



Regional Ambulatory Surgical & Specialty Health Services Feasibility Study

Update to 2013 Report



by
IHS, California Area Office

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Table of Contents

Introduction	4
• Overview	5
• Problem Statement.....	6
• Product.....	8
• Process	9
• Schedule.....	11
• Participants	13
• Glossary.....	16
Executive Summary.....	23
• A Severe Shortfall.....	24
• A Regional Solution	24
• An Enhanced Level of Care	26
• A Forward Path	27
• The Critical Concern over California User Population	28
Concept of Operation.....	30
• Regional Healthcare.....	31
• Regional Center Definition.....	32
• Update Issues.....	34
• Regional Healthcare Planning Factors	38
○ Populations	38
○ Population Table	39
○ The Critical Concern over California User Population	42
○ Regional Center Locations	42
○ Market Share Erosion	43
▪ Erosion Factor 1 – Payer Profile.....	46
▪ Erosion Factor 2 – Distance to Regional Healthcare.....	47
▪ Erosion Factor 3 – Alternative Care	49
▪ Erosion Factor 4 – Directing Payer Segments.....	51
• Market Share Projections	52
• Market Forces Tool Table	56
• Projected Services by Site	58
○ Northern Regional Center (Sacramento).....	59
▪ Service Area Communities and User Population	59
▪ Delivery Plan and Resource Allocation	60



- Building Area Summary 64
- Southern Regional Center (Temecula)..... 65
 - Service Area Communities and User Population 65
 - Delivery Plan and Resource Allocation 66
 - Building Area Summary 70
- Regional Services & Resource Requirement Summary 71
- Impact of Regional Care Relative to Level of Need Funding..... 72
- Financials..... 73
- Recommendation..... 79
- Appendices.....83**
 - Meeting Presentations..... 84
 - Add-On Services Development 95
 - Transportation 96
 - Lodging..... 102
 - Visiting Specialties 108
 - Pharmacy 115
 - Durable Medical Equipment 121
 - Data Requests 127
 - Alternate Market Forces Planning Tables..... 136
 - Service and Resource Requirements 2013 141



Introduction



Overview

The California Area Health Services Master Plan was completed in 2005. Its primary focus was quantifying the healthcare demand and delivery plan for local primary service areas. The Indian Health Service/California Area Office engaged in a 2011 planning effort to identify and understand the need for regional services that included:

- population and location research
- development of market share projection methodology
- supportable services quantified by location
- projected facility and staffing costs

California Area Indian Health Service (CAO) recently gave presentations about the Regional Specialty Centers Feasibility Study to several stakeholders. Over the course of these meetings, interest in the Regional Specialty Centers concept has grown. At the August 2022 Tribal Leaders Meeting:

- 74% of poll respondents chose to make the Regional Centers the #1 priority for California Area's next health care facility;
- 69% of poll respondents chose Sacramento and 77% of poll respondents chose Temecula for the location of the facilities (31% Redding, 8% Fresno, 8% "somewhere else"); and
- 91% of poll respondents believed we should move forward with revising the Feasibility Study.

But there have also been several questions asked by Tribal Leaders, Program Directors, and Advisory Committee members. In addition to standard updates of the feasibility study for user population, technology updates, and cost, the Tribal Leaders expressed a clear interest in exploring the additional items below (with over 80% of respondents wanting to pursue each of the options listed below).

- Including maternity and childbirth services (67% of respondents chose this option);
- Providing requested on-site services by visiting professionals from the Regional Centers to health program locations;
- Incorporating patient transportation services into Regional Center modeling; and
- Consideration of the Regional Centers serving as a Pharmacy hub for Tribal and Urban health programs to utilize in procuring medications.

While Tribal leaders are broadly supportive of the Regional Specialty Centers concept and the two locations proposed in the original feasibility study, they would like the above considerations included in a revision to the study. This revised feasibility study would have two primary purposes. First it would be the centerpiece of outreach to Tribes and health programs to secure their formal, written support for the Regional Centers concept. Secondly, if sufficient support is realized, the revised study would be the basis for requesting funding for planning activities (Project Justification Document / Program of Requirements / Environmental Review) and eventually full funding for the construction and staffing of the Regional Centers.



Consequently, the CAO requested a revision and update to the above-referenced feasibility study, completed in 2013.

Problem Statement

The problem addressed through this report can be summarized as follows:

How has the need for services grown since the 2013 Regional Study was completed and what additional services should be considered that would be supportable from an updated projection of regional populations served, updated market share to anticipate, updated volumes projected at each regional site, projected employees required, projected cost estimate, and ultimate projected impact to Level of Need Funding for California's American Indian/Alaska Native populations in California?

Detailed base revisions Identified in the Request for Proposal (RFP) included:

- Update the user population data.
- As a baseline, use 2019 IHS user population data where available and reasonably accurate.
- Several health programs are known to have no data or poor-quality data submitted to the National Data Warehouse (NDW).
- Request user population data directly from Tribal and Urban programs which have no data or poor-quality data with the NDW.
 - Programs known not to be submitting data to NDW: Colusa, Greenville, Paskenta, Redding Rancheria, Santa Ynez, Modoc / Strong Family, Susanville, Sycuan, Tejon, Warner Mountain, Wilton, Bakersfield American Indian Health Project.
 - Programs that are submitting data to NDW, but which are known to have data quality issues: Central Valley, Chicken Ranch, MACT, Riverside San Bernardino, Southern Indian Health Council, Toiyabe, AIHS Santa Barbara, Indian Health Council of Santa Clara Valley.
- Are there better data sets with more accurate population numbers available (e.g. BIA membership rolls, census data)? Consider including such data sets as may be applicable.
- Would it make sense for some Phoenix Area Tribes (e.g. those in northern Nevada) to be considered in user population counts where a California Area facility would be much closer than a comparable Phoenix Area facility?
- Update the Market Share Erosion tool given these updates to population. Does this update change any of the conclusions or recommendations of the original study?
- Refresh the contributing financial assumptions that support the calculation of costs.
- Update summary statement of need and accompanying justification narratives.
- Survey sites or acquire data supporting planning assumptions and planning additions.
- Consider utilization/services evolution since 2013. This would require some iterative conversations and study to determine what should be influencing this document.
- Unless there are drastic changes to population or drastic shifts in population, the three- and four- center scenarios should not be revisited.
- Update estimated costs of construction and staffing.



- Break down both costs by facility – Sacramento and Temecula.
- Base costs on final recommended solution. Costs should include estimated land purchase, A/E design, construction, and staffing costs at each facility.
- Update overall study for relevant and recent innovations in healthcare services.
 - What new trends in health care services or technology should be incorporated into the Regional Centers model that were not considered in the 2013 study?
- Study the feasibility of maternity and childbirth services at the Regional Centers.
 - Update construction and staffing recommendations based on results.
- Study the feasibility of some professional specialty services being provided by the Regional Centers on a traveling basis directly at Tribal or Urban health program locations.
 - Which specialty services would be most likely to have the resources and compatibility to be rendered in the field at Tribal sites?
 - (If applicable) Update construction and staffing recommendations based on results.

Additional requested revisions included:

- Study the feasibility for the Regional Centers to manage transportation options for patients and caregivers.
 - Which types of transportation (e.g., bus, shuttle, medical transport) may be feasible to maximize utilization of the center while being economically feasible?
 - How would transportation options (if any) be managed? Directly by Regional Centers or through contract providers?
 - Update construction and staffing recommendations based on results.
- Study the feasibility for the Regional Centers to manage an on-site lodging facility (i.e., hostel) for patients and caregivers.
 - Using user population and travel distance, estimate size of such facility based on expected utilization.
 - Update construction and staffing recommendations based on results.
- Study the feasibility for the Regional Centers to serve as a specialty pharmacy hub for the Tribal and Urban health programs in the region. Hub services may include case management, benefits investigation/verification (BI/BV), prior authorization assistance, distribution support, nursing support, health care professional education, patient adherence and education, and noncommercial pharmacy dispensing.
 - Without doing an in-depth analysis, consider the following question: Which of the above features of a pharmacy hub (if any) may be feasible given the user population and geographic distribution and pharmacy capacities of the existing urban and Tribal health programs?
 - Based on informed assumptions, make adjustments to workloads, staffing and space for such a facility.
 - Update construction and staffing recommendations based on results.



- Study the feasibility of the Regional Centers serving as a Durable Medical Equipment (DME) hub to serve tribal and urban health programs (crutches, walkers, wheelchairs, oxygen tanks, infusion pumps...etc.)
 - If such a program is recommended, based on informed assumptions, make adjustments to workloads, staffing, and space for such a facility.
 - Update construction and staffing recommendations based on results.

Product

This report identifies American Indian/Alaska Native (AI/AN) populations projected to 2033 and market share from which health services for two (2) Regional Centers were previously developed. This update identifies essential supportable services, required space and staff, and anticipates initial construction, project, and annual operating costs. This effort is limited to AI/AN populations and what IHS would support in combination with services not typically planned for in Indian Health Service (IHS) projects.

This report updates projections only to the two (2) center regional solution developed in the 2013 report. All RFP requested revisions were considered in the planning effort though not all resulted in projected staff/space for 2033. The actual planning process evolved to include workgroup formation and multiple meetings with each to assist, particularly in the consideration of additional services requested in the RFP.

The following assumptions were embedded in The Innova Group's (Consultant) work proposal, and ultimately guided the development of the report that follows.

- Baseline assumptions will be updated (market forces, etc.). Underlying assumptions (previous research studies, etc.) are not.
- Only tables/narrative contributing to the recommended two-center solution will be updated.
- Supporting maps are not updated unless supporting data for the two-center solution represented has changed.
- No appendices material will be updated. This will be left as a point of reference to the current update.
- Phase 2 additional revisions will be conceptual in nature, providing a feasibility analysis based on the quality of data available.
- Project will await fulfillment of data request submitted to sites in Phase 1 prior to proceeding beyond that.
- Projection year is 2033.
- Project cost estimate will rely on Consultant internal tools/metrics – DES will not be providing FBES estimate.
- Financial updates include staff and space costs. They do not include revenue/expense/margin projections. Per encounter costs and LNF impact will be escalated by appropriate inflation over time. A new data request to the IHS NDW and ensuing analysis is not included.
- Payor Profile update will rely on updated data from California Area IHS.



Process

The effort required two (2) phases of work over a thirteen (13) month period. A description of each phase as scoped follows. Actual meetings were increased to support stakeholders participation.

Phase 1 - Regional Centers Plan Update

The purpose of this phase was to identify and assess the potential impact of planning assumptions supporting the conceptual development of health services for two (2) Regional Centers. The Consultant prepared demographic data and a regional discussion guide to facilitate clarity in the CAO's vision for regional centers and how this planning effort should support such.

Phase 1 tasks included:

- Review existing Regional Centers Report, key findings, and supporting assumptions. Outline updated report and workplan.
- Gather critical assumptions and draft data request.
- Preliminary study of Health Systems Planning (HSP) populations and projections for sites and Regional Centers.
- **Project Call 1:** Discuss key assumptions status and data requirements with California Area
- Complete and submit data request
- Support data request fulfillment / QC
- Vet / align current PSA sites with the 2 Regional Center proposal
- Update Market Forces Tool and Contributing Assumptions
- Evaluate likelihood of Phoenix IHS Area user populations using Regional Centers
- Adjust / edit tool for update effort
 - Update User Populations
 - Update Payer Profile
 - Update Payer Shift
 - Update Distance to Regional Centers
 - Update Alternative Care Impact
 - Update Directing Payer Segments
- Research recent innovations in health care services/delivery pertinent to this report and add as appropriate. Update staffing, space, and costs.
- Study feasibility for incorporating maternity and childbirth services at Regional Centers. Update staffing, space, and costs.
- Study feasibility of visiting specialty services from Regional Centers. Update staffing, space, and costs.
- Update Projected Services and Key Characteristics for 2-Center solution
- Update per encounter cost data
- Update supporting financials for two-center solution



- Update LNF Impact
- Update final recommendation
- Develop narrative on implications of unexpected increased population and utilization
- Update relevant narrative sections
- Assemble Draft Report for Review.
- **Project Call 2:** Review Draft Report with Area
- Area Internal Review Period
- **Project Call 3:** Receive Area comments and discuss
- Edits analysis & projections / comments
- Update all narratives
- Assemble updated final report, print, and ship

Phase 2 - Regional Centers Concept Development

The purpose of this phase was to utilize agreed upon planning assumptions from Phase 1 to develop planning documentation that identified two (2) concepts for two (2) Regional Centers by projection year, identifying the services, staff, space, and costs.

Phase 2 Tasks included:

- Prepare to study feasibility of Regional Centers managing transportation options for patients and caregivers.
 - Determine transportation assumptions for volumes, sites, and schedule
 - Determine preferred transportation mode and management options
 - Update report with findings and supporting narrative
 - Update facility staff, space, and costs
 - Review draft with Area
 - Edit per comments and ability for Final Report
- Prepare to study feasibility of Regional Centers managing onsite lodging for patients and caregivers.
 - Study other lodging services provided in Indian Country
 - Determine patient and provider lodging volumes and utilization assumptions
 - Determine size of lodging facility for patients and caregivers
 - Update report with findings and supporting narrative
 - Update facility staff, space, and costs
 - Review draft with Area
 - Edit per comments and ability for Final Report
- Prepare to study feasibility of Regional Centers serving as a Pharmacy Hub for Tribal and Urban health programs. In-depth analysis will not be provided per SOW.
 - Research and identify which features may be feasible per planned population, distribution, and pharmacy capabilities.



- Update report with findings and supporting narrative
 - Update facility staff, space, and costs
 - Review draft with Area
 - Edit per comments and ability for Final Report
- Prepare to study feasibility of Regional Centers serving as Durable Medical Equipment Hub to service tribal and urban health programs.
 - Develop critical assumptions
 - Develop projected workloads
 - Update report with findings and supporting narrative
 - Update facility staff, space, and costs
 - Review draft with Area
 - Edit per comments and ability for Final Report

Schedule

The graphic on the following page illustrates the process and timeline for project completion along with an overview of the work effort occupying Consultant between meetings/reports. There can often be delays associated with data acquisition and this project was no exception. Population/payer data by service unit took several months to acquired and slowed project progress.



Project Schedule

Conference Video Call => Deliverable => Adtl. Revisions Mtgs => Past Meetings/Calls=>

Month=>	Dec-22				23-Jan				23-Feb				23-Mar				23-Apr				23-May				23-Jun				23-Jul				23-Aug				23-Sep				23-Oct				23-Nov				23-Dec				24-Jan							
Project Week #=>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	
Ph 1 Regional Centers Plan Update																																																												
Project set up and data request preparation	[Blue bar from week 1 to week 4]																																																											
Project call #1	[Black star icon at week 3]																																																											
Data request submission and fulfillment support	[Blue bar from week 1 to week 35] [Yellow bar from week 5 to week 35] National Data Warehouse Data Acquisition																																																											
Assumptions & Market Forces tool update (and Leadership Review Call)	[Blue bar from week 6 to week 13] [Black star icon at week 38] [Arrow from week 38 to week 45] [Black star icon at week 45]																																																											
Innovations in health care research and addition	[Blue bar from week 9 to week 16]																																																											
Maternity & childbirth services addition study	[Blue bar from week 44 to week 51]																																																											
Visiting Specialties to sites addition study (see below)*	[Grey bar from week 1 to week 55] See below (Ph. 2 Additional Revisions)																																																											
Update key characteristic projections	[Blue bar from week 44 to week 51]																																																											
Update site, staff, facility requirements	[Blue bar from week 44 to week 51]																																																											
Update supporting financials & LNF	[Blue bar from week 44 to week 51]																																																											
Assemble and submit draft report for Area review	[Blue bar from week 44 to week 51]																																																											
Project call #2	[Black star icon at week 53]																																																											
Area Review Cycle	[Blue bar from week 53 to week 56]																																																											
Project call #3	[Black star icon at week 57]																																																											
Update and edit draft report per Area concerns	[Blue bar from week 57 to week 58]																																																											
Assemble and submit final updated report	[Blue bar from week 58 to week 59] [Yellow box icon at week 59]																																																											
Ph 2 Additional Revisions																																																												
Regional Centers Transportation Service Feasibility Study	[Blue bar from week 1 to week 59] [Black circle icon at week 7] [Black circle icon at week 13] [Black circle icon at week 23] [Black circle icon at week 29]																																																											
Regional Centers Lodging Services Feasibility Study	[Blue bar from week 1 to week 59] [Black circle icon at week 10] [Black circle icon at week 14] [Black circle icon at week 24]																																																											
Regional Centers Visiting Specialties Feasibility Study*	[Blue bar from week 1 to week 59] [Black circle icon at week 13] [Black circle icon at week 14] [Black circle icon at week 29]																																																											
Regional Centers Pharmacy Hub Services Feasibility Study	[Blue bar from week 1 to week 59] [Black circle icon at week 13] [Black circle icon at week 15] [Black circle icon at week 29]																																																											
Regional Centers Durable Medical Equip. Feasibility Study	[Blue bar from week 1 to week 59] [Black circle icon at week 13] [Black circle icon at week 14] [Black circle icon at week 29]																																																											



Participants

A project such as this achieves success only as a result of the dedicated participation of many people. This effort is indebted to the following participants who have given of their time to be thought leaders in shaping and encouraging meaningful analysis and actionable conclusions.

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**Regional Ambulatory Surgical & Specialty
Health Services Feasibility Study Update**

IHS, California Area Office

Report Update

Introduction



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Glossary

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

ACA.....	American Patient Protection and Affordable Care Act, signed into law by President Obama March 23, 2010, otherwise referred to in this document as Reform.
ADA.....	Americans With Disabilities Act, signed into law in 1990.
AI/AN.....	American Indian and/or Alaskan Native.
Alternative Care	Alternative rural or urban hospitals accessible by patients anywhere in route to a proposed Regional Center.
Area.....	The IHS consists of 12 large geographic and/or tribally organized administrative units responsible for the planning and provision of healthcare within each of their Service Areas.
b	Billion.
BGSM(F)	Building Gross Square Meters (or Feet). Building space requirements can be understood and quantified at the room, department and building level. The building level incorporates all space within the building, including all rooms, departments, circulation and shared mechanical/electrical.
BIA.....	Bureau of Indian Affairs.
CAO	IHS, California Area Office, one of twelve IHS Areas.
CAO Workgroup	California Area Office Workgroup consisting of IHS Area Staff Members for most meetings and supplemented by members of the CATAC (see below).
CATAC.....	California Area Tribal Advisory Committee, a standing workgroup that was part of the CAO workgroup (see above).
CHS.....	Contract Health Services. Healthcare services that must be purchased from Non-IHS providers, based upon threshold issues or high acuity. These are generally facility and professional services of greater scope and intensity than are available through IHS facilities and providers.
CHSDA	Now referred to as PRCDA. Counties defined all or in part as the Contract Health Services (PRC) Delivery Area. To receive



Contract Health Services (PRC) payment for needed services outside of the IHS delivery system, an American Indian/Alaska Native must reside within this area.

- Construction Cost..... The sum of construction and equipment costs for a facility project. This does not include site acquisition and preparation.
- Deliverable A specific planned report from The Innova Group given to the Planning workgroup, Area Office and/or Primary Service Area.
- DES Division of Engineering Services.
- DGSM(F) Department Gross Square Meters (or Feet). Building space requirements can be understood and quantified at the room, department and building level. The department level incorporates all rooms and circulation spaces within departmental boundaries.
- DME..... Durable Medical Equipment. Equipment and supplies ordered by a health care provider for everyday or extended use.
- DPW Delivery Planning Workbook - The Innova Group’s proprietary planning tool that utilizes historical workloads, national, and Health Systems Planning (HSP) software utilization rates, and IHS accepted planning benchmarks to facilitate delivery planning and calculate the resulting resource requirements.
- Discipline A specific medical specialty (e.g.: primary healthcare, dentistry, or radiology).
- Efficiency Factor..... A percentage applied to service workload/staffing to determine adjusted workload/staffing in case of user error, travel difficulty, holidays, and hours of operations, patient cancellations, and no-shows.
- FBES..... Facilities Budget Estimating System.
- FTE..... Full-Time Equivalent is a unit of measurement used to figure out the number of full-time hours worked employees.
- Health Program A California Primary Care Delivery System for one or more Tribes, often a consortium, consisting of one or more clinics. This is somewhat synonymous with Service Unit.
- Health Services Master Plan An Area wide planning exercise driven by a “ground-up” consideration of who should access care at each of the Area’s healthcare facilities, a breakdown of their age and sex by which



to project workloads for a target planning year, typically 10 years out. Workloads by service line are then considered for delivery options: delivery needed care on-site, through PRC Services, referral to the Service Unit, or through some regional partnership. On-site workloads are converted into needed space and staff. PRC Services workloads are converted into need dollars. All service areas are “rolled-up” into an Area-wide Summary.

- HFPCS Healthcare Facilities Construction Priority System – IHS’ methodology for scoring and ranking facility projects for funding and ultimately construction and staffing. It currently scores applicants out of 850 possible points for Phase 1, and 150 possible points for Phase 2. Projects that score the highest may be place on the Priority System for funding as it becomes available.

- HSP Health Systems Planning process software - the computer application that manages the IHS tool for the planning, programming, and design of health facilities.

- IHS The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes.

- Justification Used within the context of whether or not workload, criteria and market assessment “justify” the placement of resources or services at an identified location.

- KC Key Characteristic. The recognized significant component of a discipline’s ability to deliver care (e.g.: physician, radiology room).

- LNF Level of Need Funding. A measure that assesses how American Indian/Alaska Natives are funded by the Federal Government relative to the Federal Employees Health Benefit (FEHB). It is most often presented as a percentage. It does not include environmental or preventive health. It is not comparable to per capita spending on healthcare nationally, federally, or by state.



Local Sites.....	Tribal clinics not located in Sacramento or Temecula that would benefit from Regional Center services.
MFT	Market Forces Tool. An analytical tool that matriculates Health Program User populations through each of the erosion factors to arrive at a high and low market share for each Regional Center.
m	Million.
Market Share	The percentage of the user population from a specific community that is expected to be served at a facility for a specific discipline.
Market Erosion.....	The effect of distance, competitors, and payment ability on patients who seek care at a given facility. For example, if 92% market share is planned for a facility, it means the full market (100%) has been eroded by 8%. Such erosion may occur because some users will not drive that far, or because their service is not covered, or because they simply chose to go somewhere else.
NDW.....	National Data Warehouse. A state-of-the-art, enterprise-wide data warehouse environment for the Indian Health Service's (IHS) national data repository.
NIUOIS.....	National Indian Urban Organization Infrastructure Study
OUIHP.....	Office of Urban Indian Health Programs
Payer Profile.....	An analysis of the payer mix for a Service Area, typically focusing on Medicare, Medicaid, Veterans and other third party payers that may or may not affect the Service Area's ability to raise third party billing thereby increasing revenue.
Payer Segment	One payer within the Payer Mix, such as the commercial payer component or segment, or Medicare segment. All segments together form the complete Payer mix.
PJD.....	Program Justification Document justifies the need of health care services that are to be provided in a proposed new or renovated/expanded health care facility, the workloads and population being served, and a description of the space that will house the proposed health care services.



- POR.....Program of Requirements is a detailed description of the space that will house the proposed health care services.

- PRC.....Purchased/ Referred Care. The PRC Program is for medical/dental care provided away from an IHS or tribal health care facility. PRC is not an entitlement program and an IHS referral does not imply the care will be paid. If IHS is requested to pay, then a patient must meet the residency requirements, notification requirements, medical priority, and use of alternate resources.

- PRCDA.....Purchased/Referred Care Delivery Area. Now referred to as PRCDA. Counties defined all or in part as the Contract Health Services (PRC) Delivery Area. To receive Contract Health Services (PRC) payment for needed services outside of the IHS delivery system, an American Indian/Alaska Native must reside within this area.

- Primary Care The standard benefits offered at most IHS and tribal clinics serving smaller typically rural populations, consisting of family practice, dental, behavioral health, pharmacy, some preventive care.

- PSA A group of communities and its population for which, at a minimum, the primary care disciplines are being planned and resourced. Referred to as the Primary Service Area.

- Project Cost..... The sum of site acquisition, preparation, construction, and equipment costs for a facility project. This is a larger amount than simple construction costs.

- RC..... Regional Center.

- Reform The American Patient Protection and Affordable Care Act (see above).

- RRM..... Resource Requirements Methodology: The IHS staffing methodology.

- Regional Care Services offered through extended service areas to appropriately grouped user populations (referral partners), most often specialty care, advanced diagnostics, imaging, surgery, and acute care.



Regional Centers	Specific sites offering Regional Care, sometimes referred to as Regional Centers, Referral Centers, secondary care sites, etc.
RCPW.....	Regional Center Planning Workgroup
Regionalization/Referral Partners.....	The grouping of workload from different Primary Service Areas for the purpose of stretching resources and improving access. A region may be as simple as a referral pattern among facilities creating effective leverage to purchase commonly needed services, or it may be a facility where on site resources are justified and can be offered to one or more Primary Service Areas thereby stretching PRC dollars.
RPMS.....	Registered Patient Management System: the IHS standard Patient record system that forms the data basis for the master planning process.
Secondary Care	The next step in higher acuity from Primary Care, most often consisting of specialty care, advanced diagnostics, imaging, surgery, and acute care.
Service Area	The communities and its population intended to be supported by a specific discipline’s resources.
Service Population	The IHS understanding of the number of American Indian/Alaska Natives living within a county which may or may not be users. Census based and projected into the future. Primarily used for growth projection and market opportunities.
Service Unit	An administrative unit overseeing the delivery of healthcare to a specific geographic area. May consist of one or more facilities, Service Areas, or Primary Service Areas.
SOW.....	Scope of Work
Specialty Medicine.....	Medications typically harder to access or at high costs that are often prescribed for chronic or more severe illnesses.
SSER.....	Site Selection and Evaluation Report.
TBD.....	To Be Determined.
Tertiary Care	The next step in higher acuity from Secondary Care, most often consisting of higher acuity inpatient care and interventional services such as Neonatal Intensive Care Unit (NICU), Cardiac Catheterization, Open Heart Surgery, etc. These services are usually referred out of IHS/Tribal facilities to the private sector.



- Threshold The minimum workload and/or remoteness necessary to justify the provision of a specific discipline.
- Travel Distance..... The distance a User has to travel from his home to a facility to receive care.
- User An American Indian/Alaska Native that has received or registered to receive healthcare in the past three years.
- User Population The number of Active Indian Registrants in the healthcare system from a specified area that have utilized the system in the past 3 years.
- Visiting Specialists..... Specialty Care providers traveling to local sites to provide patient care.



Executive Summary



A Severe Shortfall

California American Indian/Alaska Natives (AI/AN) continue to experience a severe shortfall in secondary care, most often provided through referrals to the private sector for inpatient and specialty care. This is a hardship to an already challenged population.

California Indian Health Service (IHS) presents this updated study supporting two Regional Ambulatory Surgical & Specialty Centers for AI/AN as a strategy for improving access to documented and needed secondary care, closing the Level of Need Funding (LNF) shortfall by as much as 49.9 percentage basis points, and providing a path for IHS to demonstrate its ability to build and operate culturally appropriate healthcare facilities.

A Regional Solution

This updated study suggests that two Regional Ambulatory Surgical & Specialty Centers, owned/operated by IHS, providing culturally appropriate care, are the best solution, potentially increasing California Area's LNF from 37.3% to 87.2%.

- One facility centrally located in the central/northern region, such as Sacramento, to serve the referral needs of central and northern California tribal governments:
 - 573,474 building gross square feet (BGSF) with 1,611.0 FTEs. *For additional information see Concept of Operation.*
- One facility centrally located in the southern region, such as Temecula, to serve the referral needs of southern California tribal governments:
 - 308,018 building gross square feet (BGSF) with 831.5 FTEs. *For additional information see Concept of Operation.*

Each would provide an enhanced level of secondary healthcare for AI/AN residing in California, including Medical & Surgical Specialty care, Surgery, advanced Diagnostic Imaging, and Acute Care, to name a few.

- The updated total project cost for both locations is estimated at \$1.21b.
- The updated annual operating cost for both locations is estimated at \$446.4m.

The summary provided on the following page shows the projected regional center user population, clinical services, associated key characteristics, departmental gross square feet, total staff, and total building gross square feet for each location. Administrative, facility, and support services are not shown, though staff and departmental space are included in the totals.

Regional Ambulatory Surgical & Specialty Health Services Feasibility Study Update

IHS, California Area Office

Report Update
Executive Summary



Regional Population KC = Key Characteristic =>	2 Regional Centers					
	Temecula		Sacramento			
	KC #	DGSF	KC #	DGSF		
Ambulatory						
<i>Audiology (Audiologists)</i>	2.9	2,554	5.1	4,458		
<i>Dental Care - Specialty Only (Sp. Dentists)</i>	10.2	15,748	17.6	31,143		
<i>Oral Surgery, Pediatric, Endodontist, Orthodontist, Prosthodontist, Peridontist</i>						
Specialty Care						
Medical Specialties (Providers) *						
<i>Cardiologist</i>	1.8	18,341	3.4	36,324		
<i>Dermatologist</i>	1.4		2.5			
<i>Neurologist</i>	1.0		1.8			
<i>Other Medical Specialists</i>	8.6		15.8			
Surgical Specialties (Providers) *						
<i>General Surgeons</i>	2.6	18,341	4.9	36,324		
<i>Ophthalmologists</i>	2.9		4.9			
<i>Orthopedist</i>	3.0		5.5			
<i>Otolaryngologist</i>	1.5		2.6			
<i>Urologist</i>	1.3		2.0			
<i>Other Surgical Specialists</i>	1.9		3.6			
Ancillary						
<i>Outpatient Endoscopy (Suites)</i>	1.0		16,825		2.0	30,284
<i>Outpatient Surgery Cases (OP ORs)</i>	4.0	7.0				
<i>Short Stay / Observation (Beds)</i>	1.0	1.0				
<i>Laboratory (FTE)</i>	16.8	5,764	30.0	7,705		
Diagnostic Imaging						
<i>Radiography (Rooms)</i>	3.0	16,772	6.0	22,487		
<i>Fluoroscopy (Rooms)</i>	1.0		2.0			
<i>Bone Density (Rooms)</i>	0.0		1.0			
<i>Ultrasound (Rooms)</i>	2.0		3.0			
<i>Mammography (Rooms)</i>	2.0		4.0			
<i>CT (Rooms)</i>	2.0		2.0			
<i>MRI (Rooms)</i>	2.0		2.0			
<i>Radiologist</i>	4.1		6.0			
<i>Pharmacy (Pharmacists)</i>	18.1	10,263	35.0	19,893		
Inpatient Care						
<i>Pediatric (Beds)</i>	5	34,553	9	56,668		
<i>Adult Medical (Beds)</i>	37		62			
<i>Adult Surgical (Beds)</i>	24		39			
<i>ICU (beds)</i>	12		18			
Physical Rehab Services						
<i>Occupational Therapist</i>	4.3	3,823	7.5	6,745		
<i>Speech Therapist</i>	0.9		1.6			
Behavioral Health						
<i>Psychiatry (Psychiatrists)</i>	2.5	858	5.4	1,883		
Other Programs						
<i>Case Management (FTEs)</i>	15.6	2,948	26.6	5,031		
<i>Pain Management (DGSF in Specialty Care)</i>	1.0	-	1.8	-		
<i>Lodging (BGSF)</i>	20.3	17,653	108.2	-		
<i>Transportation</i>	27.5	620	161.9	1,091		
<i>Visiting Specialties (DGSF In Specialty Care)</i>	3.3	-	6.0	-		
<i>Durable Medical Equipment</i>	9.5	5,599	14.0	9,684		
Regional Center All Clinical and Support Services Summary						
Total FTEs		831.5		1,611.0		
Total BGSF		308,018		573,474		

* For detail see Regional Concept of Operation Delivery Plan and Resource Allocation

Regional Services & Resource Requirement Summary

This updated feasibility study completed by the IHS, California Area Office, refreshes the prior study that found that two Regional Centers are the best solution to close the disparity gap in funding.

One center for northern and central California and one for southern California would provide desperately needed access to secondary, inpatient, surgical, and specialty care.

Costs

- Total Construction Cost for Regional Ambulatory Center development in two locations is estimated at \$900.4m (not including site acquisition).
- Total Project Cost for Regional Ambulatory Center development in two locations is estimated at \$1.21b (not including site acquisition).
- The Annual Operating Cost for Regional Ambulatory Center development in two locations is estimated at \$446.4m.

Impact

- The Level of Need Funded (LNF) could improve from 37.3% to 87.2%, closing the gap toward the Federal Benchmark by 49.9 basis points. This represents a projected increase from \$2,285 to \$5,347.
- The LNF increase is based on a projected 2033 area-wide user population of 145,791 (or a projected regional user population of 137,110).



An Enhanced Level of Healthcare

These two Regional Ambulatory Surgical & Specialty Centers would enhance the level of healthcare for AI/AN residing in California in at least five important ways.

1. **First, these facilities would provide statewide access to needed healthcare.** Appropriate locations for regional care in the north/central and southern parts of California would provide reasonable travel time to access consistent secondary care. The alternative, creating agreements with local hospitals, would result in inconsistent access and care for many tribal healthcare programs (*see Concept of Operation*).
2. **Second, secondary services currently not accessible, but sponsored by IHS in other IHS areas, would be available.** Other IHS areas have access to the levels of regional care identified in this study (examples include Phoenix Indian Medical Center in the Phoenix Area, Gallup Indian Medical Center in the Navajo Area, and Alaska Native Medical Center in the Alaska Area). Such facilities in California would not only help eliminate current gaps in the continuum of care for AI/AN residing in California but increase the level of access and presence of direct care services to what is currently available in other IHS areas.
3. **Third, healthcare in a culturally appropriate environment would be rendered.** The provision of secondary care through contracts with local hospitals fails to address the need for cultural awareness. Providing needed services in a culturally appropriate environment will help raise the health of California AI/AN to the highest level.
4. **Fourth, they would make limited Purchased and Referred Care (PRC) funding more available for higher levels of acute care.** Providing direct secondary care at Regional Centers allows local health programs to spend limited PRC dollars on other care that must be secured from the private sector, stretching those dollars while increasing access to higher level care.
5. **Fifth, these facilities could close the disparity gap in Level of Need Funded (LNF).** The 2023 annual Federal Employee Health Benefit (FEHB) is \$6,131. California's present recurring federal funding is estimated to be \$2,285 per user, or 37.3% of the FEHB. The projected value of secondary care satisfied by these Regional Centers would significantly reduce the existing disparity gap between the two, from 62.7% to 12.8%, a reduction of 49.9 percentage basis points. This represents an estimated increase in LNF from \$2,285 per-user to \$5,347 per-user for AI/AN residing in California, an additional \$3,062 per-user for a projected 2033 area-wide user population of 145,971.

This estimated LNF impact is calculated by relating total anticipated operational costs (operations plus depreciation) to the projected California Area user population to produce a per-user dollar value. This value reflects the LNF investment IHS is being asked to make in healthcare delivery for AI/AN residing in California. This value also approximates the market cost of all referred healthcare demand projected to be satisfied at two Regional Ambulatory Surgical & Specialty Centers (*see Concept of Operation*).



A Forward Path

This updated study provides the concept, requirements, and guiding assumptions to continue the process of bringing regional care from recommendation to reality in improving health outcomes of AI/AN residing in California to the highest level. Implementation requires active IHS/Tribal involvement and the following steps:

- Support from the California tribal governments for the development of planning and project approval documentation, design, construction, and staffing
- Tribal and IHS adoption of this report
- IHS support in review and consideration of appropriate additional planning documentation
 - Comprehensive California User Population Study
 - This study should involve the CATAC, California Program Directors, California IHS Area Leadership, and IHS HQ to examine and resolve concerns over California's user population counts. Documented reporting errors, numerous non-reporting sites, and significant potential urban user counts offer suggest HSP user counts underestimate the need for regional care. See *The Critical Concern over California User Population* in the following section.
 - Regional Centers Financial Analysis
 - This study should provide financial planning typical for a capital investment of such kind. The analysis would include a projection of income, expenses, and net revenue for key service lines, environment scan/competitive landscape review, and risk analysis. While the projection of regional care feasibility as presented in this report are primarily concerned with user need and access, a projection of financial performance should be developed and understood.
 - Program Justification Documents & Program of Requirements
 - These are standard planning documents that determine and justify the need for services and the facility requirements to support required services. A Facility Budget Estimating (FBE) cost estimate should be part of this. Special provision should be made for study beyond what is typically necessary for the following add-on services:
 - Transportation – involvement of an appropriate transportation planning contractor or subcontractor is highly recommended
 - Lodging – involvement of an appropriate lodging/hotel planning contractor or subcontractor is highly recommended
 - Site Study
 - This effort would include the standard Site Selection and Evaluation Report I (SSER) in the identification of potential sites and more rigorous analysis of the recommended site in an SSER II.



- It might also consider a preliminary site availability/cost study supported by real estate expertise.
- Additional Planning Considerations
 - California Area Health Services Master Plan Update
 - An update of this important contextual document should be strongly considered. It can provide valuable site level information concerning needed regional services, anticipated user population travelling to regional care, obstacles to sites participating in regional care, visiting specialty experience, and more. The rollup of site level conversations on regional care for all of California's programs would greatly inform the regional planning steps identified above.
 - Traffic Study
 - While general analysis may happen as part of an SSER II, the urban nature of these Regional Centers suggests a more comprehensive traffic study should be considered in support of each.
 - Broadband and Technology Assessment
 - The current healthcare landscape increasingly relies on Telemedicine for patient/provider interaction and is a growing means of delivering healthcare. Regional care will rely on adequate connectivity to support its mission. Local sites will need to undergo an assessment of their respective technology and broadband capabilities, California IHS should assist in coordinating these efforts.
- Funding
 - Because of the likelihood that regional care may be implemented through a phased approach, participating planning program directors have expressed concern that funding be provided for the entire project with this in mind. This would ensure that the entire program of regional care is realized rather than only a portion of it.

The Critical Concern over California User Population

This updated study is primarily built on 2019 HSP user populations (to minimize the impact of COVID-19) projected to 2033. However, for many California service units, the HSP user population reported is not accurate due either to known reporting problems or non-reporting sites. Where these issues were substantiated, site-reported user populations were utilized (if submitted in response to the site data request) instead of the HSP user population. Urban populations are also of concern relative to those in the HSP. Projections can vary dramatically depending on the urban service area definition or anticipated new users attracted by the possibility of no-cost secondary care at a regional site. Consequently, where the HSP user population for urban centers was unacceptable to the Regional Center Planning Workgroup (RCPW), an alternative was used instead – typically, the user population from the recently completed



National Indian Urban Organization Infrastructure Study (NIOUIS from the Office of Urban Indian Health Programs (OUIHP).

As part of the path forward, a comprehensive study of user population across California must be engaged in with the direct involvement of Tribes, Area, and IHS Headquarters (IHS HQ).



Concept of Operation



Regional Healthcare

Regional Healthcare is not new to American Indian/Alaska Native (AI/AN) Healthcare, whether operated by IHS or Tribal entities. It is, however, unusual to consider it apart from anchor services typically associated with a concept of operations; services such as primary care, dental, and preventive health. Such is the healthcare focused on in this planning effort: one or more regional locations offering secondary specialty, surgical, and acute care for the expressed purpose of supporting primary healthcare assets already in place at local health programs serving AI/AN across the state.

From California's point of view, the rationale for pursuing such healthcare is clear:

- To provide AI/AN who reside in California secondary services currently not accessible
- To provide AI/AN who reside in California secondary services through direct care, eliminating a long-standing barrier to access
- To stretch limited future PRC Dollars for California Tribal Health Programs
- To close the gap between projected California PRC funding and projected demand (this has been a historic concern)
- To respond to the requests of California Tribes and their continuing interest in Regional Healthcare (while regional services planning was not a formal part of the 2005 Health Services Master Plan, health programs were asked which services would be most attractive and needed if offered at an appropriate location)
- To complete the continuum of healthcare and eliminate current gaps in services for AI/AN who reside in California
- To provide a healing place designed for AI/AN who reside in California for secondary healthcare that is:
 - Culturally Appropriate
 - Patient Sensitive
 - Clinically Excellent
 - Providing a menu of Tribally Requested Services
 - Providing Advanced Healthcare
 - Raising the health of American Indian/Alaska Natives who reside in California to the highest level

This concept of addressing unmet need for AI/AN who reside in California is under increasing study as IHS Areas are starting to view its potential as the best option for providing secondary healthcare in light of IHS' traditional PRC funding increase methodology (which is historically tied to new construction only) and IHS' support infrastructure (which is historically facility based). The Portland Area IHS completed a similar effort that resulted in the request for a demonstration project to test the effectiveness of providing such healthcare at a site in the Seattle area. That planning effort recently completed an update to their Regional Specialty Referral Center projections and draft facility planning documents (Program Justification Document & Program of Requirements).



This study is similar to the Portland updated effort in that it focuses on a menu of secondary services and plans those services using available IHS planning tools such as the Health Systems Planning Software (HSP) and Required Resources Methodology (RRM). However, as previously articulated, the HSP software and RRM are problematic when used in regional planning and require alteration to better support future efforts of like kind.

This updated study addresses:

- What services are appropriate for regional healthcare
- The appropriate grouping of populations to maximize their offering – specifically two (2) points of care as established in the 2013 study
- What additional services of interest/need are feasible for consideration at regional sites

The 2013 study clearly identified the purpose of regional care planning:

- Regional Center planning should help to establish a baseline for Congress for Tribal requests
- To increase the level of complex medical facilities (like Phoenix Area, Navajo Area, Great Plain Area), to use as leverage in increasing funding levels
- To make California comparable to other IHS areas
- To allow California to track PRC services more closely to establish better funding
- To foster Centers of clinical competence enhanced by telemedicine technology, allowing specialty and sub-specialty healthcare to be accessed by even the most remote populations in the state
- To provide a full range of specialty healthcare options

In short, this update upholds the assumption that regional care will support better healthcare at a better price in cooperation with IHS' historic model for providing services to AI/AN.

Regional Center Definition

As mentioned above, the California Area Planning Workgroup defined Regional Healthcare by specific criteria. A regional site would offer the following services:

- Specialty Healthcare
- Ambulatory Surgery
- Tele-Medicine
- Overnight Stays
- Acute Care/Inpatient
- Short Stay
- Referrals Only

Conversely, a regional site would not offer the following services:

- Primary Care



- General Dentistry
- Emergency Care
- Deliveries or OB Services
 - This assumption was challenged as part of the update effort.
 - Planners concluded such service remains unfeasible, due to low market and limited services capabilities
- Walk In Services for Local AI/ANs

There are many reasons for the inclusion and exclusion of these services.

- Regional Healthcare is designed to support, not replace, services presently offered at Health Programs across the state
- Regional Healthcare is not designed to compete with existing Health Programs
- Regional Healthcare is not designed to increase or manipulate California's existing or future user population
 - Healthcare is sized based on user population presently served* at existing health programs grown by appropriate rates to 2033
 - Such healthcare is not anticipated to be "overrun" with locals seeking services because healthcare would come by referrals only from existing health programs
- Regional Healthcare is designed to continue such support as need is recognized for the extension of Primary Care assets to future tribal populations
- Regional Care is envisioned to provide services currently not available at existing Health Programs, ones that would most stretch limited PRC service dollars (thus currently paid for with limited PRC dollars or ones that simply go unmet due to an absence of PRC dollars) including:
 - Endoscopy
 - Women's OB/Gyn outpatient type surgeries
 - Arthroscopic surgeries (e.g. knee, shoulder)
 - Oral Surgery
 - Pediatric Dentistry
 - Endodontics
 - Preventative Healthcare
 - Treatment of chronic conditions
- Regional Care does not remove PRC funding currently provided to programs/sites and reassign it to a regional center. No existing PRC funding is removed from programs/sites.
- To address services identified as desirable from the 2005 California Area Health Services Master Plan including:
 - Preventive Healthcare
 - Non-acute ambulatory surgery
 - Treatment for chronic conditions

*At times as reported by sites that are non-reporting or have known reporting issues.



- General Surgery
- Psychiatry
- Gastroenterology
- Endocrinology
- Pediatric Dentistry
- Oral Surgery
- Orthopedics
- Cardiology
- Colonoscopy
- Women's Health
- Knee Replacements
- Pain Management
- Mammography

In summary, the Regional Healthcare Concept of Operation is based on willing and often isolated partners experiencing shared needs who are unable to deliver referred healthcare, and when they can, are dissatisfied with cultural insensitivity to their tribal members. It assumes tribal members are willing and motivated to travel (figure 1) to appropriately located IHS owned/operated facility (ies) or facility (ies) that are compacted by a consortium of tribes offering culturally appropriate advanced diagnostic, specialty, and acute services as desired by tribes. Such services are offered that are sustainable in terms of staffing, recruitment, tertiary support, operations, and revenue.

Figure 1



Update Issues

This updated study does not attempt to address all issues potentially problematic to regional healthcare delivery. However, it does project draft solutions to some regional care challenges and opportunities identified as “add-on” services.

Each of these services falls outside of IHS’ planning tool capabilities, as well as typical project experience. However, each are important to a regional concept of care that considers not only what happens inside the regional facility, but also what needs to happen outside to support regional patient access.

- **Transportation** – In the last study, transportation was recognized as a challenge in the delivery of regional care. This study presents a draft planning model, associated assumptions, and a resulting projection of a regional solution for consideration and further study. The process



considered potential methods of regional patient transportation to regional care, developed a model to project needed resources, and documented the planning path. Additional detail is provided in the Appendices of this document. The conceptual model projects the following resulting resource requirements:

- For the North (Sacramento) Regional Center:
 - Additional Staff161.9 FTEs
 - Additional Space 1,091 DGSF
- For the South (Temecula) Regional Center:
 - Additional Staff27.5 FTEs
 - Additional Space 620 DGSF
- **Lodging** – Because most patients will be travelling some distance for care at a regional site, some provision for overnight stays for patients, caregivers, and family members is important. It is also an appropriate planning consideration in support of transportation. The process considered potential options and developed a draft planning model, associated assumptions, and a resulting projection of a regional lodging solution for consideration and further study. Additional detail is provided in the Appendices of this document. The conceptual model projects the following resulting resource requirements:
 - For the North (Sacramento) Regional Center:
 - Additional Staff108.2 FTEs
 - Additional Space94,285 BGSF
 - For the South (Temecula) Regional Center:
 - Additional Staff20.3 FTEs
 - Additional Space17,653 BGSF
- **Visiting Specialties** – Because specialty care is a cornerstone requirement for regional care, consideration was desired for those who, despite thoughtful and vetted market share assumptions, do not or are not able to travel to a regional point of care. That and continued Tribal interest led to the exploration of a visiting specialty program. The process considered the potential of visiting specialists to support regional care, developed a model to project needed resources, and documented the planning path. Additional detail is provided in the Appendices of this document. The conceptual model projects the following resulting resource requirements:
 - For the North (Sacramento) Regional Center:
 - Additional Staff6.0 FTEs
 - Reflecting a 10% aggregate of all site regional center specialty providers for each product line anticipated
 - Additional Space Included in Specialty Care
 - For the South (Temecula) Regional Center:
 - Additional Staff3.3 FTEs



- Reflecting a 10% aggregate of all site regional center specialty providers for each product line anticipated
 - Additional Space Included in Specialty Care

- **Pharmacy Hub** – This study considered potential roles a Pharmacy Hub might fulfill, identified those most important, developed a model to project needed resources, and documented the planning path. The process developed a draft solution for regional care providing pharmacy hub services focused on assisting users in accessing expensive and hard to get medications. Additional detail is provided in the Appendices of this document. The conceptual model projects the following resulting resource requirements:
 - For the North (Sacramento) Regional Center:
 - Additional Pharmacists 1.0 FTEs
 - Additional Staff 1.1 FTEs
 - Additional Space Included in Pharmacy
 - For the South (Temecula) Regional Center:
 - Additional Pharmacists 0.5 FTEs
 - Additional Staff 0.7 FTEs
 - Additional Space Included in Pharmacy

- **Durable Medical Equipment (DME)** – Ongoing payer/insurance issues create access problems for DME. Though demand for this service is commonly accessed through a virtual portal by non-Native populations, such a portal is not a good option for California Natives. Consequently, planning projections are provided for provision of DME through each regional point of care in the Add-on Services section of this document. The process considered potential options of DME support a Regional Center might offer, developed a model to project needed resources, and documented the planning path. Additional detail is provided in the Appendices of this document. The conceptual model projects the following resulting resource requirements:
 - For the North (Sacramento) Regional Center:
 - Additional Staff 14.0 FTEs
 - Additional Space 9,684 DGSF
 - For the South (Temecula) Regional Center:
 - Additional Staff 9.5 FTEs
 - Additional Space 5,599 DGSF

It should be stressed that each of the resource requirement projections is based on a conceptual model. While some of the first questions for each are answered, many additional questions remain and should be answered as the depth of planning increases. Each service study was supported by the formation of a workgroup focused on the consideration of various elements driving the quantification of services, development of a projection model, and acquisition of needed information. The final projected resource requirements for each of these services are included in the projected services by site section below.



Additional information supporting the development of the projection model for each of these can be found in the appendices of this document.

Innovations in Healthcare

The planning team was asked to consider additional services of interest, specifically new and innovative services in healthcare delivery. When site directors were asked about which services were of interest, the following top five (5) answers were documented:

1. Telemedicine
2. Electronic Health Record (EHR)
3. Wearable Medical Devices (CGM, mHealth, Biosensors, etc.)
4. Point of Care Diagnostics
5. Hepatitis C Treatment

Though each of these is important, the ability to quantify their impact on staff and space projections at this early stage of facility planning is difficult. These should be considered relative to staff and facility requirements when this project enters facility planning documentation preparation.

That said, Telemedicine is included in this updated report in two (2) ways:

- First, in updated workload numbers that add back the market share for certain lines of care that are projected for recapture through the extensive use of telemedicine.
- By projecting dedicated telemedicine coordinators and space to support each Regional Centers' mission.

It should be noted that full funding requirements for elevating all California Service Unit sites' telemedicine infrastructure must be studied to fully support regional capabilities.

Labor & Delivery Services

The feasibility of Labor & Delivery services was considered in response to Area guidance in spite of the earlier definition of regional care not including such. Preliminary projections in consideration of site data projecting the percentage of expectant mothers that might travel to a regional site to deliver resulted in volumes that would only support low risk services. Low risk deliveries are those that have no active complications or health factors that may cause an increased risk to the expectant mother or fetus. This means that services (like C-Sections) which might motivate expectants mothers to travel a significant distance to regional care will not be available. The planning team, therefore, did not consider this reduced or low risk level of care appropriate to support regional labor and delivery services.



Regional Healthcare Planning Factors

This concept of operation supporting regional care serving geographically dispersed populations considers the following components and each will be discussed in the following pages. Additional detail is available in the Appendices of this report and the previous 2013 study. This study can be found on the IHS website at the following link: <https://www.ihs.gov/california/index.cfm/tribal-resources/regional/>.

- Populations
 - User, Service, Census,
 - PSA to Regional Site Alignment
- The Critical Concern over California Populations
- Regional Healthcare Locations
 - Scenario Development (eight)
 - 4 Locations – 3 outpatient and 1 inpatient
 - 4 locations – all inpatient
 - 3 locations – 2 outpatient and 1 inpatient
 - 3 locations – all inpatient
 - 2 locations – 1 outpatient and 1 inpatient
 - 2 locations* – all inpatient
 - *The two (2) locations scenario is the only one considered in this update. For additional information on the other options, please consult the previous 2013 study.
- Market Share Erosion
 - Erosion Factor 1 – Payer Profile
 - Erosion Factor 2 – Distance to Regional Healthcare
 - Erosion Factor 3 – Alternative Care
 - Erosion Factor 4 – Directing Payer Segments
- Market Share Projection
- Projected Services
- Resource Requirements

Populations

Healthcare is a population-based business. Two critical decisions must be made in projecting regional services that are related to population.

- First, which populations will be utilized in planning services? (Population Types)
- Second, how will populations be clustered to provide the best possible healthcare? (Population Alignments)

A complete Regional Center Planning population table for A/AN who reside in California is shown below and forms the basis for the conversation and conclusions that follow.



Regional Center User Population by Region & Source

Service Unit	Region	2019 User Pop (Select UIO Sites 2021 User Population)	2033 Projected User Population with Growth Rate Applied	Source for 2019 User Pop (2021 for Select UIO Sites as Noted)
Central Valley Indian Hlth.	Sacramento, CA	7,466	9,166	IHS Hlth.care Systems Planning (HSP) FY 19 User Population
Chapa De Indian Hlth. Prg.	Sacramento, CA	5,643	6,928	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
Colusa Indian Hlth. Comm. Hlth. Council	Sacramento, CA	94	115	IHS Hlth.care Systems Planning (HSP) FY 19 User Population
Consolidated Tribal Hlth. Project	Sacramento, CA	3,178	3,901	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
Feather River Tribal Hlth.	Sacramento, CA	5,343	6,559	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
Fresno American Indian Hlth. Project	Sacramento, CA	1,180	1,449	CA Regional Project Questionnaire 2019 User Population
Greenville Rancheria Tribal Hlth. Prg.	Sacramento, CA	6,890	8,458	CA Regional Project Questionnaire 2019 User Population
Indian Hlth. Ctr. of Santa Clara Valley	Sacramento, CA	883	1,084	IHS Hlth.care Systems Planning (HSP) FY 19 User Population
Karuk Tribe	Sacramento, CA	2,136	2,622	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
K'ima:w Medical Ctr. (Hoopa)	Sacramento, CA	2,931	3,598	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
Lake County Tribal Hlth. Consortium	Sacramento, CA	2,458	3,018	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
MACT Hlth. Board	Sacramento, CA	3,206	3,936	Site Response to email for 2019 User Population dated October 10, 2023
Mathiesen Mem. Hlth. Clinic (Chicken Ran	Sacramento, CA	25	31	IHS Hlth.care Systems Planning (HSP) FY 19 User Population
Native Amer. Hlth. Ctr. (SF Bay Area)	Sacramento, CA	1,683	2,066	UIO User Population 2021 per National Study from HSP Counties
Northern Valley Indian Hlth.	Sacramento, CA	2,992	3,673	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
Pit River Hlth. Svcs.	Sacramento, CA	961	1,180	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
Quartz Valley Prg.	Sacramento, CA	254	312	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
Redding Rancheria Tribal Hlth. Systems	Sacramento, CA	3,578	4,392	IHS Hlth.care Systems Planning (HSP) FY 19 User Population
Rolling Hills	Sacramento, CA	0	0	Not reported in any source document
Round Valley Indian Hlth. Ctr.	Sacramento, CA	1,183	1,452	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
Sacramento Native American Hlth. Ctr.	Sacramento, CA	2,553	3,134	UIO User Population 2021 per National Study from HSP Counties
Shingle Springs Tribal Hlth. Prg.	Sacramento, CA	1,352	1,660	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
Sonoma County Indian Hlth. Project	Sacramento, CA	4,819	5,916	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
Strong Family Hlth. Ctr. (Modoc)	Sacramento, CA	228	280	IHS Hlth.care Systems Planning (HSP) FY 19 User Population
Susanville Indian Rancheria	Sacramento, CA	842	1,034	IHS Hlth.care Systems Planning (HSP) FY 19 User Population
Table Mountain Medical	Sacramento, CA	5	6	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
Toiyabe Indian Hlth. Project	Sacramento, CA	2,339	2,871	CA Regional Project Questionnaire 2019 User Population
Tule River Indian Hlth. Ctr.	Sacramento, CA	2,467	3,029	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
Tuolumne Me-Wuk Indian Hlth. Ctr.	Sacramento, CA	348	427	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
United Indian Hlth. Service	Sacramento, CA	8,726	10,712	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
Warner Mountain Indian Hlth. Prg.	Sacramento, CA	92	113	IHS Hlth.care Systems Planning (HSP) FY 19 User Population
Wilton Rancheria	Sacramento, CA	1,489	1,828	IHS Hlth.care Systems Planning (HSP) FY 19 User Population
Amer. Ind. Hlth. & Svcs. (Santa Barbara)	Temecula, CA	1,812	2,221	UIO User Population 2021 per National Study from HSP Counties
Bakersfield American Indian Hlth. Project	Temecula, CA	3,615	4,432	National UIO AI/AN 2021 Unique Patients Based on Site Data
Cabazon Band of Cahuilla Indians	Temecula, CA	7	9	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
Indian Hlth. Council	Temecula, CA	5,185	6,356	IHS FY 19 User Population Estimated - Final Memo dated July 1, 2021
Riverside San Bernadino Cty Ind. Hlth.	Temecula, CA	14,710	18,033	Site Project Questionnaire 2019 User Population
San Diego American Indian Hlth. Ctr.	Temecula, CA	7,985	9,789	UIO User Population 2021 per National Study from HSP Counties
Santa Ynez Tribal Hlth. Clinic	Temecula, CA	3,841	4,709	CA Regional Project Questionnaire 2019 User Population
Southern Indian Hlth. Council	Temecula, CA	2,408	2,952	CA Regional Project Questionnaire 2019 User Population
Sycuan Band of the Kumeyaay Nation	Temecula, CA	295	362	CA Regional Project Questionnaire 2019 User Population
Tejon Indian Tribe	Temecula, CA	432	530	IHS Hlth.care Systems Planning (HSP) FY 19 User Population
United Amer. Indian Involvement (LA)	Temecula, CA	1,183	1,450	UIO User Population 2021 per National Study from HSP Counties
Total		118,817	145,791	
Uneroded Population				
	2019	2033		
	Sacramento	77,344	94,950	
	Temecula	41,473	50,841	
	Total	118,817	145,791	
Growth Rate 2019 to 2033				
	Sacramento	22.8%	User population assigned to Sacramento for planning.	
	Temecula	22.6%	User population assigned to Temecula for planning.	
Market Forces Tool (MFT) % with No Choice - Used for 2019 HSP Override				
	Sacramento	91.5%	The percentage of projected regional users anticipated at each site after	
	Temecula	98.8%	lost market share.	
Eroded Population with MFT % and Growth Rate				
	2019	2033		
	Sacramento	70,770	86,879	
	Temecula	40,975	50,231	
	Total	111,745	137,110	



Population Types

Regarding the first, several population data sets are available from which to plan healthcare. They differ greatly.

- User population - counts the number of AI/AN who reside in California that have received service from a local IHS/Tribal Health Program or Primary Healthcare site at least one time within the last three years. This number is agreed upon annually between IHS and Tribes and is accessible through the HSP software.
- Service population - counts the total number of AI/AN who reside in California living within a county and has some relationship to the US Census count of AI/AN who reside in California. That relationship is not consistent, for at times the service population and census population are essentially identical, while at other times there is no service population when there is considerable census population. IHS has generally utilized the service population growth rates to project user population growth.
- Census population - is provided by the US Census and counts AI/AN who reside in California that self-identify as either single or two or more races.

User population is typically the planning standard utilized in IHS and tribal projects for planning services. Since the concept of operations assumes this to be an IHS owned and operated facility (ies), user population was selected as the planning population.

Population Alignments

A variety of population clustering alignments were evaluated in the 2013 study relative to:

- Their ability to provide the kind of services AI/AN who reside in California are interested in.
- Their ability to provide locations accessible to the majority of potential users.

This balancing act is not easy for the following reasons.

First, as mentioned, increasing population generates increased services. The graphic below (figure 2) helps to illustrate how services grow relative to an increasing user population. While ambulatory surgery is desirable, it is not sustainable until it serves a population of about 15,000 users. On-site specialists such as general surgery and orthopedics are desirable but unsustainable until they are serving a population of about 30,000 users. In fact, the kinds of services most desirable by AI/AN who reside in California require a user population of 30,000 or more. True regional healthcare starts when planning is able to cluster about 30,000 users.



Figure 2



Second, it is desirable to place required healthcare as close to the user population as possible. This complicates planning since user population is not evenly distributed across the state. The north contains more users than the south. Distribution of services to more regional locations, while desirable from the viewpoint of patient access, *diminishes* the level of healthcare sustainable because fewer populations are clustered or grouped for healthcare. Consolidation of services to fewer regional locations, while undesirable from the viewpoint of patient access, *increases* the level of healthcare sustainable because greater population is clustered or grouped for healthcare.

As a result, the California Area Planning Workgroup, though originally considering six (6) possible locations (and 12 scenarios) for healthcare, realized that the “two (2) location all inpatient” option provided the greatest amount of regional care while balancing patient access.

Various access times for regional healthcare were evaluated, ranging from two to four hours. No access time considered was inclusive of all Health Program locations. Unfortunately, some (Crescent City and Toiyabe for example) will always face considerable travel times for regional healthcare (4+ hours). It should be understood that they currently face similar travel times for secondary healthcare, and when they eventually arrive, must pay for the healthcare (personal funds or PRC dollars). Though such travel time is not desirable, covered healthcare at the time of arrival represents an improvement over the present situation.

Alignment of populations for regional services consideration was driven by the following assumptions

Each Regional Center was supported by a corresponding population grouping. Complete documentation supporting the decision-making process is found in Appendix #1 of the 2013 study. This study can be found on the IHS website at the following link: <https://www.ihs.gov/california/index.cfm/tribal-resources/regional/>.



- Health Program service areas were not split. In other words, the entire user population was assumed to travel to Sacramento or Redding. There was no split on a community-by-community basis.
- The majority of planning populations were drawn from the HSP software 2019 user populations.
- Unassigned or non-service unit HSP software populations were not assigned to any Regional Center.
- The typical access travel time utilized in 2013 (which still forms the basis of this update) assumes 3 hours, though some sites will travel much less and others much longer.

The Critical Concern over California User Population

This updated study is primarily built on 2019 HSP User populations (to minimize the impact of COVID-19 on User counts) projected to 2033. However, for many California service units, the HSP User population reported is not accurate due either to known reporting problems or non-reporting sites. Where these issues were substantiated, site-reported user populations were utilized (if submitted in response to the site data request) instead of the HSP User population. Urban populations are also of concern relative to those in the HSP. Projections can vary dramatically depending on the urban service area definition or anticipated new Users attracted by the possibility of no-cost secondary care at a regional site. Consequently, where the HSP User population for urban centers was unacceptable to the Regional Center Planning Workgroup (RCPW), an alternative was used instead – typically, the User population from the recently completed National Indian Urban Organization Infrastructure Study (NIOUIS) from the Office of Urban Indian Health Programs (OUIHP). This national planning effort was facilitated and documented by the Consultant and was completed in 2022.

As part of the path forward, a comprehensive study of User population across California must be engaged in with the direct involvement of Tribes, Area, and IHS Headquarters (IHS HQ).

Regional Center Locations

Locations for regional healthcare are supported by appropriate clustering of User populations as outlined and illustrated above. Locations must also meet the following criteria to be truly supportive:

- Locations balanced geographically relative to User populations
- Reasonable road capabilities allowing users to travel safely barring weather and other unintended consequences
- Adequate infrastructure necessary for visiting patients and family members (food, lodging, entertainment, airlift/airport capabilities, and other support services)
- Immediately available tertiary healthcare with on-call specialists should a secondary procedure or acute healthcare episode deem necessary

In developing the 2013 Study, and as mentioned previously, the California Area Planning Workgroup engaged in the following process to decide on regional points of care:



- Separation of California into 3 geographic regions with associated populations (User, service, census) to support regional site discussions
- Identification of regional location concepts by the California Area Planning Workgroup
- Vetting of initial California Area Planning Workgroup concepts
 - Review of California Area Planning Workgroup location concepts
 - Review of regional location requests from Health Programs (from 2005 Area Health Services Master Plan)
 - Review of travel times and access patterns
 - Review of User population groupings and relative regional opportunities
 - Identification and prioritization of options
- Review of regional locations – concepts confirmation for draft services development
- Discussion and decision making

Through a nine-month process, the California Area Planning Workgroup settled on two regional sites serving relative User populations, each of which were modeled for consideration of effectiveness in delivering regional healthcare. This led to the next critical question in the 2013 study: “who will come?” Typically, when a primary healthcare clinic is built, everyone comes; sometimes more than the service or census populations identifies as present. For regional healthcare, that assumption is not supportable.

Market Share Erosion

Who should regional healthcare be sized for? Since the primary assumption is that most will need to travel out of their primary care service areas for some distance, it is safe to assume that some will either choose not to or simply cannot. The 2013 California Area Planning Workgroup acknowledged the reality that not everyone will come to a regional point of healthcare for a variety of reasons:

- Transportation is not available
- Unfamiliarity with regional location
- Outside of daily world
- Choose to receive healthcare at an alternative, closer site
- Choose not to receive healthcare

Research identifies a number of factors that drive the reduction in the percentage of those willing/able to travel for healthcare relative to the distance that must be travelled. This reduction is called market share erosion. Factors that affect access include:

- Social structure
- Health beliefs
- Enabling resources
- Demographic variables
- Health status
- Health behaviors



- Distance to healthcare
- Access to transportation

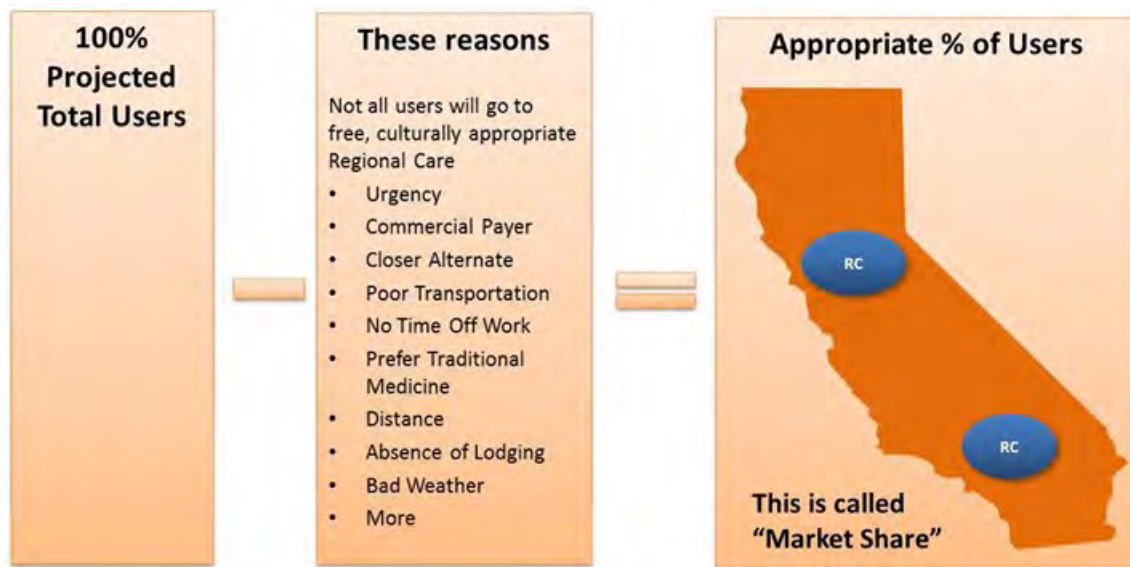
Although access can be measured in many ways, geographic access is of primary concern in many rural areas. This erosion is best understood within a conceptual model that integrates concepts from health geography with a health behavior model, which considers:

- Predisposing factors
 - Family composition
 - Social structure
 - Health beliefs
- Enabling Factors
 - Income
 - Health insurance status
 - Physician availability
- Need for Healthcare

Perhaps the most comprehensive thinking on factors affecting market share erosion is found in an article by Arcury, Gester, Preisser, Sherman, Spencer and Perin, *The Effects of Geography and Spatial Behavior on Health Care Utilization among the Residents of a Rural Region* (2005). Additional information is available in Appendix #4.

The graphic below (figure 3) shows the basic formula that must be considered.

Figure 3





Since this project could not quantify the impact of *all* possible variables driving market share erosion, it focused on available data that would support modeling of the ultimate impact of each variable on market share. Five (5) erosion factors were considered as part of the 2013 study. However, because the ACA is now operational, there is no need to speculate on who might be reliant on regional care following ACA implementation. Consequently, this update has refreshed the data supporting the following four (4) erosion factors

1. Health Program Payer Profiles – This data was utilized to identify what percentage of the population is most reliant on regional healthcare: those without a third party payer. It provides an answer to the question *“Who is reliant on regional services?”* The factor was not “predicted” in the current update since the ACA is now operational. Any shift in payer mix has already taken place and is reflected in the updated data received from the National Data Warehouse (NDW).
2. Health Program Distance to Regional Healthcare – This data was utilized to identify how procedures and DRGs by payer diminish as the patient’s location of residence is increasingly rural. It provides a partial answer to the question *“How will the market erode enroute to regional healthcare?”*
3. Alternative Healthcare – This data was utilized to identify how patients with a choice may choose to exercise such and select an alternative point of healthcare rather than drive to distant regional healthcare. It provides a partial answer to the question *“How will the market erode enroute to regional healthcare?”*
4. Directing Payer Segments – This data was utilized to anticipate the impact of directing certain payer segments to distant regional healthcare; essentially overriding their ability to use Medicaid or PRC (previously Contract Health) Services dollars at an alternative location. It answers the question *“How can market erosion be limited by directing certain payer segments?”*

Discussion of each dataset’s utilization follows. Additional detail is available in the Appendices section of the 2013 study. This study can be found on the IHS website at the following link:

<https://www.ihs.gov/california/index.cfm/tribal-resources/regional/>.



Erosion Factor 1 - Payer Profile

Who is reliant on access to distant regional healthcare (figure 4)?

Figure 4

Erosion Factor	1	2	3	4
Erosion Question	Who is truly reliant on Regional Care?	Will distance to Regional care affect market share?	How will alternative care affect market share?	Can Medi-Cal and CHS eligible payers be directed?
Erosion Decision Strategy and Resulting Assumption	Define high reliance by number & percentage of present AI/AN users with no 3rd party payer	Study Medicare utilization relative to urban-to-rural access patterns and determine % erosion per travel time.	Reduce number of users by a percentage per alternate care opportunity en route	Assume both segments of each Health Program population can be directed to care

The IHS/California Area Office provided updated Health Program enrollee data by payer where available. 36 of 43 Health Programs had such payer data and 29 of these were deemed reliable. This data was utilized in identifying what portion of the base user population should be considered as “highly reliant” on distant regional healthcare. To arrive at this percentage, the number of users with no third party coverage in the PRC Delivery Area and all geographies were divided into the number of AI/AN active users in the PRC Delivery Area and all geographies and averaged. This resulting current percentage was applied to projected user populations to identify those that:

- Would likely drive to regional healthcare
- Bypass all alternative healthcare options
- And demonstrate resilience toward market erosion as a result of distance

Additionally, this percentage was utilized later in the market share calculations to determine what portion of user populations could potentially be directed to regional healthcare by the local Health Programs.

Detailed Health Program payer profile information and a sample Health Program profile, outlining how data was utilized, is available in Appendix #4 of the 2013 study. This study can be found on the IHS website at the following link: <https://www.ihs.gov/california/index.cfm/tribal-resources/regional/>.



Erosion Factor 2 - Distance to Regional Healthcare

How will the market erode enroute to regional healthcare (figure 5)?

Figure 5

Erosion Factor	1	2	3	4
Erosion Question	Who is truly reliant on Regional Care?	Will distance to Regional care affect market share?	How will alternative care affect market share?	Can Medi-Cal and CHS eligible payers be directed?
Erosion Decision Strategy and Resulting Assumption	Define high reliance by number & percentage of present AI/AN users with no 3rd party payer	Study Medicare utilization relative to urban-to-rural access patterns and determine % erosion per travel time.	Reduce number of users by a percentage per alternate care opportunity en route	Assume both segments of each Health Program population can be directed to care

Earlier this document referenced a comprehensive treatment of the relationship between market share and distance (Arcury, Gester, Preisser, Sherman, Spencer and Perin, *The Effects of Geography and Spatial Behavior on Health Care Utilization among the Residents of a Rural Region* (2005)). While research shows market share erodes relative to distance, quantifying the rate of erosion is of primary concern for this effort.

Two separate data sets were studied to understand how erosion by distance happens in California. Since secondary and tertiary cares are abundant in the state, there are few test sites useful in coordinating data relative to distance. But two were appropriate:

- The “urban to rural” path from Los Angeles to Bishop (figure 6)
- The “urban to rural” path from San Francisco to Garberville (figure 7)



Figure 6



Figure 7



So the issue of payment for services could largely be eliminated, Medicare utilization was selected for study relative to data available from the Dartmouth Atlas of Healthcare and California State Inpatient Data. Utilization was considered for sample zip codes in distances of roughly 60 miles in an increasingly “rural” direction from the urban center (Los Angeles or San Francisco). Since Medicare patients do not



typically worry about payment for services, the question was “will there be a noticeable reduction in utilization in the Dartmouth data and state inpatient data as populations are increasingly rural?”

Various DRG and Procedures were selected for analysis depending on the presence of a health data set and a geographically appropriate zip code with statistically significant population. Examples include:

- Coronary Angiography
- Bacterial Pneumonia Discharge
- Hospitalization for Hip Fracture
- Cellulitis
- Nutritional and Metabolic Disorder

When both data sets’ utilization by urban-to-rural path were averaged, the result was an average drop in utilization of -4.0% for every 60 miles a Medicare patient is removed from urban secondary and/or tertiary care. This assumption was embedded in the market share calculations

Detailed erosion by distance information is available in Appendix #4 of the 2013 study. This study can be found on the IHS website at the following link: <https://www.ihs.gov/california/index.cfm/tribal-resources/regional/>.

Erosion Factor 3 - Alternative Healthcare

How will the market erode enroute to regional healthcare (figure 8)?

Figure 8

Erosion Factor	1	2	3	4
Erosion Question	Who is truly reliant on Regional Care?	Will distance to Regional care affect market share?	How will alternative care affect market share?	Can Medi-Cal and CHS eligible payers be directed?
Erosion Decision Strategy and Resulting Assumption	Define high reliance by number & percentage of present AI/AN users with no 3rd party payer	Study Medicare utilization relative to urban-to-rural access patterns and determine % erosion per travel time.	Reduce number of users by a percentage per alternate care opportunity en route	Assume both segments of each Health Program population can be directed to care

Using ESRI-GIS, The Innova Group identified California Tribal/Urban Health Programs and updated the distance to their particular Regional Center (RC) assignment. The following settings were used to standardize driving time between the Health Program and the Regional Center assignment:

- No driving breaks were allotted
- All driving speeds on the various types of roadway were set to “average”



- Segments were based on preferred roads rather than the quickest route or shortest distance to minimize needless market share erosion resulting from weather, road repairs, etc.

The distance was calculated using the primary point of healthcare (ex: for United Indian Health Services, Potawot in Arcata was used) as opposed to calculating distance from all possible points of healthcare. This assumption was made because measuring true distance for referred healthcare would require street addresses for all Native Users (data that is not available) or measuring referrals from each Health Program clinic regardless of whether it was the actual source of the referral or not (an effort that added little value in light of the fact that such has little bearing on where the patient actually lives).

The AMA Hospital Guide was utilized to locate points of Secondary and Tertiary Care across the state relative to all California Health Program locations. GIS made it possible to count the number of alternative secondary and tertiary care options between the Health Program and the Regional Center assignment. Any alternative healthcare sites that were within 15 miles distance of the planned route were counted as a possible healthcare site. Any alternative healthcare sites located in the area of a regional center site were not counted as possible healthcare sites. The total number passed “in route” was entered on the Market Share projection table. Only secondary and tertiary alternative healthcare was considered.

Discussions with the California Area Planning Workgroup resulted in the assumption that user population seeking regional healthcare will erode by 10-20% per alternative healthcare opportunity enroute, depending on reliance.

Detailed information on Erosion by Alternative Healthcare is available in Appendix #4 of the 2013 study. This study can be found on the IHS website at the following link:

<https://www.ihs.gov/california/index.cfm/tribal-resources/regional/>.



Erosion Factor 4 - Directing Payer Segments

“Can market erosion be limited by directing certain payer segments (figure 9)?”

Figure 9

Erosion Factor	1	2	3	4
Erosion Question	Who is truly reliant on Regional Care?	Will distance to Regional care affect market share?	How will alternative care affect market share?	Can Medi-Cal and CHS eligible payers be directed?
Erosion Decision Strategy and Resulting Assumption	Define high reliance by number & percentage of present AI/AN users with no 3rd party payer	Study Medicare utilization relative to urban-to-rural access patterns and determine % erosion per travel time.	Reduce number of users by a percentage per alternate care opportunity en route	Assume both segments of each Health Program population can be directed to care

With the steady reduction in market share as a result of shifting payers, distance, and alternative healthcare, the California Area Planning Workgroup considered the question of whether Health Programs could limit erosion by directing certain payer segments to distant regional healthcare.

This is a question also considered by the Portland Area Facilities Advisory Committee (PAFAC). Like the PAFAC, the California Area Planning Workgroup determined that two payer segments could be directed to distant regional healthcare:

- PRC Services eligible patients with no third party coverage
- Medicaid covered patients

In the final market share calculations, results were considered that:

- Gave those payer segments the choice in whether or not they decide to go to regional healthcare
 - The assumption was they would choose not to go to distant regional healthcare
- Removed those payer segments’ choice in whether or not they decide to go to regional healthcare
 - The assumption was they would go to distant regional healthcare

The result of those two variations produced a high and low market share projection for each scenario modeled. While both market shares were updated as part of this current effort, the California Area Planning Workgroup opted to plan regional care based on the “no choice” or high market share assumption, assuming the aggressive use of telemedicine to capture some of the eroded volumes.



Detailed information on directing Payer Segments as it affects market share can be found in Appendix #4 of the 2013 study. Detailed information on telemedicine impacted is found in Appendix #3 of the previous study. This study can be found on the IHS website at the following link:

[https://www.ihs.gov/california/index.cfm/tribal-resources/regional/.](https://www.ihs.gov/california/index.cfm/tribal-resources/regional/)

Market Share Projections

The market share erosion factors discussed above have been imported into the sub-tables and Market Forces Tool (MFT) utilized in the previous study. The MFT functions by matriculating Health Program User populations through each of the erosion factors to arrive at a high and low market share for each Regional Center.

The table is understood from left to right. Because of publishing limitations, an image of the table is displayed and explained by section (erosion factor). Sections of images are intentionally removed to allow them to fit on the page. Additional detail is provided in the Concept of Operation section of the 2013 study.

Erosion Factor 1

The far left of the MFT table (figure 10) includes Service Areas (Health Programs) and their 2019 total User population and Purchase & Referred Care Delivery Area (PRCDA) user population. These columns stratify those populations by payer and create a composite understanding of users by level of present reliance on regional healthcare. This analysis comes from the payer profiles provided by the IHS National Data Warehouse (NDW).

Figure 10

Service Area	Users by Payer		Direct Care Only				PRC Eligible- PRCDA					All Payers Rate			Market %			Post Reform Uneroded Market		
	All	PRCDA	All				PRCDA					H Reliance			M Reliance			L Reliance		
	Does not include "Other Eligible" or "Non-Indian" payers		No 3rd Party Coverage		w 3rd Party Coverage		w 3rd Party (All)					Direct Care Only No 3P			Direct Care, PRC			Direct Care, PRC, 3P		
	Total 2019	Total 2019	#	%	#	%	#	%	#	%	All PRCDA Blended %	All PRCDA Blended %	All PRCDA Blended %	PRCDA Users	w/out 3rd Party Coverage	w/out 3rd Party Coverage	w/out 3rd Party Coverage	w 3rd party Coverage		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19		
American Indian Health and Services (Santa Barbara) (SB Urban Indian Hlth)	805	607	593	73.7%	212	26	0.0%	0	0.0%	183	22.7%	71.7%	0.0%	28.3%	607	435	0	172		
Bakersfield American Indian Health Project (American Ind Hlth Coun)	332	19	16	4.8%	32	9	36.8%	8	42.1%	47	14.2%	10.3%	31.2%	58.5%	19	2	6	11		
Cabazon Band of Cahulla Indians															0					
Central Valley Indian Health	8,874	7,369	846	9.5%	2,168	24	13.3%	4,071	55.2%	3,343	37.7%	9.0%	13.3%	77.7%	7,369	665	980	5,724		
Chapa De Indian Health Program	4,446	3,852	1,134	25.5%	2,129	47	7.3%	755	19.6%	293	6.6%	25.1%	7.4%	67.5%	3,852	969	285	2,598		

Erosion Factor 2

The next set of columns (figure 11) to the right erode the population stratification according to assumptions on erosion by distance. Each Health Program is assigned to a Regional Center for modeling purposes and the distance to that site is identified. Moderate and Low reliance populations are eroded accordingly (10-20% per 60 miles) and new subtotals are displayed in the columns on the right.



Figure 11

Erosion Factor #2 - How far is Regional Care?

Service Area	Regional Center Location	Svc Unit Drive Time to RC (in minutes)	Market Erosion by Distance						Net Users	Net Users
			Direct Care Only No 3P	Direct Care, PRC (No Choice)	Direct Care, PRC (Choice)	Direct Care, PRC, 3P (Medicaid Only)	Direct Care, PRC, 3P (Medicaid Reduced)	Direct Care, PRC, 3P		
			w/out 3rd Party Coverage	w/out 3rd Party Coverage	w/out 3rd Party Coverage	w 3rd party Coverage	w 3rd party Coverage	w 3rd party Coverage		
	28	29	30	31	32	33	34	35	36	37
American Indian Health and Services (Santa Barbara Urban Indian Hlth)	Temecula, CA	163	400	0	0	36	125	158	561	558
Bakersfield American Indian Health Project (American Indian Hlth Coun)	Temecula, CA	172	2	5	5	1	9	10	18	17
Cabazon Band of Cahuilla Indians	Temecula, CA	84							0	0
Central Valley Indian Health	Sacramento, CA	156	611	900	900	1,982	3,439	5,260	6,933	6,772
Chapa De Indian Health Program	Sacramento, CA	37	969	285	285	171	2,427	2,598	3,852	3,852

Erosion Factor 3

The next set of columns (figure 12) further erode the distance impacted population stratification according to assumptions on erosion by alternative healthcare. Each Health Program is assigned to a Regional Center for modeling purposes and the distance to that site is identified. The number of alternative healthcare sites in route from each Health Program to the assigned Regional Center is then totaled using mapping software and the user population (market share) is eroded accordingly.

Figure 12

Erosion Factor #3 - How many alternative care opportunities are there?

Service Area	# of Alt Care in route (Sec or Trty)	Sub Market Erosion by Competitors					
		Direct Care Only No 3P	Direct Care, PRC (No Choice)	Direct Care, PRC (Choice)	Direct Care, PRC, 3P (Medicaid Only)	Direct Care, PRC, 3P (Medicaid Reduced)	Direct Care, PRC, 3P
		w/out 3rd Party Coverage	w/out 3rd Party Coverage	w/out 3rd Party Coverage	w 3rd party Coverage	w 3rd party Coverage	w 3rd party Coverage
	38	39	40	41	42	43	44
American Indian Health and Services (Santa Barbara Urban Indian Hlth)	13	400	0	0	36	125	63
Bakersfield American Indian Health Project (American Indian Hlth Coun)	8	2	5	4	1	9	4
Cabazon Band of Cahuilla Indians	4						
Central Valley Indian Health	9	611	900	630	1,982	3,439	2,104
Chapa De Indian Health Program	4	969	285	199	171	2,427	1,039



Erosion Factor 4

The last set of columns to the right offer two alternative final market shares for consideration based on whether PRC services patients and Medicaid patients will be directed to regional healthcare (high market share option) or whether they will not and be left with the choice (low market share option). The results of each are represented as population and percentage of the original population constituting 100% market share. The percentage figures are not utilized beyond this point. The total Users, or remaining market by Health Program, are totaled and used for a final market share (figure 13) and associated explanation.

Figure 13

Erosion Factor #4 - Can you direct Medicaid?

Service Area	Intentional Gap in Image	Market Share			
		<i>M Reliance - CHS No Choice & Medicaid Only</i>		<i>M Reliance - Choice</i>	
		Total Users	% of User Pop	Total Users	% of User Pop
		45	45	47	45
American Indian Health and Services (Santa Barbara Urban Indian Hlth)		561	92.4%	463	76.3%
Bakersfield American Indian Health Project (American Hlth Coun)		18	92.5%	10	51.0%
Cabazon Band of Cahuilla Indians		0	0.0%	0	0.0%
Central Valley Indian Health		6,933	94.1%	3,346	45.4%
Chapa De Indian Health Program		3,852	100.0%	2,207	57.3%

Resulting Market Share

The bottom rows of the MFT (figure 14) identify the resulting shares utilized in the updated planning effort for each facility. They total the high and low market share total users and divide those totals by the corresponding full market share total populations. The following market shares resulted from all erosion factor applications for the updated 2 Center Scenario:

- Low Market Share
 - 59.6% for Sacramento
 - 93.1% for Temecula
- High Market Share (utilized in Services Planning Update)
 - 91.5% for Sacramento
 - 98.8% for Temecula



Figure 14

Service Area	Market Share			
	<i>M Reliance - CHS No Choice & Medicaid Only</i>		<i>M Reliance - Choice</i>	
	Total Users	% of User Pop	Total Users	% of User Pop
	45	45	47	48
Sacramento, CA	47,733	91.5%	31,080	59.6%
Temecula, CA	31,958	98.8%	30,090	93.1%

In summary, 2019 Health Program user populations were matriculated through four erosion factors or gates, resulting in eroded User populations by Health Program. These populations were totaled and related to full User populations by Regional Center assignment, which resulted in a market share percentage that was utilized in projecting 2033 User populations for regional services planning by facility by scenario. The complete MFT projection table is found on the following pages.



IHS, California Area Office

Erosion Factor #1 - Patient Reliance (2019 Payer Mix)

Unaltered NDW Data	Users by Payer		Direct Care Only								PRC Eligible								All Payers Rate		Market %			PRCDA	Post Reform Uneroded Market		
	All	PRCDA	All				PRCDA				All				PRCDA				w 3rd Party (Medicaid Only)		H Reliance	M Reliance	L Reliance	PRCDA	H Reliance	M Reliance	L Reliance
	Does not include "Other Eligible" or "Non-Indian" payers		No 3rd Party Coverage		w 3rd Party Coverage		No 3rd Party Coverage		w 3rd Party Coverage		No 3rd Party Coverage		w 3rd Party (All)		No 3rd Party Coverage		w 3rd Party (All)				Direct Care Only No 3P	Direct Care, PRC	Direct Care, PRC, 3P	Total Users (or)	Direct Care Only No 3P	Direct Care, PRC	Direct Care, PRC, 3P
	Total 2019	Total 2019	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	All/PRCDA Blended %	All/PRCDA Blended %	All/PRCDA Blended %	PRCDA Users	w/out 3rd Party Coverage	w/out 3rd Party Coverage	w 3rd party Coverage
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	
American Indian Health and Services (Santa Barbara) (SB Urban Indian Hlth)	805	607	593	73.7%	212	26.3%	423	69.7%	184	30.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	183	22.7%	71.7%	0.0%	28.3%	607	435	0	172
Bakersfield American Indian Health Project (American Ind Hlth Coun)	332	19	16	4.8%	32	9.6%	3	15.8%	1	5.3%	85	25.6%	199	59.9%	7	36.8%	8	42.1%	47	14.2%	10.3%	31.2%	58.5%	19	2	6	11
Cabazon Band of Cahuilla Indians																							0				
Central Valley Indian Health	8,874	7,369	846	9.5%	2,168	24.4%	628	8.5%	1,687	22.9%	1,176	13.3%	4,684	52.8%	983	13.3%	4,071	55.2%	3,343	37.7%	9.0%	13.3%	77.7%	7,369	665	980	5,724
Chapa De Indian Health Program	4,446	3,852	1,134	25.5%	2,129	47.9%	955	24.8%	1,861	48.3%	333	7.5%	850	19.1%	281	7.3%	755	19.6%	293	6.6%	25.1%	7.4%	67.5%	3,852	969	285	2,598
Colusa Indian Health Community Health Council																							0				
Consolidated Tribal Health Project	3,235	3,035	207	6.4%	622	19.2%	172	5.7%	526	17.3%	531	16.4%	1,875	58.0%	511	16.8%	1,826	60.2%	1,423	44.0%	6.0%	16.6%	77.3%	3,035	183	505	2,347
Feather River Tribal Health	6,335	5,834	2,804	44.3%	1,392	22.0%	2,474	42.4%	1,253	21.5%	65	1.0%	2,074	32.7%	62	1.1%	2,045	35.1%	116	1.8%	43.3%	1.0%	55.6%	5,834	2,528	61	3,245
Fresno American Indian Health Project	381	18	153	40.2%	224	58.8%	3	16.7%	15	83.3%	1	0.3%	3	0.8%	0	0.0%	0	0.0%	133	34.9%	28.4%	0.1%	71.5%	18	5	0	13
Greenville Rancheria Tribal Health Program	495	401	358	72.3%	0	0.0%	272	67.8%	0	0.0%	137	27.7%	0	0.0%	129	32.2%	0	0.0%	0	0.0%	70.1%	29.9%	0.0%	401	281	120	0
Indian Health Center of Santa Clara Valley																							0				
Indian Health Council	5,364	4,861	1,246	23.2%	3	0.1%	929	19.1%	3	0.1%	3,887	72.5%	228	4.3%	3,722	76.6%	207	4.3%	48	0.9%	21.2%	74.5%	4.3%	4,861	1,029	3,622	210
Karuk Tribe	2,481	2,099	142	5.7%	342	13.8%	44	2.1%	221	10.5%	225	9.1%	1,772	71.4%	197	9.4%	1,637	78.0%	233	9.4%	3.9%	9.2%	86.9%	2,099	82	194	1,823
K'ima:w Medical Center (Hoopa)	3,712	3,382	103	2.8%	527	14.2%	61	1.8%	367	10.9%	204	5.5%	2,878	77.5%	192	5.7%	2,762	81.7%	1,115	30.0%	2.3%	5.6%	92.1%	3,382	77	189	3,116
Lake County Tribal Health Consortium	2,824	2,487	260	9.2%	728	25.8%	200	8.0%	584	23.5%	137	4.9%	1,699	60.2%	127	5.1%	1,576	63.4%	186	6.6%	8.6%	5.0%	86.4%	2,487	214	124	2,149
MACT Health Board	0	0	0		0		0		0		0		0		0		0						0				
Mathiesen Memorial Health Clinic (Chicken Ranch)	20	12	9	45.0%	0	0.0%	4	33.3%	0	0.0%	11	55.0%	0	0.0%	8	66.7%	0	0.0%	0	0.0%	39.2%	60.8%	0.0%	12	5	7	0
Native American Health Center (SF Bay Area)	0	0	0		0		0		0		0		0		0		0						0				
Northern Valley Indian Health	5,144	2,983	932	18.1%	2,690	52.3%	385	12.9%	1,238	41.5%	77	1.5%	1,445	28.1%	69	2.3%	1,291	43.3%	1,646	32.0%	15.5%	1.9%	82.6%	2,983	463	57	2,463
Pit River Health Services	1,271	966	107	8.4%	290	22.8%	54	5.6%	138	14.3%	82	6.5%	792	62.3%	74	7.7%	700	72.5%	52	4.1%	7.0%	7.1%	85.9%	966	68	68	830
Quartz Valley Program	368	223	3	0.8%	195	53.0%	2	0.9%	96	43.0%	1	0.3%	169	45.9%	0	0.0%	125	56.1%	74	20.1%	0.9%	0.1%	99.0%	223	2	0	221
Redding Rancheria Tribal Health Systems	0	0	0		0		0		0		0		0		0		0						0				
Riverside San Bernardino County Indian Health	19,749	19,599	7,128	36.1%	6,029	30.5%	7,067	36.1%	5,983	30.5%	3,353	17.0%	3,239	16.4%	3,325	17.0%	3,224	16.4%	260	1.3%	36.1%	17.0%	47.0%	19,599	7,070	3,326	9,202
Rolling Hills																							0				
Round Valley Indian Health Center	1,451	1,385	145	10.0%	124	8.5%	130	9.4%	109	7.9%	153	10.5%	1,029	70.9%	144	10.4%	1,002	72.3%	106	7.3%	9.7%	10.5%	79.8%	1,385	134	145	1,106
Sacramento Native American Health Center	537	4	537	100.0%	0	0.0%	4	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	100.0%	0.0%	0.0%	4	4	0	0
San Diego American Indian Health Center	2,198	1,401	881	40.1%	1,317	59.9%	497	35.5%	904	64.5%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	794	36.1%	37.8%	0.0%	62.2%	1,401	529	0	872
Santa Ynez Tribal Health Clinic	2,063	1,559	727	35.2%	334	16.2%	425	27.3%	212	13.6%	576	27.9%	426	20.6%	523	33.5%	399	25.6%	504	24.4%	31.3%	30.7%	38.0%	1,559	487	479	593
Shingle Springs Tribal Health Program	1,765	1,350	405	22.9%	947	53.7%	278	20.6%	714	52.9%	83	4.7%	330	18.7%	71	5.3%	287	21.3%	154	8.7%	21.8%	5.0%	73.2%	1,350	294	67	989
Sonoma County Indian Health Project	6,874	6,408	1,151	16.7%	717	10.4%	1,005	15.7%	628	9.8%	3,114	45.3%	1,892	27.5%	2,959	46.2%	1,816	28.3%	1,550	22.5%	16.2%	45.7%	38.0%	6,408	1,039	2,931	2,438
Southern Indian Health Council	4,452	3,341	1,619	36.4%	1,131	25.4%	985	29.5%	731	21.9%	893	20.1%	809	18.2%	842	25.2%	783	23.4%	110	2.5%	32.9%	22.6%	44.4%	3,341	1,100	756	1,485
Strong Family Health Center (Modoc)	180	171	0	0.0%	0	0.0%	0	0.0%	0	0.0%	8	4.4%	172	95.6%	8	4.7%	163	95.3%	73	40.6%	0.0%	4.6%	95.4%	171	0	8	163
Susanville Indian Rancheria	897	839	82	9.1%	281	31.3%	64	7.6%	244	29.1%	16	1.8%	518	57.7%	16	1.9%	515	61.4%	360	40.1%	8.4%	1.8%	89.8%	839	70	15	753
Sycuan Band of the Kumeyaay Nation	118	100	42	35.6%	73	61.9%	34	34.0%	63	63.0%	0	0.0%	3	2.5%	0	0.0%	3	3.0%	0	0.0%	34.8%	0.0%	65.2%	100	35	0	65
Table Mountain Medical																							0				
Tejon Indian Tribe																							0				
Toiyabe Indian Health Project	3,563	3,170	311	8.7%	775	21.8%	205	6.5%	556	17.5%	80	2.2%	2,397	67.3%	74	2.3%	2,335	73.7%	311	8.7%	7.6%	2.3%	90.1%	3,170	241	73	2,857
Tule River Indian Health Center	3,939	3,868	875	22.2%	562	14.3%	841	21.7%	542	14.0%	1,457	37.0%	1,045	26.5%	1,441	37.3%	1,044	27.0%	258	6.5%	22.0%	37.1%	40.9%	3,868	850	1,436	1,582
Tuolumne Me-Wuk Indian Health Center	1,387	461	248	17.9%	735	53.0%	29	6.3%	170	36.9%	16	1.2%	388	28.0%	9	2.0%	253	54.9%	242	17.4%	12.1%	1.6%	86.4%	461	56	7	398
United American Indian Involvement (LA) (LA American Indian)	923	849	198	21.5%	725	78.5%	176	20.7%	673	79.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	579	62.7%	21.1%	0.0%	78.9%	849	179	0	670
United Indian Health Service	2,377	1,758	1,880	79.1%	40	1.7%	1,282	72.9%	35	2.0%	192	8.1%	265	11.1%	182	10.4%	259	14.7%	37	1.6%	76.0%	9.2%	14.8%	1,758	1,336	162	260
Warner Mountain Indian Health Program	83	73	6	7.2%	0	0.0%	3	4.1%	0	0.0%	77	92.8%	0	0.0%	70	95.9%	0	0.0%	0	0.0%	5.7%	94.3%	0.0%	73	4	69	0
Wilton Rancheria																							0				
Sacramento, CA	62,639	52,148	12,698	20%	15,488	25%	9,095	17%	10,984	21%	8,176	13%	26,277	42%	7,607	15%	24,462	47%	11,705	18.7%	18.9%	13.8%	67.3%	52,148	9,833	7,207	35,108
Temecula, CA	36,004	32,336	12,450	35%	9,856	27%	10,539	33%	8,754	27%	8,794	24%	4,904</														



Regional Center Market Share Calculation

Erosion Factor #2 - How far is Regional Care?

Erosion Factor #3 - How many alternative care opportunities are there?

Erosion Factor #4 - Can you direct Medicaid?

Unaltered NDW Data	Service Area	Regional Center Location	Market Erosion by Distance							M Reliance No Choice	M Reliance Choice	# of Alt Care in route (Sec or Trty)	Sub Market Erosion by Competitors						Market Share				
			Svc Unit Drive Time to RC (in minutes)	Direct Care Only No 3P	Direct Care, PRC (No Choice)	Direct Care, PRC (Choice)	Direct Care, PRC, 3P (Medicaid Only)	Direct Care, PRC, 3P (Medicaid Reduced)	Direct Care, PRC, 3P				Direct Care Only No 3P	Direct Care, PRC (No Choice)	Direct Care, PRC (Choice)	Direct Care, PRC, 3P (Medicaid Only)	Direct Care, PRC, 3P (Medicaid Reduced)	Direct Care, PRC, 3P	M Reliance - CHS No Choice & Medicaid Only		M Reliance - Choice		
				w/out 3rd Party Coverage	w/out 3rd Party Coverage	w/out 3rd Party Coverage	w 3rd party Coverage	w 3rd party Coverage	w 3rd party Coverage				Net Users	Net Users	w/out 3rd Party Coverage	w/out 3rd Party Coverage	w/out 3rd Party Coverage	w 3rd party Coverage	w 3rd party Coverage	w 3rd party Coverage	Total Users	% of User Pop	Total Users
		28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	
	American Indian Health and Services (Santa Barbara) (SB Urban Indian Hlth)	Temecula, CA	163	400	0	0	36	125	158	561	558	13	400	0	0	36	125	63	561	92.4%	463	76.3%	
	Bakersfield American Indian Health Project (American Ind Hlth Coun)	Temecula, CA	172	2	5	5	1	9	10	18	17	8	2	5	4	1	9	4	18	92.5%	10	51.0%	
	Cabazon Band of Cahuilla Indians	Temecula, CA	84							0	0	4							0	0.0%	0	0.0%	
	Central Valley Indian Health	Sacramento, CA	156	611	900	900	1,982	3,439	5,260	6,933	6,772	9	611	900	630	1,982	3,439	2,104	6,933	94.1%	3,346	45.4%	
	Chapa De Indian Health Program	Sacramento, CA	37	969	285	285	171	2,427	2,598	3,852	3,852	4	969	285	199	171	2,427	1,039	3,852	100.0%	2,207	57.3%	
	Colusa Indian Health Community Health Council	Sacramento, CA	64							0	0	2							0	0.0%	0	0.0%	
	Consolidated Tribal Health Project	Sacramento, CA	153	168	464	464	949	1,285	2,157	2,866	2,789	1	168	464	417	949	1,285	1,726	2,866	94.4%	2,311	76.2%	
	Feather River Tribal Health	Sacramento, CA	67	2,426	58	58	57	3,059	3,114	5,600	5,598	3	2,426	58	41	57	3,059	1,245	5,600	96.0%	3,712	63.6%	
	Fresno American Indian Health Project	Sacramento, CA	153	5	0	0	4	8	12	17	17	7	5	0	0	4	8	5	17	93.8%	9	52.5%	
	Greenville Rancheria Tribal Health Program	Sacramento, CA	148	258	110	110	0	0	0	369	369	4	258	110	77	0	0	0	369	91.9%	335	83.7%	
	Indian Health Center of Santa Clara Valley	Sacramento, CA	107							0	0	8							0	0.0%	0	0.0%	
	Indian Health Council	Temecula, CA	29	1,029	3,622	3,622	2	208	210	4,861	4,861	0	1,029	3,622	3,622	2	208	210	4,861	100.0%	4,861	100.0%	
	Karuk Tribe	Sacramento, CA	290	65	154	154	137	1,345	1,454	1,702	1,674	2	65	154	124	137	1,345	872	1,702	81.1%	1,061	50.6%	
	K'ima:w Medical Center (Hoopa)	Sacramento, CA	261	62	151	151	746	1,890	2,485	2,848	2,697	2	62	151	121	746	1,890	1,491	2,848	84.2%	1,673	49.5%	
	Lake County Tribal Health Consortium	Sacramento, CA	124	197	114	114	130	1,855	1,975	2,296	2,286	1	197	114	102	130	1,855	1,580	2,296	92.3%	1,879	75.6%	
	MACT Health Board	Sacramento, CA	83							0	0	2							0	0.0%	0	0.0%	
	Mathiesen Memorial Health Clinic (Chicken Ranch)	Sacramento, CA	100	5	7	7	0	0	0	12	12	2	5	7	6	0	0	0	12	96.0%	10	84.3%	
	Native American Health Center (SF Bay Area)	Sacramento, CA	73							0	0	3							0	0.0%	0	0.0%	
	Northern Valley Indian Health	Sacramento, CA	90	444	55	55	756	1,638	2,364	2,893	2,862	1	444	55	49	756	1,638	1,891	2,893	97.0%	2,384	79.9%	
	Pit River Health Services	Sacramento, CA	187	59	60	60	30	703	729	852	849	2	59	60	48	30	703	438	852	88.2%	545	56.4%	
	Quartz Valley Program	Sacramento, CA	248	2	0	0	35	148	176	185	178	2	2	0	0	35	148	106	185	83.0%	107	48.1%	
	Redding Rancheria Tribal Health Systems	Sacramento, CA	138							0	0	2							0	0.0%	0	0.0%	
	Riverside San Bernardino County Indian Health	Temecula, CA	58	7,070	3,326	3,326	121	9,081	9,202	19,599	19,599	0	7,070	3,326	3,326	121	9,081	9,202	19,599	100.0%	19,599	100.0%	
	Rolling Hills	Sacramento, CA								0	0								0	0.0%	0	0.0%	
	Round Valley Indian Health Center	Sacramento, CA	199	118	127	127	71	909	971	1,225	1,217	1	118	127	115	71	909	777	1,225	88.5%	1,010	72.9%	
	Sacramento Native American Health Center	Sacramento, CA	2	4	0	0	0	0	0	4	4	1	4	0	0	0	0	0	4	100.0%	4	100.0%	
	San Diego American Indian Health Center	Temecula, CA	53	529	0	0	315	557	872	1,401	1,401	4	529	0	0	315	557	349	1,401	100.0%	878	62.7%	
	Santa Ynez Tribal Health Clinic	Temecula, CA	190	428	421	421	127	409	521	1,385	1,370	13	428	421	295	127	409	208	1,385	88.8%	931	59.7%	
	Shingle Springs Tribal Health Program	Sacramento, CA	35	294	67	67	86	903	989	1,350	1,350	2	294	67	54	86	903	593	1,350	100.0%	941	69.7%	
	Sonoma County Indian Health Project	Sacramento, CA	155	955	2,694	2,694	505	1,776	2,241	5,930	5,889	3	955	2,694	1,885	505	1,776	896	5,930	92.5%	3,737	58.3%	
	Southern Indian Health Council	Temecula, CA	66	1,055	725	725	35	1,391	1,425	3,207	3,206	1	1,055	725	653	35	1,391	1,140	3,207	96.0%	2,848	85.2%	
	Strong Family Health Center (Modoc)	Sacramento, CA	287	0	6	6	53	88	130	147	136	5	0	6	4	53	88	52	147	86.0%	56	33.0%	
	Susanville Indian Rancheria	Sacramento, CA	185	62	14	14	266	428	662	769	737	5	62	14	10	266	428	265	769	91.7%	336	40.0%	
	Sycuan Band of the Kumeyaay Nation	Temecula, CA	68	33	0	0	0	63	63	96	96	2	33	0	0	0	63	38	96	96.0%	71	70.9%	
	Table Mountain Medical	Sacramento, CA	160							0	0	6							0	0.0%	0	0.0%	
	Tejon Indian Tribe	Temecula, CA	135							0	0	8							0	0.0%	0	0.0%	
	Toiyabe Indian Health Project	Sacramento, CA	268	192	58	58	199	2,120	2,278	2,568	2,528	2	192	58	46	199	2,120	1,367	2,568	81.0%	1,605	50.6%	
	Tule River Indian Health Center	Sacramento, CA	231	747	1,261	1,261	91	1,310	1,390	3,409	3,398	8	747	1,261	883	91	1,310	556	3,409	88.1%	2,186	56.5%	
	Tuolumne Me-Wuk Indian Health Center	Sacramento, CA	104	53	7	7	67	318	382	445	442	2	53	7	5	67	318	229	445	96.5%	288	62.5%	
	United American Indian Involvement (LA) (LA American Indian)	Temecula, CA	79	172	0	0	403	256	643	831	815	4	172	0	0	403	256	257	831	97.9%	429	50.5%	
	United Indian Health Service	Sacramento, CA	290	1,066	129	129	3	205	207	1,403	1,402	2	1,066	129	103	3	205	124	1,403	79.8%	1,293	73.6%	
	Warner Mountain Indian Health Program	Sacramento, CA	322	3	55	55	0	0	0	58	58	4	3	55	38	0	0	0	58	79.8%	42	57.2%	
	Wilton Rancheria	Sacramento, CA	28							0	0	2							0	0.0%	0	0.0%	
	Sacramento, CA																		Sacramento, CA	47,733	91.5%	31,080	59.6%
	Temecula, CA																		Temecula, CA	31,958	98.8%	30,090	93.1%



Projected Services by Site

The following tables detail the projected 2033 services deemed feasible for each regional site providing the following information for each:

- The projected Disciplines by Department and Service line
- 100% of the projected 2033 regional workload for the site service area
- The eroded 2033 regional workload (% market share) in the site service area
- The projected impact of telemedicine on lost workload recovery
 - Y=High (80% recovery of lost market workloads)
 - N=None
- The total 2033 adjusted regional workload for Direct Care at the regional site
- The resulting required Key Characteristics (KC) in 2033 to serve the projected workload
 - KC are typically the most important/expensive aspect of care delivery: the provider, dentist, specialist, bed, room, etc. for each service line
- The Regional Direct Care site planned workload
- The KC quantified
- The number of KCs required
- The PRC \$ value of the Regional Direct Care workload
 - In other words, the cost to PRC \$ that would be incurred if those volumes were satisfied through PRC referrals instead
- Any necessary remark codes



Service Area Communities and User Population

HSP Adjusted Current and Projected User Populations

Primary Service Area (PSA)

	Year	<1-14	15-44	45-64	65+	Total
Male	2019	8,891	14,601	6,439	3,173	33,104
	2033	10,901	17,932	7,887	3,891	40,611
Female	2019	8,527	16,733	7,902	4,504	37,666
	2033	10,458	20,568	9,705	5,537	46,268
Combined	2019	17,418	31,334	14,341	7,677	70,770
	2033	21,359	38,500	17,592	9,428	86,879

**Service Units
Served**

Central Valley Indian Health, Chapa De Indian Health Program, Colusa Indian Health Community Health Council, Consolidated Tribal Health Project, Feather River Tribal Health, Fresno American Indian Health Project, Greenville Rancheria Tribal Health Program, Indian Health Center of Santa Clara Valley, Karuk Tribe, K'ima:w Medical Center (Hoopa), Lake County Tribal Health Consortium, MACT Health Board, Mathiesen Memorial Health Clinic (Chicken Ranch), Native American Health Center, North Valley Indian Health, Pit River Health Services, Quartz Valley, Redding Rancheria Tribal Health Systems, Rollings, Hills, Round Valley Health Center, Sacramento Native American Health Center, Shingle Springs Tribal Health Program, Sonoma County Indian Health Project, Strong Family Health Center (Modoc), Susanville Indian Rancheria, Table Mountain Medical, Toiyabe Indian Health Project, Tule River Indian Health Center, Tuolumne Me-Wuk Indian Health Center, United Indian Health Service, Warner Mountain Indian Health Program, Wilton Rancheria

**Regional Ambulatory Surgical & Speciality Health
Services Feasibility Study Update**

IHS, California Area Office

Sacramento
Concept of Operation



Delivery Plan and Resource Allocation - Native American (IHS)

Eroded Market Percentage => 91.5% 2033 Projected Regional Center Eroded User Pop => 86,879

Discipline	Workloads				Delivery Plan Decision		Projected Resource Requirements		
	2033 100% Market	2033 Eroded Market	Telemed Impact (Y / N)	2033 Total Adjusted Regional Workload	2033 KC	Regional Direct Care On Site	Key Characteristic	HSP Result Formula	PRC \$ Value
								# in 2033	

Specialty Care Specialty

Planned Crossover=> 0.0%

Medical Specialties

Cardiology	8,909	8,152	Y	8,758	3.4	8,758 <i>Visiting Providers to outlying areas.</i>	Providers 3.0 0.4	\$2,644,795
Dermatology	10,624	9,721	Y	10,443	2.5	10,443 <i>Visiting Providers to outlying areas.</i>	Providers 2.2 0.3	\$1,733,604
Neurology	4,308	3,941	Y	4,235	1.8	4,235 <i>Visiting Providers to outlying areas.</i>	Providers 1.6 0.2	\$1,219,565

Other Medical Specialties

Allergy & Immunology	1,416	1,296	Y	1,392	0.6	1,392 <i>Visiting Providers to outlying areas.</i>	Providers 0.6 0.0	\$714,123
Gastroenterology	1,173	1,073	Y	1,153	0.5	1,153 <i>Visiting Providers to outlying areas.</i>	Providers 0.5 0.0	\$591,452
Hematology / Oncology	869	795	Y	854	0.3	854 <i>Visiting Providers to outlying areas.</i>	Providers 0.3 0.0	\$438,113
Pulmonology	608	556	Y	598	0.2	598 <i>Visiting Providers to outlying areas.</i>	Providers 0.2 0.0	\$306,679
Other Medical Specialties	38,687	35,399	Y	38,029	15.4	38,029 <i>Visiting Providers to outlying areas.</i>	Providers 13.8 2.0	\$19,509,082

Surgical Specialties

General Surgery	7,911	7,238	Y	7,776	4.7	7,776 <i>Visiting Providers to outlying areas.</i>	Providers 4.3 0.6	\$2,737,293
Ophthalmology	19,320	17,678	N	17,678	4.8	17,678 <i>Visiting Providers to outlying areas.</i>	Providers 4.3 0.6	\$6,187,300
Orthopedics	14,961	13,689	Y	14,707	5.3	14,707 <i>Visiting Providers to outlying areas.</i>	Providers 4.8 0.7	\$5,029,657
Otolaryngology	7,322	6,700	Y	7,198	2.6	7,198 <i>Visiting Providers to outlying areas.</i>	Providers 2.3 0.3	\$2,389,603
Urology	6,196	5,670	N	5,670	2.0	5,670 <i>Visiting Providers to outlying areas.</i>	Providers 1.8 0.2	\$1,735,020

Other Surgical Specialties

Other Surgical Specialties	9,795	8,962	Y	9,628	3.5	9,628 <i>Visiting Providers to outlying areas.</i>	Providers 3.1 0.5	\$4,939,369
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Pain Management

Pain Management	0	0	Y	0	1.8	0 <i>Visiting Providers to outlying areas.</i>	Providers 1.8	
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Specialty Care Sub-Total	132,099	120,870		128,119	49.3	128,119	Providers Exam Rooms Dept. Gross Sq. Ft.	50.7 59 36,324	\$50,175,656
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Telemedicine

						Telemedicine Coordinators	3.0	
						Telemedicine Rooms	3	
						DGSF	1,098	



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Discipline	Workloads				Delivery Plan Decision		Projected Resource Requirements		
	2033 100% Market	2033 Eroded Market	Telemed Impact (Y / N)	2033 Total Adjusted Regional Workload	2033 KC	Regional Direct Care On Site	Key Characteristic	HSP Result Formula	PRC \$ Value
								# in 2033	
Other Ambulatory Care Services									
Visits converted to User Pop to match HSP workload output*									
Dental User Pop HSP	94,951	86,879		86,879		86,879			
Orthodontics					6.4		Dental Specialists	17.6	
Endodontics					2.0				
Pediatrics					2.0				
Periodontics					2.6				
Oral Surgery					2.9				
Prosthodontics					1.6		Dental Chair Specialist Chair	48.0	
							Dept. Gross Sq. Ft.	31,143	
Audiology Visits	11,538	10,557		10,557	5.1	10,557	Audiologists	5.1	\$2,026,944
							Audiology Booths	5.0	
							Dept. Gross Sq. Ft.	4,458	
Other Ambulatory Care Sub-Total							Dept. Gross Sq. Ft.	35,601	\$2,026,944
Behavioral Health									
Visits									
Psychiatry	9,426	8,625	Y	9,266	5.4	9,266	Providers	5.4	\$1,223,085
Behavioral Health Total	9,426	8,625		9,266	5.4	9,266	Total Providers / Counselors PCT Offices	5.4	
							Dept. Gross Sq. Ft.	1,883	\$1,223,085
Inpatient Care									
Bed Days									
Pediatric	1,961	1,794	N	1,794	9	1,794	# of Beds	9	\$4,310,982
							Dept. Gross Sq. Ft.	4,422	
Adult Medical	19,956	18,260	N	18,260	62	18,260	# of Beds	62	\$16,963,540
							Dept. Gross Sq. Ft.	31,847	
Adult Surgical Acute	12,136	11,104	N	11,104	39	11,104	# of Beds	39	\$23,507,168
							Dept. Gross Sq. Ft.	20,398	
Intensive Care	4,994	4,570	N	4,570	18	4,570	# of Beds	18	\$11,447,850
							Dept. Gross Sq. Ft.	15,986	
Inpatient Care Total	43,672	39,959		39,959	128	35,728	# of patient beds	128	\$56,229,540
							Dept. Gross Sq. Ft.	72,654	
Ancillary Services									
Rehabilitation Services									
Therapy Visits									
OT Visits	14,827	13,346	N	13,346	7.5	13,346	Therapy FTE	7.5	\$5,578,628
Speech Therapy Visits	3,263	2,915	N	2,915	1.6	2,915	Therapy FTE	1.6	\$1,542,035
Rehab Total	87,799	78,987		78,987	9.1	16,261	Therapy FTE	9.1	\$7,120,663
							Dept. Gross Sq. Ft.	6,745	
Laboratory Services									
Lab Billable									
Clinical Lab	480,213	236,589	N	236,589		236,589			
Microbiology Lab	112,057	44,489	N	44,489		44,489			
Blood Bank	12,074	7,729	N	7,729		7,729			
Anatomical Pathology	10,046	5,889	N	5,889		5,889			
Lab Total	614,390	294,696		294,696		294,696	Total FTE	30.0	\$48,330,089
							Dept. Gross Sq. Ft.	7,705	



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Discipline	Workloads				Delivery Plan Decision		Projected Resource Requirements		
	2033 100% Market	2033 Eroded Market	Telemed Impact (Y / N)	2033 Total Adjusted Regional Workload	2033 KC	Regional Direct Care On Site	Key Characteristic	HSP Result Formula	PRC \$ Value
								# in 2033	

Planned Crossover=> 0.0%

Pharmacy				OP Scripts / IP Orders					
OP Pharmacy Scripts	1,131,215	427,039	N	427,039		427,039			
OP Pharmacy WLUs HSI	5,425,154	2,049,789	N						
IP Pharmacy WLU/ Ord	231,654	194,039							
IP Pharmacy Scripts		40,460	N	40,460		40,460			
Hub Pharmacy Scripts		22,585		22,585		22,585			

Pharmacy Total					490,084		Pharmacists	35.0	\$0
							Dept. Gross Sq. Ft.	19,893	

Diagnostic Imaging				Imaging Exams					
Radiographic Exams	40,706	30,724	N	30,724	6.0	30,724	Rooms	6.0	\$13,733,630
Fluoroscopy Exams	2,898	2,593	N	2,593	2.0	2,593	Rooms	2.0	
Bone Density Exams	2,818	2,579	N	2,579	1.0	2,579	Rooms	1.0	\$1,152,813
Ultrasound Exams	5,970	5,401	N	5,401	3.0	5,401	Rooms	3.0	\$2,678,666
Mammography Exams	13,867	12,688	N	12,688	4.0	12,688	Rooms	4.0	\$6,432,816
CT Exams	6,430	10,913	N	10,913	3.0	10,913	Rooms	2.0	\$5,904,020
MRI Exams	4,051	6,936	N	6,936	4.0	6,936	Rooms	2.0	\$3,336,064

Diagnostic Imaging Total	79,174	71,833		71,833	23.0	71,833	Radiologists	6.0	\$33,238,009
							Dept. Gross Sq. Ft.	22,487	

Surgery				Surgical Episodes					
Endoscopy Cases	1,894	1,733	N	1,733	2	1,733	Endoscopy Suites	2.0	\$3,037,949
OP Surgery Cases	6,658	6,092	N	6,092	7	6,092	Outpatient ORs	7.0	\$11,934,228

Surgical Case Total	11,342	10,378		10,378	9.0	7,825	# of ORs/Suites	9	\$14,972,177
							Dept. Gross Sq. Ft.	30,284	

Administrative Support									
Administration			N		73.8		# of FTE	73.8	
							Dept. Gross Sq. Ft.	9,684	
Information Management			N		42.0		# of FTE	42.0	
							Dept. Gross Sq. Ft.	7,728	
Health Information Management			N		29.9		# of FTE	29.9	
							Dept. Gross Sq. Ft.	2,478	
Business Office			N		41.2		# of FTE	41.2	
							Dept. Gross Sq. Ft.	6,649	
Security			N		26.7		# of FTE	26.7	
							Dept. Gross Sq. Ft.	994	

Administration Total							# of FTE	213.6	
							Dept. Gross Sq. Ft.	27,533	

Facility & Support Services									
Clinical Engineering			N		7.3		# of FTE	7.3	
							Dept. Gross Sq. Ft.	2,246	
Facility Management			N		40.3		# of FTE	40.3	
							Dept. Gross Sq. Ft.	6,201	
Central Sterile			N		4.7		# of FTE	4.7	
							Dept. Gross Sq. Ft.	2,250	
Dietary/Food Services			N		22.6		# of FTE	22.6	
							Dept. Gross Sq. Ft.	6,213	
Property & Supply			N		23.6		# of FTE	23.6	
							Dept. Gross Sq. Ft.	12,697	
Housekeeping & Linen			N		61.4		# of FTE	61.4	
							Dept. Gross Sq. Ft.	7,262	



Delivery Plan and Resource Allocation - Native American (IHS)

Eroded Market Percentage => 91.5% 2033 Projected Regional Center Eroded User Pop => 86,879

Discipline	Workloads				Delivery Plan Decision		Projected Resource Requirements		
	2033 100% Market	2033 Eroded Market	Telemed Impact (Y / N)	2033 Total Adjusted Regional Workload	2033 KC	Regional Direct Care On Site	Key Characteristic	HSP	PRC \$ Value
								Result	
								Formula	
							# in 2033		
Education & Group Consulting			N		0.0		# of FTE	0.0	
							Dept. Gross Sq. Ft.	12,418	
Employee Facilities			N		0.0		# of FTE	0.0	
							Dept. Gross Sq. Ft.	13,330	
Public Facilities			N		0.0		# of FTE	0.0	
							Dept. Gross Sq. Ft.	2,747	
Facility Support Total							# of FTE	159.9	
							Dept. Gross Sq. Ft.	65,364	
Additional Services - IHS Supportable									
Lodging	(staff and space is shown below)				0.0		# of FTE	0.0	
							Dept. Gross Sq. Ft.		
Transportation					161.9		# of FTE	161.9	
							Dept. Gross Sq. Ft.	1,091	
Visiting Specialties	(space is included in Specialty Care above)				6.0		# of FTE	6.0	
							Dept. Gross Sq. Ft.	0	
DME					14.0		# of FTE	14.0	
							Dept. Gross Sq. Ft.	9,684	
Case Management					26.6		# of FTE	26.6	
							Dept. Gross Sq. Ft.	5,031	
Additional Services					208.5		# of FTE	202.5	
							Dept. Gross Sq. Ft.	15,805	
Projected Total Staff (Excluding Lodging)								1,502.8	
Projected Space - Building Gross Square Feet (Excluding Lodging)								479,189	
Projected Total Lodging Staff								108.2	
Projected Space Lodging - Building Gross Square Feet								94,285	
Projected Regional Center Grand Total All Staff								1,611.0	
Projected All Space - Building Gross Square Feet								573,474	
Total Projected Adjusted PRC Dollars Value									\$213,316,164



Building Area Summary

<u>Additional Services</u>	<u>Gross Square Feet</u>
Case Management	5,031
Transportation	1,091
Pharmacy Hub (Planned in Pharmacy Department)	0
Durable Medical Equipment	9,684
Visiting Specialties (Planned in Specialty Care)	0
	15,805
Administration	
Administration	9,684
Business Office	6,649
Health Information Management	2,478
Information Technology	7,728
Security	994
	27,533
Ambulatory	
Audiology	4,458
Psychiatry	1,883
Dental Specialty	31,143
Specialty Care	36,324
	73,808
Ancillary	
Diagnostic Imaging	22,487
Laboratory	7,705
Pharmacy	19,893
Physical Rehab Services	6,745
Outpatient Surgery	30,284
	87,114
Facility Support	
Clinical Engineering	2,246
Facility Management	6,201
	8,447
Inpatient	
Acute Care	56,668
Intensive Care	15,986
	72,654
Support Services	
Dietary	6,213
Education & Group Consulting	12,418
Employee Facilities	13,330
Housekeeping & Linen	7,262
Medical Supply	2,250
Property & Supply	12,697
Public Facilities	2,747
	56,917
Department Gross Square Feet	342,278
Building Circulation and Envelope (0.25)	85,569
Floor Gross Square Feet	427,847
Major Mechanical Space (0.12)	51,342
Building Gross Square Feet (Excluding Lodging)	479,189
Lodging Facility Building Gross Square Feet	94,285
Total Building Gross Square Feet	573,474



Service Area Communities and User Population

HSP Adjusted Current and Projected User Populations

Primary Service Area (PSA)

	Year	<1-14	15-44	45-64	65+	Total
Male	2019	4,748	8,385	3,838	1,733	18,704
	2033	5,807	10,289	4,695	2,119	22,910
Female	2019	4,804	10,196	4,813	2,457	22,270
	2033	5,872	12,522	5,911	3,016	27,321
Combined	2019	9,552	18,581	8,651	4,190	40,974
	2033	11,679	22,811	10,606	5,135	50,231

**Service Units
Served**

American Indian Health and Services (Santa Barbara), Bakersfield American Indian Health Project, Cabazon Band of Cahuilla Indians, Indian Health Council, Riverside San Bernadino County Indian Health, San Diego American Indian Health Center, Santa Ynez Tribal Health Clinic, Southern Indian Health Council, Sycuan Band of the Kumeyaay Nation, Tejon Indian Tribe, United American Indian Involvement (LA American Indian)



Delivery Plan and Resource Allocation - Native American (IHS)

Eroded Market Percentage => 98.8% 2033 Projected Regional Center Eroded User Pop => 50,231

Discipline	Workloads				Delivery Plan Decision		Projected Resource Requirements		
	2033 100% Market	2033 Eroded Market	Telemed Impact (Y / N)	2033 Total Adjusted Regional Workload	2033 KC	Regional Direct Care On Site	Key Characteristic	HSP Result Formula # in 2033	PRC \$ Value
Specialty Care									
<i>Specialty</i>									
Medical Specialties									
Cardiology	4,761	4,704	Y	4,750	1.8	4,750	Providers	1.6	\$1,434,379
						<i>Visiting Providers to outlying areas.</i>		0.2	
Dermatology	5,676	5,609	Y	5,663	1.4	5,663	Providers	1.2	\$939,992
						<i>Visiting Providers to outlying areas.</i>		0.2	
Neurology	2,301	2,273	Y	2,295	1.0	2,295	Providers	0.9	\$661,075
						<i>Visiting Providers to outlying areas.</i>		0.1	
Other Medical Specialties									
Allergy & Immunology	819	809	Y	817	0.3	817	Providers	0.3	\$419,019
						<i>Visiting Providers to outlying areas.</i>		0.0	
Gastroenterology	678	670	Y	676	0.3	676	Providers	0.3	\$347,040
						<i>Visiting Providers to outlying areas.</i>		0.0	
Hematology / Oncology	502	496	Y	501	0.2	501	Providers	0.2	\$257,067
						<i>Visiting Providers to outlying areas.</i>		0.0	
Pulmonology	352	347	Y	351	0.1	351	Providers	0.1	\$179,947
						<i>Visiting Providers to outlying areas.</i>		0.0	
Other Medical Specialties	20,672	20,425	Y	20,623	8.3	20,623	Providers	7.5	\$10,579,394
						<i>Visiting Providers to outlying areas.</i>		1.1	
Surgical Specialties									
General Surgery	4,218	4,167	Y	4,208	2.6	4,208	Providers	2.3	\$1,481,146
						<i>Visiting Providers to outlying areas.</i>		0.3	
Ophthalmology	10,176	10,177	N	10,177	2.7	10,177	Providers	2.5	\$3,561,950
						<i>Visiting Providers to outlying areas.</i>		0.4	
Orthopedics	7,976	7,881	Y	7,957	2.9	7,957	Providers	2.6	\$2,721,294
						<i>Visiting Providers to outlying areas.</i>		0.4	
Otolaryngology	3,903	3,857	Y	3,894	1.4	3,894	Providers	1.3	\$1,292,742
						<i>Visiting Providers to outlying areas.</i>		0.2	
Urology	3,304	3,265	N	3,265	1.2	3,265	Providers	1.1	\$999,090
						<i>Visiting Providers to outlying areas.</i>		0.2	
Other Surgical Specialties									
Other Surgical Specialties	5,222	5,160	Y	5,210	1.9	5,210	Providers	1.7	\$2,672,525
						<i>Visiting Providers to outlying areas.</i>		0.2	
Pain Management									
Pain Management	0	0	Y	0	1.0	0	Providers	1.0	
						<i>Visiting Providers to outlying areas.</i>		0.0	
Specialty Care Sub-Total	70,684	69,841		70,386		70,386	Providers	27.8	\$27,546,657
							Exam Rooms	33	
							Dept. Gross Sq. Ft.	18,341	
Telemedicine									
							Telemedicine Coordinators	3.0	
							Telemedicine Rooms	3	
							DGSF	1,098	



Delivery Plan and Resource Allocation - Native American (IHS)

Eroded Market Percentage => 98.8% 2033 Projected Regional Center Eroded User Pop => 50,231

Discipline	Workloads			Delivery Plan Decision		Projected Resource Requirements			
	2033 100% Market	2033 Eroded Market	Telemed Impact (Y / N)	2033 Total Adjusted Regional Workload	2033 KC	Regional Direct Care On Site	Key Characteristic	HSP Result Formula	PRC \$ Value
								# in 2033	
Other Ambulatory Care Services									
Visits converted to User Pop to match HSP workload output*									
Dental User Pop HSP	50,840	50,231		50,231		50,231			
Orthodontics					3.7		Dental Specialists	10.2	
Endodontics					1.2				
Pediatrics					1.2				
Periodontics					1.5				
Oral Surgery					1.7		Dental Chair		
Prosthodontics					1.0		Specialist Chair	25.0	
							Dept. Gross Sq. Ft.	15,748	
Audiology Visits	6,063	5,990		6,048	2.9	6,048	Audiologists	2.9	\$1,161,293
							Audiology Booths	3.0	
							Dept. Gross Sq. Ft.	2,554	
Other Ambulatory Care Sub-Total							Dept. Gross Sq. Ft.	18,302	\$1,161,293
Behavioral Health									
									Visits
Psychiatry	4,233	4,183	Y	4,223	2.5	4,223	Providers	2.5	\$557,477
Behavioral Health Total	4,233	4,183		4,223	27.5	4,223	Total Providers / Counselors / Therapists	2.5	
							PCT Offices		
							Dept. Gross Sq. Ft.	858	\$557,477
Inpatient Care									
									Bed Days
Pediatric	993	981	N	981	5	981	# of Beds	5	\$2,357,343
							Dept. Gross Sq. Ft.	2,781	
Adult Medical	10,496	10,370	N	10,370	37	10,370	# of Beds	37	\$9,633,730
							Dept. Gross Sq. Ft.	19,202	
Adult Surgical Acute	6,451	6,374	N	6,374	24	6,374	# of Beds	24	\$13,493,758
							Dept. Gross Sq. Ft.	12,570	
Intensive Care	2,638	2,606	N	2,606	12	2,606	# of Beds	12	\$6,528,030
							Dept. Gross Sq. Ft.	10,054	
Inpatient Care Total	22,968	22,692		22,692	78	20,331	# of patient beds	78	\$32,012,861
							Dept. Gross Sq. Ft.	44,607	
Ancillary Services									
Rehabilitation Services									
									Therapy
OT Visits	7,829	7,610	N	7,610	4.3	7,610	Therapy FTE	4.3	\$3,180,980
Speech Therapy Visits	1,665	1,606	N	1,606	0.9	1,606	Therapy FTE	0.9	\$849,574
Rehab Total	46,915	45,590		45,590	5.1	9,216	Therapy FTE	5.1	\$4,030,554
							Dept. Gross Sq. Ft.	3,823	
Laboratory Services									
									Lab Billable
Clinical Lab	257,055	132,556	N	132,556		132,556			
Microbiology Lab	60,166	25,017	N	25,017		25,017			
Blood Bank	6,453	4,368	N	4,368		4,368			
Anatomical Pathology	5,367	3,393	N	3,393		3,393			
Lab Total	329,041	165,334		165,334		165,334	Total FTE	16.8	
							Dept. Gross Sq. Ft.	5,764	



Delivery Plan and Resource Allocation - Native American (IHS)

Eroded Market Percentage => 98.8% 2033 Projected Regional Center Eroded User Pop => 50,231

Discipline	Workloads				Delivery Plan Decision		Projected Resource Requirements		
	2033 100% Market	2033 Eroded Market	Telemed Impact (Y / N)	2033 Total Adjusted Regional Workload	2033 KC	Regional Direct Care On Site	Key Characteristic	HSP	PRC \$ Value
								Result Formula	
							# in 2033		
Pharmacy									
					<i>OP Scripts / IP Orders</i>				
OP Pharmacy Scripts	610,844	236,219	N	236,219		236,219			
OP Pharmacy WLUs HS	2,929,527	1,132,874	N						
IP Pharmacy WLU/ Ord	121,968	110,418							
IP Pharmacy Scripts		23,024		23,024		23,024			
Hub Pharmacy Scripts		12,185		12,185		12,185			
Pharmacy Total						248,404	Pharmacists	18.1	\$0
							Dept. Gross Sq. Ft.	10,263	
Diagnostic Imaging									
					<i>Imaging Exams</i>				
Radiographic Exams	21,961	17,522	N	17,522	3.7	17,522	Rooms	3.0	\$7,832,351
Fluoroscopy Exams	1,563	1,479	N	1,479	0.9	1,479	Rooms	1.0	
Bone Density Exams	1,508	1,490	N	1,490	0.3	1,490	Rooms	0.0	\$666,030
Ultrasound Exams	3,217	3,080	N	3,080	1.4	3,080	Rooms	2.0	\$1,527,481
Mammography Exams	7,554	7,463	N	7,463	2.3	7,463	Rooms	2.0	\$3,783,741
CT Exams	3,443	10,913	N	10,913	3.4	10,913	Rooms	2.0	\$5,904,020
MRI Exams	2,191	6,936	N	6,936	4.3	6,936	Rooms	2.0	\$3,336,064
Diagnostic Imaging Total	42,887	48,882		48,882	16.4	48,882	Radiologists	4.1	\$23,049,688
							Dept. Gross Sq. Ft.	16,772	
Surgery									
					<i>Surgical Episodes</i>				
Endoscopy Cases	1,008	996	N	996	1	996	Endoscopy Suites	1.0	\$1,745,988
OP Surgery Cases	3,566	3,524	N	3,524	4	3,524	Outpatient ORs	4.0	\$6,903,516
Surgical Case Total	6,064	5,992		5,992	5.0	4,520	# of ORs/Suites	5	\$8,649,504
							Dept. Gross Sq. Ft.	16,825	
Administrative Support									
Administration			N		53.5		# of FTE	53.5	
							Dept. Gross Sq. Ft.	7,764	
Information Management			N		22.0		# of FTE	22.0	
							Dept. Gross Sq. Ft.	4,086	
Health Information Management			N		23.4		# of FTE	23.4	
							Dept. Gross Sq. Ft.	1,939	
Business Office			N		32.3		# of FTE	32.3	
							Dept. Gross Sq. Ft.	5,213	
Security			N		15.3		# of FTE	15.3	
							Dept. Gross Sq. Ft.	813	
Administration Total							# of FTE	146.5	
							Dept. Gross Sq. Ft.	19,815	
Facility & Support Services									
Clinical Engineering			N		4.9		# of FTE	4.9	
							Dept. Gross Sq. Ft.	1,508	
Facility Management			N		24.6		# of FTE	24.6	
							Dept. Gross Sq. Ft.	3,785	
Central Sterile			N		6.0		# of FTE	6.0	
							Dept. Gross Sq. Ft.	2,873	
Dietary/Food Services			N		17.2		# of FTE	17.2	
							Dept. Gross Sq. Ft.	6,213	
Property & Supply			N		12.0		# of FTE	12.0	
							Dept. Gross Sq. Ft.	6,456	
Housekeeping & Linen			N		38.1		# of FTE	38.1	
							Dept. Gross Sq. Ft.	4,177	



Delivery Plan and Resource Allocation - Native American (IHS)

Eroded Market Percentage => 98.8% 2033 Projected Regional Center Eroded User Pop => 50,231

Discipline	Workloads				Delivery Plan Decision		Projected Resource Requirements		
	2033 100% Market	2033 Eroded Market	Telemed Impact (Y / N)	2033 Total Adjusted Regional Workload	2033 KC	Regional Direct Care On Site	Key Characteristic	HSP	PRC \$ Value
								Result	
								Formula	
							# in 2033		
Education & Group Consulting			N		0.0		# of FTE	0.0	
							Dept. Gross Sq. Ft.	6,923	
Employee Facilities			N		0.0		# of FTE	0.0	
							Dept. Gross Sq. Ft.	8,259	
Public Facilities			N		0.0		# of FTE	0.0	
							Dept. Gross Sq. Ft.	2,674	
Facility & Support Total							# of FTE	102.8	
							Dept. Gross Sq. Ft.	42,867	

Additional Services - IHS Supportable

Lodging	(staff and space is shown below)	0.0		# of FTE	0.0
				Dept. Gross Sq. Ft.	0
Transportation		27.5		# of FTE	27.5
				Dept. Gross Sq. Ft.	620
Visiting Specialties	(space is accounted for in Specialty Care)	3.3		# of FTE	3.3
				Dept. Gross Sq. Ft.	0
DME		9.5		# of FTE	9.5
				Dept. Gross Sq. Ft.	5,599
Case Management		15.6		# of FTE	15.6
				Dept. Gross Sq. Ft.	2,948
Additional Services		55.9		# of FTE	52.6
				Dept. Gross Sq. Ft.	9,168

Projected Total Staff (Excluding Lodging)	811.2
Projected Space - Building Gross Square Feet (Excluding Lodging)	290,365
Projected Total Lodging Staff	20.3
Projected Space Lodging - Building Gross Square Feet	17,653
Projected Regional Center Grand Total All Staff	831.5
Projected All Space - Building Gross Square Feet	308,018

Total Projected Inflation Adjusted PRC Dollars Value **\$97,008,034**



Building Area Summary

	Gross Square Feet
Additional Services	
Case Management	2,948
Transportation	620
Pharmacy Hub (Planned in Pharmacy Department)	0
Durable Medical Equipment	5,599
Visiting Specialties (Planned in Specialty Care)	0
	9,168
Administration	
Administration	7,764
Business Office	5,213
Health Information Management	1,939
Information Technology	4,086
Security	813
	19,815
Ambulatory	
Audiology	2,554
Psychiatry	858
Dental Specialty	15,748
Specialty Care	18,341
	37,502
Ancillary	
Diagnostic Imaging	16,772
Laboratory	5,764
Pharmacy	10,263
Physical Rehab Services	3,823
Outpatient Surgery	16,825
	53,446
Facility Support	
Clinical Engineering	1,508
Facility Management	3,785
	5,293
Inpatient	
Acute Care	34,553
Intensive Care	10,054
	44,607
Support Services	
Dietary	6,213
Education & Group Consulting	6,923
Employee Facilities	8,259
Housekeeping & Linen	4,177
Medical Supply	2,873
Property & Supply	6,456
Public Facilities	2,674
	37,574
Department Gross Square Feet	207,404
Building Circulation and Envelope (0.25)	51,851
Floor Gross Square Feet	259,255
Major Mechanical Space (0.12)	31,111
Building Gross Square Feet (Excluding Lodging)	290,365
Lodging Facility Building Gross Square Feet	17,653
Total Building Gross Square Feet	308,018

Regional Ambulatory Surgical & Specialty Health Services Feasibility Study Update

IHS, California Area Office

Report Update
Concept of Operation



Regional Population KC = Key Characteristic =>	2 Regional Centers					
	Temecula		Sacramento			
	KC #	DGSF	KC #	DGSF		
Ambulatory						
Audiology (Audiologists)	2.9	2,554	5.1	4,458		
Dental Care - Specialty Only (Sp. Dentists)	10.2	15,748	17.6	31,143		
Oral Surgery, Pediatric, Endodontist, Orthodontist, Prosthodontist, Periodontist						
Specialty Care						
Medical Specialties (Providers) *						
Cardiologist	1.8	18,341	3.4	36,324		
Dermatologist	1.4		2.5			
Neurologist	1.0		1.8			
Other Medical Specialists	8.6		15.8			
Surgical Specialties (Providers) *						
General Surgeons	2.6	18,341	4.9	36,324		
Ophthalmologists	2.9		4.9			
Orthopedist	3.0		5.5			
Otolaryngologist	1.5		2.6			
Urologist	1.3		2.0			
Other Surgical Specialists	1.9		3.6			
Ancillary						
Outpatient Endoscopy (Suites)	1.0		16,825		2.0	30,284
Outpatient Surgery Cases (OP ORs)	4.0	7.0				
Short Stay / Observation (Beds)	1.0	1.0				
Laboratory (FTE)	16.8	5,764		30.0	7,705	
Diagnostic Imaging						
Radiography (Rooms)	3.0	16,772	6.0	22,487		
Fluoroscopy (Rooms)	1.0		2.0			
Bone Density (Rooms)	0.0		1.0			
Ultrasound (Rooms)	2.0		3.0			
Mammography (Rooms)	2.0		4.0			
CT (Rooms)	2.0		2.0			
MRI (Rooms)	2.0		2.0			
Radiologist	4.1		6.0			
Pharmacy (Pharmacists)	18.1		10,263		35.0	19,893
Inpatient Care						
Pediatric (Beds)	5	34,553	9	56,668		
Adult Medical (Beds)	37		62			
Adult Surgical (Beds)	24		39			
ICU (beds)	12		10,054		18	15,986
Physical Rehab Services						
Occupational Therapist	4.3	3,823	7.5	6,745		
Speech Therapist	0.9		1.6			
Behavioral Health						
Psychiatry (Psychiatrists)	2.5	858	5.4	1,883		
Other Programs						
Case Management (FTEs)	15.6	2,948	26.6	5,031		
Pain Management (DGSF in Specialty Care)	1.0	-	1.8	-		
Lodging (BGSF)	20.3	17,653	108.2	-		
Transportation	27.5	620	161.9	1,091		
Visiting Specialties (DGSF In Specialty Care)	3.3	-	6.0	-		
Durable Medical Equipment	9.5	5,599	14.0	9,684		
Regional Center All Clinical and Support Services Summary						
Total FTEs	831.5		1,611.0			
Total BGSF	308,018		573,474			

* For detail see Regional Concept of Operation Delivery Plan and Resource Allocation

Regional Services & Resource Requirement Summary

This updated feasibility study completed by the IHS, California Area Office, refreshes the prior study that found that two Regional Centers are the best solution to close the disparity gap in funding.

One center for northern and central California and one for southern California would provide desperately needed access to secondary, inpatient, surgical, and specialty care.

Costs

- Total Construction Cost for Regional Ambulatory Center development in two locations is estimated at \$900.4m (not including site acquisition).
- Total Project Cost for Regional Ambulatory Center development in two locations is estimated at \$1.21b (not including site acquisition).
- The Annual Operating Cost for Regional Ambulatory Center development in two locations is estimated at \$446.4m.

Impact

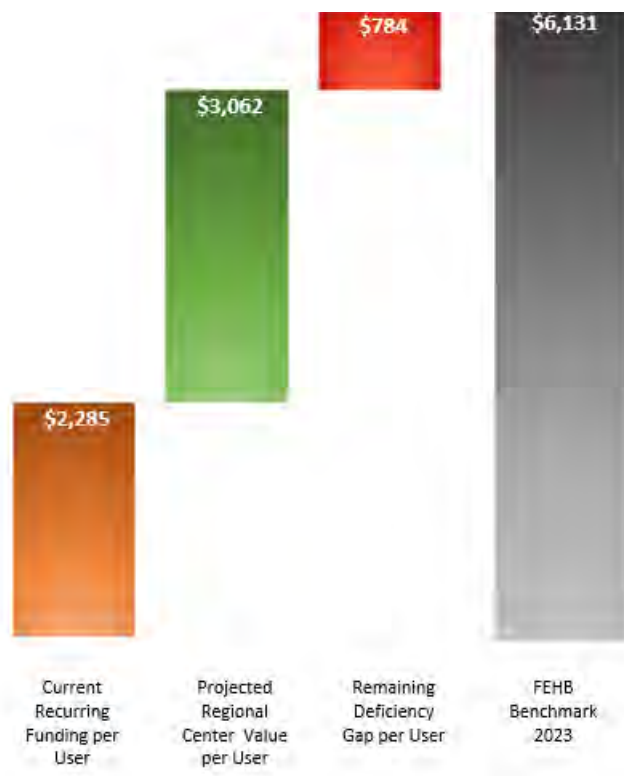
- The Level of Need Funded (LNF) could improve from 37.3% to 87.2%, closing the gap toward the Federal Benchmark by 49.9 basis points. This represents a projected increase from \$2,285 to \$5,347.
- The LNF increase is based on a projected 2033 area-wide user population of 145,791 (or a projected regional user population of 137,110).



Impact of Regional Healthcare Relative to Need

The ultimate value of regional healthcare to American Indian/Alaska Natives residing in California can be considered relative to Level of Need Funded (LNF). LNF compares funding for Native healthcare relative to a Federal Employee Health Benefit benchmark (FEHB). Though published LNF numbers, nationally and for California, are presently unavailable, estimates have been developed that update the graphic

Figure 15



provided in the original report (figure 15). Inflationary pressures related to a global pandemic and associated supply chain issues have escalated all numbers significantly since 2013.

The present federal benchmark is calculated to be \$6,131 annually. The current recurring funding per California user is calculated at \$2,285, based on financial information provided by the California IHS inclusive of standard categories (Hospital & Clinics, Dental, Mental Health, etc.). It does not include certain services like preventive healthcare or environmental services. This number falls far short of the FEHB and farther from the national per capita spending on healthcare, \$13,493 (CMS.gov, 2022).

Two regional centers, as presented in this updated report, can significantly close the gap between current LNF per user in California and the FEHB benchmark, a current shortfall of 62.7%

The average value of healthcare (annual operational plus depreciation costs) of two regional centers divided by the California HSP AI/AN user population (adjusted per concept of operation), produces an updated value of regional healthcare per user in today’s dollars (figure 15): \$3,062. That number suggests an impact in closing the LNF gap for every AI/AN in California of 49.9 percentage basis points. In other words, by establishing two Regional Ambulatory Surgical & Specialty Centers, the LNF gap would shrink from 62.7% to 12.8%, or from \$3,846 per user to \$784. That means the present LNF of \$2,285 per user would increase to \$5,347 per user toward the Federal Benchmark of \$6,131.



This projection of resources for California in raising the healthcare of American Indian/Alaska Natives who reside in California to the highest level is significant. It does not address all of California's needs, but it does identify the strategic value of regional healthcare.

Financials

The financials utilized in and emerging from this report are primarily focused on costs and required resources. In other words:

- How many staff are required?
- What size departments are required?
- What size facility is required?
- How much will it cost to build?
- How much will it cost to operate?
- What is the value of projected referred healthcare provided at each location?

There has been no attempt to determine the expected 3rd party collections that may be used to offset the anticipated operating costs which will influence margin projections. Revenue projections and 3rd party collections should be included at some point in future planning prior to implementation.

There are three major elements to consider related to costs:

- Operational costs (and the resulting scenario costs)
- Facility costs (and the resulting scenario costs)
- Referred Healthcare costs (Purchased and Referred Care (PRC) Impact)

Operation Costs Projections

1. The first step was the development of a KC level staffing plan based on projected workloads using IHS Required Resources Methodology (RRM) equivalent allocations. Such a staffing plan was developed by facility as summarized earlier in this section (Projected Services by Regional Site).
2. The second step was the development of an average salary by Regional Center. Since salary rates are geographically specific, a source of data was required capable of providing standardized annual staff salaries and overhead costs based on the location of each of the facilities. Web-based resources, such as Salaries.com, were utilized in conjunction with the Consultant's in-house data of selected IHS and Tribal Health facilities salary records. Parameters used to develop these costs included:
 - The city the facility is located in
 - Average facility wages for like-sized facilities in the same geographic area
 - Utilized the median wage rate for like facilities with similar services in the geographic area



- Benefit factor of 23.5% of direct salaries was applied as benefits costs to cover such expenses as employee related taxes, insurance, retirement, employee incentives, etc.
3. Other operating expenses were developed consistent with IHS' metrics in determining the annual funding amount for new facilities.
 - This methodology assumes that personnel costs (includes direct salaries and benefits) make up 70% of total operation costs while other costs comprise the remaining 30% of total operating costs.
 - Consequently, direct salaries were determined, benefit ratios were applied, and that total was assumed to be 70% of total costs.
 - The remainder includes operating costs such as utilities, repairs, maintenance, and other fixed costs which exclude any payment for PRC services outside the facility.
 4. The costs are based on FY2023 costs. An appropriate annual inflation factor based on historical inflation factors was applied by cost category to arrive at projected costs in future periods. The future periods used in this analysis are FY2028 - FY2033.

Facility Cost Projections (Construction and Project)

Capital costs were determined using the cost information obtained from estimators for the Portland Area Regional Center* estimate located in the Seattle metro area. This estimating tool considers the various building clinic and department types as well as any specific requirements of federal government financed buildings. These costs also considered the OSHPD building codes for California.

Facilities with inpatient services were calculated using a hospital building type. Facilities with office visits and some ancillary services were calculated using a medical office building type.

This estimate includes a per square foot estimator for each type of functional use and building code construction requirement. Space design square footages calculated from the HSP software by functional department were then applied to the cost per square foot for each type of space based on the various costs of construction per square foot.

These departmental costs were then aggregated and grossed up using a standard government grossing factor to arrive at a total cost per square foot.

The estimate then applied a standardized factor for developing a total project cost which includes architectural/engineering costs, building systems costs, furniture/fixtures costs, and any medical equipment costs. Large expensive pieces of medical equipment (such as radiology units) were itemized and added separately.

* This Regional Care Center is still in planning.



This project cost estimate does not consider, or attempt to quantify, the cost of land or any type of site development costs. Cost of land varies greatly depending on location within the community and the surrounding zoning and property uses. The amount of land is also dependent upon the style and structure of the building. The square footage for each building is shown along with the estimated parking requirements. How many stories and how the building is designed will determine the amount of property needed as well as green space requirements based on the selected site zoning regulations. For example, a one-story building with surface parking is projected to require 83 acres for Sacramento and 42 acres for Temecula. In urban settings, however, a multi-story building with a parking garage is more likely and would therefore require less acreage. These facility project costs are given for the purpose of determining the “order of magnitude” for each facility. Better estimates can be determined once the building design and a location are better conceptualized.

The following table (figure 16) outlines the building square footage and associated parking spaces.

Figure 16

Building Requirements	Temecula	Sacramento
Total Building Square Feet	308,018 BGSF	573,474 BGSF
Total parking spaces needed	896	1,692

The following tables (figures 17 and 18) show the project costs less land and land improvements using 2023 construction costs per square foot and associated fees for each of Regional Centers escalated annually.

The projected costs below assume construction completion by 2032 to support the operational cost assumptions targeting 2033. These projection years were chosen primarily because of the scope of work planning target: 2033. This is not intended to communicate an expectation that both regional centers will be constructed and fully operational by 2033. The planning team recognizes that much additional planning work is required, approval will necessitate thorough HQ review and comment, and a reasonable funding schedule is difficult to project. A more accurate project completion date will be developed as additional needed planning steps are accomplished (as identified in the executive summary).



Figure 17

Cost Estimate Summary Table for the North (Sacramento) Regional Center

California Regional Specialty Center - Sacramento		
Design		
Site Survey and Appraisal	\$	-
Site Acquisition	\$	-
A/E Design Fees	\$	48,658,641.48
Design Contingency	\$	3,945,295.25
Subtotal	\$	52,603,936.73
Construction		
A/E Const. Admin/Observ.	\$	10,520,787.35
Building Construction	\$	483,939,181.12
Other Costs	\$	3,156,236.20
Taxes	\$	38,137,854.13
Construction Contingency	\$	52,603,936.73
Subtotal	\$	588,357,995.53
Equipment		
Group II & III Equipment	\$	105,207,873.46
Special Equipment	\$	40,480,948.25
Cultural Arts	\$	2,630,196.84
Subtotal	\$	148,319,018.55
Total Project Budget:	\$	789,280,950.81



Figure 18

Cost Estimate Summary Table for the South (Temecula) Regional Center

California Regional Specialty Center - Temecula		
Design		
Site Survey and Appraisal	\$	-
Site Acquisition	\$	-
A/E Design Fees	\$	26,163,731.94
Design Contingency	\$	2,121,383.67
Subtotal	\$	28,285,115.61
Construction		
A/E Const. Admin/Observ.	\$	5,657,023.12
Building Construction	\$	255,887,798.56
Other Costs	\$	1,697,106.94
Taxes	\$	20,506,708.82
Construction Contingency	\$	28,285,115.61
Subtotal	\$	312,033,753.04
Equipment		
Group II & III Equipment	\$	56,570,231.22
Special Equipment	\$	25,926,305.32
Cultural Arts	\$	1,414,255.78
Subtotal	\$	83,910,792.32
Total Project Budget:	\$	424,229,660.98

Value of Healthcare Cost Projections (PRC Services Impact)

To help understand the relative value of regional healthcare versus PRC costs, the value of referred healthcare was calculated based on per encounter referral costs. The encounter volumes were based on the projected market share encounters that would be seen at the individual Regional Centers. These costs were projected based upon encounter data acquired from the IHS Phoenix Area Health Services Master Plan, adjusted relative to the difference in healthcare costs between Arizona and California for various service lines or categories based on CMS data. These differences are shown in the table below (figure 19) which is based on FY2020 data.



Figure 19

Per Capita Healthcare Cost FY2020 by State by Service Category

Categories	Arizona	California	Variance
1 Personal Health Care	\$ 8,756	\$ 10,299	17.62%
2 Hospital Care	\$ 3,263	\$ 3,838	17.62%
3 Physician & Clinical Services	\$ 2,291	\$ 2,715	18.51%
4 Other Professional	\$ 380	\$ 315	-17.11%
5 Dental Services	\$ 437	\$ 453	3.66%
6 Home Health Care	\$ 231	\$ 480	107.79%
7 Prescriptions/Medical Supplies	\$ 1,087	\$ 1,121	3.13%
8 Durable Medical Equipment	\$ 195	\$ 118	-39.49%
9 Nursing Home Care	\$ 345	\$ 469	35.94%
10 Other Health, Residential, Personal Care	\$ 526	\$ 790	50.19%

Source:

<https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence>

The data was adjusted to reflect the State of California only, with no further adjustments to reflect specific geographic areas within the State.

The complete table of volumes and PRC costs savings by Regional Center can be found as summarized earlier in this section (Projected Services by Regional Site).

From these location-specific per encounter costs, all facility referral values were totaled to form the amount of PRC costs that could be saved based on the projected workload for each Regional Center.

Understanding the potential 3rd party collections generated by these workloads would require a much greater scope of study by payer – something future planning efforts may wish to consider, assuming more comprehensive payer information could be obtained.

Note - The value of healthcare and PRC Services burden impact projections do not include all service lines since, even on a national scale, because per encounter costs are not available for some lines of healthcare. The following services do not have a per encounter cost and consequently are not included in the total referred healthcare values:

- Dental Specialty Care
- Pharmacy
- Case Management
- Pain Management

This means that the projected value of referred healthcare is likely conservative and already includes a “built-in” risk limiter relative to Level of Need Funded Impact and potential revenue.



Assigning a value to that limiter is difficult. But national PRC Services per encounter cost data from the IHS Fiscal Intermediary in Albuquerque shows that the value of the cost of additional healthcare paid relative to the cost of healthcare assignable to a per encounter cost, ranges from an additional 8.5% to 20.1%. This would suggest that the value of referred healthcare as shown in this study is either:

- a. Conservative by 8.5 – 20.1%
- or
- b. Market share will need to be applied to the projected workload to produce the value of referred healthcare identified.

Operating Costs

The following table (figure 20) displays each of the Regional Center’s projected facility operating costs. For this analysis, it is anticipated that the soonest a Regional Center would begin operation is in FY2033.

Figure 20

	2023 Base Line Costs	2028	2033
Facilities Operating Costs			
Personnel Costs			
Temecula	\$ 87,700,554	\$ 101,668,979	\$ 117,862,211
Sacramento	\$ 170,666,601	\$ 197,849,366	\$ 229,361,641
Non-Personnel Costs			
Temecula	\$ 26,310,166	\$ 29,767,538	\$ 33,679,237
Sacramento	\$ 51,199,980	\$ 57,928,078	\$ 65,540,304
Total Operating Cost	\$ 335,877,302	\$ 387,213,962	\$ 446,443,393

Again, as stated previously, it is important to understand that Regional Care does not remove PRC funding currently provided to programs/sites and reassign it to a regional center. No existing PRC funding is removed from programs/sites in this financial model.

Recommendation

The content and process of this updated study support the following statements:

1. The concept of regional centers in California still appears to be a viable means of delivering secondary healthcare to AI/ANs from across the state.
2. There is increasing interest among tribal leaders and health program directors in the concept as shared through multiple meetings/venues, but that interest may not be universal.
3. There is no known geographic configuration of locating regional centers in California that would create equal and fair access to all AI/ANs who reside in California while delivering a comprehensive menu of specialized services that constitutes true secondary healthcare.



4. There is presently no apparent equal and fair access to secondary healthcare for AI/ANs who reside in California when they are referred to the private sector.
5. The more centralized such healthcare is, the greater the menu of specialized services becomes, thereby truly addressing the gaps in the continuum of healthcare California AI/ANs are currently experiencing.
6. The greater the population served by a regional center, the more efficient the capital and operational costs become.
7. Not everyone will seek covered regional healthcare at a distant location, whether that distance is 2 hours away or 4 hours away – distance erodes market share.
8. Considering the criteria applied to evaluate regional center modeling, the Two Center Regional Concept delivers the most secondary healthcare by volume and best addresses the unmet need for services in California.
9. Due to the untested nature of such healthcare facilities relative to IHS Funding as well as the perennial limited funding of traditional facility models, seeking funding for fewer highly efficient regional sites appears to be a better path than seeking funding for many.
10. The current healthcare landscape increasingly relies on Telemedicine for patient/provider interaction and is a growing means of delivering healthcare. Regional care will rely on adequate connectivity to support its mission. Local sites will need to undergo an assessment of their respective technology and broadband capabilities, California IHS should assist in coordinating these efforts.

This study has not explored alternative means of delivering regional healthcare. These include:

1. Seek increased PRC Services funding from IHS to address a comparable level of unmet need. This is simply not possible under the current funding methodology.
2. Create appropriate contractual agreements between local hospitals and each Health Program that address the level of unmet need identified in this study. This is a separate work effort requiring deep alignment and involvement from Health Program directors. While conceptually doable, assuming available funding and equal interest among all Health Programs, many limiting issues remain:
 - a. Not all Health Programs can produce volumes sufficient to create any leverage in negotiating favorable rates with local hospitals.
 - b. Not all hospitals offer a consistent menu of services – some health programs will fare much better than others in finding an accessible facility offering the services they need.
 - c. Not all services for a local Health Programs will be available under “one roof” (see the point above).
 - d. Many Health Programs will still have to travel significant distances to access true secondary healthcare.
 - e. Patients or Health Programs will often still have to pay for the service if its delivered by a local hospital.



- f. Local hospitals do not provide a culturally appropriate place for delivering secondary healthcare to AI/ANs who reside in California

Consequently, this study concludes that a Two-Center Regional Facility solution provides the best chance of delivering effective, culturally appropriate, secondary healthcare to AI/ANs who reside in California. Specifically:

- One inpatient facility centrally located for the central/northern region, such as Sacramento, to serve the referral needs of central and northern California tribal governments. The facility would be sized at 573,474 building gross square feet and require a staff of 1,611.0 FTEs.

Services would include:

- Audiology
- Dental Specialty Care
- Medical Specialty Care
- Surgical Specialty Care
- Visiting Specialty Care
- Outpatient Endoscopy
- Outpatient Surgery
- Short Stay/Observation
- Lab
- Diagnostic Imaging
 - Radiography
 - Fluoroscopy
 - Ultrasound
 - CT
 - MRI
 - Radiologist
- Pharmacy
 - Regional Pharmacy Hub
- Inpatient
 - Pediatrics
 - Adult Medical
 - Adult Surgical
 - ICU
- Physical Rehab
 - Occupational
 - Speech
- Psychiatry
- Case Management
- Pain Management
- Durable Medical Equipment
- Transportation
- Lodging

As this center develops regional “buy-in” from remote populations and approaches capacity, a second facility should be considered.

- One inpatient facility centrally located in agreement with southern California tribal governments, such as Temecula, to serve the referral needs of the federally recognized tribes in southern California. The facility would be sized at 308,018 building gross square feet and require a staff of 831.5 FTEs.

Services would include:



- Audiology
- Dental Specialty Care
- Limited Medical Specialty Care
- Limited Surgical Specialty Care
- Visiting Specialty Care
- Outpatient Endoscopy
- Outpatient Surgery
- Short Stay/Observation
- Lab
- Diagnostic Imaging
 - Radiography
 - Fluoroscopy
 - Ultrasound
 - CT
 - MRI
 - Radiologist
- Pharmacy
- Regional Pharmacy Hub
- Inpatient
 - Pediatrics
 - Adult Medical
 - Adult Surgical
 - ICU
- Physical Rehab
 - Occupational
 - Speech
- Psychiatry
- Case Management
- Pain Management
- Durable Medical Equipment
- Transportation
- Lodging



Appendices

A wealth of material supports this updated Regional planning effort. The appendices following are provided to assist the reader in understanding just some of the path, challenges, decisions, assumptions, and planning elements associated with the updated recommendations put forth in this report. The reader should be aware that terms and vocabulary evolve over a planning process.



Appendix 1 - Presentations

Many meetings between the consultant and stakeholders support this planning effort. Included are presentations from those that were the most significant and marked major milestones or decisions.

Kickoff Meeting

Market Forces Tool Review

Market Forces Tool – Follow Up

Final Workgroup Meetings



CALIFORNIA REGIONAL CENTERS STUDY UPDATE

Kickoff Meeting



California Area IHS
21 December 2022 | Project Call #1

Slide 1

AGENDA

Welcome to Project Call 1 – Kick-Off

9:00 am	Welcome and Opening Remarks	Area Office
9:05 am	Introductions	Participants
9:15 am	Project Context	Innova
9:25 am	Project Overview – 2013 Study Update	Innova
	<ul style="list-style-type: none"> 2013 Study – Key Assumptions and Findings What is the project scope? What's new? (add-ons) Important considerations What is the schedule? 	
9:40 am	What are the critical drivers?	Innova
9:50 am	Data Request (Draft)	Area Office and Innova
10:10 am	Questions and Concerns	Participants
10:25 am	Next Steps	Innova
10:30 am	Meeting Adjourns	



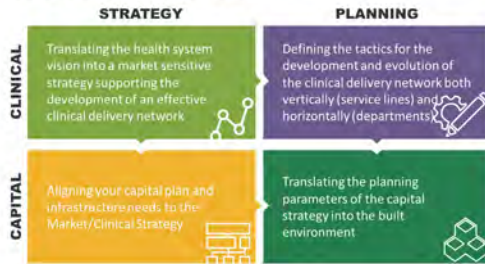
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Slide 2

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What We Do

Clients engage The Innova Group to solve strategic and planning conundrums relative to both clinical and capital concerns.



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What We Do

The Strategic Capital Planning Equation

The **RESOURCES REQUIRED** for your project are determined by the **DEMAND** in your market divided by your **OPERATIONAL MODEL**. This solution is weighed against your expectations, or "standards of care", to determine your final plan.



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Slide 4

INNOVA AND INDIAN HEALTH SERVICE

Indian Health Service and Tribal Health Experience

Replacement PID & POR	Addition/Alteration PID/PORs	Health Service Master Plans
<ul style="list-style-type: none"> TCC Chief Andrew Isaac Health Center JV Elko Southern Bands Health Center Kenaitze Indian Tribe Clinic JV Gallup Indian Medical Center Whiteriver Indian Hospital Valley Native Primary Care Center JV Sells Alternative Rural Health Facility 	<ul style="list-style-type: none"> Lakeport Health Center JV Northern Navajo Medical Center Gallup Indian Medical Center Chinle Comprehensive Health Center Yukon Kuskokwim Health Corporation JV Fort Duchesne Health Center Mt Edgcombe Hospital JV 	<ul style="list-style-type: none"> 9 of 17 IHS Areas Bristol Bay Area Health Corporation Tuba City Regional Health Care Corporation Alaska Native Medical Center Albuquerque Service Unit Southeast Alaska Tribal Health Consortium Chisle Comprehensive Healthcare

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Slide 5

OTHER EXPERIENCE

Many clients and projects cross over multiple service lines

Strategic Planning & Care Network Planning	Business & Financial Planning	Facility & Operational Planning
<ul style="list-style-type: none"> Phoenix Indian Medical Center Reliant Medical Group, MA Dignity Health, AZ Kaiser Permanente, HI Lucile Packard Children's Hospital, CA Government of Brunei Military Health, IHS, & VA Alaska Native Tribal Health Consortium 	<ul style="list-style-type: none"> Phoenix Indian Medical Center Tufts Medical Center, MA Kaiser Permanente, MD, HI, GA South Shore Hospital, MA Brookdale University Hospital & Medical Center, NY (Bed Need) Alaska Native Tribal Health Consortium 	<ul style="list-style-type: none"> Phoenix Indian Medical Center Yale New Haven Health, CT Loma Linda University Medical Center, CA John Muir Health, CA University of New Mexico Health Science Center, NM Children's Health, TX Alaska Native Tribal Health Consortium

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Slide 6



PROJECT TEAM

California Regional Study Update Team



Anthony Laird
Principal

Anthony's experience encompasses population assessment, service area definition, market opportunity assessment, space programming, functional planning, and system network planning. He brings extensive experience in large system network planning, having led multiple state/multi-state health services master planning efforts to define optimum local delivery strategy in coordination with regional opportunities for shared secondary and tertiary care.



Phyllis Klawsky
Senior Consultant

Phyllis's healthcare experience and has included work on physician planning assessments, national master planning projects, demographic and population analysis, space programming, strategic planning, and medical group due diligence and integration. She believes that client communication is a priority on any project and prides herself on her ability to relate to her clients and listen to all that they have to say.



Manon Tesche
Associate

Manon has a background in architecture and brings her passion for smart, strategic healthcare planning to all clients. She has skill in site analysis and planning and is excited to develop healthcare-focused thought processes and skills. Her goal is to create functional, user-friendly spaces with an approachable twist on healthcare facilities.

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Slide 7

CONTEXT: 2013 STUDY SCOPE

What type and location of regional centers do the Primary Service Areas (PSAs) need defined from the Health Services Master Plan considering the projected (AI/AN) population distribution in California?

Scope

- Studying statewide rural and urban American Indian/Alaska Native (AI/AN) population growth (projections and alignments) and developing a baseline understanding of a potential regional centers concept to help the Area Office staff understand the scope of services needed. The proposed regional centers concept development will include:
 - population and location research
 - development of market share projection methodology
 - supportable services quantified by location
 - general projected facility and staffing costs

Product Report

- Identifies AI/AN populations projected (rural and urban) to an agreed upon year and market share from which health services for up to three (3) Regional Centers will be conceptually developed.
- Any of these Regional Centers may be further considered for a Medical Center concept with additional services.
 - This development will identify essential supportable services, required space and staff, and anticipated initial construction and annual staffing costs.
 - This effort is limited to AI/AN populations and what IHS would support only.

Slide 8

CONTEXT: 2013 STUDY FINDINGS

What type and location of regional centers do the Primary Service Areas (PSAs) need defined from the Health Services Master Plan considering the projected (AI/AN) population distribution in California?

Two Regional Ambulatory Surgical & Specialty Centers...

- Owned/operated by IHS, providing culturally-appropriate care, are the best solution, potentially increasing California Area's (NF from 54% to 93.8%.
- One located for the central/northern region to serve the referral needs of central and northern California tribal governments (300,715 sf / 774 FTEs).
- One located in agreement with southern California tribal governments to serve the referral needs of the federally recognized tribes in southern California (119,369 sf / 269 FTEs).

Each would provide an enhanced level of secondary healthcare for AI/AN population residing in California.



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Slide 9

PROJECT OVERVIEW: PRESENT STUDY SCOPE

Revise and update the feasibility study completed in 2013. If any of the items below cannot be studied in detail, explain the constraints preventing the concept from being explored further in the study.

Scope

- Update user population data and Market Forces Tool
- Update summary statement of need and accompanying justification narratives
- Consider utilization/services evolution since 2013
- Consider feasibility of regional maternity/childbirth services* & site-visiting specialty services*
- Refresh contributing financial assumptions, costs, BGGF, and FTEs.
- Survey sites or acquire data supporting planning assumptions and planning additions.

Additions*

- Study the feasibility for the Regional Centers to manage transportation options for patients and caregivers
- Study the feasibility for the Regional Centers to manage an on-site lodging facility (i.e., hostel) for patients and caregivers
- Study the feasibility for the Regional Centers to serve as a specialty pharmacy hub for the Tribal and Urban health programs in the region
- Study the feasibility for the Regional Centers to serve as a durable medical equipment hub for the Tribal and Urban health programs in the region

Slide 10

PROJECT OVERVIEW: PRESENT STUDY SCOPE

Revise and update the feasibility study completed in 2013. If any of the items below cannot be studied in detail, explain the constraints preventing the concept from being explored further in the study.

Important Considerations...

- Update does not include 2013 underlying research supporting Market Forces Tool (MFT) assumptions, non-Two Center Scenarios (and supporting material), and Appendices/Historic documents
- Additional revisions will be conceptual in nature, providing a feasibility analysis based on the quality of data available.
- Projection year is 2033
- Project cost estimate will rely on Innova internal tools/metrics
- Financial updates do not include revenue/expense/margin projections
- The proposal schedule does not consider impact of Fall 2022 Holiday Season (this will be discussed on Project Call 1 - today)

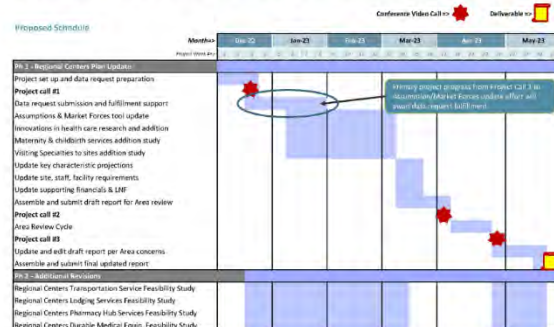


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PROJECT OVERVIEW: PROPOSED SCHEDULE

Does this pace seem acceptable? Are there any dates/events that will skew the schedule?



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Slide 12



CRITICAL DRIVERS: POPULATION & PAYER

The Market Forces Tool (MFT) is foundational in projecting demand for Regional Care

This tool considers the following questions in projecting future demand for services:

1. What is the population?
 - Total & PRCA (CHSDA)
2. Who is reliant on regional services?
 - Payer mix
3. How far is regional care?
4. Are there alternatives in route?
5. Can you influence some of your payers?
 - MediCal & PRC



Slide 13

CRITICAL DRIVERS: POPULATION

2013 study and 2022 population comparison - HSP Base Year Implications for 2019 & 2021

Proposed Population for Study Update

Region	HSP 2019	HSP 2033	HSP 2021	HSP 2033
Sacramento	66,045	81,084	64,275	76,705
Temecula	25,176	30,918	20,529	24,510

The HSP projects user population (AI/AN who touches the IHS system of care once in five years). This projects plans to use the 2019 user population for the base year. Why? Because of the "COVID-19 effect" - the decrease for base year 2021 when compared to 2019 - fewer users touching the IHS system during the Pandemic due to reduced utilization.

Population Used from 2013 Study

Region	Population
Sacramento	61,981
Temecula	25,185

- HSP = Health Systems Planning Software (IHS' Primary Facility Planning Tool).
- Not all site user data is presently captured by the HSP...

Slide 14

CRITICAL DRIVERS: POPULATION

Many sites have data issues/challenges (x marks the sites)

Service Areas 2013 Study	Sacramento			Temecula		
	HSP 2022 for Sacramento	No Data to NDW	NDW Issues	HSP 2022 for Temecula	No Data to NDW	NDW Issues
Central Valley	X					
Chico De	X					
Chicken Ranch	X	X				
Colusa HHC	X	X				
Constitution	X					
Feather River	X					
Fedora American Indian Health Prtg.	X					
Grass Valley Rancheria	X	X				
Hopala	X					
Indian HC of San Clara Valley (East Side)	X					
Karuk	X					
Lake County	X					
MACT	X					
Medford	X	X				
Native American HC (Oakland)	X					
Northern Valley	X					
PI River	X					
Quincy Valley	X					
Reading Rancheria	X					
Round Valley	X					
Sacramento Native American HC	X					
Shasta County	X					
Susville Rancheria	X	X				
Tahoe National	X					
Tayvalde	X	X				
Tuba River	X					
Tulelake-Mt-Wuk	X					
United Indian Health Svc	X					
Winnemuccia	X	X				

- The project data request will be sent to non-reporting sites and sites with NDW Quality Issues to capture reliable User Population.
- There are additional sites not included in the 2013 site that will be added.

Slide 15

CRITICAL DRIVERS: PAYER

What is the best path for collecting payer information?

Option 1 - An Area-run query comparable to what was run for the last study

- This is the preferred option

Option 2 - A fresh query returning raw data per the columns shown. Innova would run the analysis

Option 3 - Sites are requested to provide their payer mix (*this lacks consistency in data quality/control)

Slide 16

DATA REQUEST: IN DEVELOPMENT

Substantial progress on project requires fulfillment of data request.

- Stakeholder Identification
 - Provide guidance at Project Calls
 - Provide interim guidance in between as requested by Project POC
 - Champion the process and site participation
- Site Data
 - Location
 - Point of Contact (data collection)
 - User Population (several years)
- Payer Mix Data
 - Path to be determined
- Questionnaire Data
 - Update related
 - Specific to feasibility add-on services



Slide 17

WHAT QUESTIONS DO YOU HAVE?

Questions and Concerns?

Slide 18



KEY QUESTIONS

- Which payer/population option should be utilized going forward?
 - Option 1: NDW Data Unaltered
 - Option 2: California "Normalized"
 - Option 3: Sacramento & Temecula "Site Normalized"
- Are there any changes to the assumption table percentages that should be made?
 - Erosion by Distance Table
 - Erosion by Alternative Care Table
- Is the "no choice" planning assumption still appropriate?
 - Can Medicaid users be directed to seek higher level care at a Regional Center?

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Slide 11

MARKET FORCES TOOL DECISION #3 - POPULATION

Baseline Population Dilemma – Site or NDW Reported Populations vs. IHS HSP FY19 Population

	Baseline 2019 Populations AM	Baseline 2019 Populations PREDA
Unaltered NDW	98,643	84,484
California All	141,732	122,475
Sacramento Temecula	141,732	122,475
IHS HSP	88,227	N/A

- It is unlikely that IHS will approve population changes without considerable and consistent analysis and the oversight of Kirk Greenway.
- Past studies (California & Portland) have applied the MFT % to the IHS HSP population.
- Do you want to diverge from past studies' methodology or maintain such?

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Slide 12

POPULATION METHODOLOGY PROS & CONS

Maintain Methodology: Apply MFT % to HSP User Populations

- Consistent & supports consensus that brought us to this point
- Allows project to move forward without additional delay
- Eliminates IHS HQ contention on a project without historic precedent
- Does not prohibit the study of population in the future*

Diverge from Methodology: Push for Revised Populations

- Requires a modification to Innova's contract (additional work)
- Would likely require the involvement of Kirk Greenway (IHS HQ Statistician)
- Elevates the level of risk in an already risky project
- Requires additional data acquisition from sites (apples to apples)
- Additional project delay

* Potential of pursuing population evaluation as part of PID/PDR Phase 1 – Populations, Services, and Workloads

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Slide 13

NEXT STEPS

- Finalize decisions: NDW data profiles (1, 2, or 3), access assumptions, baseline populations
- Update the MFT tool
- Apply eroded user population to the additional studies by Regional Center
- Determine projected staffing and space needed at each Regional Center
- Review additional study results with respective user workgroups
- Develop updated Regional Center Projections for Sacramento & Temecula
- Begin work on Draft Report

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Slide 14

QUESTIONS AND CONCERNS

What questions or concerns do you have on the material presented today?

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Slide 15

ADJOURN

Thank you for attending



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Slide 16



MARKET FORCES TOOL – BACK TO QUESTION #1

Which approach to utilization of payer data should be adopted?

	Market Reliance "No Choice" (PRC & Medicaid Patients Directed to RC)	Market Reliance "Choice" (PRC & Medicaid Patients Not Directed to RC)
	% of User Population	% of User Population
Option #1: Unaltered NDW Payer Data		
Sacramento	91.5%	59.6%
Temecula	98.8%	93.1%
Option #2: California Payer Profile Normalized		
Sacramento	93.1%	59.4%
Temecula	97.9%	87.2%
Total		
Option #3: Sacramento and Temecula Payer Profiles Normalized		
Sacramento	93.2%	58.1%
Temecula	97.8%	88.4%

*California Leadership's Choice in the last report

Slide 7

POPULATION METHODOLOGY OPTIONS

Subtitle goes here

Maintain Methodology

(Apply MFT % to HSP User Populations)

- Consistent & supports consensus that brought us to this point
- Allows project to move forward without additional delay
- Eliminates IHS HQ contention on a project without historic precedent
- Does not prohibit the study of population in the future*

Diverge from Methodology

(Push for Revised Populations)

- Requires a modification to Innova's contract (additional work)
- Would likely require the involvement of Kirk Greenway (IHS HQ Statistician)
- Elevates the level of risk in an already risky project
- Requires additional data acquisition from sites (apples to apples)
- Additional project delay



Is there a middle road? Perhaps...

* Potential of pursuing population evaluation as part of FIC/PDR Phase 1 – Populations, Services, and Workflows

Slide 8

MIDDLE ROAD

What would this middle road look like? Why take it?

What?

- Override HSP populations (real or missing) for non-reporting sites and sites with known reporting issues...
 - With User Pops reported in questionnaire at outset of study
 - Consultant would attempt to acquire from unresponsive sites once more***
 - No override from sites unresponsive to latest effort
 - Urban HSP populations (real or missing) with baseline unique AI/AN patient populations from recent National Urban Program Infrastructure study (Unique Patients – 3 years max) or UIQ User Pop.

Why?

- Compensates for missing HSP user populations that will contribute to under-sizing the facility
- Identifies a potential path for including urban AI/ANs without overstating the case
- Suggests to IHS HQ why further study is required if/when the project moves into a Facility Planning Documents preparation effort (PJD/POR)

Slide 9

POTENTIAL IMPACT – QUICK LOOK

Service Site/Concession	Site Located in NDW	Submitting to NDW with Known Data Issues	Not Submitting to NDW	On Reported User Pop	Adjusted for Unique Populations (HSP-based HSP-based User Pop)	Adjusted for Unique Populations (HSP-based HSP-based User Pop)	Adjusted for Unique Populations (HSP-based HSP-based User Pop)	Adjusted for Unique Populations (HSP-based HSP-based User Pop)
1 Central Valley Indian Health Inc.		X	148	10,474				2,210
2 Colusa Indian Health	X		11					7
3 Graceland Rancheria Tribal Health Program	X		5,810	6,890				5,434
4 HACT Health Services Inc.	X	X	2,791					7
5 Kachemac Memorial (Chukchi Ranch)		X	26					7
6 Redding Healthcare	X	X	3,578					7
7 Riverbank/San Bernardino County Indian Health Inc.	X	X	14,021	14,710				789
8 Santa Feval Tribal Health Clinic	X		1,112	1,841				2,729
9 Shoshone Indian Health Center Inc. (HARR)	X	X	2,362	2,458				48
10 Strong Family (Mule)	X		328					7
11 Susanville Indian Healthcare	X		842					7
12 Tulelake Band of the Kumpunay National	X		38	295				207
13 Yreka Tribe	X		437					7
14 Yreka Indian Health Project Inc. (under CHRB)	X	X	2,108	2,259				7,997
15 Warner Mountain	X		87					7
16 Wilson Rancheria	X		1,489					7
17 YAO - Redfield American Indian Health Project (American Indian Health Care)	X		72	4,167	3,815	882		3,542
18 YAO - Fresno American Indian Health Project	X		1,113	175	1,248	710		49
19 YAO - Indian Health Center of Santa Clara Valley	X	X	27	21,749	21,472	265		836
Potential Total Additional Non-HSP "AI/AN" Population to Consider for Regional Centers Planning								14,128

Santa Clara is an outlier of great concern

Slide 10

QUESTIONS AND CONCERNS

What questions or concerns do you have?

What is your guidance?

Can we move forward?

Slide 11

ADJOURN

Thank you for attending



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Slide 12



CALIFORNIA REGIONAL CENTERS STUDY UPDATE

Final Workgroup Meetings



California Area IHS
November 2023 | Meeting #4 (per Updated Project Schedule)

Slide 1

A QUICK LOOK BACK

Steps in Workgroup that bring us to this point

- Original Questionnaire
- NDW Payer Data
- Matrix Development
 - Goals
 - Facts
 - Precepts
 - Concepts
 - Solution
- Three previous workgroup meetings for each of the following add-on services to develop the Matrix
 - Transportation
 - Lodging
 - Visiting Specialties
 - Pharmacy
 - Durable Medical Equipment

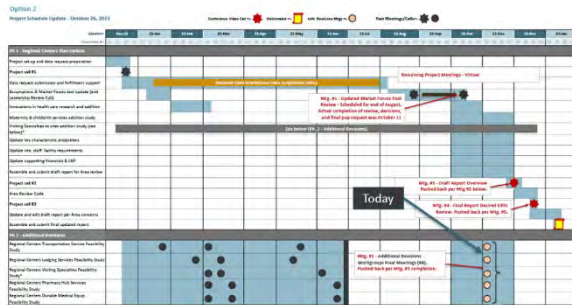


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Slide 2

PROJECT UPDATE

Updated Schedule



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Slide 3

DRAFT FEASIBILITY - LODGING

What has our effort resulted in? Does it seem feasible?

Key Drivers	Measure	Regional Facility	Draft Projection
Workload (307,723)	Outpatient Visits	Sacramento	120 Rooms
	Admits		108.2 FTE
Length of Stay	0.9 Nights	Temecula	94,285 BGSF
			22 Rooms
% of Users Requiring Lodging	38.1%		20.3 FTE
Access Threshold for Users Needing Lodging	>120 Minutes One Way		17,653 BGSF
Rooms Per Patient	1		
Guests Per Room	2		
Workload Units Per User	1.5		
Room Usage Efficiency	70%		

Slide 4

DRAFT FEASIBILITY – VISITING SPECIALTIES

What has our effort resulted in? Does it seem feasible?

Key Drivers	Measure	Regional Facility	Draft Projection
Total Area Workload	196,366 SCPVs	Sacramento	0.6 Total SC Visiting Providers
% Workload Seen at Regional Centers	93.9%		XX Total FTE
Unserviced Workload	11,698 SCPVs	Temecula	XX DGSF
% Unserviced Workload to be Served by SCVPS	6.1%		0.9 Total SC Visiting Providers
% of Specialties planning for Telemed Impact	80%		XX Total FTE
VP Travel Threshold	>90 Minutes One Way		XX DGSF
VP Productivity	75% of IHS Criteria		

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Slide 5

DRAFT FEASIBILITY – TRANSPORTATION

What has our effort resulted in? Does it seem feasible?

Key Drivers	Measure	Regional Facility	Draft Projection
Workload (307,723)	Outpatient Visits	Sacramento	82 Drivers/Cars
	Admits		86.7 Total FTE
% of Users Requiring Transport	48.8%	Temecula	828 DGSF
			20 Drivers/Cars
Access Threshold for Users	>53 Miles		22.3 Total FTE
Users per Vehicle	2		602 DGSF
Workload Units Per User	1.5		
Transport Efficiency Factor	127.5%		
Transportation Day	8 Hours		
Days Transportation is Available	250 Days		

Slide 6



DRAFT FEASIBILITY – PHARMACY HUB

What has our effort resulted in? Does it seem feasible?

Key Drivers	Measure	Regional Facility	Draft Projection
Total Workload Units - S	5,429,831	Sacramento	5 Pharmacists
Total Scripts - S	1,129,264		10.7 Hub FTE
% Requiring Hub Support	10%		SF in Final DGSF
Hub Scripts - S	112,926		
Hub Scripts per day - S	452		
Total Workload Units - T	2,929,527	Temecula	2.7 Pharmacists
Total Scripts - T	609,266		5.7 Hub FTE
% Requiring Hub Support	10%		SF in Final DGSF
Hub Scripts - T	60,927		
Scripts per day - T	244		

THE INNOVA GROUP | 7

Slide 7

DRAFT FEASIBILITY – DURABLE MEDICAL EQUIPMENT

What has our effort resulted in? Does it seem feasible?

Key Drivers	Measure	Regional Facility	Draft Projection
User Pop	All, Regional Center Aligned	Sacramento	94,950 Users
Top 6 Requested DMD	Ambulation Assistance		26.4 Total FTE
	CPAP	Temecula	10,583 DGSF
	Oxygen Equipment		50,841 Users
	Personal Care Aids		14.1 Total FTE
	Blood Sugar Monitors, CGM		5,667 DGSF
	Hospital Beds		
FTE/User Pop	0.00027		
DNSF/User Pop	0.1		

THE INNOVA GROUP | 8

Slide 8

NEXT STEPS

- Adjust model per guidance (if any)
- Finish Draft Regional Center Projections
- Adjust Add-On Projections relative to those if/as needed
- Assemble and Publish Draft Updated Report
- Area Review Period
- Review and Comments Meeting
- Edit and Publish Final Updated Report

THE INNOVA GROUP | 9

Slide 9

QUESTIONS AND CONCERNS

What questions or concerns do you have on the material presented today?

THE INNOVA GROUP | 10

Slide 10

ADJOURN

Thank you for attending



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THE INNOVA GROUP | 11

Slide 11



Appendix 2 – Add-On Services Modeling

The following pages provide the planning path summary, conceptual planning matrix, and conceptual resource planning model for each of the following regional services:

Transportation

Lodging

Visiting Specialties

Hub Pharmacy

Durable Medical Equipment



Conceptual Feasibility Study Summary – Transportation

I. Purpose – Why was the feasibility study completed?

To explore the feasibility of providing transportation services for patients and caregivers/family to and from the Regional Center for treatment.

II. Methodology – How was this feasibility study completed?

A special workgroup including tribal and IHS leaders was formed to hold discussions, in a series of four meetings, about current issues, future ideas, and resulting priorities surrounding the topic. Based on these discussions, a supporting conceptual matrix was developed to organize information gathered into a structure capable of shepherding the process and facilitate decision-making.

This study was conceptual in nature, intended to determine feasibility and required staff and space. It provides no operational or financial performance projections.

Where available, additional resources were used to gain knowledge and inform the feasibility study about transportation's potential role in regional care.

III. Matrix – What were the findings on Regional Center transportation and conceptual feasibility?

1. Goals – What are the goals of a transportation program that would support the delivery of Regional Care?

- a. To ensure patients using Regional Center transportation are safely transported in a timely manner without cost being a barrier.
- b. To ensure the maximum access for patients who need regional care by providing transportation.

2. Facts – What present facts support these goals and establish the need for a transportation program to support the delivery of regional care?

- a. Many patients do not have the resources or capabilities to drive themselves to the Regional Center.
- b. Many patients have a long drive-time to the Regional Center and could experience unfavorable driving conditions.

3. Precepts – What were the initial ideas proposed by the workgroup supporting development and potential concepts for refinement?

- a. Regional Center provided driver picks up patient at the site/clinic and drives them to the Regional Center and back to the site after their visit.
- b. Local Site/Clinic provided driver to shuttle patients to Regional Center and back.
- c. 50/50: Regional Center and site/clinic choose a pickup point to meet at and split the travel per driver in half.



- d. Regional Center has a contract with medical transport agencies to support patient transportation from site to the Regional Center.
- e. A Hybrid Model that would suggest utilizing public transportation when available (California High-speed rail) into Sacramento, pick up via Regional Center shuttle at the station upon arrival.
- f. Air travel suggested for longer distance travel if airport access is available with RC shuttle pickup at the terminal.
- g. Patients commute to the RC via personal transportation, receive reimbursement for lodging, mileage, gas, and meals.
- h. A group pickup model using a “Clinic Day” fixed schedule where either an RC driver or site/clinic CHR provides transportation services on certain days of the week/month using a larger vehicle.

Feasibility criteria – The workgroup identified the following criteria by which to evaluate or score the feasibility of each precept.

- a. Cost Efficient: Does this option cost a reasonable amount?
- b. Patient Comfort/Acuity: Is this option maximizing the patient’s comfort?
- c. Time Efficiency: Does this option minimize commute time?
- d. ADA Friendly: Does this option respect the American Disability Act? Are ADA patients able to benefit from this option?
- e. Rural Access: Are patients in rural areas able to benefit from this option?
- f. Long-distance Friendly: Is this option beneficial to patients who have a longer distance to travel (4+ hours)?

4. Concepts – What precepts were scored as more feasible and developed into concepts for workgroup consideration?

- a. Regional Center Provided Driver
- b. 50/50 Split Responsibility
- c. Group Pickup Option

5. Solution – Which concept was scored as most feasible and translated into needed staff (FTE) and space (BGSF) for inclusion in the Regional Center study update?

“The Regional Center will operate patient transportation services. This will include Regional Center drivers and vehicles” was chosen as the most feasible concept and was developed into needed staff and space.

IV. Decision

An excel based model was developed to quantify elementary aspects of the department (staff and space) and reviewed/vetted with workgroup members.



This service was deemed feasible by the workgroup and projected staff and space requirements have been added to the updated Regional Center report.

V. Conceptual Design Notes

1. The Regional Center provided driver would provide pick up and shuttle to the Regional Center for those patients incapable of transporting themselves.
2. Operating 250 days a year with an 8-hour driving period per day.
3. Regional Center drivers would pick up the patients at the local site and then drive them back to the Regional Center for patient care. Drivers would have a limited workday, depending on drive-time. If transport time exceeded the 8-hour day limiter, patients might be housed in the Regional Center lodging facility until the next day and then driven back to the local site.
4. Key Planning Metrics included:
 - Workload Requiring Transports (Total OPVs, Surgical Episodes, Admits)
 - Workload Units per Transport
 - Patients per Transport
 - Percentage Requiring Transport
 - Travel Time
 - Travel Threshold
5. Vehicles & Drivers
 - For the Sacramento Regional Center, 153 cars and drivers are projected as needed
 - For Temecula, 25 cars and drivers are projected as needed
6. Staff requirements:
 - For Sacramento, 162 total staff are projected as needed
 - For Temecula, 28 total staff are projected as needed
7. Size requirements:
 - The transportation service in Sacramento is projected to require 1,091 DGSF
 - The transportation service in Temecula is projected to require 620 DGSF

VI. Path Forward

Facility planning should be supported by further study of actual transportation systems already functioning at tribal locations and in a commercial capacity that might mirror the size and function of this projection. More thorough workload definition and modeling is essential. Sophisticated driver utilization and patient pickup/drop off travel must be demonstrated to the extent possible. This should be done before or during a PJD/POR facility planning document development effort.



Goals What are the goals of regional transportation?	Facts What facts drive this conceptual feasibility study?	Precepts What initial ideas might suggest solutions?	Precept Evaluation				Precept Feasibility Scoring by Workgroup						
			Assumptions	Challenges	Benefits	Need to know	Cost Efficient	Patient Comfort/Acuity	Time Efficiency	ADA Friendly	Rural Access	Long-distance Friendly	Group Avg
To ensure patients using Regional Center transportation are safely transported in a timely manner.	Many patients do not have the resources or capabilities to drive themselves to the Regional Center.	Regional Center Provided Driver	Use a driver based at the RC in car or van to drive to the site/clinic, pick up the patient and drive them back to the RC	<ol style="list-style-type: none"> 1. Time consuming depending on the distance from the site. 2. Driver would make two roundtrips per pickup. 3. Limited driving time per driver. 4. Cost. 5. Potentially not enough drivers which could cause scheduling inefficiency. 6. Training & hiring drivers (CDL, first aid). 	<ol style="list-style-type: none"> 1. Would remove burden from the sites (vehicles and drivers). 2. RC could potentially provide newer vehicles. 3. Depending of vehicle size, multiple patients can be transported. 4. Group pickup from multiple sites depending on distance. 5. Potential driver swap. 	<ol style="list-style-type: none"> 1. Does RC own or lease the vehicles? 2. Does RC employ the driver or contract with an agency? 3. Need to quantify vehicle demand. 	4	3	3	3	4	2	4.8
To ensure the maximum access for patients who need regional care by providing transportation.	Many patients have a long drive-time to the Regional Center and could experience unfavorable driving conditions.	Local Site/Clinic Provided Driver	Use a local driver, perhaps CHR using car or van, to drive the patient all the way to the RC and then transport them back home.	<ol style="list-style-type: none"> 1. Long day for the driver, long day for the patient, maximum time driver can drive, limits scheduling at RC, etc. 2. Removes CHR from site for the day. 3. Limited patient capacity in vehicle. 	<ol style="list-style-type: none"> 1. Driver and patient know each other, caregiver could accompany and tend to any needs, etc. 2. Could support limited contact with others. 	<ol style="list-style-type: none"> 1. Total time of transport for example(s), mileage, cost, scheduling window, etc. 2. What happens if time goes above CHR work limit? 3. If patient needs to stay overnight at RC, what is the status of the CHR? 	3	2	3	2	4	2	4.0
		50/50	<ol style="list-style-type: none"> 1. Driver/CHR from site drives patient to RC, RC driver drives patient back to the site. OR 2. Driver/CHR meets RC driver at designated pickup point, driver goes to RC with patient. 	<ol style="list-style-type: none"> 1. Liability 2. Potential opportunity for missed appointments. 3. Patients moves between two vehicles. 4. Would need to map specific pickup points for each site. 5. Does not support group pickup. 6. Coordination and lack of time efficiency. 	<ol style="list-style-type: none"> 1. Alleviates CHR driving time, especially for longer distances. 2. Cost efficient 	<ol style="list-style-type: none"> 1. Designated pick up points need to be determined. 2. How will scheduling be coordinated? 3. What are the liabilities? 4. Is it ADA friendly? 5. Maximum time-span for each driver (choose between option 1 or 2). 	3	2	3	2	3	3	4.0
		Contracted Driver	RC has a contract with medical transport agencies to support patient transportation from site to RC.	<ol style="list-style-type: none"> 1. Not RC or site known employees. 2. Communication deficiency potential. 3. Cost. 4. Conflicts in scheduling for longer travel. 	<ol style="list-style-type: none"> 1. RC and site do not have vehicle responsibility. 2. Frees up CHR schedule. 	<ol style="list-style-type: none"> 1. Cost of contract. 2. Would drivers be on-call or have scheduled days? 3. Location of their hub relative to RC and site. 	3	0	3	3	4	1	3.5
		Hybrid Model (train/shuttle)	Utilizing public transportation if possible (California high speed rail) into Sacramento, pick up via RC shuttle at station.	<ol style="list-style-type: none"> 1. The rail is not in service. 2. Not patient-comfort friendly. 3. Potentially missed appointments. 4. Are the trains ADA accessible? 5. Only certain patients would be able to benefit from this option as access to public transport may be sparse. 	<ol style="list-style-type: none"> 1. Cost friendly. 2. Quicker transport time potential. 3. Scheduled times. 	<ol style="list-style-type: none"> 1. When would the rail be finished and in-service? 2. What is the rail schedule and map? 3. How many patients would benefit from this option? 4. Who would pay the cost (reimbursement vs booked ticket). 5. Who accompanies the patient? 	0	0	0	1	0	1	0.5
		Air Travel	For longer distances, patients would utilize air travel as a means to get to the RC.	<ol style="list-style-type: none"> 1. High costs. 2. Potential delays. 3. Questionable patient comfort. 4. Scheduling conflicts. 5. Site accessibility to local airport. 6. If patient cannot travel alone, who accompanies? 7. Flight cancellation issues. 	<ol style="list-style-type: none"> 1. Helps cut travel time for sites further away from RC (dependent on airport location). 	<ol style="list-style-type: none"> 1. Nearest airport location to site. 2. Who accompanies the patient? 3. Scheduling shuttle pick up to and from airport. 4. Scheduling appointments to RC ahead of time (booking a calendar year ahead). 	1	2	2	3	1	2	2.8
		Patient Reimbursement	Patient commutes to the RC via personal transportation, receives reimbursement for lodging, mileage, gas, food.	<ol style="list-style-type: none"> 1. Patient may not be able to drive. 2. Patient may not have a reliable vehicle or mode of transportation to get to the center. 3. No trained medical professional on board in case of emergencies. 	<ol style="list-style-type: none"> 1. No additional CHR or driver costs. 2. CHRs and drivers have a freed up schedule. 3. Patient travels at their convenience. 4. No vehicle maintenance costs/responsibility. 5. Schedule is more patient-friendly. 	<ol style="list-style-type: none"> 1. Reimbursement rates. 2. Patient capability of self-transport. 3. Liability issues? 	2	2	3	2	3	1	3.3
		Group Pickup	Clinic Day where either RC driver or Site CHR schedules days in the week/month to go to RC. Encourages more people to schedule on those days.	<ol style="list-style-type: none"> 1. Scheduling. 2. Patient wait times. 3. Larger vehicle needed. 4. Patient proximity to others. 	<ol style="list-style-type: none"> 1. Cost efficiency. 2. Reduced driving hours per CHR or RC driver. 3. Scheduling. 4. Patient comfort friendly. 	<ol style="list-style-type: none"> 1. How often would Clinic Days occur? 2. What size vehicle is optimal? 3. Schedule of transportation coordinated with RC visits. 4. Site coordination for no conflicts. 5. Each site having staff/vehicle to accommodate group transport. 	4	1	1	2	2	2	3.0



Concepts What concept emerges from the most supported precept?	Concept Drivers				Concept Variables						Solution What is the most feasible conceptual solution?
	Projected 2033 Eroded User Population	Workload (OP Visits, IP Admits, Surgical Procedures)	Travel Time	Percentage Needing Transport from Questionnaire	Percentage of Patients Requiring Transportation	Minimum Distance Requiring Transportation	Transportation Inefficiency Factor	Operating Days	Workload Unit per Transport	Patients per Vehicle	
Regional Center Provided Driver	National Data Warehouse (NDW) to provide User Population payer profile data. This will be used to determine the portion of users who have 3rd party insurance that will not be utilizing the RC. Other erosion factors include distance and competition. Report cannot assume 100% of Users will seek care at the RC.	IHS HSP workload for those specialty services that will be supported at the RC based on the 2033 eroded User Population.	The distance a User travels from the home SU to the RC as determined by mapping.	The percentage of the User Population that would require IHS supported transportation to the RC. Users may elect to drive themselves, have a family member/friend drive, or take public transportation to the RC which will reduce the percentage.	48.8%	75 miles	1.50	250	1.5	1.5	The Regional Center will operate patient transportation services. This will include Regional Center drivers and vehicles.
					The columns above are the outcomes of meeting 4 - final decision concept planning.						

Regional Ambulatory Surgical & Specialty Health Services Feasibility Study

IHS, California Area Office

Appendices



Regional Center Transportation

Concept: Regional Center Provides Driver and Vehicles

2033 Eroded Population	137,110		Percentage Requiring Transport	48.8%
OP Visits	264,977	HSP	Inefficiency Factor *	1.50
Admits	30,882	HSP	Distance (Miles) Requiring Transportation	75
Surgical Procedures	11,864	HSP	Workload Units Per Transport	1.5
Total Relevant Workload	307,723	Total	Patients per Vehicle	1.5

* Accounting for repairs, driver illness, weather etc.

Service Unit	Regional Center Alignment	Total Workload Distributed Relative to User Population	Gross Number of Transports (Workload x % Requiring Transport)	Transports with 1.5 Workload Units Per Trip	Transports with 1.5 Patients Per Vehicle	Travel Time to Regional Center 1 Way (Minutes)	Total Round Trip Transport Time (Minutes)	Adjusted Total Round Trip Transport Time (Minutes) with Inefficiency Factor
American Indian Hlth and Services (Santa Barbara)	Temecula	4,689	2,288	1,525	1,017	163	331,506	497,259
Bakersfield American Indian Health Project	Temecula	9,354	4,564	3,043	2,028	172	697,785	1,046,677
Cabazon Band of Cahuilla Indians	Temecula	18	9	6	4	84	672	1,008
Central Valley Indian Health	Sacramento	19,346	9,440	6,293	4,196	156	1,309,013	1,963,520
Chapa De Indian Health Program	Sacramento	14,622	7,135	4,757	3,171	37	0	0
Colusa Indian Health Community Health Council	Sacramento	244	119	79	53	64	0	0
Consolidated Tribal Health Project	Sacramento	8,235	4,018	2,679	1,786	153	546,448	819,672
Feather River Tribal Health	Sacramento	13,845	6,756	4,504	3,003	67	0	0
Fresno American Indian Health Project	Sacramento	3,058	1,492	995	663	153	202,912	304,368
Greenville Rancheria Tribal Health Program	Sacramento	17,853	8,712	5,808	3,872	148	1,146,112	1,719,168
Indian Health Center of Santa Clara Valley	Sacramento	2,288	1,117	745	496	107	106,239	159,359
Indian Health Council	Temecula	13,416	6,547	4,365	2,910	29	0	0
Karuk Tribe	Sacramento	5,535	2,701	1,801	1,200	290	696,258	1,044,387
K'ima:w Medical Center (Hoopa)	Sacramento	7,595	3,706	2,471	1,647	261	859,792	1,289,688
Lake County Tribal Health Consortium	Sacramento	6,369	3,108	2,072	1,381	124	342,571	513,856
MACT Health Board	Sacramento	8,307	4,054	2,703	1,802	83	299,095	448,643
Mathiesen Memorial Health Clinic (Chicken Ranch)	Sacramento	65	32	21	14	100	2,844	4,267
Native American Health Center (SF Bay Area)	Sacramento	4,361	2,128	1,419	946	73	0	0
Northern Valley Indian Health	Sacramento	7,753	3,783	2,522	1,681	90	302,640	453,960
Pit River Health Services	Sacramento	2,490	1,215	810	540	187	201,960	302,940
Quartz Valley Program	Sacramento	658	321	214	143	248	70,763	106,144
Redding Rancheria Tribal Health Systems	Sacramento	9,271	4,524	3,016	2,011	138	554,944	832,416
Riverside San Bernardino County Indian Health Rolling Hills	Temecula	38,062	18,573	12,382	8,255	58	0	0
Round Valley Indian Health Center	Sacramento	0	0	0	0	0	0	0
Round Valley Indian Health Center	Sacramento	3,065	1,496	997	665	199	264,626	396,939
Sacramento Native American Health Center	Sacramento	6,615	3,228	2,152	1,435	2	0	0
San Diego American Indian Health Center	Temecula	20,661	10,082	6,721	4,481	53	0	0
Santa Ynez Tribal Health Clinic	Temecula	9,939	4,850	3,233	2,156	190	819,111	1,228,667
Shingle Springs Tribal Health Program	Sacramento	3,503	1,710	1,140	760	35	0	0
Sonoma County Indian Health Project	Sacramento	12,487	6,093	4,062	2,708	155	839,480	1,259,220
Southern Indian Health Council	Temecula	6,231	3,040	2,027	1,351	66	0	0
Strong Family Health Center (Modoc)	Sacramento	591	288	192	128	287	73,472	110,208
Susanville Indian Rancheria	Sacramento	2,182	1,065	710	473	185	175,133	262,700
Sycuan Band of the Kumeyaay Nation	Temecula	763	372	248	165	68	0	0
Table Mountain Medical	Sacramento	13	6	4	3	160	853	1,280
Tejon Indian Tribe	Temecula	1,118	545	363	242	135	65,400	98,100
Toiyabe Indian Health Project	Sacramento	6,061	2,958	1,972	1,315	268	704,661	1,056,992
Tule River Indian Health Center	Sacramento	6,392	3,119	2,079	1,386	231	640,435	960,652
Tuolumne Me-Wuk Indian Health Center	Sacramento	902	440	293	196	104	40,676	61,013
United American Indian Involvement (LA)	Temecula	3,061	1,494	996	664	79	104,912	157,368
United Indian Health Service	Sacramento	22,611	11,034	7,356	4,904	290	2,844,320	4,266,480
Warner Mountain Indian Health Program	Sacramento	238	116	77	52	322	33,202	49,803
Wilton Rancheria	Sacramento	3,858	1,883	1,255	837	28	0	0
Total		307,723	150,161	100,107	66,738		14,277,835	21,416,752

Sacramento Transportation DGSF	1,091
Sacramento Transportation Staff	161.9

Temecula Transportation DGSF	620
Temecula Transportation Staff	27.5



Conceptual Feasibility Study Summary – Lodging

I. Purpose – Why was the feasibility study completed?

To explore the feasibility of providing lodging that would offer overnight stays for patients and caregivers/family while visiting the Regional Center for treatment.

II. Methodology – How was this feasibility study completed?

A special workgroup including tribal and IHS leaders was formed to hold discussions, in a series of four meetings, about current issues, future ideas, and resulting priorities surrounding the topic. Based on these discussions, a supporting conceptual matrix was developed to organize information gathered into a structure capable of shepherding the process and facilitate decision-making.

This study was conceptual in nature, intended to determine feasibility and required staff and space. It provides no operational or financial performance projections.

Where available, additional resources were used to gain knowledge and inform the feasibility study about lodging's potential role in regional care. Some of these included:

- *Rotary House International at MD Anderson*
- *Brent House Hotel, A Service of Ochsner*
- *VA Fisher House*
- *ANMC's Lodging facilities*

III. Matrix – What were the findings on Regional Center lodging and conceptual feasibility?

1. Goals – What are the goals of a lodging program that would support the delivery of Regional Care?

- a. To ensure that patients who live at a great distance to the RC or require overnight non-hospital stays have access to lodging that is safe, affordable, and comfortable.
- b. To ensure that patient escorts/caregivers have accommodations that are safe and comfortable as they may not be relatives (CHR).

2. Facts – What present facts support these goals and establish the need for a lodging program to support the delivery of regional care?

- a. Patients and caregivers must travel great distances for regional care (sometimes 8-12 hours return travel).



- b. Environmental challenges often occur and extend the time commitment and our length of stay.
- c. Families or patients coming for treatment that escalates in an unforeseen manner creates an unstable emotional condition for travel.
- d. The presence of a family support system is necessary for patients facing important treatment or procedure.
- e. This is an additional hardship for Medical patients who are already in financial hardship.
- f. Mileage reimbursement is insufficient to cover multi-day (or night) referral stays.

3. Precepts – What were the initial ideas proposed by the workgroup supporting development and potential concepts for refinement?

- a. Regional Center owns and operates the facility.
- b. Regional Center owns and contracts with a 3rd party to operate, staff, and maintain the facility.
- c. Regional Center contracts with 3rd party to construct, operate, staff, and maintain the facility.
- d. Regional Center contracts with local lodging facilities at a negotiated rate.
- e. Form 2 non-profits - 1 for each RC - and build and operate lodging.

Feasibility criteria – The workgroup identified the following criteria by which to evaluate or score the feasibility of each precept?

- a. Cost Efficient: Does this option cost a reasonable amount?
- b. Patient/Family Comfort & Safety: Is this option maximizing the patient’s comfort and safety?
- c. Convenient Location to Regional Center: Does this option minimize commute time?
- d. ADA Friendly: Does this option respect the American Disability Act?
- e. Proximate to needed amenities: Is this model located in an easily accessible area and close to the Regional Center?
- f. Long-distance Friendly (flexible check-in times): Does this model provide flexible hours for check-in for patients traveling long distances?

4. Concepts – What precepts were scored as more feasible and developed into concepts for workgroup consideration?

- a. Regional Center owns and operates

5. Solution – Which concept was scored as most feasible and translated into needed staff (FTE) and space (BGSF) for inclusion in the Regional Center study update

“The Regional Center will own, operate, and staff a lodging facility at each site” was chosen as the most feasible concept and was developed into needed staff and space.



IV. Decision

An excel based model was developed to quantify elementary aspects of the department (staff and space) and reviewed/vetted with workgroup members.

This service was deemed feasible by the workgroup and projected staff and space requirements have been added to the updated Regional Center report.

V. Conceptual Design Notes

1. Mission is to ensure patients and families attending the Regional Center for care have adequate and comfortable lodging during their length of stay at no cost.
2. The lodging facility will operate 365 days a year.
3. The regional center will own and operate a lodging facility on-site. Patients and their families seeking care at the Regional Center will be able to benefit from lodging if their commute time exceeds 120 minutes of one-way travel, or if the patient is being kept for observation overnight or goes through a procedure requiring recovery time.
4. Key planning metrics included:
 - Lodging related workload (Total OPV, Surgical Episodes, Admits)
 - Percentage requiring Lodging
 - Travel threshold supporting Lodging
 - Rooms per Patient
 - Guests per Room
 - Lodging Occupancy Percentage
5. Room requirements:
 - Sacramento is projected to require 120 rooms to house potential patients
 - Temecula is projected to require 22 rooms
6. Staff requirements:
 - Sacramento is projected to require 108 staff to operate the lodging facility
 - Temecula is projected to require 20 staff.
7. Size requirements:
 - Sacramento is projected to require 94,285 BGSF
 - Temecula would require 17,653 BGSF.

VI. Path Forward

Facility planning should be supported by further development through study of actual hotel/lodging operations at physical locations to better quantify needed staff and space. Visit to and study of ANMC's lodging facility is highly recommended. More thorough workload modeling is recommended. This should be done before or during a PJD/POR facility planning document development effort.



Goals What are the goals of lodging?	Facts What facts drive this conceptual feasibility study?	Precepts What initial ideas might suggest solutions?	Precept Evaluation				Precept Feasibility Scoring by Workgroup						
			Assumptions	Challenges	Benefits	Need to know	Cost Efficient	Patient/Family Comfort & Safety	Convenient Location to Regional Center	ADA Friendly	Proximate to needed amenities.	Long-distance Friendly (feasible check in times)	Group Avg
To ensure the patients who live at a great distance to the RC or require overnight non-hospital stays have access to lodging that is safe and comfortable.	Patients and caregivers must travel great distances for regional care (8-12 hours).	Regional Center owns and operates	1. Land is available adjacent to the RC. 2. Funding is available to purchase land, construct, operate, and maintain the facility. 3. RC and lodging connected and built at the same time.	1. Does CA IHS have knowledge to manage lodging. 2. Operating and maintenance cost.	1. Maintains complete control. 2. Patient convenience (on-site facility). 3. Can be culturally welcoming within CA occupancy and building code adherence. 4. Control of building design.	1. Up front costs and annual operating expenses. 2. How does funding come into play.	1	2	3	2	3	1	4.0
To ensure that patient escorts have accommodations that are safe and comfortable as they may not be relatives (CHR).	Environmental challenges often occur and extend the time commitment and our length of stay.	Regional Center owns and contracts with 3rd party to operate, staff, and maintain	1. Land is available adjacent to the RC. 2. Funding is available to purchase land and construct facility. 3. Willingness of 3rd party to operate, staff, and maintain an IHS lodging facility.	1. Lack of day to day control. 2. Will 3rd party be culturally sensitive to the needs of the guests.	1. Professional lodging organization runs facility. 2. Need minimal additional RC staff/space. 3. Can be culturally welcoming within CA occupancy and building code adherence. 4. Control of building design.	1. Contract terms and annual cost. 2. How does funding come into play.	0	0	1	1	0	0	0.7
	Families or patients coming for treatment that escalates in an unforeseen manner creates an unstable emotional condition for travel.	Regional Center contracts with 3rd party to construct, operate, staff, and maintain	1. Land is available adjacent to the RC or in close proximity. 2. Willingness of 3rd party to operate, staff, and maintain an IHS lodging facility.	1. Issues with property ownership. 2. Will 3rd party be culturally sensitive to the needs of the guests. 3. Lack of day to day control. 4. Who will set the daily rate. 5. Will facility be on RC property.	1. No responsibility to maintain a lodging facility. 2. Cost limited to overnight rate. 3. Need minimal additional RC staff/space. 4. Will all rooms be dedicated for RC patients/escorts.	1. Contract terms and annual cost. 2. Location of facility - on RC property or in the vicinity.	1	1	1	2	1	1	2.3
	The presence of a family support system is necessary for patients facing important treatment or procedure.	Regional Center contracts with local lodging facilities at negotiated rate	1. There are safe and comfortable lodging facilities willing to contract with IHS. In the vicinity of the RC. 2. Rooms will be guaranteed to be available when needed. 3. Facilities will need to meet IHS defined standards. 4. Transportation to RC will be available through RC if own traveling vehicle is not accessible.	1. Will enough rooms be available when needed. 2. ADA rooms will need to be guaranteed if needed.	1. CA IHS not in the lodging business. 2. Cost is based on nights reserved. 3. Need minimal additional RC staff/space.	1. Contracted rate: will it be area federal rate, discount off of rack rate, will rate fluctuate seasonally. 2. What will be the radius of contracted facilities to RC be.	2	2	0	2	1	1	2.7
	This is an additional hardship for Medical patients who are already in financial hardship.	Form 2 non-profits - 1 for each RC - and build and operate lodging.	1. Tribes can come together to form a non-profit. 2. Funding is available. 3. Non-profit runs the facility.	1. Who owns the land - RC, non-profit, or does RC lease land to the non-profit. 2. Non-profits needs to be set-up. 3. Where will funding come from to build, maintain, and staff?	1. Tribally run and culturally sensitive. 2. Control of building design.	1. Will funding be sustainable to keep facility maintained and running in the long-term. 2. Who is funding the facility. 3. Who is operating the facility.	0	0	0	0	0	0	0
	Mileage reimbursement is insufficient to over multi-day (or night) referral stays.												



Concepts	Concept Drivers				Concept Variables							Solution	
What concept emerges from the most supported precept?	Projected 2033 Eroded User Population	Workload (OP Visits, IP Admits, Surgical Procedures)	Travel Time	Percentage Needing Lodging from Questionnaire	Minimum Distance for Lodging	Rooms per Patient	Guests per Room	Workload Units per User	% Requiring Lodging	Operating Days per year	Occupancy Rate	Nights per Stay	What is the most feasible conceptual solution?
Regional Center owns and operates	National Data Warehouse (NDW) to provide User Population payer profile data. This will be used to determine the portion of users who have 3rd party insurance that will not be utilizing the RC. Other erosion factors include distance and competition. Report cannot assume 100% of Users will seek care at the RC.	IHS HSP workload for those specialty services that will be supported at the RC based on the 2033 eroded User Population.	The distance a User travels from the home SU to the RC as determined by mapping.	The percentage of Users that would require IHS supported lodging while seeking care at the RC.	120 minutes / 1 way	1	2 (Patient and Companion)	1.5	38.1%	365	70%	0.90	The Regional Center will own, operate, and staff a lodging facility.
					The columns above are the outcomes of meeting 4 - final decision concept planning.								

Regional Ambulatory Surgical & Specialty Health Services Feasibility Study

IHS, California Area Office

Appendices



Regional Center Lodging

Concept: Regional Center Owns and Operates

OP Visits	264,977	HSP	Distance Requiring Lodging	120 Minutes 1 way
Admits	30,882	HSP	Rooms per Patient	1
Surgical Procedures	11,864	HSP	Per Room (Patient & Companion Only)	2
Total Relevant Workload	307,723	Total	Workload Units Per User	1.5
Percentage of Users Requiring Lodging	38.1%	Analysis		

Service Unit	Regional Center Alignment	Projected 2033 Eroded User Population	Total Workload Distributed Relative to User Population	Travel Time to Regional Center 1 Way (Minutes)	Lodging Needed Based on 1 Way Travel at 120 Minutes	Net Estimated Users Needing Lodging Based on Drive Time >= 120 minutes from RC
American Indian Health and Services (Santa Barbara)	Temecula	2,089	4,689	163	Need Lodging	1,192
Bakersfield American Indian Health Project	Temecula	4,168	9,354	172	Need Lodging	2,379
Cabazon Band of Cahuilla Indians	Temecula	8	18	84	No	0
Central Valley Indian Health	Sacramento	8,620	19,346	156	Need Lodging	4,919
Chapa De Indian Health Program	Sacramento	6,515	14,622	37	No	0
Colusa Indian Health Community Health Council	Sacramento	109	244	64	No	0
Consolidated Tribal Health Project	Sacramento	3,669	8,235	153	Need Lodging	2,094
Feather River Tribal Health	Sacramento	6,169	13,845	67	No	0
Fresno American Indian Health Project	Sacramento	1,362	3,058	153	Need Lodging	777
Greenville Rancheria Tribal Health Program	Sacramento	7,955	17,853	148	Need Lodging	4,540
Indian Health Center of Santa Clara Valley	Sacramento	1,019	2,288	107	No	0
Indian Health Council	Temecula	5,978	13,416	29	No	0
Karuk Tribe	Sacramento	2,466	5,535	290	Need Lodging	1,407
K'ima:w Medical Center (Hoopa)	Sacramento	3,384	7,595	261	Need Lodging	1,931
Lake County Tribal Health Consortium	Sacramento	2,838	6,369	124	Need Lodging	1,619
MACT Health Board	Sacramento	3,701	8,307	83	No	0
Mathiesen Memorial Health Clinic (Chicken Ranch)	Sacramento	29	65	100	No	0
Native American Health Center (SF Bay Area)	Sacramento	1,943	4,361	73	No	0
Northern Valley Indian Health	Sacramento	3,454	7,753	90	No	0
Pit River Health Services	Sacramento	1,110	2,490	187	Need Lodging	633
Quartz Valley Program	Sacramento	293	658	248	Need Lodging	167
Redding Rancheria Tribal Health Systems	Sacramento	4,131	9,271	138	Need Lodging	2,357
Riverside San Bernardino County Indian Health	Temecula	16,959	38,062	58	No	0
Rolling Hills	Sacramento	0	0		No	0
Round Valley Indian Health Center	Sacramento	1,366	3,065	199	Need Lodging	779
Sacramento Native American Health Center	Sacramento	2,948	6,615	2	No	0
San Diego American Indian Health Center	Temecula	9,206	20,661	53	No	0
Santa Ynez Tribal Health Clinic	Temecula	4,428	9,939	190	Need Lodging	2,527
Shingle Springs Tribal Health Program	Sacramento	1,561	3,503	35	No	0
Sonoma County Indian Health Project	Sacramento	5,564	12,487	155	Need Lodging	3,175
Southern Indian Health Council	Temecula	2,776	6,231	66	No	0
Strong Family Health Center (Modoc)	Sacramento	263	591	287	Need Lodging	150
Susanville Indian Rancheria	Sacramento	972	2,182	185	Need Lodging	555
Sycuan Band of the Kumeyaay Nation	Temecula	340	763	68	No	0
Table Mountain Medical	Sacramento	6	13	160	Need Lodging	3
Tejon Indian Tribe	Temecula	498	1,118	135	Need Lodging	284
Toiyabe Indian Health Project	Sacramento	2,700	6,061	268	Need Lodging	1,541
Tule River Indian Health Center	Sacramento	2,848	6,392	231	Need Lodging	1,625
Tuolumne Me-Wuk Indian Health Center	Sacramento	402	902	104	No	0
United American Indian Involvement (LA)	Temecula	1,364	3,061	79	No	0
United Indian Health Service	Sacramento	10,074	22,611	290	Need Lodging	5,750
Warner Mountain Indian Health Program	Sacramento	106	238	322	Need Lodging	61
Wilton Rancheria	Sacramento	1,719	3,858	28	No	0
Total		137,110	307,723			40,469

Sacramento Rooms	120
Temecula Rooms	22

Sacramento Staff	108.2
Temecula Staff	20.3

Sacramento BGSF	94,285
Temecula BGSF	17,653



Conceptual Feasibility Study Summary – Visiting Specialties

I. Purpose – Why was the feasibility study completed?

To explore the feasibility of providing visiting specialists that would offer services to patients without requiring them to visit the Regional Center for treatment.

II. Methodology – How was this feasibility study completed?

A special workgroup including tribal and IHS leaders was formed to hold discussions, in a series of four meetings, about current issues, future ideas, and resulting priorities surrounding the topic. Based on these discussions, a supporting conceptual matrix was developed to organize information gathered into a structure capable of shepherding the process and facilitate decision-making.

This study was conceptual in nature, intended to determine feasibility and required staff and space. It provides no operational or financial performance projections.

Where available, additional resources were used to gain knowledge and inform the feasibility study about traveling specialties' potential role in regional care.

III. Matrix – What were the findings on Regional Center Visiting Specialties and conceptual feasibility?

1. Goals – What are the goals of a traveling specialties program that would support the delivery of Regional Care?

- a. To ensure maximum patient access to medical specialties for those unable to travel to a regional site

2. Facts – What present facts support these goals and establish the need for a traveling specialties program to support the delivery of regional care?

- a. Familiarity of going to one's own local clinic creates feeling of safety and increases trust of providers, thereby increasing patient willingness to seek care
- b. Receiving care at home provides for family support
- c. With the proven integrated patient centered medical home, patients are used to coming to clinic for care - specialty care brought to the sites increases appointment adherence and improved wellness
- d. Hard to recruit specialty care providers.
- e. There is no need to add transportation from the sites.
- f. Unacceptable wait times for specialty care

3. Precepts – What were the initial ideas proposed by the workgroup supporting development and potential concepts for refinement?

- a. Visiting specialists meet patients at site locations and use existing clinic space.
- b. Variety of traveling specialists meet patients at multiple sub-regional locations in a mobile clinic.



- c. Variety of visiting specialists meet patients at multiple sub-regional locations in leased or built space.
- d. Variety of visiting specialists meet patients at site locations that have available space to support the visiting providers.
- e. Visiting specialists meet patients at site locations in a mobile clinic.

Feasibility criteria – The workgroup identified the following criteria by which to evaluate or score the feasibility of each precept?

- a. Cost Efficient: Does this option cost a reasonable amount?
 - b. Patient Comfort/Trust/Familiarity: Does this option provide patient comfort and security, an established level of trust with the Regional Center, and Familiarity as this would provide consistency between patient and provider?
 - c. Time Efficiency for Provider Travel and Less Travel for Patient: Does this option ensure both parties are comfortable with either reduced travel or shorter commute than to the Regional Center?
 - d. Is space available at the site?
 - e. Rural Access: Are patients in rural areas able to benefit from this option?
 - f. Long-distance Friendly for Provider: Does this option take under consideration provider travel time and account for patient care hours on-site?
4. **Concepts – What precepts were scored as more feasible and developed into concepts for workgroup consideration?**
- a. Visiting specialists meet patients at site locations and use existing clinic space.
5. **Solution – Which concept was scored as most feasible and translated into needed staff (FTE) and space (BGSF) for inclusion in the Regional Center study update?**

“Visiting specialists will see patients at site locations and use existing clinic space” was chosen as the most feasible concept and was developed into needed staff and space.

IV. Decision

An excel based model was developed to quantify elementary aspects of the department (staff and space) and reviewed/vetted with workgroup members. Projected staff and space requirements have been added to the updated Regional Center report.

This service, while deemed feasible by the workgroup, is limited in its capacity since most specialty care for the Area is being modelled as happening at both regional sites (market share projections are extremely optimistic). Consequently, remaining visiting workloads are not big.



V. Conceptual Design Notes

1. Mission is to provide local PSA site services to patients by a specialist from the regional center.
2. Key Planning Metrics included:
 - Patient care provided (5 hours per day) at local sites, per established visiting schedule.
 - Specialists will be based in the regional center and travel to certain sites on schedule. They will see patients for 5 hours per day (14-16 patients), including regional center registered and non-registered patients.
 - Limitations of duration of travel are dependent on provider comfort, one way travel time to site set to a maximum of 90 minutes.
 - Provider throughput efficiency is reduced to 75% of IHS criteria.
 - Ten percent of regional KC requirement will be identified for visiting specialist work. This ten percent will then be increased by the reduced throughput percentage to net the workload requirements.
3. Both regional sites will strive to provide visiting specialty care for all projected specialty product lines.
4. Staffing requirements are carved out of regional projected KCs per product line per notes above (10% of projected regional KC requirement)
5. Size requirements are calculated as part of the Specialty Care department for each site. This will be negligible since specialists will be on the road. Because of the small portion of KCs delivering such care and the tentative nature of its delivery due to extensive travel, departmental specialty care space at each regional site will not be reduced from the full regional requirements.

VI. Path Forward

Projected workloads and staffing should be reviewed and further vetted before or during a PJD/POR facility planning document development effort.

Goals What are the goals of regional traveling specialties?	Facts What facts drive this conceptual feasibility study?	Precepts What initial ideas might suggest solutions?	Precept Evaluation				Precept Feasibility Scoring by Workgroup						
			Assumptions	Challenges	Benefits	Need to know	Cost Efficient	Patient Comfort/Trust/Familiarity	Time Efficiency for Provider Travel and Less Travel for Patient	Is space available at the site	Rural Access	Long-distance Friendly for Provider	Group Avg
To ensure maximum patient access to medical specialties close to home.	Familiarity of going to own clinic creates feeling of safety and increases trust of providers. Thereby increasing patient willingness to seek care. Receiving care at home provides for family support.	Visiting specialists meet patients at site locations and use existing clinic space	1. Specialists schedule allows for "road travel" vs. RC clinic time. 2. Sites have space available to host traveling specialists.	1. Is space available at site for visiting specialists to see patients. 2. Will available space be enough for patient volume. 3. How and where will scheduling be done.	1. Easy access for patients as care is provided locally. 2. Increases specialty care services to remote areas. 3. Reduced costs vs. if patient was transported to RC. 4. Reduced appointment cancellations.	1. Determine which specialties are able to provide care outside of the RC. 2. Determine which sites have appropriate space. 3. Lodging availability for providers. 4. How will visiting specialists affect regional capabilities?	6	6	5	4	5	3	4.9
	With the proven integrated patient centered medical home, patients are used to coming to clinic for care. When specialty care is brought in to the sites there is increased appointment adherence and improved wellness.	Variety of traveling specialists meet patients at multiple sub-regional locations in a mobile clinic	1. There are central locations that are optimal for visiting specialists to meet patients. 2. Specialists schedule allows for "road travel" vs. RC clinic time. 3. There are specialty service lines that can coordinate care together.	1. Transporting multiple patients to site (capacity in vehicle) where specialists are seeing patients if own vehicle is not an option. 2. Will mobile clinic be able to accommodate the patient volume. 3. How and where will scheduling be done.	1. Limits distance traveled by patients for specialty care. 2. Increases specialty care services to remote areas. 3. Potential for reduced costs vs. if patient was transported to RC. 4. Reduced appointment cancellations. 5. New sites can be added as clinic is mobile. 6. Patients can see multiple specialists in one visit.	1. Determine which specialties are able to provide care outside of the RC. 2. Determine locations that will have the most impact on patients seen. 3. Lodging availability for providers. 4. Cost of owning or leasing a mobile clinic. 5. How will visiting specialists affect regional capabilities?	4	3	5	6	6	0	3.9
	Hard to recruitment specialty care providers.	Variety of traveling specialists meet patients at multiple sub-regional locations in leased or built space	1. There are central locations that are optimal for visiting specialists to meet patients. 2. Specialists schedule allows for "road travel" vs. RC clinic time. 3. There are specialty service lines that can coordinate care together.	1. Transporting multiple patients to site (capacity in vehicle) where specialists are seeing patients if own vehicle is not an option. 2. Building and financing space over and above the cost of the regional center. 3. How and where will scheduling be done.	1. Limits distance traveled by patients for specialty care. 2. Increases specialty care services to remote areas. 3. Potential for reduced costs vs. if patient was transported to RC. 4. Reduced appointment cancellations. 5. Potential for leased or built site to see more patients than a mobile clinic due to size. 6. Patients can see multiple specialists in one visit.	1. Determine which specialties are able to provide care outside of the RC. 2. Determine locations that will have the most impact on patients seen. 3. Lodging availability for providers. 4. Cost of leasing or building /operating / maintaining a dedicated site. 5. How will visiting specialists affect regional capabilities?	2	4	5	4	5	3	3.6
	There is no need to add transportation it is in place at the sites.	Variety of traveling specialists meet patients at site locations that have available space to support the visiting providers	1. Specialists schedule allows for "road travel" vs. RC clinic time. 2. There are sites that have space available to host traveling specialists. 3. There are specialty service lines that can coordinate care together.	1. Transporting multiple patients to site (capacity in vehicle) where specialists are seeing patients if own vehicle is not an option and home site has no avail space. 2. Will available space be enough for patient volume. 3. How and where will scheduling be done.	1. Limits distance traveled by patients for specialty care. 2. Increases specialty care services to remote areas. 3. Potential for reduced costs vs. if patient was transported to RC. 4. Reduced appointment cancellations. 5. Patients can see multiple specialists in one visit.	1. Determine which specialties are able to provide care outside of the RC. 2. Determine locations that will have the most impact on patients seen. 3. Determine which sites have appropriate space. 4. Lodging availability for providers. 5. How will visiting specialists affect regional capabilities?	5	6	4	5	5	3	4.6
	Unacceptable wait times for specialty care.	Visiting specialists meet patients at site locations in a mobile clinic	1. Specialists schedule allows for "road travel" vs. RC clinic time.	1. Will mobile clinic be able to accommodate the patient volume. 2. How and where will scheduling be done.	1. Easy access for patients as care is provided locally. 2. Increases specialty care services to remote areas. 3. Reduced costs vs. if patient was transported to RC. 4. Reduced appointment cancellations.	1. Determine which specialties are able to provide care outside of the RC. 2. Lodging availability for providers. 3. Cost of owning or leasing a mobile clinic. 4. How will visiting specialists affect regional capabilities?	3	4	5	5	6	2	4.0



Concepts What concept emerges from the most supported precept?	Concept Drivers				Concept Variables				Solution
	Projected 2033 Eroded User Population	% of Remaining non-Regional Center Specialty Care Workload	Specialty Care Workload (Specialty Care Provider Visits)	Visiting Provider - Travel Time Willingness	Most desired specialties (Questionnaire)	Visiting Provider Productivity	Non-RC workload seen by VP	Provider Travel time one way	What is the most feasible conceptual solution?
Visiting specialists meet patients at site locations and use existing clinic space	National Data Warehouse (NDW) to provide User Population payer profile data. This will be used to determine the portion of users who have 3rd party insurance that will not be utilizing the RC. Other erosion factors include distance and competition. Report cannot assume 100% of Users will seek care at the RC.	The percentage of the specialty care workload that is not seen at the RC and thereby can potentially be seen at a Service Unit site of care by a visiting provider.	The quantifiable HSP specialty care workload is defined as visits provided by medical or surgical providers not including primary care.	The length of time a provider is willing to travel one-way from the RC to a local site of care.	1. Cardiology 2. Endocrinology 3. Neurology 4. Orthopedics 5. Pain Mgmt.	75%	50%	90 minutes	Visiting specialists will see patients at site locations and use existing clinic space.
					The columns above are the outcomes of meeting 4 - final decision concept planning.				



IHS, California Area Office

Regional Center Visiting Specialties

Concept: Visiting specialists meet patients at site locations and use existing clinic space

Key		Cardiology		Dermatology		General Surgery		Neurology		Ophthalmology	
HSP provided data	Yellow	13,670	SCPVs - HSP	16,300	SCPVs - HSP	12,129	SCPVs - HSP	6,609	SCPVs - HSP	29,620	SCPVs - HSP
Formula	Orange	12,856	SCPVs - HSP	15,330	SCPVs - HSP	11,405	SCPVs - HSP	6,214	SCPVs - HSP	27,855	SCPVs - HSP
Matrix/Workgroup Guidance	Green	814	SCPVs - Result	970	SCPVs - Result	724	SCPVs - Result	395	SCPVs - Result	1,765	SCPVs - Result
Total Workload (RC Service Line, Non Eroded Pop - HSP #1)											
RC Workload (RC Service Line, Eroded Pop - HSP #3)											
Remaining Workload Not Seen at RC											
Remaining Workload to be Satisfied by VP (50% per Matrix)	50%	407	SCPVs - Result	485	SCPVs - Result	362	SCPVs - Result	198	SCPVs - Result	1,765	SCPVs - Result
I (Max Minutes Traveled One Way)	90			90		90		90		90	
SCVP Productivity % (per Matrix)	75%			75%		75%		75%		100%	

Service Unit	Regional Center Alignment	Projected 2033 Eroded User Population	SC VP Reduced Service Line Workload	Distance to RC in Minutes	VP Travel Threshold Applied	Net SC VP Workload	SC VP Reduced Service Line Workload	Distance to RC in Minutes	VP Travel Threshold Applied	Net SC VP Workload	SC VP Reduced Service Line Workload	Distance to RC in Minutes	VP Travel Threshold Applied	Net SC VP Workload	SC VP Reduced Service Line Workload	Distance to RC in Minutes	VP Travel Threshold Applied	Net SC VP Workload	SC VP Reduced Service Line Workload	Distance to RC in Minutes	VP Travel Threshold Applied	Net SC VP Workload
American Indian Health and Services (Santa Barbara) (SB Urban Indian Hlth)	Temecula	2,089	6	163	no VP	0	7	163	no VP	0	6	163	no VP	0	3	163	no VP	0	27	163	no VP	0
Bakersfield American Indian Health Project	Temecula	4,168	12	172	no VP	0	15	172	no VP	0	11	172	no VP	0	6	172	no VP	0	54	172	no VP	0
Cabazon Band of Cahuilla Indians	Temecula	8	0	84	84	0	0	84	84	0	0	84	84	0	0	84	84	0	0	84	84	0
Central Valley Indian Health	Sacramento	8,620	26	156	no VP	0	30	156	no VP	0	23	156	no VP	0	12	156	no VP	0	111	156	no VP	0
Chapa De Indian Health Program	Sacramento	6,515	19	37	37	19	23	37	37	23	17	37	37	17	9	37	37	9	84	37	37	84
Colusa Indian Health Community Health Council	Sacramento	109	0	64	64	0	0	64	64	0	0	64	64	0	0	64	64	0	1	64	64	1
Consolidated Tribal Health Project	Sacramento	3,669	11	153	no VP	0	13	153	no VP	0	10	153	no VP	0	5	153	no VP	0	47	153	no VP	0
Feather River Tribal Health	Sacramento	6,169	18	67	67	18	22	67	67	22	16	67	67	16	9	67	67	9	79	67	67	79
Fresno American Indian Health Project	Sacramento	1,362	4	153	no VP	0	5	153	no VP	0	4	153	no VP	0	2	153	no VP	0	18	153	no VP	0
Greenville Rancheria Tribal Health Program	Sacramento	7,955	24	148	no VP	0	28	148	no VP	0	21	148	no VP	0	11	148	no VP	0	102	148	no VP	0
Indian Health Center of Santa Clara Valley	Sacramento	1,019	3	107	no VP	0	4	107	no VP	0	3	107	no VP	0	1	107	no VP	0	13	107	no VP	0
Indian Health Council	Temecula	5,978	18	29	29	18	21	29	29	21	16	29	29	16	9	29	29	9	77	29	29	77
Karuk Tribe	Sacramento	2,466	7	290	no VP	0	9	290	no VP	0	7	290	no VP	0	4	290	no VP	0	32	290	no VP	0
K'ima:w Medical Center (Hoopa)	Sacramento	3,384	10	261	no VP	0	12	261	no VP	0	9	261	no VP	0	5	261	no VP	0	44	261	no VP	0
Lake County Tribal Health Consortium	Sacramento	2,838	8	124	no VP	0	10	124	no VP	0	7	124	no VP	0	4	124	no VP	0	37	124	no VP	0
MACT Health Board	Sacramento	3,701	11	83	83	11	13	83	83	13	10	83	83	10	5	83	83	5	48	83	83	48
Mathiesen Memorial Health Clinic (Chicken Ranch)	Sacramento	29	0	100	no VP	0	0	100	no VP	0	0	100	no VP	0	0	100	no VP	0	0	100	no VP	0
Native American Health Center (SF Bay Area)	Sacramento	1,943	6	73	73	6	7	73	73	7	5	73	73	5	3	73	73	3	25	73	73	25
Northern Valley Indian Health	Sacramento	3,454	10	90	no VP	0	12	90	no VP	0	9	90	no VP	0	5	90	no VP	0	44	90	no VP	0
Pit River Health Services	Sacramento	1,110	3	187	no VP	0	4	187	no VP	0	3	187	no VP	0	2	187	no VP	0	14	187	no VP	0
Quartz Valley Program	Sacramento	293	1	248	no VP	0	1	248	no VP	0	1	248	no VP	0	0	248	no VP	0	4	248	no VP	0
Redding Rancheria Tribal Health Systems	Sacramento	4,131	12	138	no VP	0	15	138	no VP	0	11	138	no VP	0	6	138	no VP	0	53	138	no VP	0
Riverside San Bernardino County Indian Health	Temecula	16,959	50	58	58	50	60	58	58	60	45	58	58	45	24	58	58	24	218	58	58	218
Rolling Hills	Sacramento	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Round Valley Indian Health Center	Sacramento	1,366	4	199	no VP	0	5	199	no VP	0	4	199	no VP	0	2	199	no VP	0	18	199	no VP	0
Sacramento Native American Health Center	Sacramento	2,948	9	2	2	9	10	2	2	10	8	2	2	8	4	2	2	4	38	2	2	38
San Diego American Indian Health Center	Temecula	9,206	27	53	53	27	33	53	53	33	24	53	53	24	13	53	53	13	119	53	53	119
Santa Ynez Tribal Health Clinic	Temecula	4,428	13	190	no VP	0	16	190	no VP	0	12	190	no VP	0	6	190	no VP	0	57	190	no VP	0
Shingle Springs Tribal Health Program	Sacramento	1,561	5	35	35	5	6	35	35	6	4	35	35	4	2	35	35	2	20	35	35	20
Sonoma County Indian Health Project	Sacramento	5,564	17	155	no VP	0	20	155	no VP	0	15	155	no VP	0	8	155	no VP	0	72	155	no VP	0
Southern Indian Health Council	Temecula	2,776	8	66	66	8	10	66	66	10	7	66	66	7	4	66	66	4	36	66	66	36
Strong Family Health Center (Modoc)	Sacramento	263	1	287	no VP	0	1	287	no VP	0	1	287	no VP	0	0	287	no VP	0	3	287	no VP	0
Susanville Indian Rancheria	Sacramento	972	3	185	no VP	0	3	185	no VP	0	3	185	no VP	0	1	185	no VP	0	13	185	no VP	0
Sycuan Band of the Kumeyaay Nation	Temecula	340	1	68	68	1	1	68	68	1	1	68	68	1	0	68	68	0	4	68	68	4
Table Mountain Medical	Sacramento	6	0	160	no VP	0	0	160	no VP	0	0	160	no VP	0	0	160	no VP	0	0	160	no VP	0
Tejon Indian Tribe	Temecula	498	1	135	no VP	0	2	135	no VP	0	1	135	no VP	0	1	135	no VP	0	6	135	no VP	0
Toiyabe Indian Health Project	Sacramento	2,700	8	268	no VP	0	10	268	no VP	0	7	268	no VP	0	4	268	no VP	0	35	268	no VP	0
Tule River Indian Health Center	Sacramento	2,848	8	231	no VP	0	10	231	no VP	0	8	231	no VP	0	4	231	no VP	0	37	231	no VP	0
Tuolumne Me-Wuk Indian Health Center	Sacramento	402	1	104	no VP	0	1	104	no VP	0	1	104	no VP	0	1	104	no VP	0	5	104	no VP	0
United American Indian Involvement (LA) (LA American Indian)	Temecula	1,364	4	79	79	4	5	79	79	5	4	79	79	4	2	79	79	2	18	79	79	18
United Indian Health Service	Sacramento	10,074	30	290	no VP	0	36	290	no VP	0	27	290	no VP	0	15	290	no VP	0	130	290	no VP	0
Warner Mountain Indian Health Program	Sacramento	106	0	322	no VP	0	0	322	no VP	0	0	322	no VP	0	0	322	no VP	0	1	322	no VP	0
Wilton Rancheria	Sacramento	1,719	5	28	28	5	6	28	28	6	5	28	28	5	2	28	28	2	22	28	28	22

Totals	137,110	407	182	485	217	362	162	198	88	1,765	789
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Visiting Providers		
Specialty	Sacramento	Temecula
Cardiology	0.4	0.2
Dermatology	0.3	0.2
General Surgery	0.6	0.3
Neurology	0.2	0.1
Ophthalmology	0.6	0.4
Orthopedics	0.7	0.4
Otolaryngology	0.3	0.2
Urology	0.2	0.2
Other Medical Specialties	2.0	1.1
Other Surgical Specialties	0.5	0.2
Total	6.0	3.3

Regional Ambulatory Surgical & Specialty Health Services Feasibility Study Update



IHS, California Area Office

Regional Center Visiting Specialties

Concept: Visiting specialists meet patients at site locations and use existing clinic space

Key		Orthopedics		Otolaryngology		Urology		Other Medical Specialties		Other Surgical Specialties	
HSP provided data	Yellow	22,937	SCPVs - HSP	11,225	SCPVs - HSP	9,500	SCPVs - HSP	59,359	SCPVs - HSP	15,017	SCPVs - HSP
Formula	Orange	21,570	SCPVs - HSP	10,557	SCPVs - HSP	8,935	SCPVs - HSP	55,824	SCPVs - HSP	14,122	SCPVs - HSP
Matrix/Workgroup Guidance	Green	1,367	SCPVs - Result	668	SCPVs - Result	565	SCPVs - Result	3,535	SCPVs - Result	895	SCPVs - Result
Total Workload (RC Service Line, Non Eroded Pop - HSP #1)											
RC Workload (RC Service Line, Eroded Pop - HSP #3)											
Remaining Workload Not Seen at RC											
Remaining Workload to be Satisfied by VP (50% per Matrix)	50%	684	SCPVs - Result	334	SCPVs - Result	565	SCPVs - Result	1,768	SCPVs - Result	448	SCPVs - Result
I (Max Minutes Traveled One Way)	90										
SC VP Productivity % (per Matrix)	75%										

Service Unit	Regional Center Alignment	Projected 2033 Eroded User Population	SC VP Reduced Service Line Workload	Distance to RC in Minutes	VP Travel Threshold Applied	Net SC VP Workload	SC VP Reduced Service Line Workload	Distance to RC in Minutes	VP Travel Threshold Applied	Net SC VP Workload	SC VP Reduced Service Line Workload	Distance to RC in Minutes	VP Travel Threshold Applied	Net SC VP Workload	SC VP Reduced Service Line Workload	Distance to RC in Minutes	VP Travel Threshold Applied	Net SC VP Workload	SC VP Reduced Service Line Workload	Distance to RC in Minutes	VP Travel Threshold Applied	Net SC VP Workload
American Indian Health and Services (Santa Barbara) (SB Urban Indian Hlth)	Temecula	2,089	10	163	no VP	0	5	163	no VP	0	9	163	no VP	0	27	163	no VP	0	7	163	no VP	0
Bakersfield American Indian Health Project	Temecula	4,168	21	172	no VP	0	10	172	no VP	0	17	172	no VP	0	54	172	no VP	0	14	172	no VP	0
Cabazon Band of Cahuilla Indians	Temecula	8	0	84	84	0	0	84	84	0	0	84	84	0	0	84	84	0	0	84	84	0
Central Valley Indian Health	Sacramento	8,620	43	156	no VP	0	21	156	no VP	0	36	156	no VP	0	111	156	no VP	0	28	156	no VP	0
Chapa De Indian Health Program	Sacramento	6,515	32	37	37	32	16	37	37	16	27	37	37	27	84	37	37	84	21	37	37	21
Colusa Indian Health Community Health Council	Sacramento	109	1	64	64	1	0	64	64	0	1	64	64	0	1	64	64	1	0	64	64	0
Consolidated Tribal Health Project	Sacramento	3,669	18	153	no VP	0	9	153	no VP	0	15	153	no VP	0	47	153	no VP	0	12	153	no VP	0
Feather River Tribal Health	Sacramento	6,169	31	67	67	31	15	67	67	15	25	67	67	25	80	67	67	80	20	67	67	20
Fresno American Indian Health Project	Sacramento	1,362	7	153	no VP	0	3	153	no VP	0	6	153	no VP	0	18	153	no VP	0	4	153	no VP	0
Greenville Rancheria Tribal Health Program	Sacramento	7,955	40	148	no VP	0	19	148	no VP	0	33	148	no VP	0	103	148	no VP	0	26	148	no VP	0
Indian Health Center of Santa Clara Valley	Sacramento	1,019	5	107	no VP	0	2	107	no VP	0	4	107	no VP	0	13	107	no VP	0	3	107	no VP	0
Indian Health Council	Temecula	5,978	30	29	29	30	15	29	29	15	25	29	29	25	77	29	29	77	20	29	29	20
Karuk Tribe	Sacramento	2,466	12	290	no VP	0	6	290	no VP	0	10	290	no VP	0	32	290	no VP	0	8	290	no VP	0
K'ima:w Medical Center (Hoopa)	Sacramento	3,384	17	261	no VP	0	8	261	no VP	0	14	261	no VP	0	44	261	no VP	0	11	261	no VP	0
Lake County Tribal Health Consortium	Sacramento	2,838	14	124	no VP	0	7	124	no VP	0	12	124	no VP	0	37	124	no VP	0	9	124	no VP	0
MACT Health Board	Sacramento	3,701	18	83	83	18	9	83	83	9	15	83	83	15	48	83	83	48	12	83	83	12
Mathiesen Memorial Health Clinic (Chicken Ranch)	Sacramento	29	0	100	no VP	0	0	100	no VP	0	0	100	no VP	0	0	100	no VP	0	0	100	no VP	0
Native American Health Center (SF Bay Area)	Sacramento	1,943	10	73	73	10	5	73	73	5	8	73	73	8	25	73	73	25	6	73	73	6
Northern Valley Indian Health	Sacramento	3,454	17	90	no VP	0	8	90	no VP	0	14	90	no VP	0	45	90	no VP	0	11	90	no VP	0
Pit River Health Services	Sacramento	1,110	6	187	no VP	0	3	187	no VP	0	5	187	no VP	0	14	187	no VP	0	4	187	no VP	0
Quartz Valley Program	Sacramento	293	1	248	no VP	0	1	248	no VP	0	1	248	no VP	0	4	248	no VP	0	1	248	no VP	0
Redding Rancheria Tribal Health Systems	Sacramento	4,131	21	138	no VP	0	10	138	no VP	0	17	138	no VP	0	53	138	no VP	0	13	138	no VP	0
Riverside San Bernardino County Indian Health	Temecula	16,959	85	58	58	85	41	58	58	41	70	58	58	70	219	58	58	219	55	58	58	55
Rolling Hills	Sacramento	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Round Valley Indian Health Center	Sacramento	1,366	7	199	no VP	0	3	199	no VP	0	6	199	no VP	0	18	199	no VP	0	4	199	no VP	0
Sacramento Native American Health Center	Sacramento	2,948	15	2	2	15	7	2	2	7	12	2	2	12	38	2	2	38	10	2	2	10
San Diego American Indian Health Center	Temecula	9,206	46	53	53	46	22	53	53	22	38	53	53	38	119	53	53	119	30	53	53	30
Santa Ynez Tribal Health Clinic	Temecula	4,428	22	190	no VP	0	11	190	no VP	0	18	190	no VP	0	57	190	no VP	0	14	190	no VP	0
Shingle Springs Tribal Health Program	Sacramento	1,561	8	35	35	8	4	35	35	4	6	35	35	6	20	35	35	20	5	35	35	5
Sonoma County Indian Health Project	Sacramento	5,564	28	155	no VP	0	14	155	no VP	0	23	155	no VP	0	72	155	no VP	0	18	155	no VP	0
Southern Indian Health Council	Temecula	2,776	14	66	66	14	7	66	66	7	11	66	66	11	36	66	66	36	9	66	66	9
Strong Family Health Center (Modoc)	Sacramento	263	1	287	no VP	0	1	287	no VP	0	1	287	no VP	0	3	287	no VP	0	1	287	no VP	0
Susanville Indian Rancheria	Sacramento	972	5	185	no VP	0	2	185	no VP	0	4	185	no VP	0	13	185	no VP	0	3	185	no VP	0
Sycuan Band of the Kumeyaay Nation	Temecula	340	2	68	68	2	1	68	68	1	1	68	68	1	4	68	68	4	1	68	68	1
Table Mountain Medical	Sacramento	6	0	160	no VP	0	0	160	no VP	0	0	160	no VP	0	0	160	no VP	0	0	160	no VP	0
Tejon Indian Tribe	Temecula	498	2	135	no VP	0	1	135	no VP	0	2	135	no VP	0	6	135	no VP	0	2	135	no VP	0
Toiyabe Indian Health Project	Sacramento	2,700	13	268	no VP	0	7	268	no VP	0	11	268	no VP	0	35	268	no VP	0	9	268	no VP	0
Tule River Indian Health Center	Sacramento	2,848	14	231	no VP	0	7	231	no VP	0	12	231	no VP	0	37	231	no VP	0	9	231	no VP	0
Tuolumne Me-Wuk Indian Health Center	Sacramento	402	2	104	no VP	0	1	104	no VP	0	2	104	no VP	0	5	104	no VP	0	1	104	no VP	0
United American Indian Involvement (LA) (LA American Indian)	Temecula	1,364	7	79	79	7	3	79	79	3	6	79	79	6	18	79	79	18	4	79	79	4
United Indian Health Service	Sacramento	10,074	50	290	no VP	0	25	290	no VP	0	42	290	no VP	0	130	290	no VP	0	33	290	no VP	0
Warner Mountain Indian Health Program	Sacramento	106	1	322	no VP	0	0	322	no VP	0	0	322	no VP	0	1	322	no VP	0	0	322	no VP	0
Wilton Rancheria	Sacramento	1,719	9	28	28	9	4	28	28	4	7	28	28	7	22	28	28	22	6	28	28	6

Totals 137,110 684 306 334 149 565 253 1,768 790 448 200

Visiting Providers		
Specialty	Sacramento	Temecula
Cardiology	0.4	0.2
Dermatology	0.3	0.2
General Surgery	0.6	0.3
Neurology	0.2	0.1
Ophthalmology	0.6	0.4
Orthopedics	0.7	0.4
Otolaryngology	0.3	0.2
Urology	0.2	0.2
Other Medical Specialties	2.0	1.1
Other Surgical Specialties	0.5	0.2
Total	6.0	3.3



Conceptual Feasibility Study Summary – Pharmacy Hub

I. Purpose – Why was the feasibility study completed?

To explore the feasibility of providing a Pharmacy Hub that would offer specialty care medication and preventative education to patients and providers while visiting the Regional Center.

II. Methodology – How was this feasibility study completed?

A special workgroup including tribal and IHS leaders was formed to hold discussions, in a series of four meetings, about current issues, future ideas, and resulting priorities surrounding the topic. Based on these discussions, a supporting conceptual matrix was developed to organize information gathered into a structure capable of shepherding the process and facilitate decision-making.

This study was conceptual in nature, intended to determine feasibility and required staff and space. It provides no operational or financial performance projections.

Where available, additional resources were used to gain knowledge and inform the feasibility study about the Pharmacy Hub’s potential role in regional care. Some of these included:

- Carolyn Pumares (IHS) helped with understanding pharmacy functions from internal experience and further clarified how specialty medications need to be accessible with proper consultation.
- “Prescription Drugs: Spending, Use, and Prices” – Congressional Budget Office
- “Addressing High Priced Drugs” – New Hampshire Prescription Drug Affordability Board, Sergio Santiviago, VP Drug Policy
- “Are Specialty Drug Prices Destroying Insurers and Hurting Consumers? A Number of Efforts Are Under Way to Reduce Price Pressure” – Stephen Barlas
- “Going Beyond the Prescription in Specialty Pharmacy” – Michael Zielinski, Pharmacy Times
- “Number of Americans using \$100,000 in medicines triples: Express Scripts” – Bill Berkot via Reuters
- “ASHP Specialty Pharmacy Resource Guide” – ASHP Specialty Pharmacy Expert Panel Members
- “Specialty Drugs and Health Care Costs” – The PEW Charitable Trusts
- “Trends in Prescription Drug Spending, 2016-2021” – ASPE Office of Science and Data Policy

III. Matrix – What were the findings on Regional Center Pharmacy Hub and conceptual feasibility?

1. **Goals – What are the goals of a Pharmacy Hub program that would support the delivery of Regional Care?**
 - a. To ensure the maximum access to specialty pharmacy services for patients. The drugs are extremely expensive and hard to access.
2. **Facts – What present facts support these goals and establish the need for a Pharmacy Hub program to support the delivery of regional care?**



- a. Lack of access and cost of the drugs.
- b. Tribal sites lack capacity to provide this specialty service and supporting education.
- c. Lack of this care negatively affects the health of AI/ANs across California.
- d. Improved healthcare (per above) equals less cost.
- e. Provides a safety net due to reasons identified above (potential assistance even during emergencies - COVID).

3. Precepts – What were the initial ideas proposed by the workgroup supporting development and potential concepts for refinement?

- a. A regional pharmacy hub focused only on providing expensive and typically inaccessible specialty medications.
- b. A regional pharmacy hub providing expensive specialty medications and education/training/support services for service area sites.
- c. A regional pharmacy hub that provides only education/training/support services for service area sites.
- d. A full-service pharmacy hub providing all medications and support services to sites as needed.
- e. Pharmacy Hub that provides case management and support for specialty care follow up to ensure continuity of care.

Feasibility criteria – The workgroup identified the following criteria by which to evaluate or score the feasibility of each precept?

- a. Cost Efficient: Does this option cost a reasonable amount?
- b. Delivery Capability - multipronged, reliable. Does this option provide a reliable system of patient care delivery?
- c. Does this option duplicate local site services or threaten local resources?
- d. Does this option provide efficient, effective client education for Meds?
- e. Does this option facilitate credible order origination and identify if PRC eligible?
- f. Does this model provide options, flexibility, and accessibility (hours of operation, after hours access)?
- g. Acquisition Efficiency / Capabilities: regional vs. local fulfillment option.

4. Concepts – What precepts were scored as more feasible and developed into concepts for workgroup consideration?

- a. A regional pharmacy hub focused only on providing expensive and typically inaccessible specialty medications.

5. Solution – Which concept was scored as most feasible and translated into needed staff (FTE) and space (BGSF) for inclusion in the Regional Center study update?

A regional pharmacy hub focused only on providing expensive and typically inaccessible specialty medications.



IV. Decision

An excel based model was developed to quantify elementary aspects of the department (staff and space) and reviewed/vetted with workgroup members.

This service was deemed feasible by the workgroup and projected staff and space requirements have been added to the updated Regional Center report.

V. Conceptual Design Notes

1. Mission is to provide hard to access and high-cost specialty medications to patients from across the Area that have no other option.
2. The Pharmacy Hub would operate 250 days a year, 8 hours a day.
3. The Pharmacy Hub would source hard to access or high-cost medications and distribute to tribal patients in need. Medications would be delivered to the local site or the patient's doorstep as consultation services are needed for proper medicine administration. Patient education would be administered via telehealth or at the Regional Center if the patient is receiving care on-site.
4. Key Planning Metrics included:
 - Non-regional user population (Area)
 - Percentage Area scripts requiring Hub support
 - Hub Scripts per day
 - Hub FTE per Hub Pharmacist
5. Staff requirements:
 - Sacramento is projected to require 5.0 pharmacists to support this function and 10.7 total FTE
 - Temecula is projected to require 2.7 pharmacists to support this function and 5.8 total FTE
6. Size requirements:
 - Sacramento space is quantified within the pharmacy department as a function of pharmacists and not separately
 - Temecula space is quantified within the pharmacy department as a function of pharmacists and not separately

VI. Path Forward

Facility planning should be supported by further developed through study of actual pharmacy functions of like kind at physical locations to better quantify needed staff and space. More thorough workload modeling is also recommended. This should be done before or during a PJD/POR facility planning document development effort.



Goals What are the goals of regional pharmacy hub?	Facts What facts drive this conceptual feasibility study?	Precepts What initial ideas might suggest solutions?	Precept Evaluation				Precept Feasibility Scoring by Workgroup							
			Assumptions	Challenges	Benefits	Need to know	Cost Efficient	Delivery Capability - multipronged, reliable.	Does not duplicate local site services or threaten local resources.	Provides efficient, effective client education for Meds.	Facilitates credible order origination, identify if PRC eligible.	Options, flexible, accessible (hours of operation, after hour access).	Acquisition Efficiency / Capabilities: regional vs. local fulfillment option.	Group Avg
To ensure the maximum access to specialty pharmacy services for patients.	Lack of access and cost.	A regional pharmacy hub focused only on providing expensive and typically inaccessible specialty medications.	Pharmacy Hub would provide hard to find medications for specialty care and distribute to patients.	1. What if the medications the RC needs are still hard to access? 2. Some medications may be in higher demand than others. 3. What if the medication the patient needs is not approved by IHS? 4. Delivery time of medications.	1. Patients have a reliable source for specialty medicine. 2. Patients can have medication delivered to their home or clinic.	1. Where does the RC source the medication from? 2. Need a guarantee of access to be able to supply the medicine. 3. Do they ship medications to site clinics or directly to patient door?	3	3	2	3	3	3	2	4.8
	Tribal sites lack capacity to provides specialty services and supporting education.	A regional pharmacy hub providing expensive specialty medications and education/training/support services for service area sites.	Pharmacy Hub would provide hard to find medications for specialty care and distribute to patients while also providing preventative education, training, and support services to patients and providers.	1. What if the medications the RC needs are still hard to access? 2. Some medications may be in higher demand than others. 3. What if the medication the patient needs is not approved by IHS? 4. Delivery time of medications. 5. Who facilitates education/training workshops?	1. Patients can receive the appropriate support and resources about medication education and use of a specific pharmaceutical they need. 2. Providers get culturally sensitive training to help patients have the best experience. 3. Stigma around medication is broken. 4. Patients learn the benefits of pharmaceutical remedies in a safe environment (either online or in person).	1. What is the ratio of case managers to patients? 2. Is there a case manager availability after-hours. 3. Who facilitates these workshops?	1	2	1	2	2	1	2	2.8
	Lack of this care negatively affects the health of AI/ANs across California.	A regional pharmacy hub that provides only education/training/support services for service area sites.	Pharmacy Hub that specializes in educating and training providers and patients in proper pharmaceutical consumption, distribution, and practices.	1. Patients are still in need of specialty care medicine. 2. Who facilitates these workshops? 3. Need added staff?	1. Patients and providers receive full comprehensive training.	1. Who facilitates these workshops? 2. Need accurate information regarding specific insurances to properly educate patients. 3. What kind of education would be top priority?	0	0	1	1	0	0	0	0.5
	Improved healthcare (per above) equals less cost.	A full service pharmacy hub providing all medications and support services to sites as needed.	Pharmacy Hub will provide all types of medication (not limited to specialty care), training, education, and support services to patients and providers.	1. Need adequate number of staff for fully functioning Hub. 2. Cost of supplying all types of medicines as opposed to specialty care medication only.	1. Patient has a one-stop-shop experience and does not have to source basic medications elsewhere. 2. Easy access to both hard-to-find medications and everyday remedies with additional support.	1. Which everyday medications are in most need? 2. What is the cost of supplying basic medications? 3. How many staff is needed to be able to support full functions?	1	2	1	2	2	2	2	3
	Provides a safety net due to reasons identified above (potential assistance even during emergencies - COVID)	Pharmacy Hub that provides case management and support for specialty care follow up to ensure continuity of care.	Pharmacy Hub ensures each patient has a point of contact for medication related concerns, issues, and questions throughout course of treatment.	1. Need adequate number of case management/pharmacy staff to handle patient follow-up and general case management.	1. Patients would have access to resources for support during treatment course. 2. Case management can be done virtually. 3. Case management can lead to increased patient compliance.	1. How many patients would be assigned to a pharmacy case manager? 2. Is this a M-F 9a - 5p service, or a 24/7 service?	3	2	2	2	2	1	1	3.3



Concepts What concept emerges from the most supported precept?	Concept Drivers				Concept Variables					Solution
	Regional Pharmacy Functions	Projected Non RC User Population	Projected Workload Minutes per Year	Projected Scripts per Year	Team Structure	Operating Days	Pharmacist Productivity per Day	% of Local Site Users Requiring Pharmacy Hub Support	Workload Minutes to Script Conversion	What is the most feasible conceptual solution?
A regional pharmacy hub focused only on providing expensive and typically inaccessible specialty medications.	1. Scripts for the patients receiving care at the RC . Staff and space demand are calculated as per the original RC report and projection methodology (HSP). 2. The Hub function specifically will provide expensive and hard to access scripts for all local sites. Staff and space demand will be calculated using model developed.	User population at local sites not receiving care at the RC requiring expensive and hard to access scripts (per hub function- #2).	Projected workload minutes per year per pharmacist.	Projected number of scripts filled per year per pharmacist.	1. Pharmacy Supv. 2. Pharmacist 3. Pharmacy Tech 4. Pharmacy Billing Specialist	250	100 @ 90% Efficiency	2%	4.8	The Regional Center Pharmacy Hub will provide scripts that are expensive and hard to access.
					The columns above are the outcomes of meeting 4 - final decision concept planning.					



Concept: A regional pharmacy hub focused only on providing expensive and typically inaccessible specialty medications

The model assumes that the Regional Center Pharmacy has 2 functions:

1. Scripts for the patients receiving care at the Regional Center. Staff and space demand are calculated as per the original Regional Center report and projection methodology (HSP).
2. The "hub" function specifically will provide expensive and hard to access scripts for all local sites. Staff and space demand will be calculated using the model concept below.

Model Keys

3. Hub utilization (annual of above scripts or % of above scripts to all scripts) is an important element - requires Area Pharmacy Consultation.
4. HSP workload/staffing includes Pharmacy Case Management and Educator functions.

Workload Minutes Per Year	92,800	HSP Workload Unit
Scripts Per Year	19,300	
Workload Minutes to Script Conversion	4.8	
Annual Clinical Days	250	
Pharmacist Efficiency	20%	
Pharmacy Hub Team Structure	FTE	IHS Criteria
Pharmacy Supervisor		
Pharmacist	1.0	per 100 scripts per day (90% efficiency)
Pharmacy Tech	1.0	per Pharmacist

Regional Center	Projected Area Wide / Regional Center Only / Average Population Workload	Projected Workload Minutes Per Year	Projected Scripts Per Year	% requiring Hub Support based on Concept	Projected Hub Scripts Per Year	Per day	/100 (x 90%)	Total FTE Requirement	FTE/Position
Sacramento	5,429,831 1,900,379 3,665,105	5,429,831	1,129,264	2%	22,585	90	5.0	10.7 Total FTEs 0.6 Supervisor 5.0 Pharmacist 5.0 Tech	
Temecula	2,929,527 1,065,436 1,997,482	2,929,527	609,266	2%	12,185	49	2.7	5.8 Total FTEs 0.3 Supervisor 2.7 Pharmacist 2.7 Tech	



Conceptual Feasibility Study Summary – Durable Medical Equipment

I. Purpose – Why was the feasibility study completed?

To explore the feasibility of providing a DME Hub at the Regional Center that would offer various types of needed equipment to patients.

II. Methodology – How was this feasibility study completed?

A special workgroup including tribal and IHS leaders was formed to hold discussions, in a series of four meetings, about current issues, future ideas, and resulting priorities surrounding the topic. Based on these discussions, a supporting conceptual matrix was developed to organize information gathered into a structure capable of shepherding the process and facilitate decision-making.

This study was conceptual in nature, intended to determine feasibility and required staff and space. It provides no operational or financial performance projections.

Where available, additional resources were used to gain knowledge and inform the feasibility study about a DME Hub's potential role in regional care.

III. Matrix – What were the findings on Regional Center DME Hub and conceptual feasibility?

1. Goals – What are the goals of a DME program that would support the delivery of Regional Care?

- a. To ensure the maximum access to DME and affordability for patients.
- b. To ensure all the most needed DME is available for all patients.

2. Facts – What present facts support these goals and establish the need for a DME program to support the delivery of regional care?

- a. Lack of access and cost.
- b. Tribal sites lack capacity to provides equipment and supporting education.
- c. Lack of this provision negatively affects the health of AI/ANs across California.
- d. Improved healthcare (per above) equals less cost.
- e. Provides a safety net due to reasons identified above (potential assistance even during emergencies - COVID - where some local options close, weather, etc.)

3. Precepts – What were the initial ideas proposed by the workgroup supporting development and potential concepts for refinement?

- a. A regional DME hub providing only the most in-demand and hard to access DME for service area sites.
- b. A full-service regional DME hub stocking and shipping all potentially required DME to service area sites as needed.
- c. A DME hub service contracted by the RC to provide and ship DME on an as needed or priority basis.



Feasibility criteria – The workgroup identified the following criteria by which to evaluate or score the feasibility of each precept?

- a. Cost Efficient: Does this option cost a reasonable amount?
 - b. Does this model provide reliable delivery of DME?
 - c. Does this option provide efficient and effective client/staff education for DME?
 - d. Does this option facilitate credible order origination and identify if PRC eligible?
 - e. Acquisition Efficiency / Capabilities: regional vs. local fulfillment option
 - f. Does this option support billing protocol and education for Medicare Part B?
- 4. Concepts – What precepts were scored as more feasible and developed into a concept for workgroup consideration?**
- a. A regional DME hub providing only the most in-demand and hard to access DME for service area sites.
- 5. Solution – Which concept was scored as most feasible and translated into needed staff (FTE) and space (BGSF) for inclusion in the Regional Center study update?**
- a. “The Regional Center will own and operate a DME hub to provide the most in-demand and hard to access equipment” was chosen as the most feasible concept and was developed into needed staff and space.

IV. Decision

An excel based model was developed to quantify elementary aspects of the department (staff and space) and reviewed/vetted with workgroup members.

This service was deemed feasible by the workgroup and projected staff and space requirements have been added to the updated Regional Center report.

V. Conceptual Design Notes

1. A DME hub would supply patients in need of hard to access and high-cost equipment.
2. It would operate 250 days a year, 8 hours a day.
3. The DME Hub would keep area-wide stock of the most requested items such as Ambulation Assistance including wheelchairs, walkers, canes, crutches, and scooters, CPAP machines, oxygen equipment and accessories, personal care aides including shower chairs and commodes, blood sugar monitors and Continuous Glucose Monitors, and hospital beds. The equipment would then be distributed to patients in needs of such via the most effective delivery option (to be determined).
4. Key Planning Metrics
 - o Regional Center aligned user population served
 - o FTE per user population
 - o DNSF per user population
5. Staff requirements:



- Sacramento is projected to require 14.0 staff to operate the facility.
- Temecula is projected to require 9.5 staff.
- 6. Size requirements:
 - Sacramento is projected to require 9,684 DGSF.
 - Temecula would require 5,599 DGSF.

VI. Path Forward

Department should be further developed through study of actual DME operations at physical locations to better quantify needed staff and space. Some kind of workload expectation would be helpful for planning. This should be done before or during a PJD/POR facility planning document development effort.



Goals What are the goals of regional DME Hub?	Facts What facts drive this conceptual feasibility study?	Precepts What initial ideas might suggest solutions?	Precept Evaluation				Precept Feasibility Scoring by Workgroup						
			Assumptions	Challenges	Benefits	Need to know	Cost Efficient	Reliable delivery of DME.	Provides efficient, effective client/staff education for DME.	Facilitates credible order origination, identify if PRC eligible	Acquisition Efficiency / Capabilities: regional vs. local fulfillment option	Supports billing protocol/education (Medicare B)	Group Avg
To ensure the maximum access to DMEs and affordability for patients.	Lack of access and cost.	A regional DME hub providing only the most in-demand and hard to access DME for service area sites.	DME Hub will stock most needed equipment for patients in need and distribute via delivery.	1. Patients with rare DME need may not have access to their equipment. 2. RC needs a guaranteed supplier of equipment. 3. Delivery times.	1. Patients will have access to equipment that sites do not have access to. 2. Patient wellness and care is improved.	1. Need to identify the most in-demand equipment based on patient data. 2. Where does the Hub source the DME? Who is the provider?	3	3	2	4	3	1	4.0
To ensure all the most needed DME is available for all patients.	Tribal sites lack capacity to provides equipment and supporting education.	A full-service regional DME hub stocking and shipping all potentially required DME to service area sites as needed.	Hub will have a full-service delivery system with a vast range of equipment needed by sites.	1. Need to have consistent full stock of equipment. 2. Specialty equipment delivery time may be long. 3. Need to have full access to equipment supply.	1. Reliability of full stock. 2. Patients can fully rely on Hub to get the equipment they need. 3. Local sites can communicate with Hub what the demand is.	1. What are the shipping times for larger equipment? 2. What equipment needs to have a larger stock?	1	2	2	3	1	0	2.8
	Lack of this provision negatively affects the health of AI/ANs across California.	A DME hub service contracted by the RC to provide and ship DME on an as-needed or priority basis.	Third party DME service located in the RC to supply equipment to patients on-demand.	1. Reliability of stock. 2. Communication may be harder for need.	1. Stock may be much more reliable. 2. No responsibility of staffing/operating the hub. 3. Delivery time may be expedited.	1. Which DME company would be contracted? 2. Do they supply ALL of the harder to find/most in demand DME? 3. Is the cost of 3rd party operations lower than self-run?	3	1	0	1	1	1	1.8
	Improved healthcare (per above) equals less cost.												
	Provides a safety net due to reasons identified above (potential assistance even during emergencies - COVID - where some local options close, weather, etc.)												

Concepts What concept emerges from the most supported precept?	Concept Drivers Top 6 Requested Items (not including prosthetics)	Concept Drivers User Population	Concept Variables Past Project Metrics for FTE and DNSF	Concept Variables Population Requiring Hub Support to Account for Distance from Regional Center	Solution What is the most feasible conceptual solution?
A regional DME hub providing only the most in-demand and hard to access DME for service area sites.	1. Ambulation Assistance: (wheelchairs, walkers, canes, crutches, scooters) 2. CPAP machines 3. Oxygen equipment and accessories 4. Personal care aides (bath/shower chairs, commodes etc.) 5. Blood sugar monitors and CGMs (continuous glucose monitors) 6. Hospital beds	1. The user population for the DME Hub is the entire population of users in CA (not just those using the RC). OR 2. Only those users requiring hub support or the most reliant population.	Projects include 1 IHS and 1 VA (FTE and SF were adjusted to remove a large prosthetics mission).	The 2033 Eroded Population	The Regional Center will operate a DME hub.
				The column above is the outcome of meeting 4 - final decision concept planning.	



Concept: A regional DME hub providing only the most in-demand and hard to access DME for service area sites

DME Assumptions

1. Note - There is tremendous variance in DME concept/staffing/sizing depending on the services provided
2. Most of what is published criteria exists within the VA and predominantly deals with prosthetics
3. Perhaps the most obvious question is: *why not order this service online?*
4. Top 6 Requested Items <https://www.mdsupplies.com/>

Ambulation Assistance: wheelchairs, walkers, canes, crutches, scooters	
CPAP Machine	18
Oxygen equipment & accessories	5
Personal Care Aids (Bath/Shower Chairs, Commodes etc.)	4
Blood Sugar Monitors and CGM (Continuous Glucose Monitors)	4
Hospital Beds	3
	3

DME Model - based on eroded population

Regional Center	2033 Eroded Population	Total FTE Requirement	Total Departmental Net SF
Sacramento	86,879	14.0	9,683.9
Temecula	50,231	9.5	5,598.9

Conceptual DME Metrics

	Population	Acute Beds	DME DNSF	DME FTE	FTE/Bed	FTE / Pop	DNSF/Bed	DNSF/ Pop
Project 1	63,193	54	3,060	4.0	0.074	0.0000633	56.7	0.048
Project 2	58,904	233	10,279	29.0	0.124	0.0004923	44.1	0.175
Private Sector Example	N/A	927	6,000	8.1	0.009		6.5	
					0.069	0.0000633	35.752	0.111

Grossing Factor is 1.4

Staffing List	Sacramento	Temecula
Manager	1.0	1.0
Supervisor	0.0	0.0
Administrative Asst	1.0	1.0
Intake Coordinator	2.0	1.0
Patient Care Rep	0.0	0.0
Inventory Manager	1.0	1.0
Insurance Person	0.0	0.0
Receiver (New>Returns)	2.5	1.5
Picker/Packer	3.0	1.5
Shipper	2.5	1.5
Repair Technician	1.0	1.0
Driver	0.0	0.0
Total	14.0	9.5



Appendix 3 – Data Requests

The following pages provide the data request submitted to the California Area for fulfilment as well as the one submitted to all California Area sites (service units)

California Area Data Request Received

Site Data Request

Site Data Received (Aggregated)



Service Unit/Consortium	Primary Facility/Service Area	Address	City	Zip Code	Project Point of Contact	Email	Phone	User Population					Comments
								Year					
								2018	2019	2020	2021	2022	
Southern Indian Health Council Inc. (Alpine)	Alpine, CA	4058 Willows Road	Alpine	91903	Laura Caswell	lcaswell@sihc.org	(619) 445-1188 ext 303	2,457	2,360	2,150	1,859		Switched to COTS EHR in 2020, resulting in lower numbers, possible issues with exported data, or decline could be due to pandemic.
Strong Family Health Center (Modoc)	Alturas, CA	1203 Oak Street	Alturas	96101	Candace Carlson	ccarlson@modocsfhc.org	(530) 233-4591	209	228	149	146		No data exports in 2018-2022
MACT Health Board Inc.	Angels Camp, CA	52 South Main Street - PO Box 939	Angels Camp	95222	John Alexander	john.alexander@macthealth.org	(209) 754-6258	1,812	1,731	1,723	1,790		
United Indian Health Service Inc. (under CRIHB)	Arcata, CA	1600 Weeot Way	Arcata	95521	Elizabeth Lara-O'Rourke	liz.lara@uihs.org	(707) 825-5000	8,520	8,726	8,342	8,440		
Chapa-De Indian Health Program Inc.	Auburn, CA	11670 Altwood Road	Auburn	95603	Lisa Davies	ldavies@chapa-de.org	530-887-2800	5,376	5,643	5,292	5,389		
Tejon Tribe	Bakersfield, CA	4941 David Rd	Bakersfield	93203	Octavio Escobedo		(661) 834-8566	393	432	424	338		Their data is likely from patients seen at Bakersfield Urban Clinic, as all of Bakersfield's communities were given to Tejon when they became federally recognized
Riverside/San Bernardino County Indian Health Inc	Banning, CA	11555 1/2 Potero Road	Banning	92220	Bill Thomsen	bthomsen@rsbcihi.org	(951) 849-4761	14,331	14,001	13,192	11,089		Was having data issues in 2020 and 2021, but may be resolved as of 2022, once final 2022 data is released, can confirm
Toiyabe Indian Health Project Inc. (under CRIHB)	Bishop, CA	250 See Vee Lane	Bishop	93514	Joseph Herman	joseph.herman@toiyabe.us	(760) 873-8464	2,985	3,036	3,011	3,003		
Pit River Health Services Inc.	Burney, CA	36977 Park Avenue	Burney	96013	Loren Ellery	loren.ellery@pitriverhealthservices.org	(530) 335-5090 ext 130	960	961	1,031	1,042		
Central Valley Indian Health Inc.	Clovis, CA	2740 Herndon Avenue	Clovis	93611	Paul Bains	pbains@cvih.org	559-299-2578	7,469	7,466	6,629	6,263		
Colusa Indian Health Community Council	Colusa, CA	3710 Highway 45 - Suite A	Colusa	95932	Catrina Ross	cross@colusa-nsn.gov	(530) 458-5501	96	94	99	101		
Rollings Hills Clinic	Corning, CA	705 East Street	Corning	96021	Erich Koch	EKoch@rhclinic.org	(530) 690-2827 ext 1305	0	75	0	75		Does not export data to NDW. 75 is the number of members of the Tribe that was agreed upon as their user population when they opened their clinic several years ago
Round Valley Indian Health Center Inc.	Covelo, CA	Corner of Hwy 162 and Bigger Lane	Covelo	95428	Linda Lohne	Linda.Lohne@RVHC.com	(707) 983-6404	1,240	1,183	1,141	1,119		
Sycuan Band of the Kumeyayy National	El Cajon, CA	5442 Sycuan Road	El Cajon	92019	Maurice Smith	msmith@sycuanmed.org	(619) 445-0707	97	88	24	1		Has not been exporting data for last several years
Wilton Rancheria	Elk Grove, CA	9728 Kent Street	Elk Grove	95624	Elena Tarango	etarango@wiltonrancheria-nsn.gov	(916) 683-6000 ext 2007	1,495	1,489	1,675	1,698		Most of these active users likely are going to Sacramento NAHC urban clinic, SNAHCs communities were given to Wilton once they received recognition
Quartz Valley Program (under CRIHB)	Fort Jones, CA	13601 Quartz Valley Road	Fort Jones	96032	Toni Friden (Interim)	toni.friden@qvir-nsn.gov	530-468-4470	271	254	249	253		
Sierra Tribal Consortium Inc.	Fresno, CA	610 West McKinley Avenue	Fresno	93728	Yolanda Herrera	stdirector@sierratribal.org	(559) 445-2691						
Table Mountain Medical	Friant, CA	23638 Sky Harbor Road	Friant	93616	Marilyn Benck	mbenck@tmr.org	559-822-3785	5	5	3	3		Does not export data to NDW
Warner Mountain Indian Health Program (under CRIHB)	Fort Bidwell, CA	132 Mee Thee-Uh Road - PO Box 247	Ft. Bidwell	96112	Jana Townsend	jana.townsend@carih.org	(530) 279-6194	84	92	81	71		
Greenville Rancheria Tribal Health Program	Greenville, CA	410 Main Street	Greenville	95947	Lucretia Fletcher	lfletcher@greenvillerrancheria.com	(530) 528-8600	1,450	1,436	1,371	1,348		very few or no data exports in 2021 or 2022
Karuk Tribe	Happy Camp, CA	64236 2nd Avenue	Happy Camp	96039	Rondi Johnson	rjohnson@karuk.us	(530) 842-9200	2,291	2,136	2,051	2,079		
K'ima:w Medical Center	Hoopa, CA	535 Airport Road	Hoopa	95546	Stephen Stake	stephen.stake@kimaw.org	(530) 625-4261	2,820	2,931	2,872	2,856		
Cabazon Band of Cahuilla Indians	Indio, CA	84-245 Indio Springs Parkway	Indio	92203	Nancy Markwardt		760-342-2593	7	7	8	8		Does not export data
Mathiesen Memorial (Chicken Ranch) (under CRIHB)	Jamestown, CA	18144 Seco Street	Jamestown	95327	John Vass	johnvass19@gmail.com	(209) 984-4820	23	25	24	15		
Lake County Tribal Health Consortium	Lakeport, CA	925 Bevins Court	Lakeport	65453	Ernesto Padilla	epadilla@lcthc.org	(707) 263-8382	2,250	2,458	2,468	2,663		
Feather River Tribal Health Inc.	Oroville, CA	2145 5th. Avenue	Oroville	95965	Maria Hunzeker	maria.hunzeker@frth.org	(530) 534-5394	5,087	5,343	5,152	4,937		
Shingle Springs Tribal Health Program	Placerville, CA	5168 Honpie Road	Placerville	95667	Kyle Nelson	nelsonk@ssthp.org	(530) 387-4977	1,104	1,352	1,236	1,205		
Tule River Indian Health Center inc. (under CRIHB)	Porterville, CA	380 N. Reservation Road - PO Box 768	Porterville	93528	Zahid Sheikh	zahid.sheikh@carih.org	(559) 791-2594	2,470	2,467	2,302	2,294		
Redding Rancheria Tribal Health Systems	Redding, CA	1441 Liberty Street	Redding	96001	Glen Hayward	glenh@redding-rancheria.com	530.224.2700	3,612	3,578	3,315	2,994		No data exports in 2020-2022
Consolidated Tribal Health Project Inc. (Redwood Valley)	Redwood Valley, CA	6991 N. State Street	Redwood Valley	95470	James Stewart	jstewart@cthp.org	(707) 485-5115	2,889	3,178	2,917	2,738		Issues with exports after switching to a COTS EHR. FY 2020 and FY 2021 data not exported, but 2019 and 2022 data looks ok.
Sonoma County Indian Health Project (under CRIHB)	Santa Rosa, CA	144 Stony Point Road	Santa Rosa	95401	Betty Arterberry	betty.arterberry@scihp.org	(707) 521-4660	4,986	4,819	4,203	4,565		
Santa Ynez Tribal Health Clinic	Santa Ynez, CA	90 Via Juana Lane	Santa Ynez	93460	Richard Matens	rmatens@sythc.org	(805) 694-2650	1,129	1,112	851	1,033		

Service Unit/Consortium	Primary Facility/Service Area	Address	City	Zip Code	Project Point of Contact	Email	Phone	User Population					Comments
								Year					
								2018	2019	2020	2021	2022	
Susanville Indian Rancheria	Susanville, CA	795 Joaquin Street	Susanville	96130	Lona Ibanitoru	libanitoru@lihc.org	(530) 251-5184	866	842	783	737		
Tuolumne Me-Wuk Indian Health Center	Tuolumne, CA	18880 Cherry Valley Blvd.	Tuolumne	95379	Janice Harper	janice.harper@tmwihc.org	(209) 928-5453	215	348	340	308		
Indian Health Council Inc.	Valley Center, CA	50100 Golsh Road	Valley Center	92082	Orvin Hanson	ohanson@indianhealth.com	(760) 749 -1410 ext 5228	5,091	5,185	5,102	5,022		
Northern Valley Indian Health Inc.	Willows, CA	207 North Butte Street	Willows	95988	Inder Wadhwa	iwadhwa@nvih.org	(530) 330-8800 ext 1234	3,066	2,992	3,352	3,475		
UIO - Bakersfield American Indian Health Project	Bakersfield, CA	1617 30th Street	Bakersfield	93301	Angel Galvez	AGalvez@Bakersfieldaihp.org	661-327- 4030	46	72	80	103		Switched to new HER in 2020, very few or no data exports in 2020, 2021, or 2022
UIO - Fresno American Indian Health Project	Fresno, CA	1551 East Shaw Avenue	Fresno	93710	Selina De La Pena	sdelapena@faihp.org	559-320-0490	954	1,111	1,699	2,024		
UIO - United American Indian Involvement Inc. UIO -	Los Angeles, CA	1125 W. 6th Street - Suite 103	Los Angeles	90017	Luis Cervantes	lcervantes@uaii.org	213-202-3970	1,055	965	948	1,170		
UIO - Native American Health Center Inc.	Oakland, CA	2950 International Boulevard	Oakland	94601	Martin Waukazoo	martinw@nativehealth.org	415-417-3500	1,843	1,537	1,457	1,702		
UIO - Sacramento Native American Health Center Inc.	Sacramento, CA	2020 J Street	Sacramento	95811	Britta Guerrero	britta.guerrero@snahc.org	916-341-0576 ext. 2205	48	46	58	69		Their patients are all counted at Wilton due to community of residents assignments
UIO - San Diego American Indian Health Center	San Diego, CA	2602 First Avenue - Suite 105	San Diego	92103	Kevin LaChapelle	klachapelle@sdaihc.org	619-234-2158	1,861	1,881	1,801	1,103		Switched to COTS EHR in 2021, resulting in possible data issues with exports
UIO - Friendship House Association of American Indians	San Francisco, CA	56 Julian Avenue	San Francisco	94103	Anthony Tam	anthonyt@friendshiphousesf.org	415-865-0964						Does not export data
UIO - Indian Health Center of Santa Clara Valley	San Jose, CA	1333 Meridan Avenue	San Jose	95125	Sonya Tetnowski	stetnowski@ihcscv.org	408-445-3400	25	27	674	883		Started reporting data to NDW in 2020
UIO - American Indian Health and Services Corp.	Santa Barbara, CA	4141 State Street - Suite B2	Santa Barbara	93110	Scott Black	sblack@aihscorp.org	805-681-7144	638	584	622	671		
UIO - Native Directions, Inc.	Manteca, CA	13505 South Union Road	Manteca	95336	Ramona Valadez	rvaladez1492@gmail.com	209-858-2421						Does Not export data

Instructions

Please complete each Excel Tab by filling in the yellow colored cells.

#	Tab	Instructions
1	User Population	Please enter your Service Unit/Consortium or Urban Indian Organization user population for each of the last five years (2018 - 2022) . If there are multiple sites within your organization, add them together. Provide only one composite user population for each year.
2	Questionnaire	Please complete the eight (8) questions by entering your answers in the yellow spaces provided.

Completed data request should be collected and forwarded electronically to the following contact:

Phyllis Klawsky
The Innova Group
e. phyllis.klawsky@theinnovagroup.com
5255 E Williams Circle Suite #6000
Tucson, AZ 85711
t. (520) 886-8650

Thank you for completing this data request. Your input is extremely valuable.

Service Unit/Consortium	User Population				
	Year				
	2018	2019	2020	2021	2022

Please enter the name of your healthcare organization, service unit, urban Indian organization, or system of care. This may include one or more points of care.

Please enter the last 5 years of user population. Though the Area office has this for many SUs/UIOs some organizations do not report any longer, use a non-RPMS EHR, or have reported data issues. It is important for this study to have the correct user population.

Enter name here



Site Questionnaire

Please answer the following questions to the best of your ability. Only one questionnaire per Service Unit please. "Distant Regional Center" in the questions below refers to 2 such facilities under consideration - one in Sacramento and one in Temecula. Each, depending on population served and services interest, may or may not be able to offer the services referenced below. These proposed facilities are still in the early stages of planning.

1 Please list the top five (5) innovations in health care over the past 10 years, in order of importance, that should be considered as part of this Regional Centers Study update.

Top 5 Health Care Innovations by order of importance:

1	
2	
3	
4	
5	

2 If it was feasible, please list the top five (5) most desirable specialty care services that might visit your site from a distant Regional Center to provide needed care. How often should they visit your site? Is there space to provide care for these services at your clinic or would a mobile clinic be desirable?

Most Desirable Visiting Specialty Services
by order of importance

Frequency of Visit

Space Available or Mobile Clinic
Desirable (enter either space
available or mobile clinic)

1		
2		
3		
4		
5		

3 If Labor & Delivery services were provided, what annual percentage of your expectant mothers might choose to deliver their newborn(s) at a distant Regional Center? On average, how many family members/friends might accompany each delivering mother?

Annual percentage of newborn mothers who might deliver their newborn at a Regional Center:
Average number of family members/friends who might accompany each delivering mother:

<u>Answer:</u> 0%
0

4 If Transportation services were provided, what percentage of your user population might require transportation to a distant Regional Center for care annually? On average, how often might user transport be required annually? On average, how many friends/family members might travel with the user for each transport?

Percentage of users requiring transportation to Regional Center annually:
Number of annual transports for each user (above):
Number of family members/friends accompanying each user transport:

<u>Answer:</u> 0%
0
0

5 If Lodging services were provided, what percentage of your users travelling to receive care at a distant Regional Center might require lodging to be provided?

Percentage of user pop travelling to Regional Center requiring lodging:
Number of family/friends travelling with each user who might also require lodging:

<u>Answer:</u> 0%
0%



6 If Pharmacy Hub services were provided, please rank the following potential Pharmacy Hub services, by order of desirability, that should be provided at a distant Regional Center. Add any services not provided below.

<u>Pharmacy Hub Services:</u>	<u>Rank (ex. #1, 2, etc.)</u>
Case Management	
Benefits investigation/verification	
Prior authorization assistance	
Distribution support	
Nursing support	
Health care professional education	
Patient adherence & education	
Non commercial pharmacy dispensing	
Other	
Other	

7 If Durable Medical Equipment support was provided, what kind of Durable Medical Equipment Support should be provided for your site at a distant Regional Center? Please list your answers below in order of importance.

Type of Durable Medical Equipment support service desired (in order of importance):

1	
2	
3	
4	
5	

8 Is there anything else you would like to add regarding the questions or answers above?

Completed data request should be collected and forwarded electronically to the following contact:

Phyllis Klawsky
The Innova Group
e. phyllis.klawsky@theinnovagroup.com
5255 E Williams Circle Suite #6000
Tucson, AZ 85711
t. (520) 886-8650

Thank you for completing this data request. Your input is extremely valuable.

Facility Name	2019 Site Reported User Pop	5 Top Health Care Innovations Over the Last 10 Years	5 Most Desired Speciality Services That Might Visit Site	Frequency	Where	L&D - Annual % of Expectant Mothers Choose RC	L&D - On Average # of Family Members Accompany Expectant Mom	Transportation - % of Users Requiring Transportation to RC	Transportation - # of Annual Transports for Each User from Question #1	Transportation - # of Family Members Accompanying Each User	Lodging - % of User Population travelling to RC Requiring Lodging	Lodging - # of Family/Friends Travelling with Each User Who Might Require Lodging	Pharmacy Hub Services Ranked by Order of Desirability	Rank	DME - What Kind of DME Support Should be Provided for Your Site by the RC
Central Valley Indian Health Central Valley Indian Health Central Valley Indian Health Central Valley Indian Health Central Valley Indian Health Central Valley Indian Health Central Valley Indian Health Central Valley Indian Health Central Valley Indian Health	10,676	Diabetes Management: Continuous Glucose Monitoring, New Medications Hepatitis C Treatment Point of Care ultrasound Electronic Health Records/Artificial Intelligence for charting, orders MAT - Medication Assisted Treatment for opioid use disorder using Suboxone	Psychiatry: Child and Adult Pain Management Neurology Rheumatology Endocrinology	2 - 3 x month 2 - 3 x month 1 - 2 x month 1 - 2 x month 1 - 2 x month		5% - 10%	1 - 2	50%	3 - 6	1 - 2	20%	1 - 2	Case Management Benefits investigation/verification Prior authorization assistance Distribution support Nursing support Health care professional education Patient adherence & education Non commercial pharmacy dispensing	2 6 3 7 5 1 4 8	Prosthetics Ambulation Assistance: Wheelchairs, walkers, canes Incontinence supplies
Chapa De Indian Health Program Chapa De Indian Health Program Chapa De Indian Health Program Chapa De Indian Health Program Chapa De Indian Health Program	5,643	Telehealth Patient Portal Continuous Glucose Monitors Hepatitis C Oral Treatment Trauma Informed Care	Oral Surgeon Cardiology Endocrinology Pediatric Dentist Neurology	4 days/month 2 day/month 2 days/month 1 day/month 1 day/month	mobile clinic space available space available space available space available	10%	2	20%	3	2	0%	0%	Case Management Nursing support Patient adherence & education Mail Order, Distribution	3 1 2 4	Insulin Pump Supplies CPAP Machine Diabetic Shoes Compression Stockings Wheelchairs
Greenville Ranchiera Greenville Ranchiera Greenville Ranchiera Greenville Ranchiera Greenville Ranchiera Greenville Ranchiera Greenville Ranchiera Greenville Ranchiera Greenville Ranchiera Greenville Ranchiera	6,890	Diabetes Behavioral health Care management such as heart diseases, chronic diseases Obesity Drug and alcohol and youth	Rheumatology Cardiology Counseling OB GYN Ophthalmology	once a week once a week twice a week once a week once a week	clinic clinic clinic clinic clinic	10%	10	50%	100 +	10+	50%	10%	Case Management Benefits investigation/verification Prior authorization assistance Distribution support Nursing support Health care professional education Patient adherence & education Non commercial pharmacy dispensing Other - diabetes Other - chronic	2 3 3 3 3 3 3 1 1	Wheelchairs Walkers Portable Comodes Canes Beds
Indian Health Council Inc Indian Health Council Inc Indian Health Council Inc Indian Health Council Inc Indian Health Council Inc Indian Health Council Inc	5,326	MAT Services Clinical Specialty Services - including Physical Therapy Specialty Providers to send to Urban and Tribal Health Clinics Telehealth CGM Technology for Diabetic Care	Physical Therapy OB/GYN Neurology Orthopedics Dermatology Endocrinology	3x week 1x week Every other week Every other week Every other week Every other week	Space Available Space Available Space Available Space Available Space Available Space Available	80%	2	5%	12	1	0%	0%	Case Management Benefits investigation/verification Prior authorization assistance Patient adherence & education Specialty Pharmacy Services Patient Assistance Program Home Health Care Services (incontinence su	6 4 5 7 1 2 3	CGM (Continuous Glucose Monitoring)
Pit River health Services Pit River health Services Pit River health Services Pit River health Services Pit River health Services Pit River health Services Pit River health Services Pit River health Services Pit River health Services	2,105	MRI, CAT SCAN, Radiology Drug Treatments for Tpe 2 Diabetes Telehealth Eupip remote Monitoring Targeted mediation treatment for Hypertention Point of Care Diagnostics	Radiology Orthopedics Pediatrics Physical Therapy Cardiology	Remote Reading Quarterly Quarterly Monthly Quarterly	no space required Have Space Have Space Have Space Have Space	50%	1	50%	4	1	12%	8%	Case Management Benefits investigation/verification Prior authorization assistance Distribution support Nursing support Health care professional education Patient adherence & education Non commercial pharmacy dispensing	5 7 6 1 8 3 4 2	Blood Sugar Monitors Oxygen Equipment Wheelchairs Commonds Crutches, Canes, Walkers
Riverside San Bernadino Indian Health Riverside San Bernadino Indian Health Riverside San Bernadino Indian Health Riverside San Bernadino Indian Health Riverside San Bernadino Indian Health Riverside San Bernadino Indian Health Riverside San Bernadino Indian Health Riverside San Bernadino Indian Health Riverside San Bernadino Indian Health Riverside San Bernadino Indian Health Riverside San Bernadino Indian Health	14,710	Tele-Health Bluetooth technology Robotics More effective specialty medications Electronic health records	Endocrinology Cardiology Urology Diabetes wound care ENT	monthly monthly monthly monthly monthly	Space Available Space Available Mobile Unit Space available Mobile unit	50%	4	75%	2	2	30%	2%	Case Management Benefits investigation/verification Prior authorization assistance Distribution support Nursing support Health care professional education Patient adherence & education Non commercial pharmacy dispensing Mail order meds specialty meds	6 8 5 7 10 3 2 1 9 4	Wheelchairs Walkers Podiatry Boots Oxygen CPAP Machines
Santa Ynez Tribal Health Clinic Santa Ynez Tribal Health Clinic Santa Ynez Tribal Health Clinic Santa Ynez Tribal Health Clinic Santa Ynez Tribal Health Clinic Santa Ynez Tribal Health Clinic Santa Ynez Tribal Health Clinic	3,841	More modern Electronic Health Record systems Advances in telemedicine applications Wearable medical devices Patient portals	Endocrinology Dermatology Gastroenterology	Once per week Once per week Once per week	Mobile clinic Mobile clinic Mobile clinic	0%	0%	10%	3	1	0%	0%	Case Management Benefits investigation/verification Prior authorization assistance Distribution support Nursing support Health care professional education Patient adherence & education Non commercial pharmacy dispensing	4 5 6 7 3 8 1 2	Walkers Wheelchairs Blood pressure units Diabetic testing
Southern Indian Health Council Southern Indian Health Council Southern Indian Health Council Southern Indian Health Council Southern Indian Health Council Southern Indian Health Council Southern Indian Health Council Southern Indian Health Council	2,408	Telehealth Mobile Unit Retinal Specialist EHR Support	Cardiology Pulmonology Orthopedic OB/GYN Neurology	2x a month 2x a month 2x a month 2x a month monthly	space available space available space available space available space available	90%	2	90%	1	2	90%	2%	Case Management Nursing support Non commercial pharmacy dispensing Distribution support Benefits investigation/verification Prior authorization assistance Health care professional education Patient adherence & education	1 2 3 4 5 6 7 8	Equipment based on specialty services
Sycuan Medical and Dental Clinic Sycuan Medical and Dental Clinic Sycuan Medical and Dental Clinic Sycuan Medical and Dental Clinic Sycuan Medical and Dental Clinic Sycuan Medical and Dental Clinic Sycuan Medical and Dental Clinic	285	Technology - EHR/Telehealth Delivery Model - Value-based care, Patient centered care Affordable Care Act Collaboration - Multi-Disciplinary Team Based Approach Increase in Accreditation Standards	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Case Management Benefits investigation/verification Prior authorization assistance Nursing support Patient adherence & education Health care professional education Distribution support	1 2 3 4 5 6 7	Neck, Shoulder, Back, Arms, Wrist, Hand, Thumb, Knee, Ankle support/braces Canes, Crutches Foot molds

Facility Name	2019 Site Reported User Pop	5 Top Health Care Innovations Over the Last 10 Years	5 Most Desired Speciality Services That Might Visit Site	Frequency	Where	L&D - Annual % of Expectant Mothers Choose RC	L&D - On Average # of Family Members Accompany Expectant Mom	Transportation - % of Users Requiring Transportation to RC	Transportation - # of Annual Transports for Each User from Question #1	Transportation - # of Family Members Accompanying Each User	Lodging - % of User Population Travelling to RC Requiring Lodging	Lodging - # of Family/Friends Travelling with Each User Who Might Require Lodging	Pharmacy Hub Services Ranked by Order of Desirability	Rank	DME - What Kind of DME Support Should be Provided for Your Site by the RC	
Toiyabe Indian Health Project	2,339	Transportation Network - similar to Medical Mgmt Transportation in Nevada for its Medicaid Population Include Mobile and OR Telehealth Services Division for your outlining service areas such Inyo, Mono and El Dorado counties HINT: Study Renowns Telehealth Network Program Project IT services for a complete system point to point integration with the new hospital electronic health record system (Bilateral interfacing) to other tribal clinics Design and deploy enterprise patient care processes and document using health information system and data warehouse to be able to enter into value based insurance contracts to ensure payment is based on outcomes under PRC and insurance related reimbursement methodologies Considerations for a successful financial mapping and projection of this mapping to ensure you can enter into sustainable contractual relationships with physician medical groups to provide these services especially for call coverage, etc unless I H S intends to hire their own physicians.	Physical Therapy (IP/OP)	1,715	if space available	1%	3	25%	590	1400	80%	70%	Case Management	3	Wheel chair / Crutches / Canes / Scooters	
Toiyabe Indian Health Project			Sports Medicine - Orthopedic (IP/OP)	955	if space available									Benefits investigation/verification	2	an Occasional C Pap machine
Toiyabe Indian Health Project			Radiology (MRI, CT, Gam Cam, Nuc Med) (OP/IP)	865	if space available									Prior authorization assistance	1	Oxygen equipment & accessories
Toiyabe Indian Health Project			Physical Medicine & Rehabilitation (Pain Management)	1,130	if space available									Distribution support	4	Nebulizers & nebulizer medications
Toiyabe Indian Health Project			Cardiology (Non-invasive) (OP/IP)	645	if space available									Nursing support	6	
Toiyabe Indian Health Project Toiyabe Indian Health Project Toiyabe Indian Health Project Toiyabe Indian Health Project													Health care professional education Patient adherence & education Non commercial pharmacy dispensing	5 7 8		
Tule River	1,996	Cancer Treatment Services Immunotherapy Hepatitis Treatment Pain Management Service Bariatric Services	Gastroenterology	1 visit per week	Mobile	0%	0	5%	0	1	3%	1	Case Management	2	Oxygen Concentrators	
Tule River			Neurology	2 visit per week	Mobile									Benefits investigation/verification	3	Personal Care Aids (Bath/Shower Chairs, Commodes, CPAP, etc)
Tule River			Otolaryngology	3 visit per week	Mobile									Prior authorization assistance	4	Wheelchairs
Tule River			Cardiology	4 visit per week	Mobile									Distribution support	5	Walker/Rolators
Tule River			Pain Management	5 visit per week	Mobile									Nursing support	8	Hospital Beds
Tule River														Health care professional education	7	
Tule River														Patient adherence & education Non commercial pharmacy dispensing	1 6	
UIO Bakersfield American Indian Health Project	6,162	Heart, Kidney and Pulmonary Surgery Services Brain Trauma Psychiatric and Medication Services Affects Social Determinants of Health Research Podiatry	Podiatry	weekly	no	65%	45	90%	200	100	65%	48%	Case Management	4	Wheel Chairs	
UIO Bakersfield American Indian Health Project			Dialysis	weekly	no									Benefits investigation/verification	2	In-Home supportive Equipment for Elders and Chronic Home Bound Persons
UIO Bakersfield American Indian Health Project			Heart and Cardiovascular	weekly	no									Prior authorization assistance	3	Walkers and Cains
UIO Bakersfield American Indian Health Project			Women Prenatal and Delivery	weekly	no									Distribution support	5	Automobile Medical Equipment and Install for children and youth with Ambulatory Limitations
UIO Bakersfield American Indian Health Project			AIDS and HIV services	weekly	no									Nursing support	7	In-Home Medical grade beds for patients experiencing cancer or severe physical health issues
UIO Bakersfield American Indian Health Project UIO Bakersfield American Indian Health Project UIO Bakersfield American Indian Health Project UIO Bakersfield American Indian Health Project													Health care professional education Patient adherence & education Non commercial pharmacy dispensing	6 8 1		
UIO San Diego American Indian Health Center	4,019	Point-of-care diagnostics Wearable medical devices(e.g. mHealth, biosensors) Telehealth Retail Predictive analytics	Behavioral Health	8-12 sessions	Space available	0%	0	33%	1-2 per user	1-2 family / friends per user	33%	1-2 family / friends per user	Case Management	1	Mobility Devices(e.g. wheelchairs, walkers, etc)	
UIO San Diego American Indian Health Center			Dental Services	As needed	Space available									Benefits investigation/verification	3	Wound care supplies
UIO San Diego American Indian Health Center			Diabetes management	As needed	Space available									Prior authorization assistance	4	CPAPS
UIO San Diego American Indian Health Center			Pediatrics	As needed	Space available									Distribution support	6	Incontinence Supplies (e.g. diapers, etc.)
UIO San Diego American Indian Health Center			Youth Program	As needed	Space available									Nursing support	5	Ostomy Supplies
UIO San Diego American Indian Health Center UIO San Diego American Indian Health Center UIO San Diego American Indian Health Center													Health care professional education Patient adherence & education Non commercial pharmacy dispensing	8 2 7		
UIO Santa Clara Valley UIO Santa Clara Valley UIO Santa Clara Valley UIO Santa Clara Valley UIO Santa Clara Valley	21,749	PCMH re-certification Upgrading EMR to Ochin epic AAAHC re-creditaion HRSA qi AWARD	Gastroenterology			N/A	N/A	N/A	N/A	N/A	N/A	N/A			N/A	
UIO Santa Clara Valley			Ophthalmology													
UIO Santa Clara Valley			Podiatry													
UIO Santa Clara Valley			Rheumatology													
UIO Santa Clara Valley			Pain Management													
UIO Fresno American Health Project UIO Fresno American Health Project UIO Fresno American Health Project UIO Fresno American Health Project UIO Fresno American Health Project	375	Urology Endocrinologist Gastroenterology Neurology Ophthalmology	Mammography	every other month	Mobile	0%	0	20%	2	2	10%	20%	Case Management	1		
UIO Fresno American Health Project														Distribution Support	2	
UIO Fresno American Health Project																
UIO Fresno American Health Project																
UIO Fresno American Health Project																



Appendix 4 – Alternate Market Forces Planning Tables

The following pages provide alternative tables showing potential approaches to “normalizing” the Area payer profiles received from the NDW:

Sacramento and Temecula Normalized – specific profiles averaging payer profiles for all the sites assigned to each regional point of care were overlaid onto sites where payer data was suspect. This was ultimately not utilized for planning.

All California Normalized – specific profiles averaging payer profiles for all California sites were overlaid onto sites where payer data was suspect. This was ultimately not utilized for planning.

Regional Ambulatory Surgical & Specialty Health Services Feasibility Study

IHS, California Area Office

Sacramento and Temecula Site Normalized

Erosion Factor #1 - Patient Reliance (2019 Payer Mix)

Service Area	Users by Payer		Direct Care Only								PRC Eligible								All Payers Rate		Market %			Entry			
	All	PRCDA	All				PRCDA				All				PRCDA				w 3rd Party (Medicaid Only)	H Reliance	M Reliance	L Reliance	PRCDA	H Reliance	M Reliance	L Reliance	
	Does not include "Other Eligible" or "Non-Indian" payers		No 3rd Party Coverage		w 3rd Party Coverage		No 3rd Party Coverage		w 3rd Party Coverage		No 3rd Party Coverage		w 3rd Party (All)		No 3rd Party Coverage		w 3rd Party (All)			Direct Care Only No 3P	Direct Care, PRC	Direct Care, PRC, 3P	Total Users (or)	Direct Care Only No 3P	Direct Care, PRC	Direct Care, PRC, 3P	
	Total 2019	Total 2019	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	All/PRCDA Blended %	All/PRCDA Blended %	All/PRCDA Blended %	PRCDA Users	w/out 3rd Party Coverage	w/out 3rd Party Coverage	3rd party Cov
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	
American Indian Health and Services (Santa Barbara) (SB Urban Indian Hlth)	805	607	593	73.7%	212	26.3%	423	69.7%	184	30.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	183	22.7%	71.7%	0.0%	28.3%	607	435	0	172
Bakersfield American Indian Health Project (American Ind Hlth Council)	6,162	5,325	2,302	37.4%	1,791	29.1%	1,936	36.4%	1,561	29.3%	1,070	17.4%	999	16.2%	941	17.7%	886	16.6%	268	4.4%	36.9%	17.5%	45.6%	5,325	1,963	933	2,429
Cabazon Band of Cahuilla Indians	7	6	3	37.4%	2	29.1%	2	36.4%	2	29.3%	1	17.4%	1	16.2%	1	17.7%	1	16.6%	0	4.4%	36.9%	17.5%	45.6%	6	0	0	0
Central Valley Indian Health	8,874	7,369	846	9.5%	2,168	24.4%	628	8.5%	1,687	22.9%	1,176	13.3%	4,684	52.8%	983	13.3%	4,071	55.2%	3,343	37.7%	9.0%	13.3%	77.7%	7,369	665	980	5,724
Chapa De Indian Health Program	4,446	3,852	1,134	25.5%	2,129	47.9%	955	24.8%	1,861	48.3%	333	7.5%	850	19.1%	281	7.3%	755	19.6%	293	6.6%	25.1%	7.4%	67.5%	3,852	969	285	2,598
Colusa Indian Health Community Health Council	94	81	19	20.1%	23	24.2%	15	18.0%	16	19.7%	13	13.4%	40	42.2%	12	15.1%	38	47.2%	21	22.8%	19.1%	14.2%	66.7%	81	15	12	54
Consolidated Tribal Health Project	3,235	3,035	207	6.4%	622	19.2%	172	5.7%	526	17.3%	531	16.4%	1,875	58.0%	511	16.8%	1,826	60.2%	1,423	44.0%	6.0%	16.6%	77.3%	3,035	183	505	2,347
Feather River Tribal Health	6,335	5,834	2,804	44.3%	1,392	22.0%	2,474	42.4%	1,253	21.5%	65	1.0%	2,074	32.7%	62	1.1%	2,045	35.1%	116	1.8%	43.3%	1.0%	55.6%	5,834	2,528	61	3,245
Fresno American Indian Health Project	381	18	153	40.2%	224	58.8%	3	16.7%	15	83.3%	1	0.3%	3	0.8%	0	0.0%	0	0.0%	133	34.9%	28.4%	0.1%	71.5%	18	5	0	13
Greenville Rancheria Tribal Health Program	6,890	5,954	1,388	20.1%	1,669	24.2%	1,070	18.0%	1,173	19.7%	923	13.4%	2,910	42.2%	897	15.1%	2,813	47.2%	1,570	22.8%	19.1%	14.2%	66.7%	5,954	1,135	847	3,972
Indian Health Center of Santa Clara Valley	21,749	18,794	4,381	20.1%	5,269	24.2%	3,379	18.0%	3,704	19.7%	2,914	13.4%	9,186	42.2%	2,831	15.1%	8,880	47.2%	4,955	22.8%	19.1%	14.2%	66.7%	18,794	3,582	2,675	12,537
Indian Health Council	5,364	4,861	1,246	23.2%	3	0.1%	929	19.1%	3	0.1%	3,887	72.5%	228	4.3%	3,722	76.6%	207	4.3%	48	0.9%	21.2%	74.5%	4.3%	4,861	1,029	3,622	210
Karuk Tribe	2,481	2,099	142	5.7%	342	13.8%	44	2.1%	221	10.5%	225	9.1%	1,772	71.4%	197	9.4%	1,637	78.0%	233	9.4%	3.9%	9.2%	86.9%	2,099	82	194	1,823
K'ima:w Medical Center (Hoopa)	3,712	3,382	103	2.8%	527	14.2%	61	1.8%	367	10.9%	204	5.5%	2,878	77.5%	192	5.7%	2,762	81.7%	1,115	30.0%	2.3%	5.6%	92.1%	3,382	77	189	3,116
Lake County Tribal Health Consortium	2,824	2,487	260	9.2%	728	25.8%	200	8.0%	584	23.5%	137	4.9%	1,699	60.2%	127	5.1%	1,576	63.4%	186	6.6%	8.6%	5.0%	86.4%	2,487	214	124	2,149
MACT Health Board	1,731	1,496	349	20.1%	419	24.2%	269	18.0%	295	19.7%	232	13.4%	731	42.2%	225	15.1%	707	47.2%	394	22.8%	19.1%	14.2%	66.7%	1,496	285	213	998
Mathiesen Memorial Health Clinic (Chicken Ranch)	20	12	9	45.0%	0	0.0%	4	33.3%	0	0.0%	11	55.0%	0	0.0%	8	66.7%	0	0.0%	0	0.0%	39.2%	60.8%	0.0%	12	5	7	0
Native American Health Center (SF Bay Area)	1,537	1,328	310	20.1%	372	24.2%	239	18.0%	262	19.7%	206	13.4%	649	42.2%	200	15.1%	628	47.2%	350	22.8%	19.1%	14.2%	66.7%	1,328	253	189	886
Northern Valley Indian Health	5,144	2,983	932	18.1%	2,690	52.3%	385	12.9%	1,238	41.5%	77	1.5%	1,445	28.1%	69	2.3%	1,291	43.3%	1,646	32.0%	15.5%	1.9%	82.6%	2,983	463	57	2,463
Pit River Health Services	1,271	966	107	8.4%	290	22.8%	54	5.6%	138	14.3%	82	6.5%	792	62.3%	74	7.7%	700	72.5%	52	4.1%	7.0%	7.1%	85.9%	966	68	68	830
Quartz Valley Program	368	223	3	0.8%	195	53.0%	2	0.9%	96	43.0%	1	0.3%	169	45.9%	0	0.0%	125	56.1%	74	20.1%	0.9%	0.1%	99.0%	223	2	0	221
Redding Rancheria Tribal Health Systems	3,578	3,092	721	20.1%	867	24.2%	556	18.0%	609	19.7%	479	13.4%	1,511	42.2%	466	15.1%	1,461	47.2%	815	22.8%	19.1%	14.2%	66.7%	3,092	589	440	2,063
Riverside San Bernardino County Indian Health	19,749	19,599	7,128	36.1%	6,029	30.5%	7,067	36.1%	5,983	30.5%	3,353	17.0%	3,239	16.4%	3,325	17.0%	3,224	16.4%	260	1.3%	36.1%	17.0%	47.0%	19,599	7,070	3,326	9,202
Rolling Hills	75	65	15	20.1%	18	24.2%	12	18.0%	13	19.7%	10	13.4%	32	42.2%	10	15.1%	31	47.2%	17	22.8%	19.1%	14.2%	66.7%	65	12	9	43
Round Valley Indian Health Center	1,451	1,385	145	10.0%	124	8.5%	130	9.4%	109	7.9%	153	10.5%	1,029	70.9%	144	10.4%	1,002	72.3%	106	7.3%	9.7%	10.5%	79.8%	1,385	134	145	1,106
Sacramento Native American Health Center	537	464	108	20.1%	130	24.2%	83	18.0%	91	19.7%	72	13.4%	227	42.2%	70	15.1%	219	47.2%	122	22.8%	19.1%	14.2%	66.7%	464	88	66	310
San Diego American Indian Health Center	2,198	1,401	881	40.1%	1,317	59.9%	497	35.5%	904	64.5%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	794	36.1%	37.8%	0.0%	62.2%	1,401	529	0	872
Santa Ynez Tribal Health Clinic	2,063	1,559	727	35.2%	334	16.2%	425	27.3%	212	13.6%	576	27.9%	426	20.6%	523	33.5%	399	25.6%	504	24.4%	31.3%	30.7%	38.0%	1,559	487	479	593
Shingle Springs Tribal Health Program	1,765	1,350	405	22.9%	947	53.7%	278	20.6%	714	52.9%	83	4.7%	330	18.7%	71	5.3%	287	21.3%	154	8.7%	21.8%	5.0%	73.2%	1,350	294	67	989
Sonoma County Indian Health Project	6,874	6,408	1,151	16.7%	717	10.4%	1,005	15.7%	628	9.8%	3,114	45.3%	1,892	27.5%	2,959	46.2%	1,816	28.3%	1,550	22.5%	16.2%	45.7%	38.0%	6,408	1,039	2,931	2,438
Southern Indian Health Council	4,452	3,341	1,619	36.4%	1,131	25.4%	985	29.5%	731	21.9%	893	20.1%	809	18.2%	842	25.2%	783	23.4%	110	2.5%	32.9%	22.6%	44.4%	3,341	1,100	756	1,485
Strong Family Health Center (Modoc)	180	171	0	0.0%	0	0.0%	0	0.0%	0	0.0%	8	4.4%	172	95.6%	8	4.7%	163	95.3%	73	40.6%	0.0%	4.6%	95.4%	171	0	8	163
Susanville Indian Rancheria	897	839	82	9.1%	281	31.3%	64	7.6%	244	29.1%	16	1.8%	518	57.7%	16	1.9%	515	61.4%	360	40.1%	8.4%	1.8%	89.8%	839	70	15	753
Sycuan Band of the Kumeyaay Nation	285	246	106	37.4%	83	29.1%	90	36.4%	72	29.3%	50	17.4%	46	16.2%	44	17.7%	41	16.6%	12	4.4%	36.9%	17.5%	45.6%	246	91	43	112
Table Mountain Medical	5	4	1	20.1%	1	24.2%	1	18.0%	1	19.7%	1	13.4%	2	42.2%	1	15.1%	2	47.2%	1	22.8%	19.1%	14.2%	66.7%	4	1	1	3
Tejon Indian Tribe	432	373	161	37.4%	126	29.1%	136	36.4%	109	29.3%	75	17.4%	70	16.2%	66	17.7%	62	16.6%	19	4.4%	36.9%	17.5%	45.6%	373	138	65	170
Toiyabe Indian Health Project	3,563	3,170	311	8.7%	775	21.8%	205	6.5%	556	17.5%	80	2.2%	2,397	67.3%	74	2.3%	2,335	73.7%	311	8.7%	7.6%	2.3%	90.1%	3,170	241	73	2,857
Tule River Indian Health Center	3,939	3,868	875	22.2%	562	14.3%	841	21.7%	542	14.0%	1,457	37.0%	1,045	26.5%	1,441	37.3%	1,044	27.0%	258	6.5%	22.0%	37.1%	40.9%	3,868	850	1,436	1,582
Tuolumne Me-Wuk Indian Health Center	1,387	461	248	17.9%	735	53.0%	29	6.3%	170	36.9%	16	1.2%	388	28.0%	9	2.0%	253	54.9%	242	17.4%	12.1%	1.6%	86.4%	461	56	7	398
United American Indian Involvement (LA) (LA American Indian)	923	849	198	21.5%	725	78.5%	176	20.7%	673	79.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	579	62.7%	21.1%	0.0%	78.9%	849	179	0	670
United Indian Health Service	2,377	1,758	1,880	79.1%	40	1.7%	1,282	72.9%	35	2.0%	192	8.1%	265	11.1%	182	10.4%	259	14.7%	37	1.6%	76.0%	9.2%	14.8%	1,758	1,336		



Sacramento and Temecula Site Normalized

2 Regional Center Market Share Calculation

Erosion Factor #2 - How far is Regional Care?

Erosion Factor #3 - How many alternative care opportunities are there?

Erosion Factor #4 - Can you direct Medicaid?

Service Area	Regional Center Location	Market Erosion by Distance							Sub Market Erosion by Competitors							Market Share							
		SU/PSA Drive Time to RC (in minutes)	Direct Care Only No 3P	Direct Care, PRC (No Choice)	Direct Care, PRC (Choice)	Direct Care, PRC, 3P (Medicaid Only)	Direct Care, PRC, 3P (Medicaid Reduced)	Direct Care, PRC, 3P	M Reliance No Choice	M Reliance Choice	# of Alt Care in route (Sec or Trty)	Direct Care Only No 3P	Direct Care, PRC (No Choice)	Direct Care, PRC (Choice)	Direct Care, PRC, 3P (Medicaid Only)	Direct Care, PRC, 3P (Medicaid Reduced)	Direct Care, PRC, 3P	M Reliance - PRC No Choice & Medicaid Only	M Reliance - Choice				
			w/out 3rd Party Coverage	w/out 3rd Party Coverage	w/out 3rd Party Coverage	w 3rd party Coverage	w 3rd party Coverage	w 3rd party Coverage	Net Users	Net Users		w/out 3rd Party Coverage	w/out 3rd Party Coverage	w/out 3rd Party Coverage	w 3rd party Coverage	w 3rd party Coverage	w 3rd party Coverage	Total Users	% of User Pop	Total Users	% of User Pop		
28	20	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48			
American Indian Health and Services (Santa Barbara) (SB Urban Indian Hlth)	Temecula, CA	163	400	0	0	36	125	158	561	558	13	400	0	0	36	125	63	561	92.4%	463	76.3%		
Bakersfield American Indian Health Project (American Ind Hlth Council)	Temecula, CA	172	1,804	858	858	97	2,143	2,232	4,901	4,893	8	1,804	858	600	97	2,143	893	4,901	92.0%	3,297	61.9%		
Cabazon Band of Cahuilla Indians	Temecula, CA	84	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0.0%	0	0.0%		
Central Valley Indian Health	Sacramento, CA	156	611	900	900	1,982	3,439	5,260	6,933	6,772	9	611	900	630	1,982	3,439	2,104	6,933	94.1%	3,346	45.4%		
Chapa De Indian Health Program	Sacramento, CA	37	969	285	285	171	2,427	2,598	3,852	3,852	4	969	285	199	171	2,427	1,039	3,852	100.0%	2,207	57.3%		
Colusa Indian Health Community Health Council	Sacramento, CA	64	15	11	11	12	41	52	78	78	2	15	11	9	12	41	31	78	96.5%	55	67.6%		
Consolidated Tribal Health Project	Sacramento, CA	153	168	464	464	949	1,285	2,157	2,866	2,789	1	168	464	417	949	1,285	1,726	2,866	94.4%	2,311	76.2%		
Feather River Tribal Health	Sacramento, CA	67	2,426	58	58	57	3,059	3,114	5,600	5,598	3	2,426	58	41	57	3,059	1,245	5,600	96.0%	3,712	63.6%		
Fresno American Indian Health Project	Sacramento, CA	153	5	0	0	4	8	12	17	17	7	5	0	0	4	8	5	17	93.8%	9	52.5%		
Greenville Rancheria Tribal Health Program	Sacramento, CA	148	1,043	779	779	832	2,886	3,650	5,539	5,472	4	1,043	779	545	832	2,886	1,460	5,539	93.0%	3,048	51.2%		
Indian Health Center of Santa Clara Valley	Sacramento, CA	107	3,437	2,566	2,566	2,741	9,400	12,029	18,144	18,033	8	3,437	2,566	1,796	2,741	9,400	4,812	18,144	96.5%	10,045	53.4%		
Indian Health Council	Temecula, CA	29	1,029	3,622	3,622	2	208	210	4,861	4,861	0	1,029	3,622	3,622	2	208	210	4,861	100.0%	4,861	100.0%		
Karuk Tribe	Sacramento, CA	290	65	154	154	137	1,345	1,454	1,702	1,674	2	65	154	124	137	1,345	872	1,702	81.1%	1,061	50.6%		
K'ima:w Medical Center (Hoopa)	Sacramento, CA	261	62	151	151	746	1,890	2,485	2,848	2,697	2	62	151	121	746	1,890	1,491	2,848	84.2%	1,673	49.5%		
Lake County Tribal Health Consortium	Sacramento, CA	124	197	114	114	130	1,855	1,975	2,296	2,286	1	197	114	102	130	1,855	1,580	2,296	92.3%	1,879	75.6%		
MACT Health Board	Sacramento, CA	83	274	204	204	218	748	957	1,444	1,435	2	274	204	163	218	748	574	1,444	96.5%	1,011	67.6%		
Mathiesen Memorial Health Clinic (Chicken Ranch)	Sacramento, CA	100	5	7	7	0	0	0	12	12	2	5	7	6	0	0	0	12	96.0%	10	84.3%		
Native American Health Center (SF Bay Area)	Sacramento, CA	73	243	181	181	194	664	850	1,282	1,274	3	243	181	127	194	664	340	1,282	96.5%	710	53.4%		
Northern Valley Indian Health	Sacramento, CA	90	444	55	55	756	1,638	2,364	2,893	2,862	1	444	55	49	756	1,638	1,891	2,893	97.0%	2,384	79.9%		
Pit River Health Services	Sacramento, CA	187	59	60	60	30	703	729	852	849	2	59	60	48	30	703	438	852	88.2%	545	56.4%		
Quartz Valley Program	Sacramento, CA	248	2	0	0	35	148	176	185	178	2	2	0	0	35	148	106	185	83.0%	107	48.1%		
Redding Rancheria Tribal Health Systems	Sacramento, CA	138	542	404	404	432	1,499	1,895	2,876	2,841	2	542	404	323	432	1,499	1,137	2,876	93.0%	2,002	64.8%		
Riverside San Bernadino County Indian Health	Temecula, CA	58	7,070	3,326	3,326	121	9,081	9,202	19,599	19,599	0	7,070	3,326	3,326	121	9,081	9,202	19,599	100.0%	19,599	100.0%		
Rolling Hills	Sacramento, CA		12	9	9	10	33	43	65	65		12	9	9	10	33	43	65	100.0%	65	100.0%		
Round Valley Indian Health Center	Sacramento, CA	199	118	127	127	71	909	971	1,225	1,217	1	118	127	115	71	909	777	1,225	88.5%	1,010	72.9%		
Sacramento Native American Health Center	Sacramento, CA	2	88	66	66	71	239	310	464	464	1	88	66	59	71	239	248	464	100.0%	396	85.2%		
San Diego American Indian Health Center	Temecula, CA	53	529	0	0	315	557	872	1,401	1,401	4	529	0	0	315	557	349	1,401	100.0%	878	62.7%		
Santa Ynez Tribal Health Clinic	Temecula, CA	190	428	421	421	127	409	521	1,385	1,370	13	428	421	295	127	409	208	1,385	88.8%	931	59.7%		
Shingle Springs Tribal Health Program	Sacramento, CA	35	294	67	67	86	903	989	1,350	1,350	2	294	67	54	86	903	593	1,350	100.0%	941	69.7%		
Sonoma County Indian Health Project	Sacramento, CA	155	955	2,694	2,694	505	1,776	2,241	5,930	5,889	3	955	2,694	1,885	505	1,776	896	5,930	92.5%	3,737	58.3%		
Southern Indian Health Council	Temecula, CA	66	1,055	725	725	35	1,391	1,425	3,207	3,206	1	1,055	725	653	35	1,391	1,140	3,207	96.0%	2,848	85.2%		
Strong Family Health Center (Modoc)	Sacramento, CA	287	0	6	6	53	88	130	147	136	5	0	6	4	53	88	52	147	86.0%	56	33.0%		
Susanville Indian Rancheria	Sacramento, CA	185	62	14	14	266	428	662	769	737	5	62	14	10	266	428	265	769	91.7%	336	40.0%		
Sycuan Band of the Kumeyaay Nation	Temecula, CA	68	87	41	41	5	103	108	236	236	2	87	41	33	5	103	65	236	96.0%	185	75.1%		
Table Mountain Medical	Sacramento, CA	160	1	1	1	1	2	3	4	4	6	1	1	0	1	2	1	4	93.0%	2	51.2%		
Tejon Indian Tribe	Temecula, CA	135	126	60	60	7	150	156	344	343	8	126	60	42	7	150	63	344	92.0%	231	61.9%		
Toiyabe Indian Health Project	Sacramento, CA	268	192	58	58	199	2,120	2,278	2,568	2,528	2	192	58	46	199	2,120	1,367	2,568	81.0%	1,605	50.6%		
Tule River Indian Health Center	Sacramento, CA	231	747	1,261	1,261	91	1,310	1,390	3,409	3,398	8	747	1,261	883	91	1,310	556	3,409	88.1%	2,186	56.5%		
Tuolumne Me-Wuk Indian Health Center	Sacramento, CA	104	53	7	7	67	318	382	445	442	2	53	7	5	67	318	229	445	96.5%	288	62.5%		
United American Indian Involvement (LA) (LA American Indian)	Temecula, CA	79	172	0	0	403	256	643	831	815	4	172	0	0	403	256	257	831	97.9%	429	50.5%		
United Indian Health Service	Sacramento, CA	290	1,066	129	129	3	205	207	1,403	1,402	2	1,066	129	103	3	205	124	1,403	79.8%	1,293	73.6%		
Warner Mountain Indian Health Program	Sacramento, CA	322	3	55	55	0	0	0	58	58	4	3	55	38	0	0	0	58	79.8%	42	57.2%		
Wilton Rancheria	Sacramento, CA	28	245	183	183	196	663	858	1,287	1,287	2	245	183	146	196	663	515	1,287	100.0%	907	70.5%		
Sacramento, CA																		Sacramento, CA		78,544	93.2%	48,981	58.1%
Temecula, CA																		Temecula, CA		37,326	97.8%	33,722	88.4%

Regional Ambulatory Surgical & Specialty Health Services Feasibility Study

IHS, California Area Office

All California Normalized

Erosion Factor #1 - Patient Reliance (2019 Payer Mix)

Service Area	Users by Payer		Direct Care Only								PRC Eligible								All Payers Rate		Market %			Entry			
	All	PRCDA	All				PRCDA				All				PRCDA				All Payers Rate	H Reliance	M Reliance	L Reliance	PRCDA	H Reliance	M Reliance	L Reliance	
	Does not include "Other Eligible" or "Non-Indian" payers		No 3rd Party Coverage	w 3rd Party Coverage	No 3rd Party Coverage	w 3rd Party Coverage	No 3rd Party Coverage	w 3rd Party (All)	No 3rd Party Coverage	w 3rd Party (All)	No 3rd Party Coverage	w 3rd Party (All)	No 3rd Party Coverage	w 3rd Party (All)	w 3rd Party (Medicaid Only)	Direct Care Only No 3P	Direct Care, PRC	Direct Care, PRC, 3P	Total Users (or)	Direct Care Only No 3P	Direct Care, PRC	Direct Care, PRC, 3P					
	Total 2019	Total 2019	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	All/PRCDA Blended %	All/PRCDA Blended %	All/PRCDA Blended %	PRCDA Users	w/out 3rd Party Coverage	w/out 3rd Party Coverage	w 3rd party Coverage		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	
American Indian Health and Services (Santa Barbara) (SB Urban Indian Hlth)	805	607	593	73.7%	212	26.3%	423	69.7%	184	30.3%	0	0.0%	0	0.0%	0	0.0%	183	22.7%	71.7%	0.0%	28.3%	607	435	0	172		
Bakersfield American Indian Health Project (American Ind Hlth Council)	6,162	5,325	1,566	25.4%	1,584	25.7%	1,289	24.2%	1,223	23.0%	901	14.6%	2,111	34.3%	849	16.0%	1,964	36.9%	1,019	16.5%	24.8%	5,325	1,321	814	3,190		
Cabazon Band of Cahuilla Indians	7	6	2	25.4%	2	25.7%	1	24.2%	1	23.0%	1	14.6%	2	34.3%	1	16.0%	2	36.9%	1	16.5%	24.8%	6	0	0	0		
Central Valley Indian Health	8,874	7,369	846	9.5%	2,168	24.4%	628	8.5%	1,687	22.9%	1,176	13.3%	4,684	52.8%	983	13.3%	4,071	55.2%	3,343	37.7%	9.0%	7,369	665	980	5,724		
Chapa De Indian Health Program	4,446	3,852	1,134	25.5%	2,129	47.9%	955	24.8%	1,861	48.3%	333	7.5%	850	19.1%	281	7.3%	755	19.6%	293	6.6%	25.1%	3,852	969	285	2,598		
Colusa Indian Health Community Health Council	94	81	24	25.4%	24	25.7%	20	24.2%	19	23.0%	14	14.6%	32	34.3%	13	16.0%	30	36.9%	16	16.5%	24.8%	81	20	12	49		
Consolidated Tribal Health Project	3,235	3,035	207	6.4%	622	19.2%	172	5.7%	526	17.3%	531	16.4%	1,875	58.0%	511	16.8%	1,826	60.2%	1,423	44.0%	6.0%	3,035	183	505	2,347		
Feather River Tribal Health	6,335	5,834	2,804	44.3%	1,392	22.0%	2,474	42.4%	1,253	21.5%	65	1.0%	2,074	32.7%	62	1.1%	2,045	35.1%	116	1.8%	43.3%	5,834	2,528	61	3,245		
Fresno American Indian Health Project	381	18	153	40.2%	224	58.8%	3	16.7%	15	83.3%	1	0.3%	3	0.8%	0	0.0%	0	0.0%	133	34.9%	28.4%	18	5	0	13		
Greenville Rancheria Tribal Health Program	6,890	5,954	1,751	25.4%	1,772	25.7%	1,441	24.2%	1,367	23.0%	1,007	14.6%	2,360	34.3%	950	16.0%	2,196	36.9%	1,140	16.5%	24.8%	5,954	1,477	910	3,567		
Indian Health Center of Santa Clara Valley	21,749	18,794	5,528	25.4%	5,592	25.7%	4,549	24.2%	4,315	23.0%	3,179	14.6%	7,450	34.3%	2,998	16.0%	6,932	36.9%	3,597	16.5%	24.8%	18,794	4,663	2,872	11,259		
Indian Health Council	5,364	4,861	1,246	23.2%	3	0.1%	929	19.1%	3	0.1%	3,887	72.5%	228	4.3%	3,722	76.6%	207	4.3%	48	0.9%	21.2%	4,861	1,029	3,622	210		
Karuk Tribe	2,481	2,099	142	5.7%	342	13.8%	44	2.1%	221	10.5%	225	9.1%	1,772	71.4%	197	9.4%	1,637	78.0%	233	9.4%	3.9%	2,099	82	194	1,823		
K'ima:w Medical Center (Hoopa)	3,712	3,382	103	2.8%	527	14.2%	61	1.8%	367	10.9%	204	5.5%	2,878	77.5%	192	5.7%	2,762	81.7%	1,115	30.0%	2.3%	3,382	77	189	3,116		
Lake County Tribal Health Consortium	2,824	2,487	260	9.2%	728	25.8%	200	8.0%	584	23.5%	137	4.9%	1,699	60.2%	127	5.1%	1,576	63.4%	186	6.6%	8.6%	2,487	214	124	2,149		
MACT Health Board	1,731	1,496	440	25.4%	445	25.7%	362	24.2%	343	23.0%	253	14.6%	593	34.3%	239	16.0%	552	36.9%	286	16.5%	24.8%	1,496	371	229	896		
Mathiesen Memorial Health Clinic (Chicken Ranch)	20	12	9	45.0%	0	0.0%	4	33.3%	0	0.0%	11	55.0%	0	0.0%	8	66.7%	0	0.0%	0	0.0%	39.2%	12	5	7	0		
Native American Health Center (SF Bay Area)	1,537	1,328	391	25.4%	395	25.7%	321	24.2%	305	23.0%	225	14.6%	526	34.3%	212	16.0%	490	36.9%	254	16.5%	24.8%	1,328	330	203	796		
Northern Valley Indian Health	5,144	2,983	932	18.1%	2,690	52.3%	385	12.9%	1,238	41.5%	77	1.5%	1,445	28.1%	69	2.3%	1,291	43.3%	1,646	32.0%	15.5%	2,983	463	57	2,463		
Pit River Health Services	1,271	966	107	8.4%	290	22.8%	54	5.6%	138	14.3%	82	6.5%	792	62.3%	74	7.7%	700	72.5%	52	4.1%	7.0%	966	68	68	830		
Quartz Valley Program	368	223	3	0.8%	195	53.0%	2	0.9%	96	43.0%	1	0.3%	169	45.9%	0	0.0%	125	56.1%	74	20.1%	0.9%	223	2	0	221		
Redding Rancheria Tribal Health Systems	3,578	3,092	909	25.4%	920	25.7%	748	24.2%	710	23.0%	523	14.6%	1,226	34.3%	493	16.0%	1,140	36.9%	592	16.5%	24.8%	3,092	767	473	1,852		
Riverside San Bernardino County Indian Health	19,749	19,599	7,128	36.1%	6,029	30.5%	7,067	36.1%	5,983	30.5%	3,353	17.0%	3,239	16.4%	3,325	17.0%	3,224	16.4%	260	1.3%	36.1%	19,599	7,070	3,326	9,202		
Rolling Hills	75	65	19	25.4%	19	25.7%	16	24.2%	15	23.0%	11	14.6%	26	34.3%	10	16.0%	24	36.9%	12	16.5%	24.8%	65	16	10	39		
Round Valley Indian Health Center	1,451	1,385	145	10.0%	124	8.5%	130	9.4%	109	7.9%	153	10.5%	1,029	70.9%	144	10.4%	1,002	72.3%	106	7.3%	9.7%	1,385	134	145	1,106		
Sacramento Native American Health Center	537	464	136	25.4%	138	25.7%	112	24.2%	107	23.0%	78	14.6%	184	34.3%	74	16.0%	171	36.9%	89	16.5%	24.8%	464	115	71	278		
San Diego American Indian Health Center	2,198	1,401	881	40.1%	1,317	59.9%	497	35.5%	904	64.5%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	794	36.1%	37.8%	1,401	529	0	872		
Santa Ynez Tribal Health Clinic	2,063	1,559	727	35.2%	334	16.2%	425	27.3%	212	13.6%	576	27.9%	426	20.6%	523	33.5%	399	25.6%	504	24.4%	31.3%	1,559	487	479	593		
Shingle Springs Tribal Health Program	1,765	1,350	405	22.9%	947	53.7%	278	20.6%	714	52.9%	83	4.7%	330	18.7%	71	5.3%	287	21.3%	154	8.7%	21.8%	1,350	294	67	989		
Sonoma County Indian Health Project	6,874	6,408	1,151	16.7%	717	10.4%	1,005	15.7%	628	9.8%	3,114	45.3%	1,892	27.5%	2,959	46.2%	1,816	28.3%	1,550	22.5%	16.2%	6,408	1,039	2,931	2,438		
Southern Indian Health Council	4,452	3,341	1,619	36.4%	1,131	25.4%	985	29.5%	731	21.9%	893	20.1%	809	18.2%	842	25.2%	783	23.4%	110	2.5%	32.9%	3,341	1,100	756	1,485		
Strong Family Health Center (Modoc)	180	171	0	0.0%	0	0.0%	0	0.0%	0	0.0%	8	4.4%	172	95.6%	8	4.7%	163	95.3%	73	40.6%	0.0%	171	0	8	163		
Susanville Indian Rancheria	897	839	82	9.1%	281	31.3%	64	7.6%	244	29.1%	16	1.8%	518	57.7%	16	1.9%	515	61.4%	360	40.1%	8.4%	839	70	15	753		
Sycuan Band of the Kumeyaay Nation	285	246	72	25.4%	73	25.7%	60	24.2%	57	23.0%	42	14.6%	98	34.3%	39	16.0%	91	36.9%	47	16.5%	24.8%	246	61	38	148		
Table Mountain Medical	5	4	1	25.4%	1	25.7%	1	24.2%	1	23.0%	1	14.6%	2	34.3%	1	16.0%	2	36.9%	1	16.5%	24.8%	4	1	1	3		
Tejon Indian Tribe	432	373	110	25.4%	111	25.7%	90	24.2%	86	23.0%	63	14.6%	148	34.3%	60	16.0%	138	36.9%	71	16.5%	24.8%	373	93	57	224		
Toiyabe Indian Health Project	3,563	3,170	311	8.7%	775	21.8%	205	6.5%	556	17.5%	80	2.2%	2,397	67.3%	74	2.3%	2,335	73.7%	311	8.7%	7.6%	3,170	241	73	2,857		
Tule River Indian Health Center	3,939	3,868	875	22.2%	562	14.3%	841	21.7%	542	14.0%	1,457	37.0%	1,045	26.5%	1,441	37.3%	1,044	27.0%	258	6.5%	22.0%	3,868	850	1,436	1,582		
Tuolumne Me-Wuk Indian Health Center	1,387	461	248	17.9%	735	53.0%	29	6.3%	170	36.9%	16	1.2%	388	28.0%	9	2.0%	253	54.9%	242	17.4%	12.1%	461	56	7	398		
United American Indian Involvement (LA) (LA American Indian)	923	849	198	21.5%	725	78.5%	176	20.7%	673	79.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	579	62.7%	21.1%	849	179	0	670		
United Indian Health Service	2,377	1,758	1,880	79.1%	40	1.7%	1,282	72.9%	35	2.0%	192	8.1%	265	11.1%	182	10.4%	259	14.7%	37	1.6%	76.0%	1,758	1,336	162	260		
Warner Mountain Indian Health Program	83	73	6	7.2%	0	0.0%	3	4.1%	0	0.0%	77	92.8%	0	0.0%	70	95.9%	0	0.0%	0	0.0%	5.7%	73	4	69	0		
Wilton Rancheria	1,489	1,287	378	25.4%	383	25.7%	311	24.2%	295	23.0%	218	14.6%	510	34.3%	205	16.0%	475	36.9%	246	16.5%	24.8%	1,287	319	197	771		
Sacramento, CA	99,292	84,308	21,382	22%	25,178	25%	16,702	20%	18,461	22%	13,547	14%	39,186	39%	12,672	15%	36,473	43%	17,938	18.1%	20.7%	84,308					
Temecula, CA	42,4																										

All California Normalized

2 Regional Center Market Share Calculation

Erosion Factor #2 - How far is Regional Care?

Erosion Factor #3 - How many alternative care opportunities are there?

Erosion Factor #4 - Can you direct Medicaid?

Service Area	Regional Center Location	Market Erosion by Distance										Sub Market Erosion by Competitors						Market Share				
		SU/PSA Drive Time to RC (in minutes)	Direct Care Only No 3P	Direct Care, PRC (No Choice)	Direct Care, PRC (Choice)	Direct Care, PRC, 3P (Medicaid Only)	Direct Care, PRC, 3P (Medicaid Reduced)	Direct Care, PRC, 3P	M Reliance No Choice	M Reliance Choice	# of Alt Care in route (Sec or Trty)	Direct Care Only No 3P	Direct Care, PRC (No Choice)	Direct Care, PRC (Choice)	Direct Care, PRC, 3P (Medicaid Only)	Direct Care, PRC, 3P (Medicaid Reduced)	Direct Care, PRC, 3P	M Reliance - PRC No Choice & Medicaid Only		M Reliance - Choice		
			w/out 3rd Party Coverage	w/out 3rd Party Coverage	w/out 3rd Party Coverage	w 3rd party Coverage	w 3rd party Coverage	w 3rd party Coverage	Net Users	Net Users		w/out 3rd Party Coverage	w/out 3rd Party Coverage	w/out 3rd Party Coverage	w 3rd party Coverage	w 3rd party Coverage	w 3rd party Coverage	Total Users	% of User Pop	Total Users	% of User Pop	
			28	29	30	31	32	33	34	35		36	37	38	39	40	41	42	43	44	45	46
American Indian Health and Services (Santa Barbara) (SB Urban Indian Hlth)	Temecula, CA	163	400	0	0	36	125	158	561	558	13	400	0	0	36	125	63	561	92.4%	463	76.3%	
Bakersfield American Indian Health Project (American Ind Hlth Council)	Temecula, CA	172	1,214	748	748	485	2,486	2,931	4,933	4,893	8	1,214	748	524	485	2,486	1,173	4,933	92.6%	2,910	54.7%	
Cabazon Band of Cahuilla Indians	Temecula, CA	84	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0.0%	0	0.0%	
Central Valley Indian Health	Sacramento, CA	156	611	900	900	1,982	3,439	5,260	6,933	6,772	9	611	900	630	1,982	3,439	2,104	6,933	94.1%	3,346	45.4%	
Chapa De Indian Health Program	Sacramento, CA	37	969	285	285	171	2,427	2,598	3,852	3,852	4	969	285	199	171	2,427	1,039	3,852	100.0%	2,207	57.3%	
Colusa Indian Health Community Health Council	Sacramento, CA	64	19	12	12	8	39	47	78	78	2	19	12	10	8	39	28	78	96.3%	57	70.0%	
Consolidated Tribal Health Project	Sacramento, CA	153	168	464	464	949	1,285	2,157	2,866	2,789	1	168	464	417	949	1,285	1,726	2,866	94.4%	2,311	76.2%	
Feather River Tribal Health	Sacramento, CA	67	2,426	58	58	57	3,059	3,114	5,600	5,598	3	2,426	58	41	57	3,059	1,245	5,600	96.0%	3,712	63.6%	
Fresno American Indian Health Project	Sacramento, CA	153	5	0	0	4	8	12	17	17	7	5	0	0	4	8	5	17	93.8%	9	52.5%	
Greenville Rancheria Tribal Health Program	Sacramento, CA	148	1,358	836	836	542	2,780	3,278	5,516	5,472	4	1,358	836	585	542	2,780	1,311	5,516	92.6%	3,254	54.7%	
Indian Health Center of Santa Clara Valley	Sacramento, CA	107	4,474	2,756	2,756	1,787	9,088	10,803	18,105	18,033	8	4,474	2,756	1,929	1,787	9,088	4,321	18,105	96.3%	10,724	57.1%	
Indian Health Council	Temecula, CA	29	1,029	3,622	3,622	2	208	210	4,861	4,861	0	1,029	3,622	3,622	2	208	210	4,861	100.0%	4,861	100.0%	
Karuk Tribe	Sacramento, CA	290	65	154	154	137	1,345	1,454	1,702	1,674	2	65	154	124	137	1,345	872	1,702	81.1%	1,061	50.6%	
K'ima:w Medical Center (Hoopa)	Sacramento, CA	261	62	151	151	746	1,890	2,485	2,848	2,697	2	62	151	121	746	1,890	1,491	2,848	84.2%	1,673	49.5%	
Lake County Tribal Health Consortium	Sacramento, CA	124	197	114	114	130	1,855	1,975	2,296	2,286	1	197	114	102	130	1,855	1,580	2,296	92.3%	1,879	75.6%	
MACT Health Board	Sacramento, CA	83	356	219	219	142	723	860	1,441	1,435	2	356	219	175	142	723	516	1,441	96.3%	1,047	70.0%	
Mathiesen Memorial Health Clinic (Chicken Ranch)	Sacramento, CA	100	5	7	7	0	0	0	12	12	2	5	7	6	0	0	0	12	96.0%	10	84.3%	
Native American Health Center (SF Bay Area)	Sacramento, CA	73	316	195	195	126	642	763	1,279	1,274	3	316	195	136	126	642	305	1,279	96.3%	758	57.1%	
Northern Valley Indian Health	Sacramento, CA	90	444	55	55	756	1,638	2,364	2,893	2,862	1	444	55	49	756	1,638	1,891	2,893	97.0%	2,384	79.9%	
Pit River Health Services	Sacramento, CA	187	59	60	60	30	703	729	852	849	2	59	60	48	30	703	438	852	88.2%	545	56.4%	
Quartz Valley Program	Sacramento, CA	248	2	0	0	35	148	176	185	178	2	2	0	0	35	148	106	185	83.0%	107	48.1%	
Redding Rancheria Tribal Health Systems	Sacramento, CA	138	705	434	434	282	1,443	1,702	2,864	2,841	2	705	434	347	282	1,443	1,021	2,864	92.6%	2,074	67.1%	
Riverside San Bernardino County Indian Health	Temecula, CA	58	7,070	3,326	3,326	121	9,081	9,202	19,599	19,599	0	7,070	3,326	3,326	121	9,081	9,202	19,599	100.0%	19,599	100.0%	
Rolling Hills	Sacramento, CA		16	10	10	6	32	39	65	65		16	10	10	6	32	39	65	100.0%	65	100.0%	
Round Valley Indian Health Center	Sacramento, CA	199	118	127	127	71	909	971	1,225	1,217	1	118	127	115	71	909	777	1,225	88.5%	1,010	72.9%	
Sacramento Native American Health Center	Sacramento, CA	2	115	71	71	46	232	278	464	464	1	115	71	64	46	232	222	464	100.0%	401	86.5%	
San Diego American Indian Health Center	Temecula, CA	53	529	0	0	315	557	872	1,401	1,401	4	529	0	0	315	557	349	1,401	100.0%	878	62.7%	
Santa Ynez Tribal Health Clinic	Temecula, CA	190	428	421	421	127	409	521	1,385	1,370	13	428	421	295	127	409	208	1,385	88.8%	931	59.7%	
Shingle Springs Tribal Health Program	Sacramento, CA	35	294	67	67	86	903	989	1,350	1,350	2	294	67	54	86	903	593	1,350	100.0%	941	69.7%	
Sonoma County Indian Health Project	Sacramento, CA	155	955	2,694	2,694	505	1,776	2,241	5,930	5,889	3	955	2,694	1,885	505	1,776	896	5,930	92.5%	3,737	58.3%	
Southern Indian Health Council	Temecula, CA	66	1,055	725	725	35	1,391	1,425	3,207	3,206	1	1,055	725	653	35	1,391	1,140	3,207	96.0%	2,848	85.2%	
Strong Family Health Center (Modoc)	Sacramento, CA	287	0	6	6	53	88	130	147	136	5	0	6	4	53	88	52	147	86.0%	56	33.0%	
Susanville Indian Rancheria	Sacramento, CA	185	62	14	14	266	428	662	769	737	5	62	14	10	266	428	265	769	91.7%	336	40.0%	
Sycuan Band of the Kumeyaay Nation	Temecula, CA	68	59	36	36	23	119	142	237	236	2	59	36	29	23	119	85	237	96.3%	172	70.0%	
Table Mountain Medical	Sacramento, CA	160	1	1	1	0	2	2	4	4	6	1	1	0	0	2	1	4	92.6%	2	54.7%	
Tejon Indian Tribe	Temecula, CA	135	85	52	52	34	174	206	346	343	8	85	52	37	34	174	82	346	92.6%	204	54.7%	
Toiyabe Indian Health Project	Sacramento, CA	268	192	58	58	199	2,120	2,278	2,568	2,528	2	192	58	46	199	2,120	1,367	2,568	81.0%	1,605	50.6%	
Tule River Indian Health Center	Sacramento, CA	231	747	1,261	1,261	91	1,310	1,390	3,409	3,398	8	747	1,261	883	91	1,310	556	3,409	88.1%	2,186	56.5%	
Tuolumne Me-Wuk Indian Health Center	Sacramento, CA	104	53	7	7	67	318	382	445	442	2	53	7	5	67	318	229	445	96.5%	288	62.5%	
United American Indian Involvement (LA) (LA American Indian)	Temecula, CA	79	172	0	0	403	256	643	831	815	4	172	0	0	403	256	257	831	97.9%	429	50.5%	
United Indian Health Service	Sacramento, CA	290	1,066	129	129	3	205	207	1,403	1,402	2	1,066	129	103	3	205	124	1,403	79.8%	1,293	73.6%	
Warner Mountain Indian Health Program	Sacramento, CA	322	3	55	55	0	0	0	58	58	4	3	55	38	0	0	0	58	79.8%	42	57.2%	
Wilton Rancheria	Sacramento, CA	28	319	197	197	127	643	771	1,287	1,287	2	319	197	157	127	643	462	1,287	100.0%	939	73.0%	
	Sacramento, CA																	Sacramento, CA	78,463	93.1%	50,062	59.4%
	Temecula, CA																	Temecula, CA	37,361	97.9%	33,296	87.2%



Appendix 5 – Services & Resource Requirements

The following page provides the 2013 Regional Services & Resource Requirements Summary

Regional Ambulatory Surgical and Specialty Health Services Feasibility Study

IHS, California Area Office

Concept of Operation
Recommendation



	2 Regional Centers			
	Temecula		Sacramento	
KC #	DGSF	KC #	DGSF	
Ambulatory				
Audiology (Audiologist)	1.5	872	3.9	3,148
Dental Care - Specialty Only ¹ (Chairs)	5.6	8,553	14.5	22,284
Specialty Care				
Medical Specialties (Providers)				
Cardiologist	0.0		2.4	
Dermatologist	0.0		1.8	
Neurologist	0.0		1.2	
Other Medical Specialists ²	4.0		11.3	
Surgical Specialties (Providers)				
General Surgeon	0.0	9,052	3.1	27,907
Ophthalmologist	0.0		3.5	
Orthopedist	1.3		3.8	
Otolaryngologist	0.0		1.8	
Urologist	0.0		1.4	
Other Surgical Specialists ³	0.9		2.4	
Ancillary				
Outpatient Endoscopy (Suites)	0.0		2.0	
Outpatient Surgery Cases (OP ORs)	3.0	9,286	7.0	20,502
Short Stay / Observation (Beds)	1.0		1.0	
Laboratory (FTE)	3.0	2,158	16.0	4,187
Diagnostic Imaging				
Radiography (Rooms)	2.0		6.0	
Fluoroscopy (Rooms)	1.0		2.0	
Ultrasound (Rooms)	1.0	6,862	3.0	16,049
Mammography (Rooms)	1.0		3.0	
CT (Rooms)	1.0		2.0	
MRI (Rooms)	0.0		1.0	
Radiologist	1.7		5.1	
Pharmacy (Pharmacists)	4.5	2,400	20.8	9,115
Inpatient Care				
Pediatric (Beds)	2.6		7.3	
Adult Medical (Beds)	15.7	13,627	41.6	43,131
Adult Surgical (Beds)	7.0		31.2	
ICU (Beds)	4.4	2,357	12.9	6,932
Physical Rehab Services				
Occupational Therapist	2.0	938	5.4	2,537
Speech Pathologist	0.5		1.3	
Behavioral Health				
Psychiatry (Psychiatrists)	1.5	681	4.0	1,398
Other Programs				
Case Management (FTE's)	8.6	1,638	22.9	4,335
Pain Management (Specialists)	0.6	911	1.5	2,422
Summary				
DGSF	88,816		223,747	
Total RRM FTE's	269		774	
BGSF	119,369		300,715	

Recommendation

The feasibility study completed by the IHS, California Area Office, indicates that two Regional Ambulatory Centers are the best solution to close the disparity gap in funding.

One center for northern and central California and one for southern California would provide desperately needed access to secondary, inpatient, surgical, and specialty care.

Costs

- Total Project Cost for Regional Ambulatory Center development in two locations is estimated at \$253.5m.
- The Annual Operating Cost for Regional Ambulatory Center development in two locations is estimated at \$134.6m.

Impact

- Total Project Cost for Regional Ambulatory Center development in two locations is estimated at \$253.5m.
- The Annual Operating Cost for Regional Ambulatory Center development in two locations is estimated at \$134.6m.
- The Level of Need Funded (LNF) could improve from 54% to 93.8%, closing the gap toward the Federal Benchmark by 39.8 % basis points. This represents a projected increase from \$1,895 per-user to \$3,294, or an additional \$1,399 per user toward the Federal Benchmark of \$3,510.
- The LNF increase is based on a projected 2025 area-wide user population of 102,745 (or a projected regional user population of 97,895).