CALIFORNIA AREA'S NEXT HEALTH CARE FACILITY

CAPT JONATHAN RASH, P.E.

AUGUST 2022 TRIBAL LEADERS MEETING

AUGUST 24, 2022

TODAY'S AGENDA

1. Recap of previous meeting
2. Recap of CATAC and Program Directors' input
3. Discussion of California Area's next health care facility
4. Next Steps

PREVIOUS DISCUSSION

WHAT SHOULD THE NEXT CALIFORNIA AREA HEALTH CARE FACILITY BE?

- Regional Surgical and Specialty Care Facilities
  - Feasibility study completed in 2013
  - I'll be talking about this over next several slides
- Young Adult Regional Treatment Center
  - Repurpose existing YRTC for different age group? Or as a transitional facility?
  - No feasibility study completed
- Long Term Care Facility
  - Provide residential style services to elders or people with chronic conditions
- Other concept? (We are not limited to options above)

REGIONAL SURGICAL AND SPECIALTY CARE CENTERS

Also known as…

- Regional care centers
- Referral centers
- Specialty care centers

CONCEPT OF REGIONAL SPECIALTY CENTERS

A Regional Specialty Center would offer the following services:

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

A regional center would NOT offer the following services:

- Primary Care
- Emergency Care
- Deliveries or OB Services
- Walk In Services for Local AI/ANs

- Regional Healthcare is designed to support, not replace, services presently offered at Tribal Health Programs across the state
- Regional Healthcare is not designed to compete with existing Tribal 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 – planned for growth
- Regional Care is envisioned to provide services currently not available at existing Tribal Health Programs, ones that would most stretch limited Purchased and Referred Care dollars

BENEFITS OF A REGIONAL SPECIALTY CENTER

- Access to Clinical Specialists
- Culturally Appropriate Care
- Integrated with Tribal Health Programs
- Wraparound Care - Telemedicine Follow-Ups
- 1st Priority = Lower Wait Times
- No Caps on Service
- Saving Money on PRC

HOW MANY USERS ARE NEEDED TO JUSTIFY A REGIONAL SPECIALTY CENTER?

Not sustainable or not enough increase in services to justify regional center if user population is less than **30,000**

More specialty services are available with a user base of **60,000**

120,000 users

Still No…

NICU, Open Heart, Neurosurgery, Psych Nursing

- *ANMC (140,000 – 152 beds) GIMC (110,000 – 78 beds), PIMC (110,000 – 127 beds)*

60,000 users

Plus…

Cardiology, Neurology, Urology, MRI, Speech Therapy

- *Still No Invasive Cardiology*

We can offer more services at this level

30,000 users

Plus… General Surgery, Orthopedics, Ophthalmology, Otolaryngology, Dermatology, Ob/Gyn, CT, Labor & Delivery Ped/Med/Surg & ICU Beds

True Regional Services start to happen here

15,000 users

Plus…

Specialized Primary Care, Mammo, Ultrasound, Occupational Therapy, Ambulatory Procedures, Medical Short Stay Beds,

7,500 users

Plus…

Lab, Radiography, Physical Therapy, Podiatry, Audiology, & Psychiatry

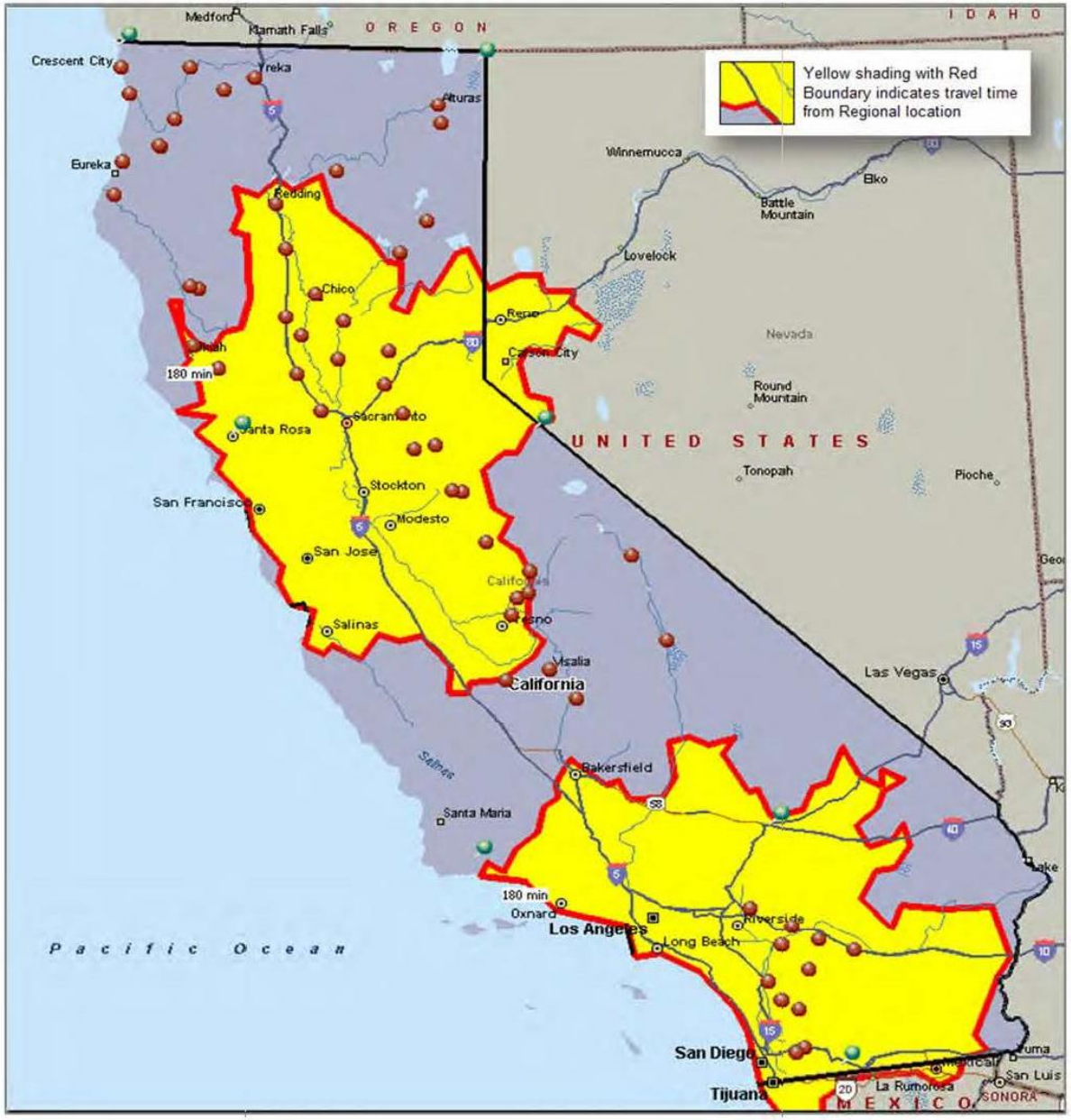
3,750 users

Full-time Services…

Primary Care, Dental, Optometry, Pharmacy, PHN, Mental Health & Substance Abuse

OPTIONS CONSIDERED IN 2013 FEASIBILITY STUDY

	One Inpatient Facility Anchoring Additional Outpatient Facilities			Multiple Inpatient Facilities RECOMMENDED		
	IP + OP			ALL IP		
Scenario	1	2	3	4	5	6
Redding	OP	OP		IP	IP	
Sacramento	IP	IP	IP	IP	IP	IP
Fresno	OP			IP		
Temecula	OP	OP	OP	IP	IP	IP
# of Centers	4	3	2	4	3	2
OP or IP	3 OP/1 IP	2 OP/1 IP	1 OP/1 IP	4 IP	3 IP	2 IP



Two Center Option

Sacramento: 61,981 users (66,795)

- 22,964 greater than 3 hours drive (24,292)
- *This gets Sacramento over the **60,000 user threshold** that would allow us to provide additional services, such as cardiology, neurology, urology, etc.*

Temecula: 25,185 users (26,010)

- 988 greater than 3 hours drive (1,112)

Black numbers are 2011 population data
Red numbers are 2019 population data

THIS IS THE RECOMMENDED SOLUTION FROM THE FEASIBILITY STUDY AND MOST LIKELY TO BE FUNDED THROUGH IHS PRIORITY SYSTEM

SERVICES INCLUDED IN TWO CENTER OPTION

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

*Services in blue text would be offered at Sacramento location, but not at (or only limited services at) Temecula location

MEDICAL, SURGICAL AND DENTAL SPECIALTIES PROPOSED

Medical Specialties:

- Cardiologist
- Dermatologist
- Neurologist
- Endocrinologist
- Gastroenterologist
- Gerontologist
- Rheumatologist
- Others

Surgical Specialties:

- General Surgeon
- Ophthalmologist
- Orthopedist
- Otolaryngologist
- Urologist
- Thoracic Surgeon
- Plastic Surgeon
- Others

Dental Specialties:

- Endodontist
- Pediatric
- Prosthodontics
- Periodontics
- Orthodontics
- Maxillofacial

Note: these specialties are mentioned in the feasibility study, but we are not limited to only these options. However, any specialty must be justified based on user population and need.

COST ESTIMATES – TWO CENTER OPTION

2013 Construction Cost Estimate for both facilities - **$254.5 million**

2013 Annual Operating Cost Estimate for both facilities - **$134.6 million**

These costs are likely **double** (or more) in 2022.

MOST LIKELY OPTIONS FOR FUNDING A NEW FACILITY

1. Revised Health Care Facilities Priority System
2. Demonstration Project
3. Congressional Earmark
4. Nonrecurring Expense Fund (NEF)
5. Other Contributions?

Don’t forget about Funding for Staffing!

WHY AREN'T WE TALKING ABOUT A HOSPITAL?

- The main services that a full hospital offers that Regional Centers would not offer are:
  - Emergency Room
  - Maternal Health / Childbirth
- The IHS hospitals that do exist (e.g. Phoenix Indian Medical Center, Gallup Indian Medical Center) are ALSO Regional Specialty Centers.
  - They have enough local population to support an emergency room and maternity services.
- Feasibility study determined not enough people would travel medium- to long-distances to justify the existence of these services at the Regional Center.
- Maternity / childbirth is considered primary care and was not considered in the study.
  - If Tribal Leaders want, we can ask for revision of feasibility study to include maternity / childbirth services for Regional Centers (this was suggested by CATAC).

MORE IMPORTANT QUESTIONS

- **Q: Why is the Regional Center not closer to my Tribe?**
- A: They need to be in reasonably large cities with amenities nearby to attract qualified specialists. The study considered Redding, Sacramento, Fresno and Temecula as cities large enough to support a center AND close enough to Tribes to be a central location.
- We could ask the consultants to consider switching locations in a feasibility study revision (e.g. Redding instead of Sacramento, Fresno instead of Temecula), but these options likely would not score as well.
- **Q: Why can’t we build more Regional Centers?**
- A: A Regional Center really needs to serve 30,000 users or more to be sustainable and viable (even more services with 60,000 users). The greater the population served, the better it will score when competing for funding.

REVISING THE FEASIBILITY STUDY

- Feasibility study was prepared in 2013 – needs to be updated not only for costs and user population changes, but also for modernization of health care delivery.
  - Maximizing telehealth options and capabilities
  - Making transportation accessible and convenient
  - Incorporating latest health care technology
- Also we can ask for changes to the parameters of the study as determined by Tribal Leaders
  - Additional services to provide (e.g. maternity / childbirth)
  - Remote services provides at Tribal sites
  - Having transportation built into model
  - Pharmacy hub? (idea mentioned at Program Directors Meeting)

FEEDBACK FROM CATAC MEETING (5/11) AND PROGRAM DIRECTORS MEETING (6/22)

QUESTIONS RAISED BY CATAC AT 5/11 MEETING

Q: Can regional specialty centers send providers (such as surgeons, audiologists) to THP locations on a rotating basis to provide on-site service?

A: This is a great and is certainly a possibility if Tribal leaders make it a priority and the regional care centers have the capacity to support this request.

- With your approval, we can ask this to be considered in the feasibility study revision.

Q: A related consideration: should (or could) the regional centers include their own transportation system – shuttle services?

A: This may be possible, though it would likely be less reliable than transportation organized by health program with PRC funding. Local accountability = better results (but higher PRC costs).

- Again, with your approval, we can ask for this to be considered in the study revision.

QUESTIONS RAISED BY CATAC AT 5/11 MEETING

Q: Could the services provided by a regional specialty center be contracted or compacted?

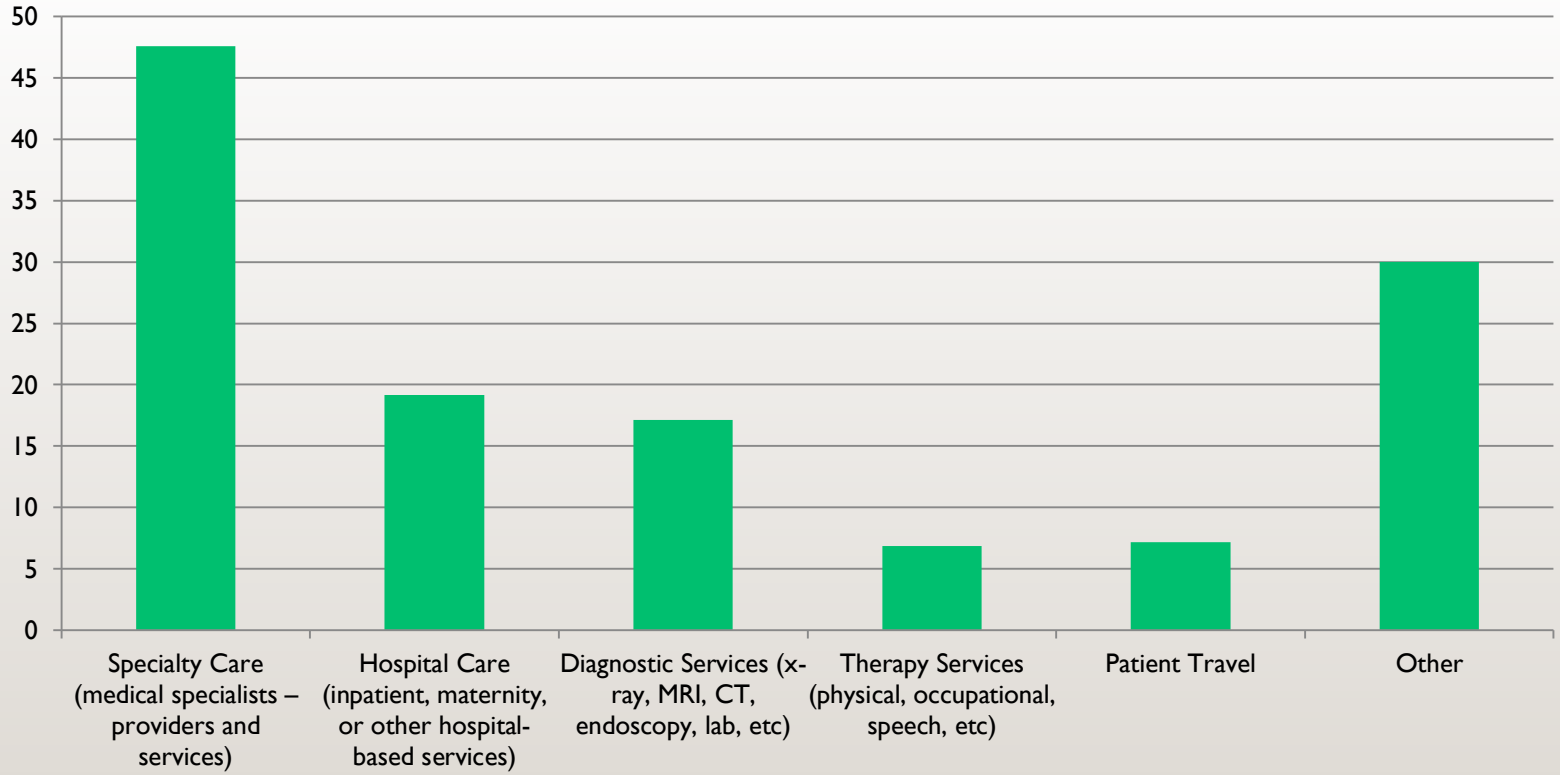
A: Like the YRTC's, the services would be contractible but not divisible. The facilities need the user base from many Tribes to justify their existence – one Tribe or program can't take their shares and render their own services.

Q: Rather than regional specialty centers, could THP's contract with nearby hospitals to provide specialized health services?

A: We already do this to some extent with PRC dollars. Not sure how this could work differently – it would likely not be under the facilities appropriation. It is a good idea, but not sure what model could be used to request additional funding for this effort.

PROGRAM DIRECTORS SURVEY

Please estimate how your health program's PRC* dollars are spent in an average year.



N =16 Responses (Tribal and Urban)

"Other" Responses:

- Dental specialty services
- Orthodontics
- Durable medical equipment
- Pharmacy
- Optometry
- Eyeglasses
- Hearing Aids

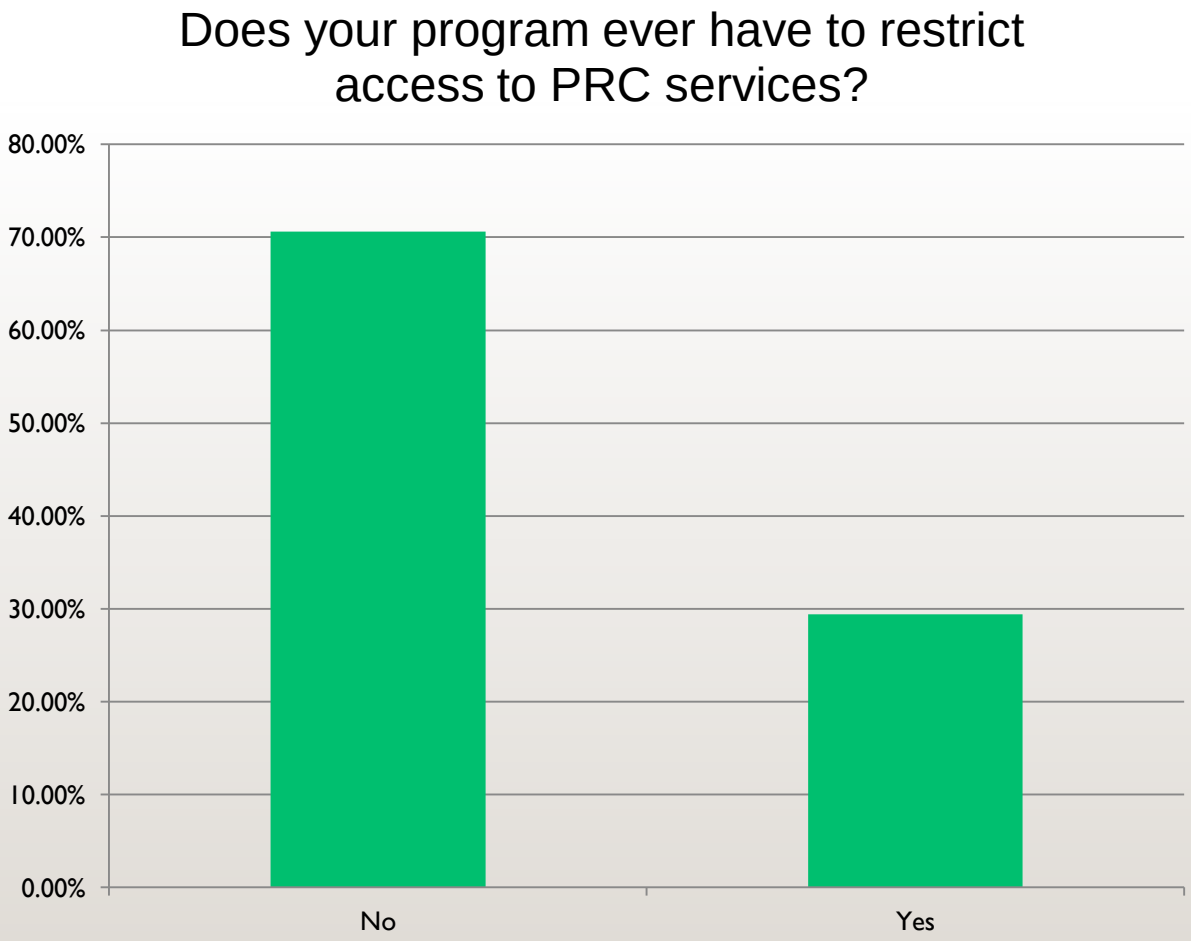
*PRC = Purchased and Referred Care

WHAT CLINICAL SPECIALTIES DO YOU SPEND THE MOST PRC FUNDS ON?

14 Responses from Tribal Program Directors (Urbans do not get PRC)

- 5 responses: Dental (Specialty), Cardiology
- 4 responses: Hospital / ER / Inpatient Services
- 3 responses: Gastroenterology, Orthopedics
- 1 response: Internal Medicine, Obstetrics / Gynecology, Urology, Neurology, Dermatology, Oncology, Endocrinology, Pain Management, Alcohol / Substance Abuse, Diabetes Care, Dialysis, Travel

PROGRAM DIRECTORS SURVEY



Describe these restrictions:

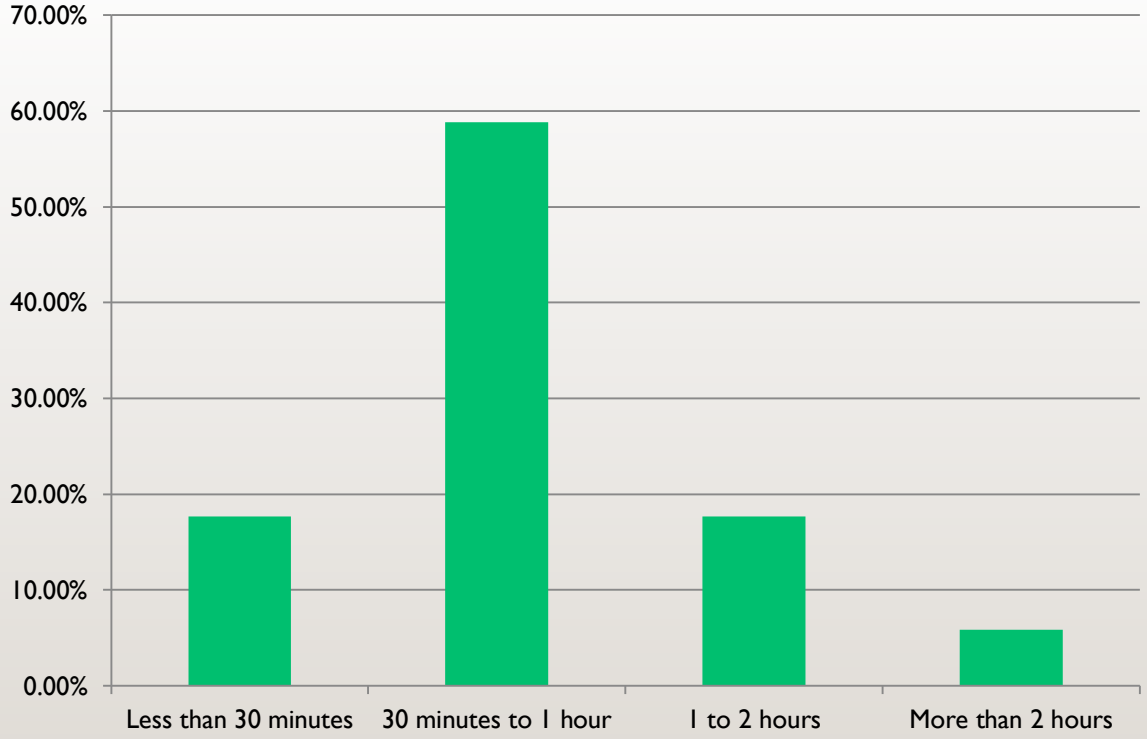
- "waiting lists - patients with diabetes diagnosis given priority"
- "We restrict the number of dental implants in order to stay within PRC funding"
- "Any services that fall under Levels 4 or 5"
- "We may have to limit the amount of money we can dedicate to a particular level of care. If the demand exceeds capacity & we have expended all funds for that category, we will not be able to pay until the next funding year starts."

How many patients per year impacted?

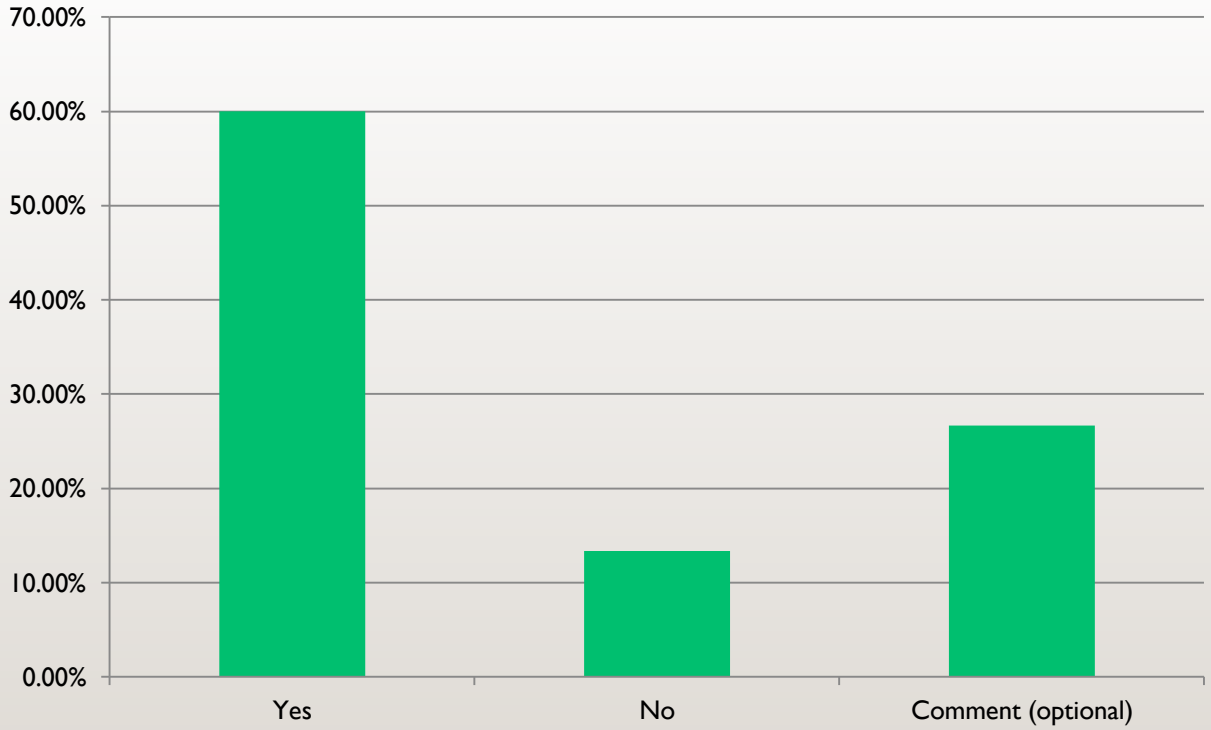
- 30
- "varies but not a high percentage"
- Under 10
- 600

PROGRAM DIRECTORS SURVEY

What is the average time your patients have to travel for PRC care? (17 responses)



Would you be able to DIRECT Medi-Cal and PRC eligible payers for care at a distant regional site? (15 responses)



FOR WHICH SERVICES WOULD YOUR POPULATION BE MOST LIKELY TO TRAVEL TO A DISTANT REGIONAL SITE TO RECEIVE CULTURALLY APPROPRIATE CARE IF COST IS NOT A BARRIER?

- Inpatient Care, Specialty Care
- Dental and optometry services
- A regional site would be 4 hours away. It would not be feasible, exhausting and may require an over night stay.
- For Medical, Cardiology, Diabetes, Gastroenterology, Endocrinology, Urology, Obstetrics & Gynecology.
- For Dental, we provide more specialty dental services and our patients would prefer to go to a closer specialist for services.
- Neurosurgery
- Specialty dental services, specialty lab & diagnostic services
- Bh in patient
- Specialty Dental; pediatric hospital dentistry
- Cardiology
- outpatient surgery
- not sure
- Unknown

PROGRAM DIRECTORS SURVEY

For what percentage of your patients would transportation to a distant regional site be prohibitive? (15 responses)

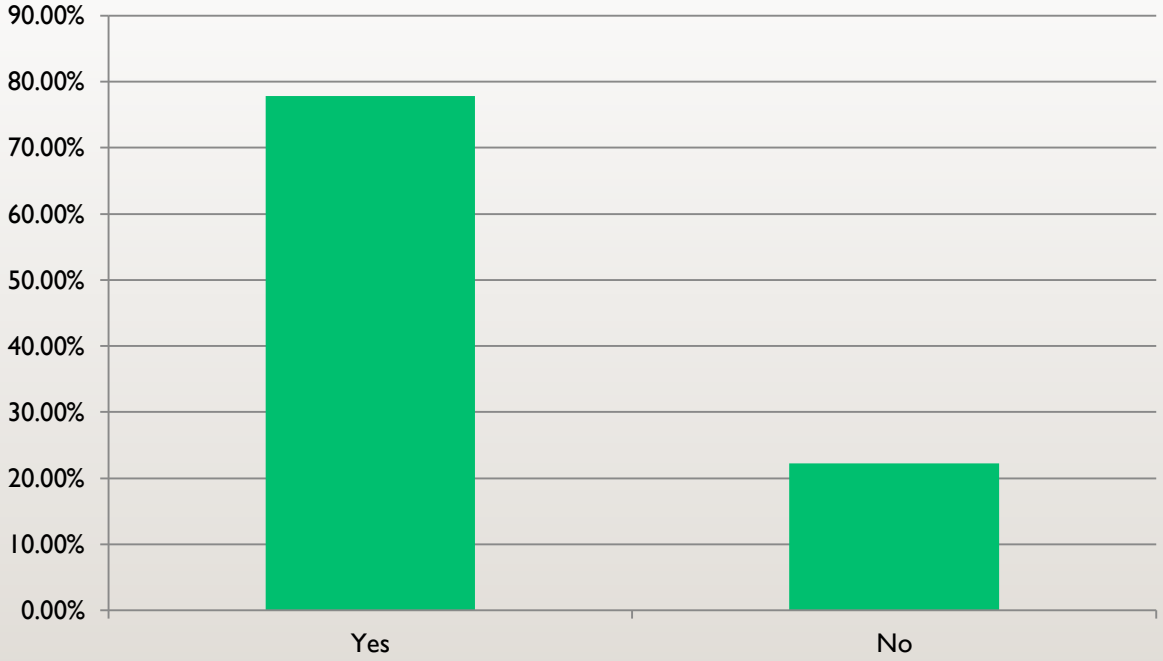
- Average: 40.3%
- Range: 5% to 99%
- Most common responses:
  - 5%, 20% (3 times)
  - 25%, 40%, 80% (2 times)
  - 50%, 90%, 99% (1 time)

What percentage of your population would be highly reliant on regional care because they do not have a third party payer? (15 responses)

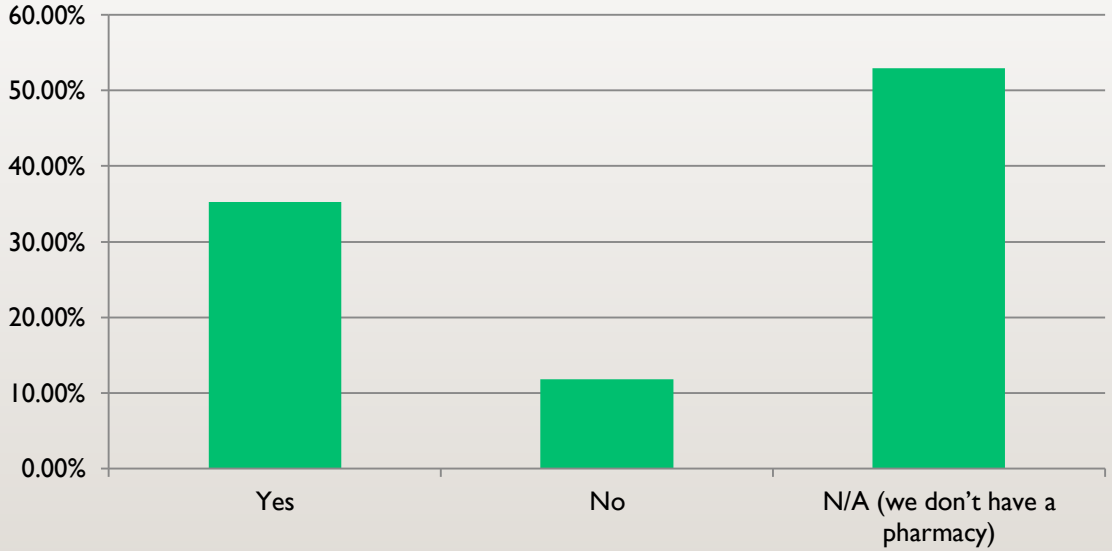
- Average: 31.8%
- Range: 2% to 75%
- Most common responses:
  - 10%, 15%, 45%, 50% (2 times)
  - 2%, 5%, 20%, 25%, 40%, 70%, 75% (1 time)

PROGRAM DIRECTORS SURVEY

Could your health program allocate space and staff for clinical specialists to provide services at your location(s) on a rotating basis? (18 responses)

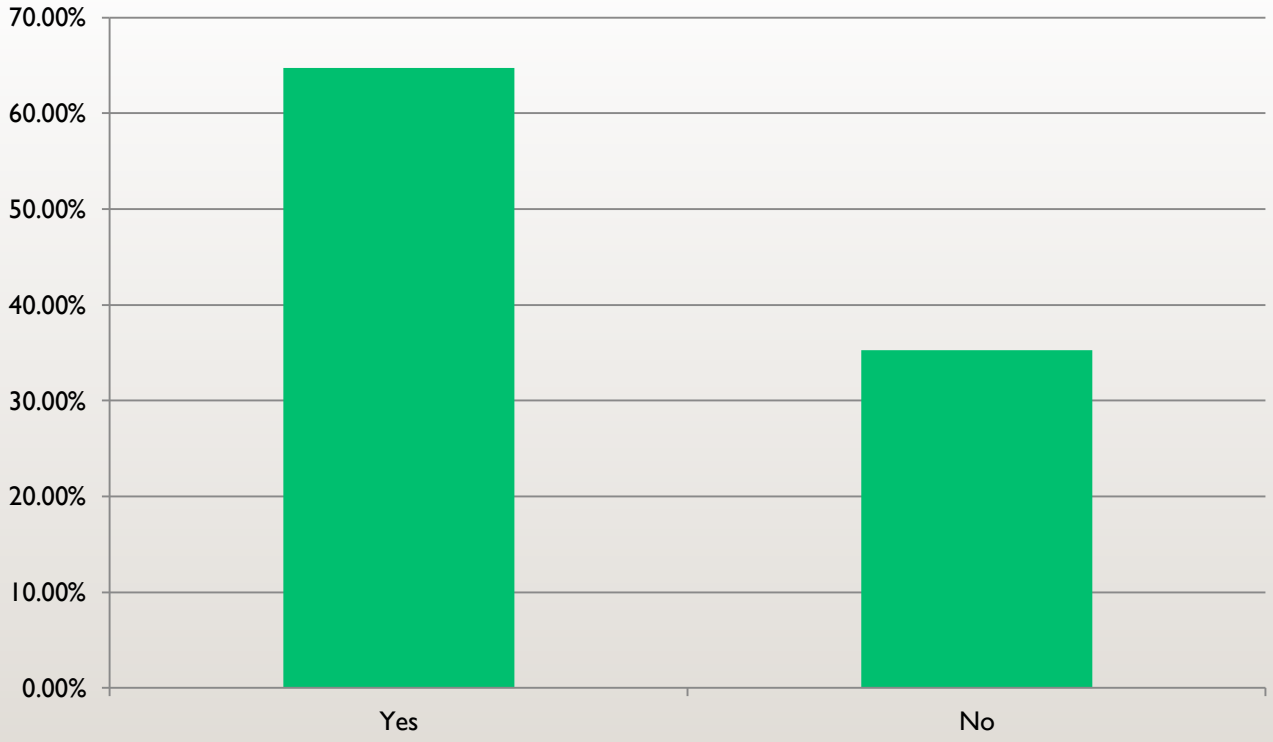


If a regional care center could serve as a pharmaceuticals hub and assist with supplying for your pharmacy – possibly at the expense of slower processing times – would your health program be interested in that service? (17 responses)



PROGRAM DIRECTORS SURVEY

Would your patients be interested in maternity services at a regional care center, given the travel distance required? (17 responses)

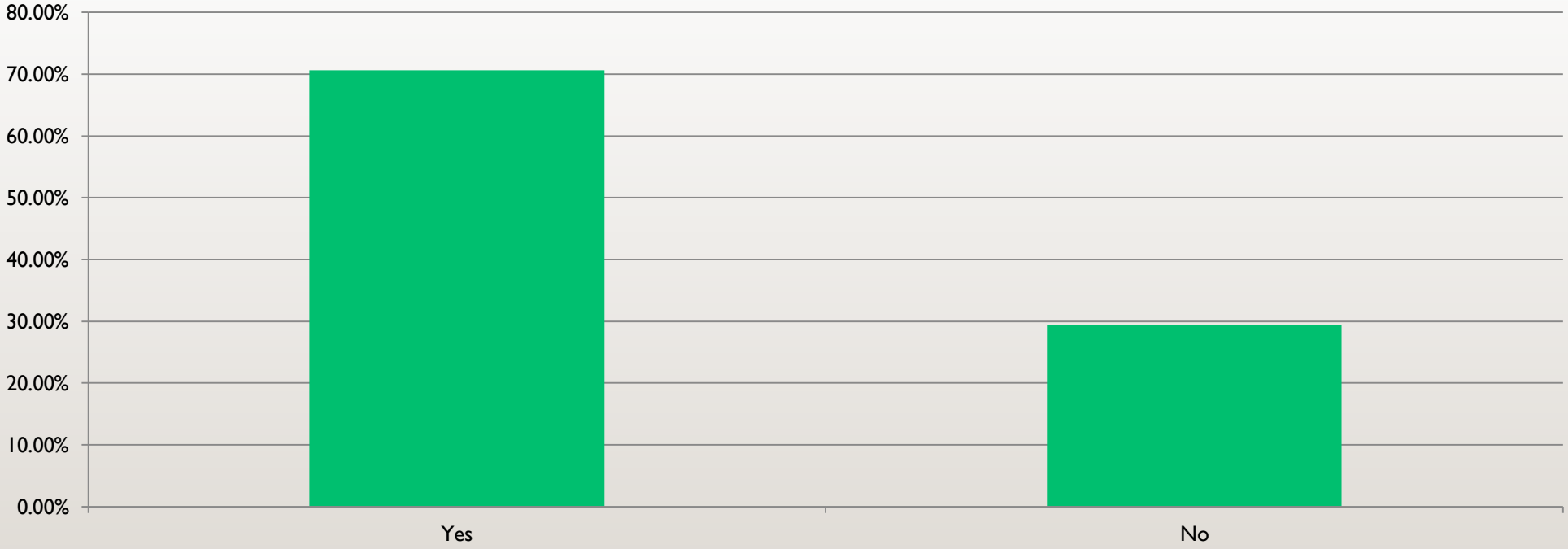


Comments on this question:

- "Probably not any further than Sacramento"
- "Currently have limited maternity services onsite. OB/GYN comes on site 1x week to manage OB. Currently delivering at local hospital 30 - 40 min away. All high risk maternity clients are referred out. Having a rotation from regional center and delivering at regional center would be an option."
- "Not sure how many would really want to travel away from home for this service. Makes more sense to contract locally for this service."

PROGRAM DIRECTORS SURVEY

Do you support Regional Care Centers as described at the Program Director's Meeting? (17 responses)



COMMENTS ON THE QUESTION OF SUPPORT

- “Yes as long as the services provided do not overlap with the types of services provided at or potentially provided by the tribal clinics. To determine this, look at the types of services that do not fit within our encounter based reimbursement structure. For example, in-patient, oral surgery with sedation, imaging, long term care, etc. There is a lot of specialty services the Tribes would be better equipped to provide within the communities we serve.”
- “I think that funds could be better used to keep care in our own communities. Sending people long distances when they are ill is not conducive to good patient care. Providing treatment in their own community with follow-up care to the THP makes more sense and is more cost efficient.”
- “I support any and all facilities IHS can provide. The biggest concern is the time it would take for one of these centers to be built. There needs to be more support to Tribal Clinics that are already providing services and using our own funds to build to clinics to replace outdated buildings. More PRC dollars are needed for CA clinics that don't have hospitals. More Joint Venture projects approved for CA and SAP shouldn't be competitive but available for clinics that are using their own funds to build new clinics when they need them.”
- “Not feasible for our program. almost all services are available locally. patients would not travel to get to services available in our area.”

PLEASE PROVIDE COMMENTS ON THE TYPE OF HEALTH CARE FACILITIES AND LOCATIONS OF THOSE FACILITIES CALIFORNIA AREA SHOULD PURSUE

- “Long term care, Dental Surgery Center”
- “Temecula (Southern Ca) would be a great area for a Regional Specialty Care Center.”
- “Specialty care and surgical care. Location Southern California.”
- “northern california-Redding Ca area”
- “We need Urgent Care Facilities, Skilled Nursing Facilities Care, and In Patient Facilities for Substance Use”
- “Mental health step down facilities for patients with severe mental illness, Contract with specialty care providers utilizing tele-health whenever possible”
- “A regional hospital would be great.”
- “assisted living for elders”
- “Specialty Dental Care would be the most helpful to our PRC program as most care is a 3-4 hour drive and not covered by Medical.”

ANY OTHER COMMENTS YOU WANT TO PROVIDE?

- “Perhaps the Tribes could more efficiently and effectively build and run the proposed facility than the IHS. Considering the CA YRTCs at 10+ years in the planning and the Northern CA facility more than 4 years in construction and still not able to accept patients.”
- “Additional PRC funds for travel and expenses for specialty care would be beneficial for families - especially if surgical care is pursued.”
- “We have started a Capital Project Campaign to relocate our main facility due to lack of space and growth. We are looking to add additional services to include Urgent Care, PT, Chiropractor Care. We have applied for SAP funding and would appreciate any and all assistance from IHS.”
- “This has been discussed for years and it never seems to move forward. THPs have had to develop their own resources in order to ensure patients get access to the services they need.”

WHICH HEALTH PROGRAMS RESPONDED?

Central Valley Indian Health, Inc. (2 responses)
Consolidated Tribal Health Project
Feather River Tribal Health, Inc.
Greenville Rancheria
Indian Health Council, Inc. (2 responses)
Lassen Indian Health Center
Pit River Health Service
Redding Rancheria Tribal Health System
Riverside San Bernardino County Indian Health, Inc.
Sacramento Native American Health Center
San Diego American Indian health center
Santa Ynez Tribal Health Clinic
Shingle Springs Tribal Health
Southern Indian Health Council, Inc.
Strong Family Health Center
United American Indian Involvement, Inc.

NEXT STEPS

SOME THINGS TO KEEP IN MIND

- Demonstration project authority is still in early stages of development – good chance to get in line early. It is starting to get funding already – $10 million in 2022.
- New priority system will launch in a few years – another opportunity for funding.
- IHS has been very successful with getting NEF funds in recent years.
- Congressional Earmarks are possible again after years of being not allowable.
- Current IHS leadership has publicly acknowledged the disparity in funding for health care facilities for California Tribes.
- Long Story Short: Many factors make this a good environment for getting funding. Not sure how long these favorable winds will blow.
- The most critical thing we must have to get access to this funding is CONSENSUS.

NEXT STEPS: FEASIBILITY STUDY / MASTER PLAN

- If we go for Regional Specialty Centers, need to amend existing Feasibility Study.
- Any other type of facility, we will need a brand new Feasibility Study.
- Alternately – either way – we can incorporate the desired health care facility into our California Area Facilities Master Plan, which we are planning to initiate in the next year or two.
- **Before we can request drafting a new Feasibility Study or revising an existing Feasibility Study, we need to have a strong sense that Tribal Leaders are behind the concept.**
  - This is a primary goal of today's meeting.
  - We can probably afford amending the existing study with funding we have available now.
  - A new feasibility study is likely beyond our funding limitations – will need to secure additional funds.
- The other option: we are anticipating receiving funding for a Master Plan next year – we can ask for chosen facility to be incorporated into our Master Plan.
  - We've expressed our concern that the ~$1.5 million HQ is budgeting may not be enough.

NEXT STEPS: REQUESTING FUNDING

- Once we have an up-to-date Feasibility Study and/or Master Plan, we can request funds.
- Before we can submit any recommended health care facility for funding, need formal approval for that facility from a majority of California Tribes.
  - This means resolutions from Tribes or Health Boards.
  - Need at least 53 Tribes represented. (The more, the better!)
  - If we get to the point of moving forward, IHS can share example language that could be incorporated into a resolution.
- Once we get this approval and updated Feasibility Study, we will make a full court press for funding.
  - Health Care Facilities Construction – New Priority System.
  - Demonstration Project.
  - Nonrecurring Expense Funds (NEF).
  - Congressional Earmarks (IHS cannot request this).

NEXT STEPS: PLANNING

- Once we submit an approved project for funding, the next step will be seeking funding for planning activities:
  1. Program of Requirements
  2. Project Justification Document
  3. Survey of Potential Locations
  4. Purchase of Land for Facilities
  5. Engineering Design
- Finally, we would use these activities to seek final funding for construction and staffing for the facility(ies).
  - Solicitation and Award
  - Construction
  - Hiring Staff for Facility(ies)

DISCUSSION TIME

DISCUSSION QUESTION:

WHAT IS THE TOP PRIORITY YOU SUPPORT FOR THE NEXT CALIFORNIA AREA HEALTH CARE FACILITY?

1. Regional Specialty Center
2. Young Adult Treatment Center / Other Substance Abuse Facility (e.g. Transitional Housing)
3. Long Term Care Facility(ies)
4. Something Else?

DISCUSSION QUESTION:

WHERE SHOULD THE FACILITY(IES) BE LOCATED? (YOU MAY CHOOSE UP TO TWO)

1. Redding
2. Sacramento
3. Fresno
4. Temecula
5. Somewhere Else?

DISCUSSION QUESTION
(RE: REGIONAL SPECIALTY CENTERS)

SHOULD WE REQUEST THAT MATERNITY / CHILDBIRTH SERVICES BE CONSIDERED IN THE UPDATED FEASIBILITY STUDY?

1. Yes
2. No
3. Not Sure

DISCUSSION QUESTION
(RE: REGIONAL SPECIALTY CENTERS)

SHOULD WE REQUEST THAT INTERNAL TRANSPORTATION SERVICES (E.G. SHUTTLE SERVICES) BE INCLUDED IN THE UPDATED FEASIBILITY STUDY?

1. Yes
2. No
3. Not Sure

DISCUSSION QUESTION
(RE: REGIONAL SPECIALTY CENTERS)

SHOULD WE REQUEST THAT PERIODIC REMOTE SPECIALTY CARE SERVICES AT TRIBAL SITES BE INCLUDED IN THE UPDATED FEASIBILITY STUDY?

1. Yes
2. No
3. Not Sure

DISCUSSION QUESTION
(RE: REGIONAL SPECIALTY CENTERS)

SHOULD WE REQUEST THAT THE FEASIBILITY STUDY INCLUDE A PHARMACY HUB TO HELP SUPPLY TRIBAL AND URBAN PROGRAMS?

1. Yes
2. No
3. Not Sure

DISCUSSION QUESTION:

IS YOUR TRIBE READY TO COMMIT TO SUPPORTING A FEASIBILITY STUDY (NEW OR UPDATED) FOR CALIFORNIA AREA'S NEXT HEALTH CARE FACILITY?

1. Yes
2. No
3. Not Sure

SUMMARY

- If everything works perfectly, this is a 10-year time frame to have a facility built and running.
- If everything works out well, this is a 15-year time frame.
- Could extend to 30 years or more if there are delays or hiccups along the way.
- We are at an important juncture – making a decision that will set our path for the next 10-20 years – to build a facility (or facilities) to benefit California Native people.
- There is no deadline, but conditions are looking good for funding now, better than they have looked in many years.

ANY FINAL QUESTIONS OR DISCUSSION?

THANK YOU!

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