database should be maintained so that the solicitations are sent only to the Tribes who would qualify to participate, such as the Phase II short list. It is confusing and frustrating to Tribes to receive the solicitation and have false hopes rise, only to find out that the solicitation was broadcast to everyone. Our greatest unmet needs for facilities construction at this time are for a Behavioral Health co-occurring disorder capable treatment facility that will replace the Dakota Pride Center chemical dependency treatment center and will integrate mental health and criminal justice components. Secondly, there is need for facilities to house long-term care services. We would appreciate the opportunity to discuss them with representatives from the IHS.

## Summarized Questions and Responses to Dr. Roubibeaux's July 3, 2012 letter

- Where is the IHS with regard to developing health systems planning templates and resource requirement modules that will drive the space and staffing of comprehensive Behavioral Health facilities? We recommend that these templates reflect the change in public policy for treatment of the co-occurring issues of substance abuse and addiction, mental health, and antisocial disorders concurrently, under one roof, through integrated programming. When we worked on the Area Health Care Facilities Master Plan nine years ago, the actuarial standards seemed to gravely underestimate workload, space, and staffing needs for Behavioral Health in Indian Country. Behavioral Health is the #1 health status problem in the Sisseton-Wahpeton Oyate Health Plan (2011-2015)."
  - The IHClA Reauthorization establishes new authorities for various levels of service that will have a need to determine staffing and operational costs. At best tribal leaders and planners outside of IHS are not aware of the formula's and systems used to benchmark for staffing and operational costs. However any new facilities, i.e., hospitals and clinics are staffed and provided operational costs equal to 85%, with an understanding that third party revenues make up the balance to fund an operation. Therefore, IHS should utilize private sector data and information to benchmark realistic costs, and should annually publish such information for tribes as a reference tool for planning. The IHS should complete a review of the new authorities and look to tribal health operations that offer and provide such services (assisted living, nursing home, hospice, home health, dialysis centers, etc.) and private sector operations to determine and benchmark staffing needs and operational costs.
7. **Do you have suggestions about how the IHS could change and improve our small ambulatory program?**
- Question: Why is this program only available to ISDEAA-contracted facilities? Why not to Federally-operated facilities, as well?
  - Since this program has not received any funding since 2006, it would be very helpful to advocate for funding for this program.
  - Out of the twenty-nine Tribes within the Nashville Area, only one Tribe has ever benefited from the small ambulatory program since its inception. IHS should consider a process similar to the aforementioned Area Distribution Fund for small ambulatory programs to make it more equitable amongst areas.
  - The Perkins Family Clinic, as an outpatient facility under P.L. 93-638 contract could benefit greatly from the grant provision opportunity under the IHClA, P.L. 94-437 authorization that would provide the ability to expand ambulatory health care service construction projects.
  - The SAP is also a priority for this Tribe and, we believe, the majority of all tribes. To ensure that all tribes have an opportunity to access this program a legislative reassessment should be implemented that would provide more flexibility to tribes in how and to whom funds might be allocated along with a staffing component. This Tribe proposes additional funding that should allow the IHS to fund at least 60 small ambulatory projects, depending on the size and scope of proposed projects. Participants may be determined based upon criteria specified in authorizing and appropriations law. The Small Ambulatory Program does not currently, but should, include funding for operation, maintenance and staffing. This Tribe requests additional funding of \$90,000,000, to allow for an SAP budget of at least \$100,000,000.
  - Overall the improvement of the construction program should include: Communication back to the Tribes; A better rating system including the small remote Tribes into the system; Innovative Strategies should include a tribal member in the meetings that has had a Community in-put meeting, locally for the work-group for IHS; The budget formation process should include traditional healing; The consideration for staffing and operational costs should include distance from other specialty clinics or give value to the Tribe for need for

## Summarized Questions and Responses to Dr. Roubibeaux's July 3, 2012 letter

the progressive needs of specialists, MIR or CAT scan devices in the over-all area of need; Physical Therapy to resume activity should also take a priority in the operational costs, NOT TRANSPORTATION.

**8. Do you have suggestions about how the IHS could change and improve our joint venture construction program?**

- We would recommend that the joint venture program be expanded to include the specialized care facilities, including long-term care, Behavioral Health treatment, and wellness rehabilitation centers. We recommend that IHS be more selective in which tribes the joint venture application solicitations are sent to.
- The joint venture construction program would be even better if more opportunities were made available for the construction of health care facilities utilizing this program. One means of providing more opportunities would be to fund the joint ventures at 75% instead of the present 100%. This would allow for an extra joint venture for every three awarded. The remaining 25% operational costs could be obtained by facilities seeking reimbursement from 3rd party sources and creating incentives for providers to be more productive.
- Request the IHS continue to accept tribal applications for the FY 2013-FY 2015 JV cycle, and establish the JVCP as a priority for additional funding in appropriation levels above the current amount of \$15,000,000.

**Andy Teuber**  
*ANTHC Chairman and President*

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August 31, 2012

Yvette Roubideaux, M.D., M.P.H.  
Director, Indian Health Service  
801 Thompson Avenue, Suite 440  
Rockville, MD 20852

Re: IHS Health Care Facilities Construction

Dear Ms. Roubideaux:

We are responding to your letter of July 3, 2012, requesting input on how the Indian Health Service (IHS) should move forward with health facilities infrastructure. Our comments are provided below:

1. We strongly support your decision to establish the Facilities Appropriation Advisory Board (FAAB). Membership comprised of one tribal leader from each IHS Area seems appropriate; this was the composition of the original FAAB, and it worked well.
2. Historically, the Facilities Needs Assessment Workgroup was a subcommittee of the FAAB that made recommendations to the FAAB. The workgroup of technical experts provided detailed program/issue analyses for tribal leader review. We recommend that this organizational structure and relationship be continued.
3. The IHS Facilities Appropriation includes three main health facility responsibilities:
  - a. New health care facilities prioritization and construction.
  - b. Existing health care facilities operations (Maintenance & Improvement and Equipment).
  - c. Sanitation facilities construction and utility operations/training.

Together, these facilities provide the platform for our health care system to function and deliver critically needed services, and each of these responsibilities needs significant improvement. We strongly recommend that the FAAB be involved in all three program planning and development arenas.

4. Regarding new health care facilities prioritization and construction, the original FAAB expended significant effort to formulate a new prioritization methodology, which was reviewed by IHS and vetted through a formal consultation process with the Tribes. Over 1,200 comments from 80 Tribes were received. This process resulted in a draft IHS Health Care Facilities Construction Priority System, which in November 2007 the IHS Director recommended to replace the 1991 Priority System.

Much of the reasoning behind the original effort is still relevant and would provide a valuable starting point for improving the IHS approach to health care facilities construction within the budget formulation process. It is also a potential source of innovative project funding strategies and opportunities. We recommend the new FAAB review and build on this effort to establish an updated priority system better aligned with today's health care best practices.



5. Protecting and maintaining the current inventory of health care facilities must receive serious attention. In Alaska during the 10-year period between 2003 and 2012, the average M&I program space/square foot funding decreased by 28 percent while the price of energy simultaneously increased by more than 75 percent. The same story can be found across Indian Country. The FAAB is an opportunity to create a central clearinghouse of facility program best practices and technological innovation to begin to address this rapidly expanding problem.
6. Adequate sanitation facilities have long been the cornerstone of an effective public health program; yet, in the last three years, the Sanitation Facilities Construction Program is the only sub activity in the IHS budget which has suffered a reduction. Since 2011, the Sanitation Facilities Construction program funding has been reduced 16.7 percent. As of 2010, the IHS estimates the unmet sanitation need in Indian Country at \$3 billion, and that number continues to rise. A recently completed study shows huge disparities between communities with piped water service and communities without piped water service. In communities with piped service:
  - a. Infants are hospitalized 5 times less for lower respiratory infection and 11 times less for pneumonia.
  - b. Children have a 30 percent reduction in Infectious Pneumococcal disease.
  - c. Residents are hospitalized 400 percent less.

The FAAB is an opportunity to communicate best practices and share strategies to sustain the sanitation facilities we have and enable their expansion to those communities who still live without benefit of safe water supply and adequate waste disposal.

We believe the FAAB has the potential to be a national platform on which to expand the understanding and knowledge of the Facilities Appropriation programs. This understanding could allow a more balanced and effective budget formulation process to emerge. This will, in turn, help ensure the sustainability of current facilities and lead to a new IHS Health Care Facilities Construction Priority System that will move us forward into the future.

Thank you for the opportunity to comment on this key IHS health facilities initiative.

Respectfully,



Andy Teuber  
Chairman and President



# Alaska Native Health Board

1840 Bragaw Street, Suite 220  
Anchorage, Alaska 99508

Phone: (907) 562-6006  
Fax: (907) 563-2001

August 27, 2012

Yvette Roubideaux, M.D., M.P.H.  
Director, Indian Health Service  
801 Thompson Avenue, Suite 440  
Rockville, MD 20852

Re: IHS Health Care Facilities Construction

Dr. Roubideaux:

On behalf of the Alaska Native Health Board (ANHB), I am writing in response to your letter of July 3, 2012, requesting input on how the Indian Health Service (IHS) should move forward with health facilities infrastructure.

ANHB is a statewide organization representing Tribes and Tribal organizations carrying out health services on behalf of the 229 federally-recognized tribes in the state of Alaska pursuant to the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended.

ANHB's comments are provided below:

1. We strongly support your decision to establish the Facilities Appropriation Advisory Board (FAAB). Membership comprised of one tribal leader from each IHS Area seems appropriate; this was the composition of the original FAAB, and it worked well.
2. Historically, the Facilities Needs Assessment Workgroup was a subcommittee of the FAAB that made recommendations to the FAAB. The workgroup of technical experts provided detailed program/issue analyses for tribal leader review. We recommend that this organizational structure and relationship be continued.
3. The IHS Facilities Appropriation includes three main health facility responsibilities:
  - a. New health care facilities prioritization and construction.
  - b. Existing health care facilities operations (Maintenance & Improvement and Equipment).
  - c. Sanitation facilities construction and utility operations/training.

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM  
ALEUTIAN/PRILOF ISLANDS ASSOCIATION  
ARCTIC SLOPE NATIVE ASSOCIATION  
BRISTOL BAY AREA HEALTH CORPORATION  
CHUGACHMIUT  
COPPER RIVER NATIVE ASSOCIATION  
COUNCIL OF ATHABASCAN TRIBAL GOVERNMENTS  
EASTERN ALEUTIAN TRIBES

KARLUK IRA TRIBAL COUNCIL  
KENAITZE INDIAN TRIBE  
KETCHIKAN INDIAN COMMUNITY  
KODIAK AREA NATIVE ASSOCIATION  
MANILAQ ASSOCIATION  
METLAKATLA INDIAN COMMUNITY  
MT.SANFORD TRIBAL CONSORTIUM  
NATIVE VILLAGE OF EKLUTNA  
NATIVE VILLAGE OF TYONEK

NINILCHIK TRADITIONAL COUNCIL  
NORTON SOUND HEALTH CORPORATION  
SELDOVIA VILLAGE TRIBE  
SOUTHCENTRAL FOUNDATION  
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM  
TANANA CHIEFS CONFERENCE  
YUKON-KUSKOKWIM HEALTH CORPORATION  
VALDEZ NATIVE TRIBE

Together, these facilities provide the platform for our health care system to function and deliver critically needed services, and each of these responsibilities needs significant improvement. We strongly recommend that the FAAB be involved in all three program planning and development arenas.

4. Regarding new health care facilities prioritization and construction, the original FAAB expended significant effort to formulate a new prioritization methodology, which was reviewed by IHS and vetted through a formal consultation process with the Tribes. Over 1,200 comments from 80 Tribes were received. This process resulted in a draft IHS Health Care Facilities Construction Priority System, which in November 2007 the IHS Director recommended to replace the 1991 Priority System.

Much of the reasoning behind the original effort is still relevant and would provide a valuable starting point for improving the IHS approach to health care facilities construction within the budget formulation process. It is also a potential source of innovative project funding strategies and opportunities. We recommend the new FAAB review and build on this effort to establish an updated priority system better aligned with today's health care best practices.

5. Protecting and maintaining the current inventory of health care facilities must receive serious attention. In Alaska during the 10-year period between 2003 and 2012, the average M&I program space/square foot funding decreased by 28 percent while the price of energy simultaneously increased by more than 75 percent. The same story can be found across Indian Country. The FAAB is an opportunity to create a central clearinghouse of facility program best practices and technological innovation to begin to address this rapidly expanding problem.
6. Adequate sanitation facilities have long been the cornerstone of an effective public health program; yet, in the last three years, the Sanitation Facilities Construction Program is the only sub activity in the IHS budget which has suffered a reduction. Since 2011, the Sanitation Facilities Construction program funding has been reduced 16.7 percent. As of 2010, the IHS estimates the unmet sanitation need in Indian Country at \$3 billion, and that number continues to rise. A recently completed study shows huge disparities between communities with piped water service and communities without piped water service. In communities with piped service:
  - a. Infants are hospitalized 5 times less for lower respiratory infection and 11 times less for pneumonia.
  - b. Children have a 30 percent reduction in Infectious Pneumococcal disease.
  - c. Residents are hospitalized 400 percent less.

The FAAB is an opportunity to communicate best practices and share strategies to sustain the sanitation facilities we have and enable their expansion to those communities who still live without benefit of safe water supply and adequate waste disposal.

We believe the FAAB has the potential to be a national platform on which to expand the understanding and knowledge of the Facilities Appropriation programs. This understanding could allow a more balanced and effective budget formulation process to emerge. This will, in turn, help ensure the sustainability of current facilities and lead to a new IHS Health Care Facilities Construction Priority System that will move us forward into the future.

**On behalf of ANHB, I appreciate the opportunity to comment. If I can provide further information, please do not hesitate to contact me.**

Sincerely,



**Lanie Fox  
President/CEO, Alaska Native Health Board**



*Sisseton-Wahpeton Oyate  
of the Lake Traverse Reservation*

Post Office Box 509  
Agency Village, South Dakota 57262

EXECUTIVE SECRETARIAT  
INDIAN HEALTH SERVICE  
2012 AUG 02 AM 10:49

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**IHS HEALTH CARE FACILITY CONSTRUCTION PRIORITY SYSTEM**

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August 9, 2012

Yvette Roubideaux, M.D., M.P.H.  
Director, Indian Health Service  
801 Thompson Avenue, Suite 440  
Rockville, MD 20852

Dear Dr. Roubideaux:

Thank you for the opportunity to comment on how the IHS should move forward in view of the new authorities for health facilities construction in the Indian Health Care Improvement Act. The new authorities are a hollow victory for Indian Country given the woefully inadequate level of appropriations by Congress of, as you state in your letter, only \$29 to \$85 million per year. It is "telling" that these appropriations are still addressing phased funding for the top ten inpatient and top ten outpatient replacement facilities that made the current IHS Health Facility Construction Priority List in 1991 - 21 years ago! - when the methodology was last applied. The Sisseton-Wahpeton Oyate is well familiar with the methodology and the list, having struggled to get on it for three decades and then actively lobbying to get phased funding to plan, construct, and staff our new facility for nearly another decade. The new authorities are much needed but it is apparent that the support of Congress is not there to get even the facilities backlog constructed. It is our recommendation that identifying the need and planning for it should not be stymied by lack of Congressional support and that alternative financing should be actively pursued by the Indian Health Service, in partnership with Tribes.

In the next several pages we will provide specific responses to the questions you pose.

BIG COULEE•BUFFALO LAKE•ENEMY SWIM•HEIPA/VEBLEN•LAKE TRAVERSE•LONG HOLLOW•OLD AGENCY

*Sisseton-Wahpeton Oyate Comments Regarding the IHS Health Care Facility Construction Priority System Page 2 of 5*

<b><i>Dr. Roubideaux's Questions:</i></b>	<b><i>SWO's Response</i></b>
<p>1. IHS plans to proceed with establishing the FAAB as authorized by Section 141 of the IHCIA. The IHCIA establishes it as advisory to the IHS Director. Do you have any recommendations on the structure, focus, or composition of the Board? Please also submit nominations for members to your IHS Area Director by July 31, 2012.</p>	<p>Because of the very complex formulaic nature of the HFCPS methodology and the required steep learning curve, retaining the participation of Tribal Leaders from the Aberdeen Area is problematic. Tribal Leaders are intensely interested in this process but may not be able to neglect their other duties to give participation in the FAAB due diligence. Several Tribes in our Area have assumed operation of their Facilities Management Programs; however, we feel the burden of representing our Area on the FAAB that would take them away from their onsite duties might cause hardship. Therefore, we feel the Tribes in our Area can best be represented on the FAAB through Federal Office of Engineering Services staff participating via videoconference and web-ex. We believe there should be one representative from each Area with at least two alternates, and the alternates should participate actively in the FAAB meetings even if the primary is able to attend.</p>
<p>2. How should the IHS proceed with establishing the Facilities Needs Assessment Workgroup as authorized by Section 141 of the IHCIA? Should this be a separate group from #1?</p>	<p>We feel this should be integrated with the Health Care Facilities Master Planning initiative with each individual Tribe in each Area. The Area's designated FAAB representative and alternates should play a key role in development of the Facilities Master Plan and with individual Tribal consultation.</p>
<p>3. How should the IHS improve our overall health care facilities planning and construction and the way we do business related to health care facility construction?</p>	<p>Integrate Health Care Facilities Master Planning with Phase I of the IHS Facilities Construction Priority System and more fully assess each Tribe's need for co-occurring disorder capable Behavioral Health</p>



*Sisseton-Wahpeton Oyate Comments Regarding the IHS Health Care Facility Construction Priority System Page 3 of 5*

<b><i>Dr. Roubideaux's Questions:</i></b>	<b><i>SWO's Response</i></b>
	treatment, long-term care, and wellness/rehabilitation facilities. We believe Phase I should be completed within the context of the Master Planning activity.
4. How could the IHS improve our approach to health care facilities construction within the Budget Formulation process?	Question: Would the total unmet need, as identified in the Area Health Care Facilities Master Plan, be embargoed information? Tribal Leaders really need this information, particularly for their own Tribes and for the Area. If memory serves, the only amount reported to Congress or provided during the Budget Formulation process is the cost of the constructing the facilities on the IHS Facilities Construction Priority List, which as we know is the very small tip of the iceberg.
5. Do you have suggestions for innovative strategies for health care facilities construction?	Given the paltry level of appropriations and inadequate status of IHS facility infrastructure, we believe the Indian Health Service has little alternative other than to study private sector models for construction financing, such as setting aside a percentage of third party collections for a capital improvement fund or utilizing private investors through tax credits.
6. How could the IHS improve the overall process for determining staffing and operational costs related to specific types of health care facilities?	In order to assess the need for long-term care facilities, the Indian Health Service MUST aggressively initiate documentation of limitations in activities of daily living and instrumental activities of daily living for patients in the medical record. There is a process for documenting this information, but when we queried records at the Sisseton Indian Health Service recently we found only one assessment documented! Documentation of ADLs and IADLs needs to commence as soon as possible.





*Sisseton-Wahpeton Oyate Comments Regarding the IHS Health Care Facility Construction Priority System Page 4 of 5*

<b><i>Dr. Roubideaux's Questions:</i></b>	<b><i>SWO's Response</i></b>
	<p>We are not sure where the IHS is at with regard to developing health systems planning templates and resource requirement modules that will drive the space and staffing of comprehensive Behavioral Health facilities. We strongly recommend that these templates reflect the change in public policy for treatment of the co-occurring issues of substance abuse and addiction, mental health, and antisocial disorders concurrently, under one roof, through integrated programming. When we were involved with the Health Systems Planning system twelve to fifteen years ago, there was no process for including chemical dependency and addiction services in our new facility. When we worked on the Area Health Care Facilities Master Plan nine years ago, the actuarial standards seemed to gravely underestimate workload, space, and staffing needs for Behavioral Health in Indian Country. Behavioral Health is the #1 health status problem in the Sisseton-Wahpeton Oyate Health Plan (2011-2015).</p>
<p>7. Do you have suggestions about how the IHS could change and improve our small ambulatory program?</p>	<p>Question: Why is this program only available to ISDEAA-contracted facilities? Why not to Federally-operated facilities, as well?</p>
<p>8. Do you have suggestions about how the IHS could change and improve our joint venture construction program?</p>	<p>In the long term we would recommend that the joint venture program be expanded to include the specialized care facilities, including long-term care, Behavioral Health treatment, and wellness / rehabilitation centers.</p> <p>For the short term we recommend that IHS be more selective in which tribes the joint venture application solicitations are sent to.</p>





*Sisseton-Wahpeton Oyate Comments Regarding the IHS Health Care Facility Construction Priority System Page 5 of 5*

<b><i>Dr. Roubideaux's Questions:</i></b>	<b><i>SWO's Response</i></b>
	<p>A database should be maintained so that the solicitations are sent only to the Tribes who would qualify to participate, such as the Phase II short list. It is confusing and frustrating to Tribes to receive the solicitation and have false hopes rise, only to find out that the solicitation was broadcast to everyone. For example, the Sisseton-Wahpeton Oyate has received joint venture solicitations after our new health center was constructed in 2007. Tribal officials have perceived it as an opportunity for construction of a new hospital and emergency room (<i>which SWO did not qualify for when the priority system was applied in 1991</i>) and have been re-traumatized angered to find out the solicitation was sent without forethought or design.</p>

In conclusion, the Sisseton-Wahpeton Oyate has experience with the IHS Facilities Construction Priority System and Budget Formulation process, having utilized these processes to establish the Woodrow Wilson Keeble Memorial Health Care Center that opened in 2007. Our greatest unmet needs for facilities construction at this time are for a Behavioral Health co-occurring disorder capable treatment facility that will replace the Dakota Pride Center chemical dependency treatment center and will integrate mental health and criminal justice components. Secondly, there is need for facilities to house long-term care services, which we do not have currently. We are engaged in work in both these areas and would appreciate the opportunity to discuss them with representatives from the Indian Health Service who might be able to assist us in making them a reality.

Please to do not hesitate to consult Tribal Health Coordinator Sara DeCoteau at 605-742-3697 or via e-mail at [sara.decoteau@ihs.gov](mailto:sara.decoteau@ihs.gov) for clarification or additional information.

Sincerely,



Robert Shepherd, Tribal Chairman





## United South and Eastern Tribes, Inc.

### Nashville, TN Office:

711 Stewarts Ferry Pike, Suite 100  
Nashville, TN 37214  
Phone: (615) 872-7900  
Fax: (615) 872-7417

### Washington, DC Office:

400 North Capitol Street, Suite 585  
Washington, D.C., 20001  
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August 31, 2012

Dr. Yvette Roubideaux, M.D., M.P.H.  
Director  
Indian Health Service  
United States Department of Health and Human Services  
810 Thompson Avenue  
Rockville, MD 20852

RE: July 6, 2012 Request for input on how to improve the Indian Health Service (IHS) health care facilities construction process.

Dear Dr. Roubideaux:

The United South and Eastern Tribes, Inc. (USET) is writing to respond to your July 6 Tribal Leader Letter soliciting input and requesting comments on how to improve the Indian Health Service (IHS) health care facilities construction process in light of new authorities provided by the Indian Health Care Improvement Act. USET and its member Tribes welcome IHS's solicitation of comments from Tribal Leaders on this important issue, and offer the following comments.

1. IHS plans to proceed with establishing the **FAAB** as authorized by Section 141 of the IHCA. The IHCA establishes it as advisory to the IHS Director. Do you have any recommendations on the structure, focus, or composition of the Board? Please also submit nominations for members to your IHS Area Director by July 31, 2012.

In addition to USET's recommendation of Ms. Meg Parsons as the Nashville Area representative on the FAAB, we must insist that the FAAB continue its work on revising the Health Care Facilities Construction priority list and its methodology. USET stresses the importance of studying and implementing ways in which both those Areas on the priority list and those who have never benefited from the priority list are able to address facilities-related needs.

2. How should the IHS proceed with establishing the **Facilities Needs Assessment Workgroup** as authorized by Section 141 of the IHCA? Should this be a separate group from #1?

As the topic of need is relevant to the work of the FAAB, the Facilities Needs Assessment Workgroup need not be a separate entity, but should include enough technical advisors to address this complex issue.

3. How should the IHS improve our overall **health care facilities planning and construction process** and the way we do business related to health care facility construction?

USET will continue to advocate for the development of an Area Distribution Fund. While USET Tribes have supported increased funding for Health Care Facilities Construction in the past, the Nashville Area (along with the Bemidji, California and Portland Areas) has not historically benefitted from the program in its current form. An Area Distribution Fund would allow the Areas currently underserved by the IHS Health Care Facilities

Construction program and the out-of-date Priority List to address major facilities needs. USET supports the Fund as a more equitable dissemination of Health Care Facilities Construction dollars.

4. How could the IHS improve our approach to health care facilities construction within the **Budget Formulation process**?

Following a protracted (and ultimately unproductive) discussion between the Areas during this year's meeting of the National Tribal Budget Formulation Workgroup regarding Health Care Facilities Construction, the Priority List, and the possibility of an Area Distribution Fund, USET recommends that the topic be addressed at a dedicated pre-meeting prior to Budget Formulation each year. Devoting the day before Budget Formulation to the issue will allow the Areas to explore it fully without detracting from the overall task at hand.

5. Do you have suggestions for **innovative strategies** for health care facilities construction?

USET does not have any recommendations at this time but reserves the right to provide comments in the future on a needed basis.

6. How could the IHS improve the overall process for determining **staffing and operational costs** related to specific types of health care facilities?

USET does not have any recommendations at this time but reserves the right to provide comments in the future on a needed basis.

7. Do you have suggestions about how the IHS could change and improve our **small ambulatory program**?

Out of the twenty-nine Tribes within the Nashville Area, only one Tribe has ever benefited from the small ambulatory program since its inception. IHS should consider a process similar to the aforementioned Area Distribution Fund for small ambulatory programs to make it more equitable amongst areas.

Due to limited access to Health Care Facilities Construction funding for USET Tribes, we are unable to provide detailed input related to questions 2, 5, and 6. Thus, USET must reiterate its support for the establishment of an Area Distribution Fund or another innovative way to ensure that all IHS Areas have access to these precious dollars to address aging or inadequate infrastructure. The current priority list does not speak to the true volume of need in Indian Country and it is incumbent on IHS to find a solution to this problem once and for all. Please know that USET is a willing partner in pursuit of a resolution that benefits all Tribes.

USET appreciates the opportunity to comment on behalf of its member Tribes and we hope that you give them careful consideration as you move forward on this issue. Should you have any questions about any aspect of the foregoing comments, please do not hesitate to contact Dee Sabattus, Director, Tribal Health Program Support, USET at (615)467-1550 or by e-mail at [dsabattus@usetinc.org](mailto:dsabattus@usetinc.org).

Sincerely,



Kitcki A. Carroll  
Executive Director





## Iowa Tribe of Oklahoma

R.R. 1, Box 721  
Perkins, Oklahoma 74059  
(405) 547-2402  
Fax: (405) 547-1032

**AUG 30 2012**

Yvette Roubideaux, M.D., M.P.H.

Director

Indian Health Service

801 Thompson Avenue, Suite 440

Rockville, Maryland 20852

EXECUTIVE SECRETARIAT  
INDIAN HEALTH SERVICE  
2012 SEP 11 AM 9:27

Re: Indian Health Service Health Care Facilities Construction Process

Dear Dr. Roubideaux,

This letter is in response to the request for input on how to improve the Indian Health Service (I.H.S.) health care facilities construction process. The Iowa Tribe of Oklahoma values the consideration given to include tribal responses, and is eager to continue this level of collaboration with the I.H.S. to examine opportunities under the Indian Health Care Improvement Act (IHCA) with regard to the I.H.S. health care facility construction process.

The Small Ambulatory Program, as mentioned in #7 is of particular interest to the Ioways of Oklahoma. The Perkins Family Clinic, as an outpatient facility under P.L. 93-638 contract could benefit greatly from the grant provision opportunity under the IHCA, P.L. 94-437 authorization that would provide the ability to expand ambulatory health care service construction projects. Currently, the clinic experiences insufficient space to deliver expanded services. To provide increased patient access to care, and to recruit additional health care providers it is crucial to increase our facility size. Adjacent to the clinic is a tribally owned building that could serve as an ideal location for a service expansion project, and requires construction to reconfigure for the development of new specialty services such as instituting an optometry clinic. Our diabetes program is working toward the addition wound and foot care services to our patients for lower extremity amputation prevention. We believe that a small ambulatory program grant opportunity could benefit our population, and lead to a health disparity reduction in our rural community.

Thank you for including the Iowa Tribe of Oklahoma in this consultation. We appreciate your ongoing leadership in this area and look forward to hearing of the developments under the IHCA Health Care Facility program.

Sincerely,

*Janice Rowe-Kurak*  
Janice Rowe-Kurak

Chairman

Iowa Tribe of Oklahoma



## Ewiiapaayp Tribal Office

### Ewiiapaayp Band of Kumeyaay Indians

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4054 Willows Road  
Alpine, CA 91901  
TEL: (619) 445-6315  
FAX: (619) 445-9126  
E-mail: [wmicklin@leaningrock.net](mailto:wmicklin@leaningrock.net)

November 9, 2012

Yvette Roubideaux, M.D., M.P.H.  
Director, Indian Health Service  
801 Thompson Avenue, Suite 440  
Rockville, MD 20852

Re: IHS Budget Priorities

Dear Dr. Roubideaux:

On behalf of the Ewiiapaayp Band of Kumeyaay Indians (the "Tribe"), a federally recognized Indian Tribe and Ewiiapaayp Indian Reservation, I write to you today to emphasize this Tribe's support, and, we believe, the support of the majority of all tribes, for the Indian Health Service (IHS) Joint Venture Construction Program (JVCP) and Small Ambulatory Program (SAP). The JVCP and SAP programs deserve support by your establishing them as top priorities of the IHS in the IHS budget, especially in the context of overall IHS budget constraints due to debt and deficit concerns for the federal budget.

The Joint Venture Construction Program is authorized in Section 818(e) of the Indian Health Care Improvement Act, Public Law 94- 437.

The JVCP authorization is in Section 818(e) of the Indian Health Care Improvement Act, Public Law (P.L.) 94-437, as amended by languages in the fiscal year (FY) 2001 appropriation, P.L. 106-291, and the FY 2002 appropriation, P.L. 107-63, authorizes the Indian Health Service (IHS) Joint Venture Construction Program (JVCP) for establishing projects where American Indian and Alaska Natives tribes can acquire a tribally owned outpatient health care facility, in exchange for the IHS providing the initial equipment, then operating and maintaining the health care facility for a minimum of 20 years. The authorization directed the Secretary of HHS to make arrangements with Indian tribes to establish joint venture projects. The program is executed through a JVCP agreement-a contract-in which a tribal entity borrows non-IHS funds for the construction of a tribally owned health care facility, and, in exchange, the IHS promises to lease the facility, to equip the facility and to staff the facility.

The Joint Venture Construction Program (JVCP) allows IHS to enter into agreements with Tribes that construct their own health facilities. Through this competitive process, applicants can and do fund equipment for the projects. Upon completion by the respective Tribe, IHS requests Congressional appropriations for staffing and operations based on the Tribes' projected dates of completion and opening. Between FY 2001 and FY 2011, sixteen joint venture project agreements signed by IHS and Tribes were initiated and eight have been

JVCP; SAP

completed. The JVCP continues to receive strong support by Tribes based upon the 55 positive responses to the FY 2009 congressionally directed solicitation for the JVCP FY 2010-FY 2012 cycle. I request the IHS continue to work on a solicitation to accept tribal applications for the FY 2013-FY 2015 cycle in accordance with tribal construction projects, and establish the JVCP as a priority for additional funding in appropriation levels above the current amount of \$15,000,000.

Under the Indian Health Service (IHS) Small Ambulatory Grants Program (SAP), as authorized by the Indian Health Care Improvement Act, Title III, Section 306, P.L. 94-437, as amended, as codified and implemented by 25 U.S.C.1636, and as further amended by language in the FY 2009 appropriation, P.L. 111-8, American Indian and Alaska Native tribes or tribal organizations, who are operating an Indian health care facility pursuant to a health care services contract or compact entered into under The Indian Self-Determination and Education Assistance Act, Public Law (P.L.) 93-638, may competitively obtain funding for the construction, expansion, or modernization of small ambulatory health care facilities.

The SAP is also a priority for this Tribe and, we believe, the majority of all tribes. To ensure that all tribes have an opportunity to access this program a legislative reassessment should be implemented that would provide more flexibility to tribes in how and to whom funds might be allocated along with a staffing component. This Tribe proposes additional funding that should allow the IHS to fund at least 60 small ambulatory projects, depending on the size and scope of proposed projects. Participants may be determined based upon criteria specified in authorizing and appropriations law. The Small Ambulatory Program does not currently, but should, include funding for operation, maintenance and staffing. This Tribe requests additional funding of \$90,000,000, to allow for an SAP budget of at least \$100,000,000.

Should you have any questions, please contact the Tribe's Chief Executive Officer, Mr. Will Micklin, by telephone at (619) 368-4382 or by email at [wmicklin@leaningrock.net](mailto:wmicklin@leaningrock.net). Thank you.

Sincerely,



Robert Pinto, Sr., Chairman  
Ewiiapaayp Band of Kumeyaay Indians

Cc: Director , Division of Facilities Planning and Construction  
Indian Health Service  
12300 Twinbrook Parkway, Suite 600C  
Rockville, MD 20852

Director, Office of Environmental and Health Engineering  
Division of Facilities Planning and Construction  
12300 Twinbrook Parkway, Suite 600 C  
Rockville, Maryland 20852



## Muscogee (Creek) Nation

**George P. Tiger**  
Principal Chief

Executive Office

**Roger Barnett**  
Second Chief

August 29, 2012

Yvette Roubideaux, MD., M.P.H.  
Director, Indian Health Service  
801 Thompson Avenue, Suite 440  
Rockville, MD 20852

**SUBJECT: How to Improve the IHS Health Care Facilities Construction Process**

Dear Dr. Roubideaux:

Thank you for the opportunity to respond to your request for input on health care facilities construction in light of new language in the I.H.C.I.A. The following suggestions are for your consideration.

1. IHS plans to proceed with establishing the **FAAB** as authorized by Section 141 of the IHCIA. The IHCIA establishes it as advisory to the IHS director. Do you have any recommendation on the structure, focus, or composition of the Board? Please also submit nominations for members to your IHS Area Director by July 31, 2012.

*Response:*

**Structure** – Upon initial formation of the Facilities Appropriation Advisory Board (FAAB) it would be necessary for at least quarterly meetings and then move to annually after first year. The chairperson would need to be filled by one of the two IHS staff members for accountability.

**Focus** – The FAAB should focus on policy review and development that covers the process for submitting requests for construction, needs assessment, selection criteria and setting of construction project priorities.

**Composition** – The board will be comprised of 12 tribal members and two IHS staff. The tribal members should be selected from various disciplines to include Administrative, Medical and support staff personnel.

2. How should the IHS proceed with establishing the **Facilities Needs Assessment Workgroup** as authorized by Section 141 of the IHCIA? Should this be a separate group from #1?

*Response:*

The development of the Facilities Needs Assessment Workgroup should be comprised of a balance between tribal staff and IHS staff, and in a way that allows all vested parties to have a voice in the decision process. It would be best if the Facilities Needs Assessment Workgroup were a separate



group from the FAAB, and their focus were to take policy and apply it to requests for construction and submit to the Director for review.

3. How should the IHS improve our overall **health care facilities planning and construction process** and the way we do business related to health care facility construction?

*Response:*

*With the development of the FAAB and the Facilities Needs Assessment Workgroup the overall facilities planning and construction process will improve. The only other item for improvement would be the communication between the IHS and the tribal entities that are on the priority list.*

4. How could the IHS improve our approach to health care facilities construction within the **Budget Formulation process**?

*Response:*

*The IHS Budget Formulation process has become a proactive tool for tribal leaders input. The process is highly developed and beneficial for making recommendations. The Indian Health Service needs to develop an informational/educational piece for tribal leaders to be used at the Area Office level Budget Planning. This educational tool should describe the backlog and provide a historic review of Budget Recommendations and Budget Appropriations.*

5. Do you have suggestions for **innovative strategies** for health care facilities construction?

*Response:*

*The rapid design/modular component construction method is a process that can help tribal entities provide health care to its members at a faster pace over traditional construction. It would be good to see IHS take a lead role in the evaluation of this methodology and make recommendations on appropriate usage.*

6. How could the IHS improve the overall process for determining **staffing and operational costs** related to specific types of health care facilities?

*Response:*

*The IHCLA Reauthorization establishes new authorities for various levels of service that will have a need to determine staffing and operational costs. At best tribal leaders and planners outside of IHS are not aware of the formula's and systems used to benchmark for staffing and operational costs. However any new facilities, i.e., hospitals and clinics are staffed and provided operational costs equal to 85%, with an understanding that third party revenues make up the balance to fund an operation. Therefore, IHS should utilize private sector data and information to benchmark realistic costs, and should annually publish such information for tribes as a reference tool for planning.*

*The IHS should complete a review of the new authorities and look to tribal health operations that offer and provide such services (assisted living, nursing home, hospice, home health, dialysis centers, etc.) and private sector operations to determine and benchmark staffing needs and operational costs.*

7. Do you have suggestions about how the IHS could change and improve our **small ambulatory program**?

*Response:*

*Since this program has not received any funding since 2006, it would be very helpful to advocate for funding for this program.*



8. Do you have suggestions about how the IHS could change and improve our joint venture construction program?

*Response:*

*The joint venture construction program is a great tool for IHS and tribal entities to partner in providing health care to tribal members. It would be even better if more opportunities were made available for the construction of health care facilities utilizing this program.*

*One means of providing more opportunities would be to fund the joint ventures at 75% instead of the present 100%. This would allow for an extra joint venture for every three awarded. The remaining 25% operational costs could be obtained by facilities seeking reimbursement from 3<sup>rd</sup> party sources and creating incentives for providers to be more productive.*

Again, thank you for the opportunity to provide you with input and recommendations on how the IHS should move forward with health care facilities construction in light of the new health facilities construction language in the IHCA.

If you need more information or have any questions, you may contact me at 918-732-7605 or email [gtiger@mcn-nsn.gov](mailto:gtiger@mcn-nsn.gov).

Sincerely,



George Tiger, Principal Chief  
Muscogee (Creek) Nation



August 31, 2012

Yvette Roubideaux, M.D.,  
Director, Indian Health Service  
801 Thompson Avenue, Suite 440  
Rockville, Maryland 20852

Dear Dr. Roubideaux,

The Inter Tribal Council of Arizona, Inc. (ITCA) appreciates this opportunity to respond to your consultation request sent to Tribal Leaders on July 3, 2012, pertaining to the new health facility construction provisions in the Indian Health Care Improvement Act (IHCA) section of the Patient Protection and Affordable Care Act. The ITCA, Inc. is an organization whose Board of Directors consists of the highest elected officials of 20 tribal governments in Arizona. The revisions to the Health Care Facility Construction priority system, including protection of projects on the current priority list and added innovations and alternatives to improve the delivery of health care services, was supported by ITCA for years leading up to the permanent reauthorization of the IHCA. The request for consultation and input on the implementation of the new authorities is important and timely.

We are aware that due to limitations in the federal budgeting process and the apparent lack of cohesive support by the United States Congress to fund the projects on the list, very few projects have advanced to the construction phase. It also appears that although the Administration was willing to include funding for two projects through Stimulus funding and certain projects, such as the San Carlos and Kayenta, Arizona ambulatory centers obtained funding in recent years through the regular federal budgeting process which has allowed phasing in construction, the overall federal commitment for health care facility construction in Indian country has not been at the level that Tribal Nations believe should be in place.

Access to health care is one of the glaring issues facing American Indian people nationwide. In Arizona, for example, the Indian Health Service (IHS) is aware of the problems that exist due to lack of space and outdated infrastructure at the Fort Yuma Service Unit, in which the Cocopah and Quechan people are served in a facility that is the oldest in the Indian health care system. The Inter Tribal Council of Arizona, supports these Tribes in their efforts to obtain a replacement facility. It must be noted that the aged facility has sustained damage due to active seismic activity, including potential damage due to another recent earthquake in the area this month. The replacement of the Phoenix Indian Medical Center is also on the current Priority List. Due to the need to maintain quality of care standards, maintenance and repair costs are high. The patient workload is one of the largest in the nation and in order for the hospital to serve as a referral hospital and provide services to patients from the seven Tribes in the Phoenix Service Unit and the large Urban Indian population, securing funding for the design and resources for construction is a priority among the ITCA member Tribes.

Ak-Chin Indian  
Community  
Cocopah Tribe  
Colorado River  
Indian Tribes  
Fort McDowell  
Yavapai Nation  
Fort Mojave Tribe  
Gila River Indian  
Community  
Havasupai Tribe  
Hopi Tribe  
Hualapai Tribe  
Kaibab-Paiute Tribe  
Pascua Yaqui Tribe  
Pueblo of Zuni  
Quechan Tribe  
Salt River Pima-  
Maricopa Indian  
Community  
San Carlos  
Apache Tribe  
Tohono O'odham  
Nation  
Tonto Apache Tribe  
White Mountain  
Apache Tribe  
Yavapai-Apache  
Nation  
Yavapai-Prescott  
Indian Tribe

For the critical issues to be analyzed that are discussed in July 3, 2012 correspondence to Tribal leaders and to address the specific questions in the letter, the Inter Tribal Council of Arizona, Inc. requests additional time to engage Tribes at the Area level in order to formulate concrete recommendations. This activity should not preempt any specific recommendations that are made by individual Tribal governments, but aid in the process of analyzing and identifying solutions that could assist Tribes that have projects on the Priority List as well as other Tribes that do not. The Inter Tribal Council of Arizona, Inc. is willing to assist the Phoenix Area Indian Health Service organize an Area wide consultation meeting or process to further analyze the policy changes that are afforded through the IHCA in order to develop recommendations on the implementation of the new construction authorities afforded in the ACA/IHCA. It is suggested that this meeting or process, to obtain further input coincide with the Phoenix Area IHS annual budget formulation meeting to be scheduled before the end of November 2012.

Please do not hesitate to inform your staff that they may contact me to follow up this request.

Sincerely,

A handwritten signature in dark ink, appearing to read "John R. Lewis". The signature is fluid and cursive, with the first name "John" and last name "Lewis" clearly distinguishable.

John R. Lewis,  
Executive Director

September 11, 2012

Director of Indian Health Service  
Yvette Roubideaux, MD., MPH.  
801 Thompson Avenue, Suite 440  
Rockville, MD. 20852  
Re: IHS Health Care Facilities Construction Program

Dear Ms. Roubideaux,

I ask your forgiveness for the lateness of this response that was received by our chairman on July 3, 2012, our Health Director on the 25<sup>th</sup>, and finally by myself today. We are very interested and involved in the process of a **new Clinic**. Our in depth process with the Small Ambulatory program started way back in 2003 and we are still pursuing a much needed new clinic. We have finished an in-depth Feasibility Study with the Community, the Council, and the IHS Engineering Dept. (Todd Schofield) of which all were excited and thoughtful of the needs of the community. We have tried every avenue in the hopes that we may qualify.

With the Architects, we have developed a traditional healing place inside the proposed new facility while in keeping with smoking & fire regulations. With the Facilities Needs Assessment, a better rating system should be developed for including the very small Tribes in each district. I realize that our grant may not have scored higher than the rest, but we didn't even receive a rating back to improve on what we wrote. Therefore, a better way of communicating back to the Tribes what is needed.

IHS needs a better way of equalizing the weight of each District regarding the Board.

Are the dates of the last improvements or needs of each facility of the Tribes a consideration to bringing the new buildings to each tribal need?

Overall the improvement of the construction program should include:

1. Communication back to the Tribes
2. A better rating system including the small remote Tribes into the system.
3. Innovative Strategies should include a tribal member in the meetings that has had a Community in-put meeting, locally for the work-group for IHS.
4. The budget formation process should include traditional healing to the facilities.
5. The consideration for staffing and operational costs should include distance from other specialty clinics or give value to the Tribe for need for the progressive needs of specialists, MIR or CAT scan devices in the over-all area of need.
6. Physical Therapy to resume activity should also take a priority in the operational costs, NOT TRANSPORTATION

I want to thank the Bemidji area office for their constant help and guidance. I want to thank you also, for requesting in-put into the Small Ambulatory of which we need funds from.

Sincerely,

Mary L. Spalding-Antilla, CHR  
Lac Vieux Desert Band of Lake Superior Chippewa

cc: Alan Shively, Chairman



**Facilities Appropriation Advisory Board**  
**for the**  
**Indian Health Service**

Jefferson Keel, Chairperson

Tim Rosette, Vice Chairperson

Bill Axlund  
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Meg Parson  
 Anslem Roanhorse  
 Carol Rollins  
 Tim Rosette  
 Donna Schuler

**JUL 21 2005**

Mr. Gary Hartz, Director  
 Office of Environmental Health and Engineering  
 Indian Health Service  
 12300 Twinbrook Parkway, Suite 600  
 Rockville, Maryland 20852

Dear Mr. Hartz:

This letter is to recommend revisions to the Healthcare Facilities Construction Priority System (HFCPS) based on comments received during review of it by the Tribes last summer.

**Background**

The FAAB has been involved with the process to revise the HFCPS for several years. We initially formed a workgroup to provide guidance on updating the HFCPS as directed by Congress in the Conference Report accompanying the fiscal year 2000 Interior Appropriations. This workgroup reported back to the FAAB in June 2002, proposing several changes to the process. In September 2003, the IHS asked the FAAB to review a draft revision of the HFCPS that was based on the FAAB recommendations and workgroup proposals. Following review of the document, the FAAB recommended that IHS revise and prepare it for tribal review. In June 2004, the IHS sent a draft of the revised HFCPS to all tribes and asked for their comment.

The FAAB met in December 2004 to review Tribal comments. The IHS had identified over 1,200 comments in the 80 letters received. Because of the complexity of the issues involved, the FAAB did not believe that it was prepared to provide a full recommendation to IHS at that time, so it established another technical workgroup (TWG) to review the comments and address specific issues identified by the FAAB. The TWG reported back to the FAAB on May 11-12, 2004. Based on this report, the FAAB developed specific recommendations for changes to the HFCPS.

The comments generated by tribes during the review process were fairly extensive, and often covered issues not directly related to revising the HFCPS. These issues include revisiting the IHS Master Planning guidelines, reviewing the IHS process for preparing, reviewing and approving facilities planning documents, and determining how IHS should address those projects currently on the Priority List or being processed for placement on the Priority List. In order focus on the HFCPS, this letter will not address these comments but only those related to revision of the HFCPS. However we believe that the other issues should be addressed and will be forwarding another letter providing our recommendations on them.

Mr. Hartz - Page 2 of 8

### **Recommendations**

The FAAB generally supports the draft HFCPS document presented to Tribes for review. However, based on comments generated during Tribal review, we recommend that the document be modified to incorporate the specific recommendations described below and that it be prepared for Tribal Leaders for final review.

### General Concepts

The FAAB has several recommendations on the general process that the IHS should consider as it edits the HFCPS for final review. Some of these recommendations flesh out concepts that appear in the Tribal review copy of the revised HFCPS and others incorporate new concepts that arose during the Tribal review process.

### *Terminology*

The FAAB recommends the following changes to nomenclature for the HFCPS Criteria:

- **Facility Deficiency** should be renamed **Facility Resource Deficiency**
- **Health Resources** should be renamed **Health Status**.

### *Recommended Process Description for the HFCPS*

The FAAB believes that the Tribal review copy of the HFCPS needs to more clearly explain the process. The IHS has committed to obtaining outside assistance in drafting the final version of the document and we believe that may help generate a clearer explanation. However the FAAB recommends that in revising the HFCPS, IHS use the following description of the process, including timelines, to develop a description of the process that clarifies what Tribes may expect.

#### Phase I - Needs Assessment Phase

- A Every 5 years the IHS and tribes should update the Master Plan/data (12-24 months)
  - a. The Area Offices submit data from these plans to IHS Headquarters.
  - b. Headquarters collects the data and uses it to populate a database that will be used to calculate scores for the HFCPS.
- B Data is scored using the HFPCS Phase I formula (3-4 months)
- C The IHS Headquarters publishes Phase I results.
  - a. Letters of notification of eligibility are sent to appropriate tribes and Area Offices. These letters should include related timelines, deadlines, requirements, etc., for Phase II. (annually)
- D Every 5 years the Phase I score is recalculated. This restarts the process at step A above.

Phase II - Project Prioritization Phase – (See below under *Grandfathering* for recommendation on the initial implementation of Phase II.)

Mr. Hartz - Page 3 of 8

- E IHS Selects the highest ranking projects in Phase I that it could expect to fund in 2 years, based on historical appropriations patterns, and estimates of project costs, to be evaluated during Phase II.
- F Tribes and Area Offices submit documentation for Phase II projects that include Business Plans, Health System Planning Process (HSP), Draft Program Justification Document (PJD), Resource Requirement Methodology (RRM) and documentation supporting "Innovations" and "Barriers" claims. Basic planning documents are reviewed per items a-c below before the proposed projects are submitted to the Validation Committee. (6 months)
  - a. HSP output – IHS staff validates and approves.
  - b. Draft PJD – IHS staff reviews and comments.
  - c. Phase I Site Selection IHS reviews and approves.
- G IHS completes Phase II site Selection and revises and approves the PJD (6 months).
- H Validation Committee reviews Business Plans, Innovation/Barriers, cost/match assurance, projects without complete supporting documentation or for which documentation does not support Phase I ranking are moved back to Phase I. Also projects that do not have a completed PJD at this time are moved back to Phase I. These projects may compete in subsequent applications of the Phase II based on their ranking in Phase I. (2 wks)
- I Projects that have not been removed from the Phase II process are scored and ranked based on validated data and are placed on the Priority List in order of ranking.
- J The IHS publishes the results and ranking of projects in Phase II by notifying appropriate Tribes and Areas.
  - a. Tribes can decide if they want to fund the project or not.
- K Annually thereafter, as projects on the Priority List are funded, new projects are pulled off National List of facilities to maintain 2 years worth of projects on the Priority List. This restarts the Phase II process at step E.
- L Once a project makes phase II by completing step I above, it stays on the list, until fully funded.
- M Facilities projects for New Tribes, after they have been incorporated into Area Master Plans, start the process at step B above.

### *Appeals Process*

- ⇒ The FAAB recommends that the appeals process should comply with common standards and administrative review requirements. The sequence of appeals should be as follows, with the Director, IHS, decision being final:
1. First to Validation Committee, then
  2. Director of OEHE and last to the
  3. Director of IHS.



Mr. Hartz - Page 4 of 8

### *Area Funds Distribution*

"The FAAB recommends that the Indian Health Service (IHS) amend the HFCPS to include an Area Fund Distribution section and methodology. The FAAB proposes that IHS allocate 20% of the annual healthcare facilities construction budget, or a minimum of \$20 million, to the Area Offices for distribution to high priority projects within the Area based on the following formula:

$$\text{Area \% factor} = \frac{\text{Most current validated Area User population} \times \text{Avg. Area locality factor}}{\text{Sum all the participating Areas' (Area User population} \times \text{Avg. Area locality factor)}}$$

This recommendation is consistent with the Congressional intent for the agency to establish "a base funding amount, which serves as a minimum annual amount in the budget request" and to develop a system that will address "projects funded primarily by the Tribes", recognize "projects that involve no or minimal increases in operational costs", and "will more readily accommodate the wide variances in tribal needs and capabilities."

The FAAB realizes that implementing this plan requires additional authorization but feels strongly that IHS should work with Congress to assure that it is implemented. Under existing authorities, the IHS may be able to allocate funds appropriated for the Small Ambulatory Program and the Modular Dental Unit Program to implement a similar program, and the FAAB believes that IHS should review these options and act to implement them if possible. We are therefore making the following two recommendations:

- ⇒ In the long term, IHS should pursue further authorization to request a line item to allocate funds to the Areas for distribution and that a minimum of 20% of the Facilities Appropriation should be allocated for this purpose.
- ⇒ In the short term, IHS should pursue allocation of some facilities construction funds (Small Ambulatory Program and Modular Dental Unit Program) to Areas for allocation to high priority projects that do not require staffing.

### *Business Plan*

- ⇒ The FAAB recommends that the Small Ambulatory Program Business Plan prototype should be adapted for the HFCPS process, and that all facilities, including larger facilities and all IHS facilities, be required to document a business plan as a part of the IHS facility planning process.

### Criteria Definitions

In addition to recommendations on the concepts of the revised HFCPS, the FAAB recommends several changes to how the Criteria are defined and applied in the formula.

### *Facility Resource Deficiency*

In the Tribal review copy of the HFCPS, The Facility Deficiency value is determined by dividing the existing space by the required space and multiplying the result by 400. Existing space is obtained from the existing IHS Facility Data System or from Tribal documentation of their existing facility and is adjusted by the age and condition of the facility. In addition to asking for general review of the process, the Tribal review copy asked Tribal leaders to indicate their preference of two options for estimating required space: the Health System Planning Process (HSP) or the Supportable Space Formula.

Mr. Hartz - Page 5 of 8

Based on comments received during Tribal review, the FAAB recommends that:

- ⇒ The Supportable Space Formula should be used to estimate required space. The FAAB also recommends that that IHS review this formula to determine if it or another similar formula should be used. In a separate letter we recommend that IHS establish a workgroup to work on this review and and other issues.
- ⇒ Existing space for Maintenance-and-Improvement-eligible leases should be estimated in the same way as for owned space, and existing space for other leases should be set at 0 in the formula.
- ⇒ Tribes that have incurred debt to acquire a facility should be permitted to adjust existing space by 12 percent of the current principal, based on the value of original principal amortized over 30 years (regardless of the actual terms of the lease, payment schedules, or actual payment). This adjustment permits tribes that have borrowed to fund construction, and so reduced the need for repair, improvement, or replacement, to be considered under the HFPCS.

#### *Facility Size Factor*

The Tribal review copy of the HFPCS capped the Facility Size Factor so that larger facilities all received no benefit for this factor.

- ⇒ The FAAB recommends that the formula for developing the Facility Size Factor should not be capped but extrapolated for larger facilities.

#### *Isolation*

- ⇒ The FAAB recommends by vote, with one dissent, that the IHS should use road miles to determine Isolation. If a facility is not on roads connecting eventually to state or Federal highway systems or is most commonly accessed by other than motor vehicle, it will receive the full benefit of the Isolation factor. Some IHS staff had suggested that off the shelf mapping software would be used to validate this data, and the FAAB indicated that IHS should make clear what this would be.

#### *Innovation*

The Tribal review copy of the HFPCS placed Innovation in Phase II, and did not include it in the initial review of Phase I. The FAAB believes that some aspect of innovation should be included in Phase I to assure that Tribes with identified innovations are not eliminated from consideration before Phase II.

- ⇒ The FAAB recommends that those elements of Innovation that can be easily measured (e.g., those that will result in a measurable cost savings to the government) should be included in Phase I and that the Phase I Innovation Factor should be based on measurable cost savings.
- ⇒ The FAAB recommends that the following formula be used to determine the Phase I Innovation factor:

$$1 - \left( \frac{\text{IHS portion of the Construction cost of the Proposed project}}{\text{Total Cost of project if total allowable space was funded by IHS}} \right) \times 50 = \text{Innovation I}$$

#### *Health Status*

The Tribal review copy of the HFPCS indicated that Health Status would include three health indicators from the Federal Health Benefits Plan Disparities Index (FDI). The FAAB believes that all four indicators should be incorporated

Mr. Hartz - Page 6 of 8

⇒ The FAAB recommends that the Health Status Factor incorporate the FDI Birth Disparities Indicator in addition to the FDI Percent of the population over 55 years old, the FDI Composite Poverty Indicator and the FDI Disease Disparity Indicator.

### *Criteria Weighting*

The Tribal review copy of the revised HFPCS weighted the Facility Resource Deficiency highest in both phases of the HFPCS. But many FAAB members believed that a community's health status should have a greater impact on where a facility should go.

The Tribal review copy of the HFPCS included a table showing weightings of each criterion as follows:

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

⇒ The FAAB recommends that weighting of the criteria in the HFPCS formula be as follows:

	Facility Deficiency	+	Health Status/Health Resources	+	Access to Care	+	Facility Size	+	Innovation	Potential Score
Phase I	300	+	300	+	100	+	150		50	900
Phase II	400	+	200	+	150	+	150	+	100	1000

⇒ In addition because the FAAB believed that IHS should reduce the chance for ties in the process, it recommends that, in both phases, the Health Status score should be the initial tie breaker with the other factors being assessed in order of the Phase I weight (i.e., Health Status, Facility Resource Deficiency, Facility Size, Isolation, and Innovation).

### *Grandfathering*

A major issue of discussion throughout the process of developing the HFPCS was the issue of how to deal with those projects identified for possible prioritization in 1993 that have not yet obtained an approved Program Justification Document. Discussion on this issue has been extensive and very difficult because some Areas and Tribes believe these projects are still high priority and that they should not be expected to re-compete for priority standing. They point out that extensive work has already been done for these projects and that, if they were removed during a prioritization process, resources expended would be lost. Other Areas and Tribes point out that many things have changed since 1993 and that the priorities identified at that time and not addressed by now, should be re-evaluated.

⇒ The FAAB recommends, with two dissenting votes, that IHS should address these projects as follows:

- 1) Projects that have already received federal earmarked funding for design or construction should not be rescored but should continue to completion.
- 2) Projects currently in the process with approved PJDs or in PJD prep that do not have earmarked funding should go directly to an interim Phase II of the revised HFPCS, without competing in Phase I. These projects would compete, as described below in

Mr. Hartz - Page 7 of 8

- items 3 through 10, with high ranking projects selected from the list of facilities generated during an application of Phase I.
- 3) All other facilities should be reviewed using the Phase I process.
  - 4) The highest ranking facilities identified by the Phase I application, based on the number of projects IHS could expect to fund in three years, should be brought forward to Phase II.
  - 5) All projects identified in items 2 and 4 above should submit documentation required for completion of Phase II, including Business Plans, the draft PJD, RRM, and documentation supporting "Innovations" and "Barriers" claims. Basic planning documents are reviewed per items A-C below before the proposed projects are submitted to the Validation Committee.
    - A HSP – IHS staff validates and approves, as appropriate.
    - B Draft PJD – IHS staff reviews and approves, as appropriate
    - C Phase I and II Site Selection is completed and approved in accordance with existing procedures.
  - 6) The Validation Committee reviews Business Plans, Innovation/Barriers, cost/match documentation. All projects without complete supporting documentation or for which documentation does not support Phase I ranking are moved back to Phase I. Also projects that do not have a completed PJD at this time are moved back to Phase I. These projects may compete in subsequent applications of the Phase II based on their ranking in Phase I.
  - 7) Validated projects are scored and ranked.
  - 8) IHS selects those highest scoring projects that could be funded in the next three years from interim Phase II process and place them on the priority list in order of ranking.
  - 9) The remaining projects will be removed from consideration for placement on the Priority List and will be returned to compete in Phase I during subsequent applications.
  - 10) Arcas and Tribes should be notified of the results of the interim Phase II.
    - a. (Tribes with successful projects may decide if they want to 638 project or not.)
  - 11) Following this interim application of Phase II, the process described above under *Recommended Process Description for the HFCPS* will apply.

#### *Population Issues*

The FAAB noted that User Population used in IHS planning is often not the latest available. We believe that for the HFCPS, the latest data available should be used.


- ⇒ The FAAB recommends that the latest available User Population data be used and that it be projected 10 years.
- ⇒ The FAAB recommends that the HSP should be updated annually with the most current available user population figures.

Mr. Hartz - Page 8 of 8

The FAAB believes it is critical to establish an IHS construction priority system that is responsive to the needs of tribes and that fairly identifies and prioritizes the construction needs in Indian Country. We are confident that the proposed revision, with our revisions incorporated, will do this. The FAAB would like to remain involved in finalizing the HFCPS and asks that IHS continue to keep members informed on progress toward finalizing the revised HFCPS.

I appreciate IHS efforts to seek a process that is fair and responsive. I ask that IHS continue to involve the Tribes and specifically that IHS provides Tribal leaders another opportunity to review and comment on this document. Thank you.

Sincerely, ~~yours~~,

A handwritten signature in black ink, appearing to read "Jefferson Keel". The signature is fluid and cursive, with the first name "Jefferson" written in a larger, more prominent script than the last name "Keel".

Jefferson Keel, Chairperson  
Facilities Appropriation Advisory Board  
Lt. Governor, Chickasaw Nation

# Facilities Appropriation Advisory Board for the

## Indian Health Service

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RADM Gary Hartz, Director  
Office of Environmental Health and Engineering/IHS  
12300 Twinbrook Pkwy, Suite 600  
Rockville, MD 20852

FEB - 2 2006

Dear RADM Hartz;

This letter is a follow up to the Letters of July 21, 2005, and March 10, 2006, in which the FAAB provided recommendations for revising the Healthcare Facilities Construction Priority System (HFCPS).

On October 27, the FAAB met to review draft reports generated by the HFCPS to assess how various options would affect outcomes. The Director, IHS, specifically asked the FAAB to review the reports with attention to three issues where IHS staff and the FAAB still had differences. The three issues in question were:

- Weighting of the Facility Deficiency Factor and the Health Status Factor;
- Using a portion of a Tribe's mortgage on a facility to adjust the facility condition; and
- Counting leased space not maintained by maintenance and improvement (M&I) funds as no space for the purposes of the HFCPS formula.

With regard to weighting, the FAAB, after reviewing priority listings based on different scoring criteria decided that weightings in the proposed HFCPS methodology presented to the Tribes for review in July 2004 should be used. This means the Facility Deficiency Factor should be weighted to a maximum of 400 points and the Health Status should be weighted to a maximum 200 points out of a total of 850 points in the Phase I methodology and a total of 1,000 points in the Phase II methodology. This is a revision of the FAAB recommendation. When we made our initial recommendation, it was understood that the health status measures used in the methodology differentiated health status of populations at the community level. However, during our review of the priority listings it was observed that the health status measures do not differentiate below the Area level, generating essentially the same health status for every facility in an Area. It is understood that, when location specific information becomes available, it will be used.

The priority listings showed that there was little impact on overall scoring or ranking associated with the mortgage and leased space issues. Scores did change if these concepts were incorporated, but in only a few situations were these changes significant; and in no situation did

Page 2 – RADM Hartz

the score change enough to affect significantly the ranking among the top 20 projects. For this reason it was decided by vote that these factors should not be included in the HFCPS methodology. This decision revises the FAAB recommendations regarding these issues.

Because these revisions to earlier FAAB recommendations mean that the HFCPS methodology as presented for consultation in June 2004 would not be changed, we do not believe that it is necessary for IHS to seek additional input from Tribes before implementing the revision to the HFCPS.

The FAAB does make one recommendation that changes the HFCPS process as it was presented to the Tribes in June 2004. This recommendation is to establish the Area Distribution concept, which IHS has agreed to include in the process. Inclusion of this concept, however, does not change the HFCPS methodology and is only implemented when funds are appropriated specifically for Area Distribution. For this reason and because we find a general consensus supporting Area Distribution, the FAAB believes no further consultation is required.

In addition to the issues discussed above, the FAAB noted that some very small facilities are included in the draft reports. Following some discussion about the efficiency of funding construction for such small populations, the FAAB, by vote, recommends that the HFCPS not consider for prioritization any facilities providing services to fewer than 138 users.

After numerous meetings and extensive deliberations by the FAAB along with many opportunities for national consultation, the FAAB is pleased that the revision to the HFCPS is nearing completion.

Respectfully,

A handwritten signature in dark ink, appearing to read "Tim U Rosette", with a stylized flourish at the end.

Tim Rosette, Chairman

# Facilities Appropriation Advisory Board for the Indian Health Service

Tim Rosette, Chairperson

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Julia Davis-Wheeler, Vice Chairperson

Dr. Yvette Roubideaux, Director  
Indian Health Service  
801 Thompson Ave  
Rockville, MD 20837

NOV 12 2009

Dear Dr. Roubideaux,

Thank you for taking the time to meet with the members of the IHS Facilities Appropriation Advisory Board (FAAB) on October 27, 2009 and to welcome us to IHS headquarters. We appreciate your interest in the work of the FAAB and your support as IHS Director for the Facilities program. During our brief meeting, you asked the FAAB for input on three important issues:

1. Should IHS move forward with the revised Health Care Facilities Construction Priority System (HFCPS) currently awaiting clearance by the Office of Management and Budget?
2. What changes would the FAAB recommend to improve the IHS budget formulation process?
3. What role should the FAAB play in the IHS tribal consultation process?

We set aside time on the second day of our meeting to discuss these issues and would like to take this opportunity to respond to your request.

1. Should IHS move forward with the revised HFCPS?

Between 2002 and 2007 the FAAB, workgroups established by the FAAB, IHS staff, and others worked very hard to revise to the existing facilities prioritization process so that it would be fair to all tribes. As a part of that process, a document was developed and sent to all Tribal Leaders for input. In response, IHS received more than 80 letters from Tribal Leaders and others. These letters contained roughly 1,200 comments and recommendations. The FAAB reviewed and discussed the comments submitted and developed recommendations for further revisions. When IHS had addressed the additional FAAB recommendations, we recommended that IHS finalize the document. The Revised Health Care Facilities Construction Priority System was finalized and approved by the Director, IHS, in November, 2007, and currently awaits clearance by the Office of Management and Budget (OMB).

While some FAAB members feel that minor improvements might be made, none believe that another review of the HFCPS would result in a better consensus document or a fairer process than the one described in the document currently awaiting clearance at OMB. The FAAB recommends that you support the FAAB recommendation on the Revised Health Care Facilities Construction Priority System and request that OMB forward the document to Congress in response to their request for the revision.



Dr. Yvette Roubideaux, Director – page 2

2. What changes would the FAAB recommend to improve the IHS budget formulation process?

The FAAB believes the current budget formulation process provides numerous opportunities for tribal involvement, but excludes Tribes from a crucial part of the process in a manner that is contrary to the relationship IHS and the Tribes enjoy as partners in the delivery of Indian health services and to the government-to-government relationship between the United States and Indian Nations. Our concern is that Tribes have no mechanism for reviewing or commenting on the IHS budget as it proceeds through the Department of Health and Human Services and the Office of Management and Budget. To remedy this, the FAAB recommends that you work with the Secretary and other members of the Administration to lift the budget embargo that the Department and OMB (*pass-back*) place on the budget development process. Tribal priorities can change if previous recommendations are not funded, or if pressing priorities of the Administration are recommended, and Tribes should be able to modify or concur with the response to the pass-back.

3. What role should the FAAB play in the IHS tribal consultation process?

The FAAB was not chartered as a consultative body under the current IHS policy on tribal consultation. This is articulated by most members early in their term and reiterated often as the issue arises. Our charge according to the “Plan of Operation for the Indian Health Service Facilities Appropriation Advisory Board” is to provide advice and recommendations on policy, including consultation policy. Specifically the FAAB is charged with:

- Evaluating existing facilities policies, procedures, and guidelines and recommending changes if necessary.
- Participating in the development and evaluation of any proposed new policies, procedures, guidelines or priorities. In addition, should any of the recommendations necessitate changes in law, this group will recommend desired legislative changes.
- Determining when it is necessary and appropriate to seek additional consultation from all Tribes.
- Providing advice and recommendations for other related issues.
- Recommending modifications to operational guidelines of the FAAB.

In October of 2006, we developed the following vision statement:

The FAAB advocates and provides guidance through tribal involvement on all Facilities Appropriations programs to meet the diverse needs of AI/AN communities. To fulfill this vision, the FAAB:

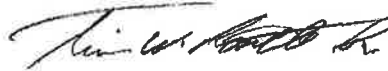
- plays a proactive advocacy role for AI/AN communities,
- develops and recommends strategic directions,
- fosters and promotes agency coordination,
- optimizes resource gathering and utilization, and
- clarifies and promotes its role among all stakeholders.”

Dr. Yvette Roubideaux, Director – page 3

We believe our current charge and our vision statement are consistent with the consultation policy. We do not believe the FAAB has a role in consultation, except as advisors to the IHS in developing issues to be presented for consultation and in developing responses to tribal comments.

As Chairperson of the FAAB, I would like to thank you for taking time from your busy schedule to meet with us, for your thoughtful questions, and for this opportunity to share our thoughts with you.

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Rosette". The signature is fluid and cursive, with a long horizontal stroke extending to the left.

Tim Rosette  
Chairperson