Overview

The California Area Health Services Master Plan (HSMP) was completed in 2005. Its primary focus was quantifying the healthcare demand and delivery plan for local primary service areas. But it also offered a conceptual framework for how Regional Care might serve the user population and stretch Purchased and Referred Care (PRC – formerly known as CHS) resources while providing better care. Currently, there are no federal healthcare facilities in California to serve the Native American population – only two Youth Substance Abuse Treatment Centers.

In 2011 the Indian Health Service/California Area Office (IHS/CAO) engaged in a planning effort to identify and understand the need for regional services as introduced in the 2005 HSMP that included:

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

The results of that study were published in the *2013 Regional Ambulatory Surgical & Specialty Health Services Feasibility Study.*

Regional Specialty Centers are health care facilities that offer the following services: specialty health care, ambulatory surgery, modern diagnostics, telemedicine, short stays, overnight stays, intensive care and inpatient services. Regional Specialty Centers would NOT offer primary care, emergency care, maternity services or walk-in services. Regional Specialty Centers are designed to support, not replace or compete with, services presently offered at Tribal and Urban Indian Health Programs across the state. A patient would require a referral to be seen.

Interest and support among Tribal leaders for the Regional Specialty Centers concept and the two locations proposed in the 2013 report has grown. Consequently, in 2023 the IHS/CAO engaged in an effort to update and revise the 2013 report in response to growing Tribal interest. This revised feasibility study would first be the centerpiece of outreach to Tribes and health programs to secure their formal, written support for the Regional Centers concept, and second if sufficient support was realized, the revised study would be the basis for requesting funding for planning activities (Project Justification Document (PJD) / Program of Requirements (POR) / Environmental Review) and eventually full funding for the construction and staffing of the Regional Centers.

The result of that study was published in January 2024 as the *Regional Ambulatory Surgical & Specialty Health Services Feasibility Study Update*. Key features of the revised update included:

- use of the 2019 HSP user population data as a baseline where available
- updates to the Market Share Erosion tool reflecting changes to populations, payer mix, distance to care, alternative care, and patient choice

- refresh to the contributing financial assumptions supporting costs
- updated summary statement of need and accompanying justification narratives
- and an updated estimated cost of construction and staffing

Additional requested revisions included study, feasibility, and conceptual recommendations on the following add-on services:

- Transportation options for patients and caregivers
- On-site Lodging facility for patients and caregivers
- Specialty Pharmacy Hub for Tribal and Urban health programs in the region
- Durable Medical Equipment (DME) hub to serve Tribal and Urban health programs
- Maternity and Childbirth services
- Visiting Specialty Care services

The 2024 Report concluded/reaffirmed that:

- Two Regional Ambulatory Surgical & Specialty Centers, owned/operated by IHS – though potentially contractible by a California Tribal consortium – providing culturally appropriate care, are the best solution, potentially increasing California Area's Level of Need Funding (LNF) from 37.3% to 87.2%.
- Each would provide an enhanced level of secondary healthcare for AI/ANs residing in California, including Medical & Surgical Specialty care, Surgery, advanced Diagnostic Imaging, and Acute Care
- Two Regional Ambulatory Surgical & Specialty Centers would enhance the level of healthcare for AI/ANs residing in California in at least five important ways:
    1. These facilities would provide statewide access to needed healthcare.
    2. Secondary services currently not accessible, but sponsored by IHS in other IHS areas, would be available.
    3. Healthcare in a culturally appropriate environment would be rendered.
    4. They would make limited Purchased and Referred Care (PRC) funding more available for higher levels of acute care.
    5. These facilities could close the disparity gap in LNF.

Problem Statement

Many planning steps must be completed to realize regional care at two locations in California. One of these is a comprehensive governance study that separately considers federal or tribal ownership options and answers the following questions:

Federal Ownership

- *How should a Board of Directors and/or Tribal Advisory Group for the Regional Centers be structured to ensure meaningful representation from Tribes throughout California? What governance options are required by statute and what are recommended as best practice?*
- *What role should Tribal and/or Urban Indian health programs play in the governance and oversight of federally-operated Regional Centers?*
- *What mechanisms should be developed to ensure Tribal and Urban Indian health programs can provide meaningful input to ensure the operation of the Regional Centers and the interface with the health programs is effective?*
- *Would services provided by the Regional Centers be contractible but not divisible?*
- *What are some high level assumptions of federally-run Regional Centers on operational flexibilities pertaining to but not limited to: land purchases, healthcare accreditation, hiring, recruitment and retention, background investigations, separations, service operations and specialty services offered, etc.? How might these factors benefit or undermine the long-term success of the Regional Centers compared to Tribal ownership?*
- *What are some high level assumptions of payment models if federally owned and operated?*

Tribal Ownership

- *What can be learned from the compacting process and governance structures from other facilities that were originally built and owned by IHS but eventually compacted by a Tribe or a consortium of Tribes?*
- *If California Tribes want to assume ownership and operation of the Regional Centers, under what statutory authority could this be realized?*
- *What legislative language and/or what independent Tribal action should be initiated to make this transfer of ownership and operations of the Regional Centers take place?*
- *How many tribal resolutions are needed to assume tribal ownership and operation of Regional Centers? What is the process and consequences if tribe(s) change direction after Regional Centers are operational?*
- *How should such a Tribal consortium be structured? Would 100% participation from all Tribes served be required? Or what level of participation would be considered representative of the whole? Could each Regional Center be compacted by a separate Tribe or Tribal organization?*
- *Could the Regional Centers be compacted prior to completion of construction or final staffing determinations? Would federal funding be impacted if the Regional Centers were compacted prior to being fully operational?*
- *Can a tribe or tribal organization limit and/or refuse healthcare services at these Regional Centers to any California Indian[i] and/or other members of federally recognized tribes? Under what circumstances could services be limited or refused to any potential AI/AN patient?*
- *What are Inherently Federal Functions (IFFs) that will remain with California Area Office and HQ? How will funding for these IFFs be allocated on a continuous basis taking into account inflation,*

population growth and increases in services and spaces in the future? Does IHS need to update Programs, Services, Function and Activities (PFSA) Manual to include these IFFs?

- *How should a Board of Directors for the Regional Centers be structured to ensure meaningful representation from California Tribes as well as federal representatives as appropriate?*
- *What role should Tribal and/or Urban Indian health programs play in the governance and oversight of Tribally-operated Regional Centers? What mechanisms should be developed to ensure Tribal and Urban Indian health programs can provide meaningful input to ensure the operation of the Regional Centers and the interface with the health programs is effective?*
- *What will be the oversight structure/governing body make-up of a tribally owned and operated Regional Centers?*
- *To what extent, if any, should the services provided by the Regional Centers be considered divisible to optimize the level of services that can be provided to the user population? Does any separate action need to take place to formalize this divisibility?*
- *What are some high level assumptions of Tribally-run Regional Centers on operational flexibilities pertaining to but not limited to: land purchases, healthcare accreditation, hiring, recruitment and retention, background investigations, service operations and specialty services offered, separations, etc.? How might these factors benefit or undermine the long-term success of the Regional Centers compared to federal ownership?*
- *What are some high level assumptions of payment models if tribally owned and operated?*

The following statement of objectives has been written to incorporate the appropriate data, stakeholders, and guidance to answer the above questions and provide guidance on how the governance of the Regional Centers should be structured, under either federal or Tribal ownership scenarios.

Requirements

The Client (IHS/CAO) will support project accomplishment by doing the following:

- Establish a California Area Governance Study Team (CAGST) consisting of representation from appropriate and essential stakeholders such as IHS, elected Tribal leaders, Tribal and Urban Indian Program executive leadership, California Rural Indian Health Board (CRIHB) and other influential community members. The CAGST will provide high level governance structure for the planning and implementation of Regional Specialty Centers, from planning to design to construction to staffing.
- The CAGST will have a maximum of 12 people to oversee and aid in coordinating this effort. The CAGST will have a single point of contact (POC) for the consultant team. The CAGST POC will coordinate data receipt, schedules, meetings, and presentations within CAO and its organization.

Per the Consultant's identification of specific data requirements at the outset of the project, the Client may be required to do some or all of the following:

- Provide the Consultant with relevant, requested, existing planning data, including all pre-existing information and reports, including the 2013 and updated 2024 Regional Study Reports. Additional items could include any Strategic Plan, Services Master Plan, preliminary planning documents, existing PJD/POR's developed and submitted to IHS headquarters for all facility related studies and/or analysis, including the most recent Facilities Condition Assessments for each of the region's facilities.
- Provide Electronic Health Record (EHR) reports and data as specifically requested, in accordance with the Tribes, Areas, and IHS Access Policy. The client will use the EHR system to gather any required workload, population, medical, and clinical data.
- Provide existing facilities data as deemed necessary, including drawings, site plans, floor plans, sections, and elevations.

Consensus Strategy

Consensus on the Governance Study will be developed through the process and meeting structure outlined in the phase below. Involvement and communication are critical to the effort and success.

Part I – Governance Study (Federal Ownership)

This portion of the study will consider the optimal structure for governance of the Regional Centers under federal ownership and operation. The contractor will work closely with the CAO, CAGST and IHS Headquarters (IHS HQ) throughout the process. Ultimately IHS HQ and CAO should agree on the final governance structure for the California Regional Centers, giving Tribes, Tribal health programs and Urban Indian health programs a voice in governance and oversight.

Part II – Governance Study (Tribal Ownership)

This portion of the study will consider mechanisms and process through which a consortium of Tribes can take over ownership and operation of the Regional Centers and will propose the optimal structure for governance of the Regional Centers under Tribal governance. The contractor will work closely with the CAO, CAGST and IHS Headquarters (IHS HQ) throughout the process. Ultimately IHS HQ and CAO should agree on the final governance structure for the California Regional Centers, ensuring the Regional Centers can provide maximum benefit to the user population.

Tasks under both Parts I and II (which may be conducted concurrently) include:

- Discuss governance concerns/path with CAO
- Develop proposed schedule
- Develop kickoff meeting materials
- Meeting #1 - Virtual Kickoff Meeting with CAGST and CAO to discuss purpose of the study and get initial feedback
- Prepare meeting minutes, distribute, address corrections
- Reach out to a minimum of three separate Tribally-compacted facilities that were originally built by IHS (at least one owned by a consortium of multiple Tribes) to gather information about A) the governance structure and B) the process by which self-governance was requested and realized.
- Engage with IHS HQ Office of Environmental Health and Engineering (OEHE), Office of General Counsel (OGC) and Office of Tribal Self Governance (OTSG) to understand the authorities and contours of how Tribal governance among a consortium of all California Area Tribes (or separate regional consortiums for each Regional Center, if this is possible) can be established
- Develop an explanation of the options and processes required for Tribal self-governance of the Regional Centers
- Meeting #2 (Virtual) – Review of federal governance questions with CAGST and CAO
- Follow up with their questions and concerns
- Prepare meeting minutes, distribute, address corrections
- Meeting #3 (Virtual) – Review of Tribal governance questions with CAGST and CAO
- Follow up with their questions and concerns
- Prepare meeting minutes, distribute, address corrections

- Develop potential scenarios, propose a preferred solution, and recommend path forward
- Prepare **Draft Regional Centers Governance Recommendation/ Report** for CAGST and CAO review and comment
- Meeting #4 (Virtual) – Review **Draft Regional Centers Governance Recommendation/ Report** with IHS HQ (OEHE, OGC and OTSG) and gather guidance
- Execute edits based on comments received
- Meeting #5 (Virtual) – Review of **Draft Regional Centers Governance Recommendation/ Report** with CAGST and CAO
- Execute edits based on comments received
- Submit **Final Regional Centers Governance Recommendation/ Report** for CAO review and approval
- Secure HQ approval on governance recommendations to support PJD/POR development
- Document close out and correspondence.

Deliverable: One report (two stages of review) that presents two different California Regional Center governance scenarios (one federal, one Tribal) with CAO and IHS HQ support.

1. Draft Regional Centers Governance Recommendation/ Report
2. Final Regional Centers Governance Recommendation/ Report

Travel: One trip is anticipated to present findings of the Governance Study at the next Annual Tribal Consultation following its completion (date and location TBD).

Duration: Approximately twelve (12) months.

[i] The Term "California Indian" includes:

(1) Any member of a federally recognized tribe.

(2) Any descendant of an Indian who was residing in California on June 1, 1952, but only if such descendant; (A) is living in California, (B) is a member of the Indian community served by a local program of the Service, and (C) is regarded as an Indian by the community in which such descendant lives.

(3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

(4) Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such Indian.