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.*

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, 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 population study that answers the following questions:

- *Does the current IHS HSP user population accurately quantify AI/AN users across the state of California?*
- *What other sources for user populations should be considered to supplement the HSP numbers?*
- *Who should be counted as urban AI/AN populations for regional care and how should they be counted?*
    - *For the two questions above, suggested data sources include census data, MediCal patients who identify as AI/AN, Covered California's enrolled Native American patient base, BIA California Indian[i] data, BIE school data, CMS data, and others.*
    - *Furthermore, as much as is practical, at a minimum try to delineate these user populations by County.*

- *What methodology for planning regional user population will secure IHS HQ's support while still respecting the healthcare needs of California's AI/AN population?*
- *What contribution and guidance can IHS Headquarters offer (HQ Division of Program Statistics, HQ Office of Public Health Support, HQ Office of Resource Access and Partnerships-ORAP, and HQ Urban Health Programs Office)?*
- *What user population should form the basis for planning two future regional points of care as identified in the 2024 Report?*
    - *This question should also consider the likelihood that members of some Nevada Tribes may prefer care at a Regional Center in California, even though they are technically in Phoenix Area. How many Nevada AI/AN users would be projected to utilize the proposed California Regional Centers?*
- *What is the relationship between California services eligibility, PRCDA definitions, user population, and how should that affect the projection of a regional user population?*
    - *This question also relates to the PRCDA expansion study being conducted concurrently.*
- *How can a supportable market share be applied to regional populations that anticipates the erosion of users who might travel to a distant point of regional care?*

The following statement of objectives has been written to incorporate the appropriate data, stakeholders, and guidance to answer the above questions and provide an IHS HQ accepted basis for projecting user population for two regional points of care to support facility planning documentation development.

Requirements

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

- Establish a California Area Population Study Team (CAPST) 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 potential influential community members. The CAPST will provide high level governance structure for the planning and implementation of Regional Specialty Centers, from planning to design to construction to staffing.
- The CAPST will have a maximum of 12 people to oversee and aid in coordinating this effort. The CAPST will have a single point of contact (POC) for the consultant team. The CAPST 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 and Deep Look Survey 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 Population 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.

Phase I – Projected Population Study

This phase will study American Indian and Alaska Native user population in California for regional care, identifying reported problems, potential variances, and an acceptable appropriate solution. The contractor will work closely with the CAO, California Service Units with reported population reporting challenges, Urban Programs, and IHS Headquarters (IHS HQ) throughout the process. Ultimately IHS HQ and the CAO should agree on the final proposed user population that will form the basis (essentially be an input) for planning regional user populations in the PJD and POR for each projected California Regional Center.

Phase tasks include:

- Discuss project concerns/path with CAO & CAPST/IHS POC
- Develop proposed schedule
- Develop kickoff meeting materials including draft data request
- Meeting #1 - Virtual Kickoff Meeting with CAPST and CAO
- Prepare meeting minutes, distribute, address corrections
- Finalize and distribute data request to Tribal and Urban Health Programs
- Develop population analysis considering the following data sets (to the extent they are feasibly available):
    - HSP population projections
    - Census AI/AN population projections
    - Recent relevant IHS project population projections
    - MediCal / Covered California AI/AN patients
    - Relevant Nevada Tribe populations (projected users)
    - BIA rolls of "California Indians[i]"
    - BIE schools and California School Districts Native American enrollees
    - Underreporting and un-reporting Tribal sites self-reporting user populations
    - Urban populations
        - This task may take additional time and should not be undervalued. The urban population may have a significant impact on projected regional user population projections and therefore regional service capabilities.
    - Relevance and impact of services eligibility and PRCDA definitions
        - As applicable, incorporate relevant findings and recommendations from California Area Wide Purchase-Referred Care/Service Delivery Area Study (a separate study)
- Identify population variances and issues
- Project user population 10 years into the future using reasonable population growth rates
- Prepare presentation to IHS HQ
- Meeting #2 (Virtual) - HQ Presentation Review with CAPST and CAO
- Edits to Presentation materials as necessary

- Arrange virtual meeting with IHS HQ
- Meeting #3 (Virtual) - Present user population problem and issues to IHS HQ and gather initial guidance
- Follow up with their questions and concerns
- Review/receive additional data and/or projections HQ offers for problem resolution
- Develop potential scenarios, propose a preferred solution, and recommend path forward
- Prepare **Draft Regional Services User Population Recommendation/Report** for CAPST and CAO review and comment
- Meeting #4 (Virtual) – Review **Draft Regional Services User Population Recommendation/Report** with IHS HQ and gather guidance
- Execute edits based on comments received
- Submit **Revised Draft Regional Services User Population Recommendation/Report** for HQ review and comment
- Review comments and path forward with HQ and Area teams
- Execute edits based on comments received
- Submit **Final Regional Services User Population Recommendation/Report** for HQ review and approval
- Secure HQ approval on regional user population to support PJD/POR development
- Document close out and correspondence.

Deliverable: One report (three stages of review) that presents a California regional user populations solution with CAO and IHS HQ support.

1. Draft Regional Services User Population Recommendation/Report
2. Revised Draft Regional Services User Population Recommendation/Report
3. Final Regional Services User Population Recommendation/Report

Travel: Contractor should be prepared to present findings of the Population 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.