DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY
Assistant Secretary for Legislation
Washington, DC 20201

June 20, 2024

The Honorable Raúl Grijalva
Ranking Member
Committee on Natural Resources
U.S. House of Representatives
Washington, DC 20515

Dear Representative Grijalva:

I am pleased to submit to you the Fiscal Year (FY) 2021 Alaska Tribal Health System Health Facilities' Needs Assessment Report to Congress. The report was prepared by the Indian Health Service (IHS) in response to the Consolidated Appropriations Act, 2019 (P.L. 116-6) Conference Report (H. Rept. 116-9).

This report is based on the 2021 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress. The report was developed in partnership with tribal organizations across Alaska and includes an assessment of facilities needs in the State of Alaska as well as recommendations for alternative financing options to meet the current and future healthcare needs of IHS beneficiaries in the state.

I hope you find this information helpful.

Sincerely,

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY
Assistant Secretary for Legislation
Washington, DC 20201

June 20, 2024

The Honorable Bruce Westerman
Chairman
Committee on Natural Resources
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Westerman:

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Washington, DC 20201

June 20, 2024

The Honorable Lisa Murkowski
Vice Chairman
Committee on Indian Affairs
United States Senate
Washington, DC 20510

Dear Vice Chair Murkowski:

I am pleased to submit to you the Fiscal Year (FY) 2021 Alaska Tribal Health System Health Facilities' Needs Assessment Report to Congress. The report was prepared by the Indian Health Service (IHS) in response to the Consolidated Appropriations Act, 2019 (P.L. 116-6) Conference Report (H. Rept. 116-9).

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DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY
Assistant Secretary for Legislation
Washington, DC 20201

June 20, 2024

The Honorable Brian Schatz
Chairman
Committee on Indian Affairs
United States Senate
Washington, DC 20510

Dear Chairman Schatz:

I am pleased to submit to you the Fiscal Year (FY) 2021 Alaska Tribal Health System Health Facilities' Needs Assessment Report to Congress. The report was prepared by the Indian Health Service (IHS) in response to the Consolidated Appropriations Act, 2019 (P.L. 116-6) Conference Report (H. Rept. 116-9).

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Assistant Secretary for Legislation

Enclosure

Alaska Tribal Health System
Health Facilities' Needs Assessment
Report to Congress

November 2020

***Atka Clinic**

* The Atka clinic was found to be unsafe last year and moved to a leased space in the community. This building was constructed in 1983 and has approximately 1,900 square feet of floor space. The clinic operations occupied approximately 670 square feet, about one-third of the building.

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A. Alaska Native Medical Center
B. Bristol Bay Area Health Corporation
C. Council of Athabascan Tribal Governments
D. Kodiak Area Native Association
E. Maniilaq Health Corporation
F. Southcentral Foundation
G. Southeast Alaska Regional Health Consortium
H. Yukon-Kuskokwim Health Corporation

Background

This report functions as an assessment of the Indian Health Service (IHS) beneficiary healthcare facilities needs in Alaska, as well as recommendations for alternative financing options to address the need for additional healthcare facilities space suitable to meet the current and future healthcare needs of IHS beneficiaries in the state.

Congress has stated that a "major national goal of the U.S. is to provide the resources, processes, and structure that will enable Indian Tribes and Tribal members to obtain the quantity and quality of healthcare services and opportunities that will eradicate the health disparities between Indians and the general population of the US."[1] This report summarizes the capacity, condition, and needs of the Alaska healthcare facilities required to assure crucial access to healthcare services.

[1] 25 U.S. Code § 1601 - Congressional findings, (2)

Executive Summary

This report was prepared in response to the Consolidated Appropriations Act, 2019 (P.L. 116-6) Conference Report (H. Rept. 116-9), which included the following instructions at page 752:

> "The Service is directed to work with appropriate Tribal organizations and submit a report to the Committees within 180 days of this Act that includes an assessment of updated facilities needs in the State of Alaska as well as recommendations for alternative financing options which could address the need for additional healthcare facilities space suitable to meet the current and future healthcare needs of IHS beneficiaries in the State."

The Alaska Tribal Health System (ATHS) is a voluntary affiliation of 35 Alaska Tribes and Tribal organizations (T/TO) providing health services for the more than 159,000 American Indian and Alaska Native (AI/AN) people residing in the state. The ATHS is a network of 171 village clinics, 27 regional clinics, 6 hospitals, and a tertiary care medical center. These facilities are in the most remote settings across a service area comprised of 20 percent of the land mass of the entire United States.

Tremendous progress has been made since the 2016 Indian Health Service and Tribal Health Facilities' Needs Report to Congress report was published, yet significant work remains to be done to eliminate the health disparities between Alaska Native people and the non-Native population. The three leading causes of death for Alaska Native people during 2012 to 2015 were cancer, heart disease, and unintentional injury. Greater longevity for our elders has increased rates of chronic illnesses, including diabetes, hypertension, heart disease, and cancer, all of which require a higher level of specialty care.

- In 2016, the IHS reported unmet healthcare facilities needs in Alaska totaling $2.8 billion, 19.3 percent of the national IHS and Tribal heath care facilities unmet need.
- The 2021 estimate is $4.4 billion, an increase of approximately 60 percent over the last five years.
- The ATHS manages seven of the 45 inpatient facilities (15.6 percent) in the national IHS/Tribal Health System. In 2018, the ATHS facilities accounted for 35 percent of all IHS/Tribal Health System total hospital inpatient days.
- Of the three IHS construction programs, the last new construction project was completed in 2013. Over the last five years, through the Joint Venture and Small Ambulatory programs, Tribal Health Organizations have made capital investments of $546.8 million and the U.S. Department of Health and Human Services (HHS)/IHS $26.3 million for new clinical space.

This report was developed in collaboration with the IHS, utilizing ATHS planning documentation, the IHS Health Systems Planning software, the IHS facilities budget estimating system, the IHS location factors, and the 2021 IHS and Tribal Health Care Facilities Needs Assessment Report to Congress.

Figure 1: 2021 Facility Type and Unmet Need

Facility Type	Maintenance & Improvement Unmet Need	New & Replacement Space Unmet Need
Clinics	$261,000,000	$1,622,000,400

Regional Hospitals	191,000,000	372,000,000
Alaska Native Medical Center	7,000,000	822,000,000
IHS Expanded Authorities Facilities		1,584,000,000
ATHS Health Facility Need	**$ 459,000,000**	**$ 4,400,000,000**

Alaska Tribal Health System Statewide Considerations

Rural Alaska Geography and Access

Alaska is the largest state, encompassing an area about one-fifth of the total landmass of the contiguous U.S. The state is 1,400 miles long and 2,700 miles wide. Alaska has 571,951 square miles of land and all of the terrain features present anywhere else in the country. Alaska has deserts, plains, swamps, forests, glaciers, ice fields, fjords, river systems, volcanoes, thousands of islands, and six major mountain ranges. With two oceans and three major seas and more than 47,000 miles of coastline, Alaska has as many miles of seacoast as the combined Atlantic and Pacific seaboards. Enormous distances separate most communities in Alaska; Anchorage is 1,445 miles from Seattle, Washington, the nearest city by airline to the contiguous 48 states. Vast mountain ranges, stretches of tundra, glaciers, impassable river systems, and open waters separate communities within the state.

Eighty percent of Alaska Native communities do not have road system links. These isolated communities rely entirely on air transport to the nearest inpatient medical facility. More than one-half of the population served through the ATHS resides in these rural and remote locations. Therefore, air transportation is the primary means of travel to access health services for those living in rural Alaska by necessity. The average Alaska rural community has 350 residents, limiting the level of healthcare to what is locally available. Due to distance and weather, air travel is unreliable and expensive. To receive basic medical care, a patient may fly in multiple aircrafts for as many as 1,100 miles. Transportation, the cost of travel, and distance has the effect of making all but emergency health services inaccessible. For comparison, the distance from many communities to the nearest medical facility is equivalent to the distance from New York to Chicago.

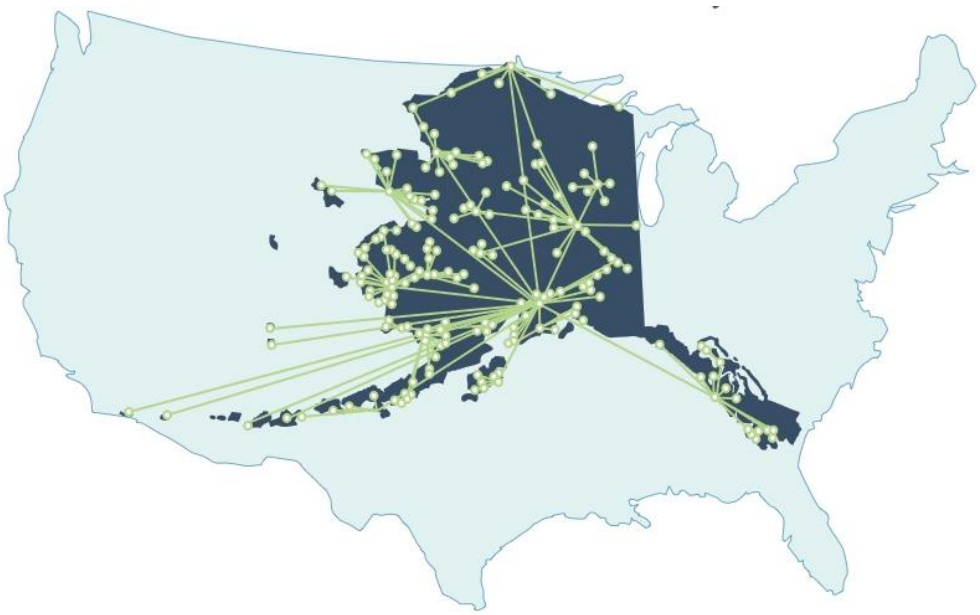

Figure 2: Alaska's Rural Tribal Health Facilities Support Network

Alaska Native Population Projections[2]

The IHS 2022 Official Alaska Native user population is reported as 159,5413. The current estimate for 2030 population is 184,843. This is based on the IHS Office of Public Health Support (OPHS), Division of Program Statistics user population deviation study for Alaska conducted in June 2020. The study results indicate an estimated user population growth of 15.36 percent between the 2022 user population of 159,541 to 184,043 in 2030. This translates to an average annual population increase of 1.92 percent. These numbers were used in the preparation of this report.

The IHS defines the active user population as eligible AI/AN persons who had a direct or contract inpatient, ambulatory, or outpatient visit with the Tribal health system at least once during the previous three-year period. The facility must have been one that reported to the National Patient Information Reporting System (NPIRS). The IHS user population data is calculated by Federal fiscal year (FY).

An independent Tribal review of historical data correlated with IHS population projections:

- The Alaska area user population was 159,541 in FY 2022.
- The FY 2022 user population is based on people who had visits during the three-year period: October 1, 2020, to September 30, 2022.
- The U.S. Census Bureau reports that the AI/AN population in Alaska increased 15.9 percent between 2010 and 2020. The White population had a negative growth of -.05 percent. (Census.gov)

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[2] IHS continues to work to ensure that these figures are accurate after becoming aware of prior data integrity issues involving user population totals reported by several Tribal Health Programs in Alaska. The figures will be amended if any errors become apparent or if the data need to be updated for any reason.

[3] The data referenced from User Population Estimates — Fiscal Year 2022 Final.

- Over one out of three (35 percent) persons who use the ATHS were under the age of 20 years old, and over one in four (28.6 percent) were over 45 years old.
- Adults aged 65 years and older represented 9.3 percent of all active users.

Figure 3: IHS 2030 Alaska Native Age Profile

Age Groups	Female	Male	Grand Total
<1	1,293	1,397	2,691
01-04	6,208	6,446	12,653
05-09	7,991	8,368	16,359
10-14	8,247	8,690	16,937
15-19	7,620	7,857	15,476
20-24	7,268	7,439	14,707
25-34	14,981	14,660	29,641
35-44	11,539	11,754	23,293
45-54	8,407	8,267	16,674
55-64	9,321	9,004	18,325
65+	9,269	8,017	17,286
Grand Total	92,144	91,899	184,043

Data Source: IHS NDW FY2022 User Population Report by age projected to FY 2030 in the IHS Health Systems Planning Software.

About the Alaska Tribal Health System

The ATHS is a comprehensive statewide system of healthcare. It is a voluntary affiliation of Alaska T/TO's providing health services across the state, developed over the last 50 years. The innovative system was created out of necessity to provide healthcare and public health services to the more than 159,541 AI/AN people across more than 570,000 square miles of predominantly road-less land. Within the ATHS each Tribal Health Organization is autonomous, each serving a specific geographical area across the state of Alaska, while remaining interconnected via ATHS's sophisticated referral pattern and a common mission of improving the health status of AI/AN people in Alaska.

The ATHS has a statewide network of over 200 health facilities:

- 171 village clinics
- 27 regional clinics
- Six regional hospitals
- One tertiary care medical center (Alaska Native Medical Center)

The ATHS is part of the national IHS/Tribal Health System. The ATHS operated seven of the 45 inpatient facilities (15.6 percent) comprising that system and, as stated in the 2018 IHS Inpatient Summary Data Report, accounted for 35 percent of all IHS/Tribal System total hospital inpatient days (64,956 of 185,361).

In rural Alaska, ATHS facilities are located in the most remote locations and harshest climatic conditions found in the U.S. In the absence of roads, travel is difficult and expensive. The ATHS offers the only available health services in most Native communities.

The ATHS provides the following healthcare services:

- Primary medical care
- Specialty care and professional support services

- Dental and oral health
- Behavioral health
- Preventative wellness programs
- Health research
- Health education for rural primary care
- Public health community infrastructure

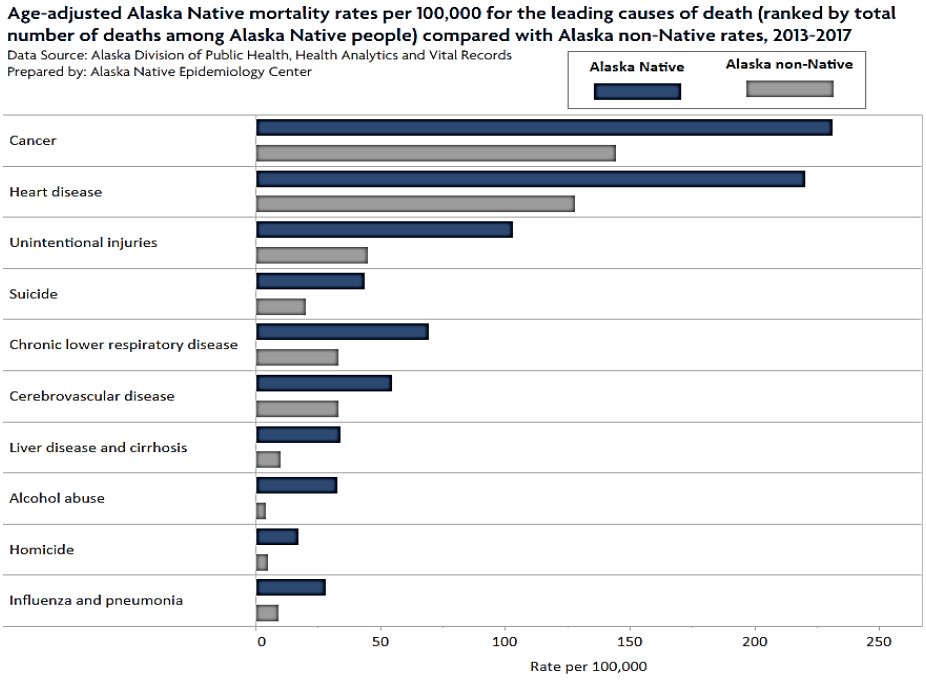
Much has been accomplished. Limited resources have necessitated innovation and yielded significant recognitions and unique healthcare delivery models, including:

- Southcentral Foundation is a two-time Baldridge Award winning healthcare organization
- Dental Health Aide Therapist Program
- Behavioral Health Aide Program
- Community Health Aide Program
- ATHS members have received Harvard Honoring Nation Awards
- ATHS members have received a number of IHS Director's Awards
- The Maniilaq Association and the Alaska Native Tribal Health Consortium (ANTHC) received the HHS Green Champion Award
- American Hospital Association Carolyn Boone Living the Vision award
- Verified Trauma Centers across the state

ATHS Challenges and Health Status

The AI/AN population is faced with several challenges in the area of health status. Disparities exist between Alaska Native people and Alaska non-Native populations on a number of mortality measures, including life expectancy, infant mortality, and leading causes of death.

Figure 4: Age-Adjusted Native Mortality Rates for Leading Causes of Death Compared with Alaska Non-Native Rates



Diabetes, heart disease, and cancer were nearly unknown among Alaska Native people during the 1950s but are common today. Cancer is now the leading cause of death among Alaska Native people, with behavioral health diagnoses becoming increasingly common.

The Alaska Native birthrate is higher than the overall U.S. birthrate, and the life expectancy of Alaska Native people continues to increase, likewise the number of Alaska Native elders is increasing. Alaska Natives at both ends of the age spectrum are frequent users of the ATHS.

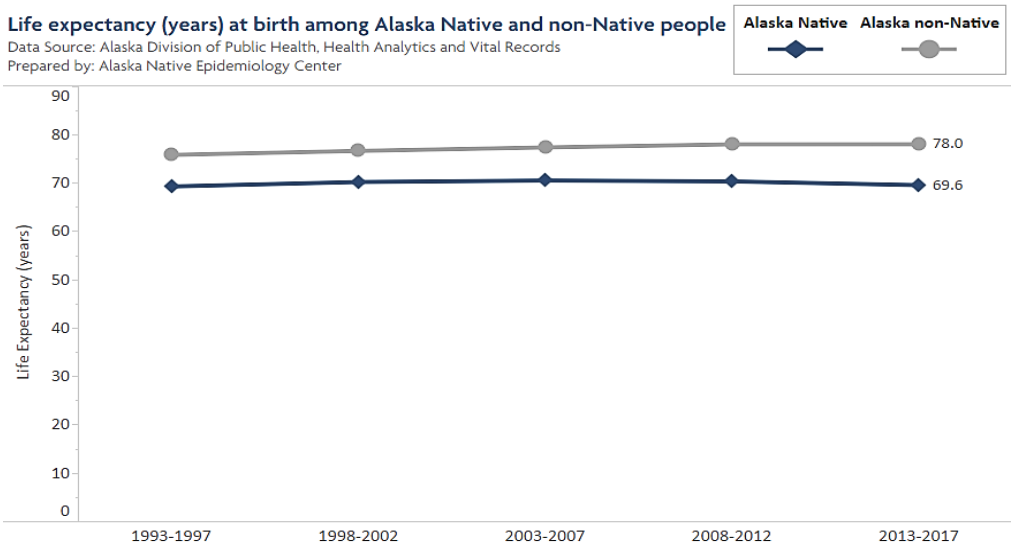
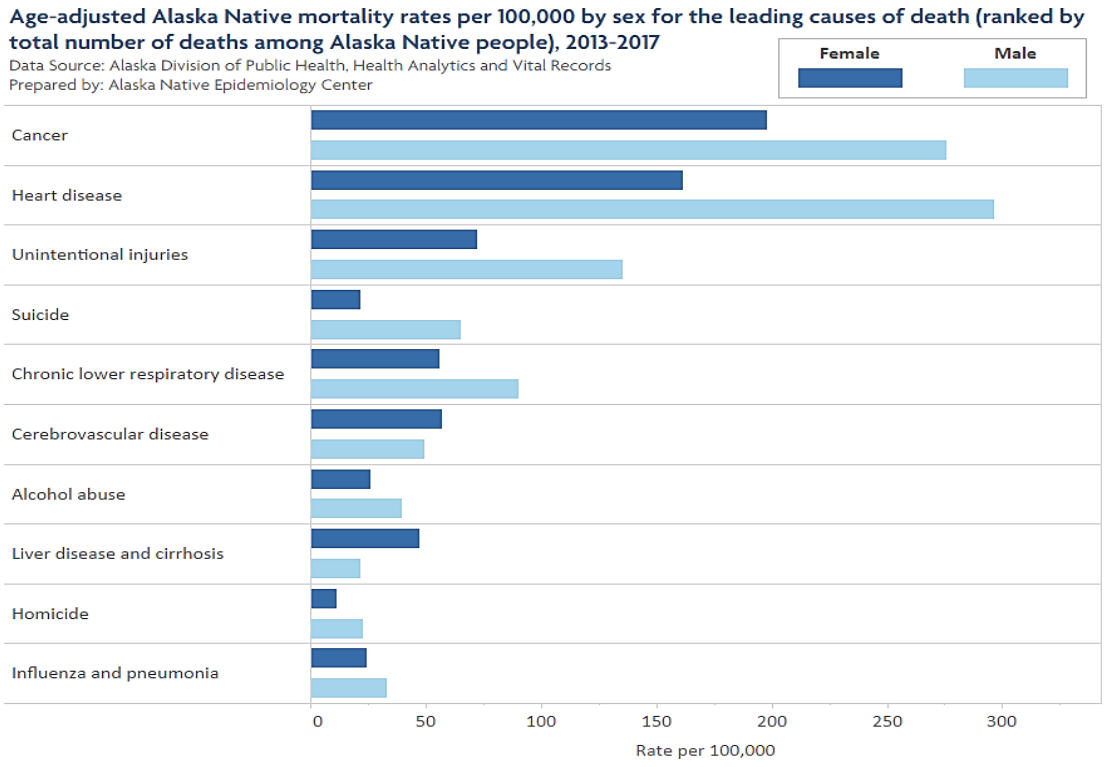


Figure 5: Life Expectancy (Years) at Birth Amount Alaska Native and Non-Native People

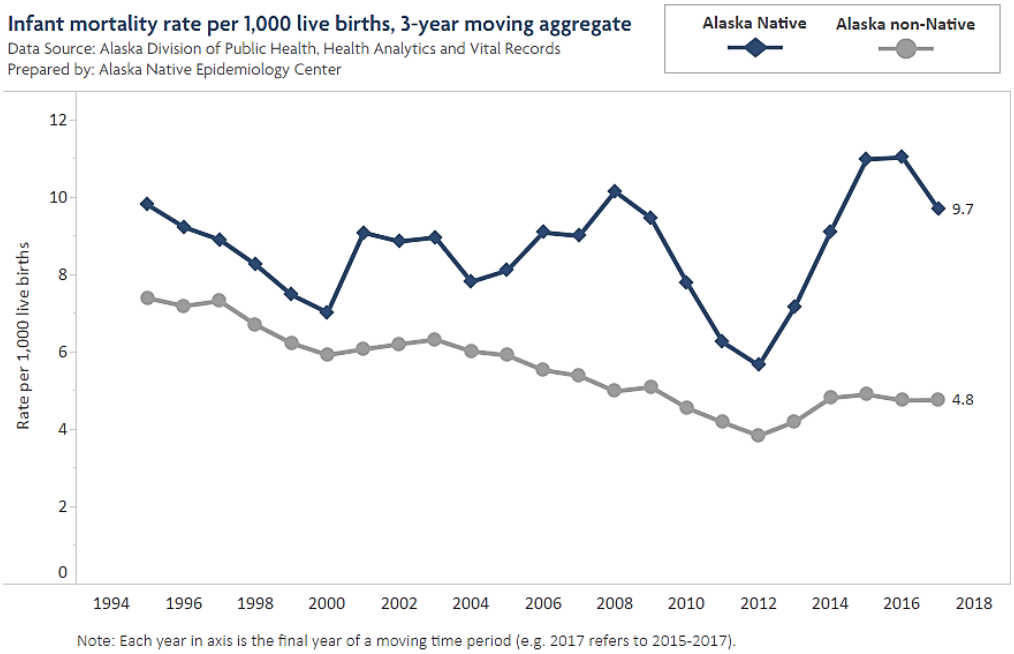
For elders, the added years of longevity bring high rates of chronic illness (including diabetes, hypertension, heart disease, and cancer) require a higher level of specialty care.

Figure 6: Age-Adjusted Alaska Native Mortality Rates by Gender



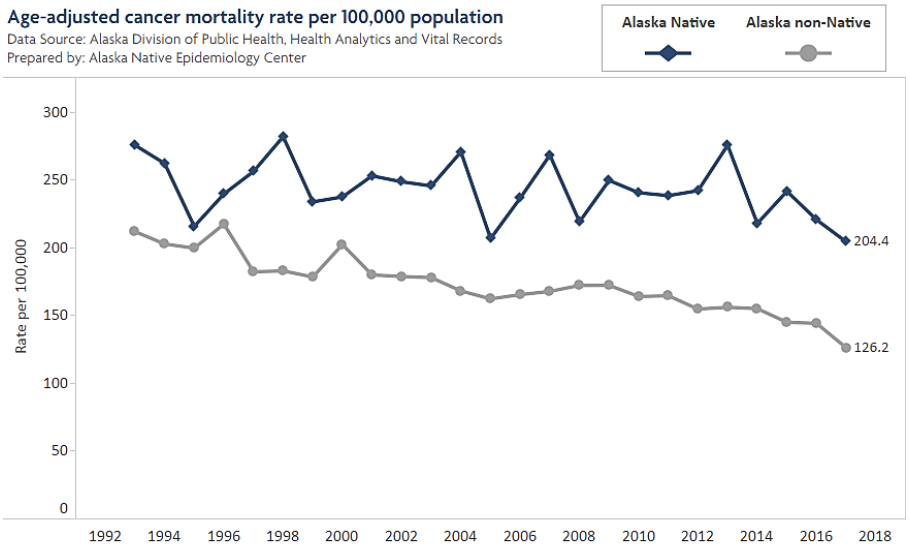
The three leading causes of death for Alaska Natives from 2012 to 2015 were cancer, heart disease, and unintentional injury. These three causes of death accounted for nearly half (47.7 percent) of all deaths during the time period.

Figure 7: Infant Mortality Rate per 1,000 Live Births



Cancer incidence rates have increased significantly among Alaska Native people during the past 40 years. The leading types of cancer among Alaska Native people are colon/rectum, lung, and breast cancer.

Figure 8: Age-Adjusted Cancer Mortality Rates



Life expectancy at birth among Alaska Native people increased by 5.4 years since 1980 to 1983, reaching 70.7 years during 2009 to 2013. Despite the steady increase in life expectancy among Alaska Native people, a gap of 7.3 years existed between Alaska Native and Alaska white life expectancies during 2009 to 2013.

The leading causes of Alaska Native infant deaths during 1999 to 2013 were congenital abnormalities (16.9 percent), sudden infant death syndrome (SIDS) (16.4 percent), and unintentional injuries (15.1 percent).

Figure 9: Leading Causes of Alaska Native Infant Mortality

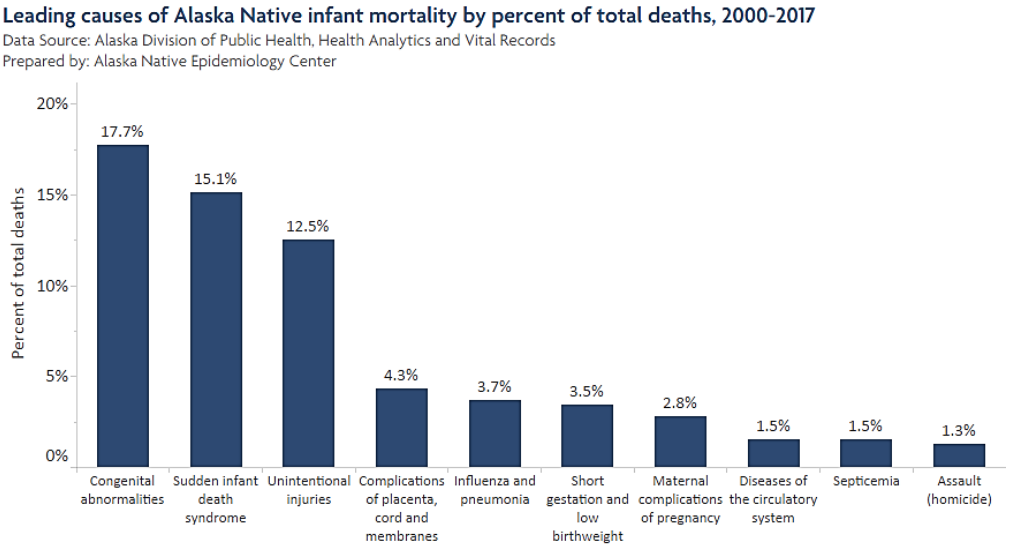
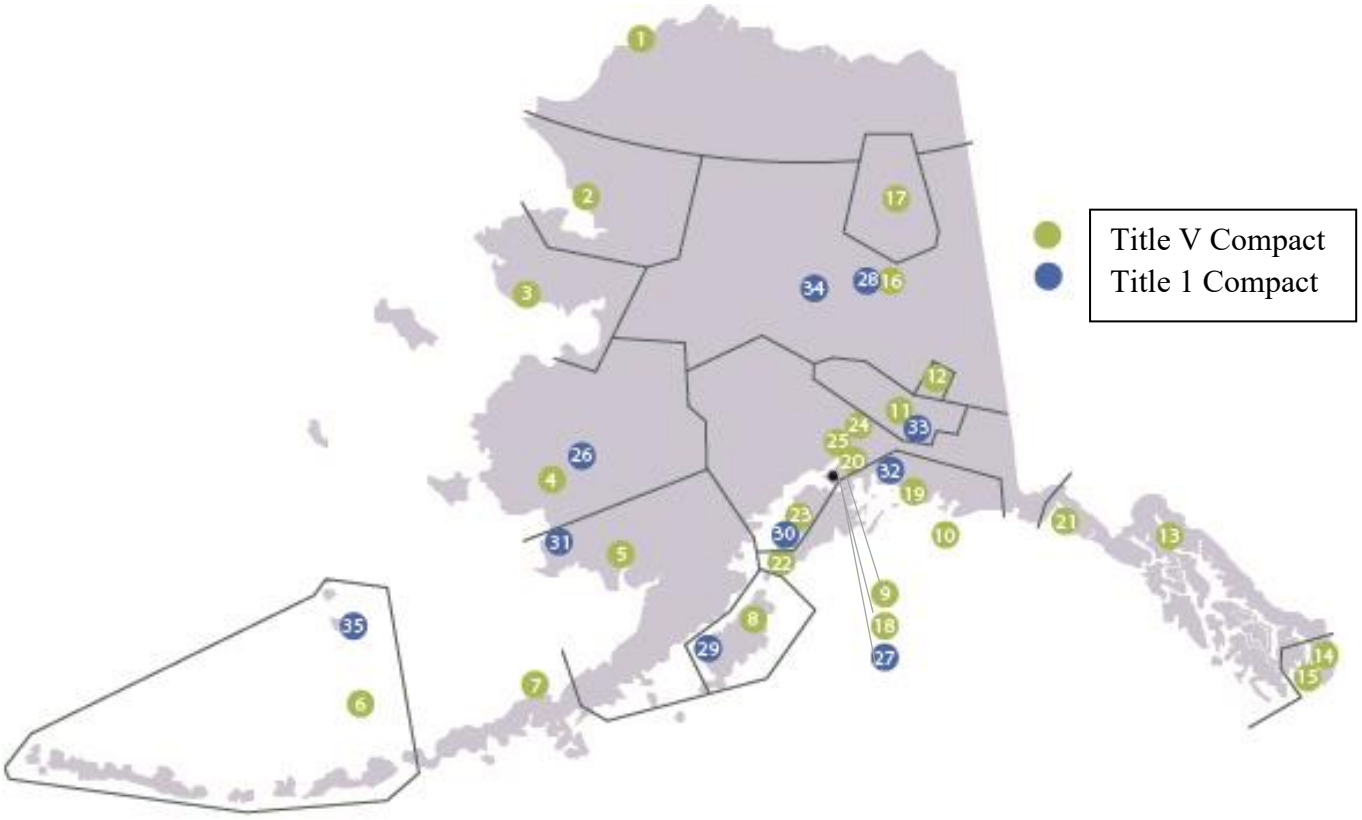


Figure 10: Alaska Tribal Health System Participating Organizations



1. Arctic Slope Native Association
2. Maniilaq Association
3. Norton Sound Health Corporation
4. Yukon-Kuskokwim Health Corporation
5. Bristol Bay Area Health Corporation
6. Aleutian Pribilof Islands Association
7. Eastern Aleutian Tribes
8. Kodiak Area Native Association
9. Southcentral Foundation
10. Chugachmiut
11. Copper River Native Association
12. Mt. Sanford Tribal Consortium
13. Southeast Alaska Regional Health Consortium
14. Ketchikan Indian Community
15. Metlakatla Indian Community
16. Tanana Chiefs Conference
17. Council of Athabascan Tribal Governments
18. Alaska Native Tribal Health Consortium
19. Native Village of Eyak
20. Native Village of Eklutna
21. Yakutat Tlingit Tribe
22. Seldovia Village Tribe
23. Kenaitze Indian Tribe
24. Chickaloon Native Village
25. Knik Tribal Council
26. Akiachak Native Community
27. Cook Inlet Traditional Council
28. Fairbanks Native Association
29. Karluk IRA Tribal Council
30. Ninilchik Traditional Council
31. Kwinhagak
32. Valdez
33. Chitina Traditional Village Council
34. Tanana IRA Native Council
35. St. George Traditional Council

Medical Care Services Levels and Referral Network

Village Clinics

The average Alaska rural community has 350 residents. Healthcare needs in these communities are served through approximately 171 small rural health clinics providing primary care provided by Community Health Aides (a certified and billable health care provider in Alaska, which helps to address the provider shortages in the State) /Practitioners, Behavioral Health Aides, Dental Health Aides, Dental Health Aide Therapists, and Home Health/Personal Care Attendants.

Regional Clinics (serving multiple communities)

There are 27 regional advanced practice clinics, located in hub communities to serve varying numbers of nearby villages. Services provided include advanced practice providers, modest radiology services, modest lab services, dental care, and behavioral health professionals.

Regional Hospitals

Accredited regional hospitals, managed by Tribal Health Organizations. While the services available vary by location, typical services include:

- Clinical care, including inpatient care, outpatient care (including audiology, clinical eye, and vision care), primary care and secondary care, and long-term care.
- Preventive health, including mammography and other cancer screening.
- Dental care.
- Mental health, including community, inpatient, dormitory, therapeutic and residential treatment centers, and training of traditional healthcare practitioners.
- Emergency medical services.
- Treatment and control of, and rehabilitative care related to, alcoholism and drug abuse.
- Injury prevention programs, including data collection and evaluation, demonstration projects, training, and capacity building.
- Home Health Care.
- Community Health Representative program services.

Tertiary Statewide Specialty Medical Care: Alaska Native Medical Center

Located in Anchorage, the Alaska Native Medical Center (ANMC) is a Federal facility jointly managed by the ANTHC and Southcentral Foundation (SCF) under the terms of Public Law 105-83. These organizations have established a Joint Operating Board to ensure unified operation of health services provided by ANMC.

As an acute, specialty, primary, and behavioral healthcare provider, ANMC provides comprehensive medical services to AI/AN people living in the state. The center includes a 173-bed hospital, as well as a full range of medical specialties, primary care services, and labs. Specialty care services include allergy and immunology, audiology, cardiology, dermatology, diabetes, endocrinology, ear nose and throat, emergency and trauma, gastroenterology, general surgery, hepatology, hospitalist, infectious disease, inpatient pediatrics, internal medicine, nephrology, neurology, neurosurgery, OB/GYN services and perinatology, oncology and hematology, ophthalmology, orthopedics, pediatric and neonatal intensive care, palliative care, podiatry, pulmonology, rehabilitation services, rheumatology, sleep medicine, and urology. Primary care services include behavioral health,

complementary medicine, dental, laboratory and imaging, pediatrics, pharmacy, and traditional healing.

ANMC also works in close partnership with Alaska's rural Tribal health facilities to support a broad range of healthcare and related services. As a statewide referral center, ANMC operates both the Quyana House and ANMC Patient Housing facility, combined provide 258 rooms for out-of-town patients and their escorts.

ATHS Tribal Health Organization Profiles

Tribes and Tribal Organizations with Hospitals that Serve Multiple Tribes

Arctic Slope Native Association

- Principal Medical Services Facility: Samuel Simmonds Memorial Hospital, a 14-bed facility located in Utqiaġvik (formerly known as Barrow)
- Number of Tribes Served: The eight Tribes of the North Slope Borough
- IHS 2022 Active User Population: 4,816

The Arctic Slope Native Association (ASNA) manages the Samuel Simmonds Memorial Hospital and provides a full array of healthcare services and administers social service programs for members of the eight Arctic Slope Tribes and residents of the North Slope Borough.

Maniilaq Association

- Principal Medical Services Facility: Maniilaq Health Services (MHS), a 17-bed facility located in Kotzebue
- Number of Tribes Served: 12; The 11 Tribes in the Northwest Arctic Borough and Point Hope
- IHS 2022 Active User Population: 7,665

The MHS provides comprehensive primary healthcare including medical, nursing and community health services based out of the Maniilaq Health Center in Kotzebue, and village health clinics located in each of their communities. Long-term skilled nursing services are also provided at Utuqqanaat Inaat in Kotzebue.

Norton Sound Health Corporation

- Principal Medical Services Facility: Norton Sound Regional Hospital, an 18-bed facility located in Nome
- Number of Tribes Served: 20 Tribes of the Bering Strait region in northwestern Alaska
- IHS 2022 Active User Population: 8,738

The Norton Sound Health Corporation provides healthcare to their villages through referral to their main hospital in Nome. Each village has a clinic staffed by local residents trained as Community Health Aides. Village patients requiring the next level of care are brought to Nome. In an emergency, staff fly to a village to transport the patient back to Nome or on to Anchorage.

Yukon-Kuskokwim Health Corporation

- Principal Medical Services Facility: Yukon-Kuskokwim Health Corporation (YKHC), a 50-bed facility located in Bethel
- Number of Tribes Served: 58 Tribes of southwest Alaska
- IHS 2022 Active User Population: 29,473

At the heart of the YKHC health system are 41 village clinics, staffed by Community Health Practitioners, providing acute, chronic, emergent, and preventative services. When a higher level of care is needed, patient referrals are often made to one of their five Sub-Regional Clinics, located in Aniak, Emmonak, Hooper Bay, St. Mary's, and Toksook Bay. Based in larger sub-regional "hub" communities, YKHC's Sub-Regional Clinics have year-round mid-level providers on staff, limited diagnostic imaging, pharmacy, and dental services. The YKHC's hospital houses the region's only emergency room and also offers inpatient care, serves as a Level Four Trauma center, and has limited surgical services on site.

Bristol Bay Area Health Corporation

- Principal Medical Services Facility: Kanakanak Hospital, a 16-bed located in Dillingham
- Number of Tribes Served: 29 Tribes of the Bristol Bay area
- IHS 2022 Active User Population: 5,284

The Bristol Bay Area Health Corporation (BBAHC) provides tribally-directed healthcare to the people of Bristol Bay serving their widely dispersed villages which are only accessible by air or water craft. The BBAHC provides healthcare support through their rural village clinics and sub-regional clinics utilizing Community Health Aides, Registered Nurse Case Managers, in making assessments, linkages and referrals, care planning, patient advocacy, monitoring and outreach, and collaboration and consultation.

SouthEast Alaska Regional Health Consortium

- Principal Medical Services Facility: Mt. Edgecumbe Hospital (MEH), a 25-bed located in Sitka
- Number of Tribes Served: 19 Tribes in 20 communities throughout SouthEast Alaska.
- IHS 2022 Active User Population: 13,296

The service area of the SouthEast Alaska Regional Health Consortium (SEARHC) stretches across southeastern Alaska. Services include primary care, secondary care, dental, behavioral health, and specialty services provided through a network of 20 community clinics and the MEH in Sitka. The Service Area's village clinics provide Community Health Aide services, health maintenance and disease prevention, telemedicine, emergency medical services, limited primary care, and itinerant dental care. Primary care for all of the villages is provided in existing facilities in Klawock, Sitka, Juneau, and Haines. The MEH is the center for itinerant healthcare providers to other Southeastern Alaska communities.

Alaska Native Tribal Health Consortium

- Principal Medical Services Facility: ANMC, a 173-bed located in Anchorage
- Number of Tribes Served: 229 Tribes of Alaska
- IHS 2022 Active User Population: 159,541

As an acute, specialty, primary and behavioral healthcare provider, ANMC provides comprehensive medical services to all AN/AI living in the state. The center includes a 173-bed hospital, as well as a full range of medical specialties, primary care services and labs. Specialty Care Services include: Allergy/Immunology, Audiology, Cardiology, Dermatology, Diabetes, Endocrinology, Ear Nose/Throat, Emergency/Trauma, Gastroenterology, General Surgery, Hospitalist, Infectious Disease, Inpatient Pediatrics, Internal Medicine, Nephrology, Neurology, Neurosurgery, OB/GYN Services, Perinatology, Oncology/Hematology, Ophthalmology, Orthopedics, Pediatric/Neonatal Intensive Care, Palliative Care, Podiatry, Pulmonology, Rehabilitation, Rheumatology, Sleep Medicine, and Urology. Primary Care includes: Behavioral Health, Dental, Laboratory and Imaging, Pediatrics, Pharmacy, and Traditional Healing.

Tribes and Tribal Organizations with Clinics that Serve Multiple Tribes and/or Native Communities

Aleutian Pribilof Islands Association

- Principal Medical Services Facility: Three Village clinics
- Number of Tribes Served: 13 Tribal communities throughout the Aleutian chain
- IHS 2022 Active User Population: 348

The Aleutian Pribilof Islands Association (APIA) provides community health services including elder care, health education, diabetes prevention, emergency medical training, social services, and health education. All APIA communities are served by itinerant primary care, behavioral health, optometry, and dental providers.

Eastern Aleutian Tribes

- Principal Medical Services Facility: Seven Village clinics
- Number of Tribes Served: Seven Aleut communities of the coastal Alaska peninsula and islands
- IHS 2022 Active User Population: 1,004

The Eastern Aleutian Tribes (EAT) provides patient-centered care through the IHS Improving Patient Care model, a patient-centered medical home concept, working in care teams and providing care in their village clinics. The EAT has the Joint Commission's Primary Care Medical Home Certification and focuses on care coordination, access to care, and partnership with the patient.

Kodiak Area Native Association

- Principal Medical Services Facility: Alutiiq Enwia Health Center
- Number of Tribes Served: Seven Tribal communities throughout the Kodiak Island Archipelago.
- IHS 2022 Active User Population: 2,504

The Kodiak Area Native Association (KANA) operates the Alutiiq Enwia Health Center and the Mill Bay Health Clinic providing primary care, dental and pharmacy services. KANA provides Community Health Aide/Practitioner services to the communities of Akhiok, Karluk, Larsen Bay, Old Harbor, Ouzinkie, and Port Lions. None of the villages are

connected by road to each other or to the city of Kodiak. An itinerant physician or physician's assistant provides scheduled visits to each village.

Southcentral Foundation

- Principal Medical Services Facility: Anchorage Native Primary Care Center (ANPCC)
- Number of Tribes Served: 55 communities in four Tribal regions
- IHS 2022 Active User Population: 58,223

The SCF provides primary care in communities throughout Southcentral Alaska. The SCF provides comprehensive primary care to AI/AN living in Anchorage, the Matanuska-Susitna Valley, Palmer, Talkeetna, Wasilla, and the McGrath region. The SCF operates the Valley Native Primary Care Center in Wasilla, the SCF Primary Care Center in Anchorage and the Nilavena Subregional Clinic in Iliamna. The McGrath Community Health Center provides primary healthcare services to the community of McGrath, Medfra, Nikolai, Takotna and Telida. There is no road system between McGrath and the nearby villages, or between McGrath and Anchorage.

Chugachmiut

- Principal Medical Services Facility: ANPCC and ANMC
- Number of Tribes Served: Seven Tribal communities
- IHS 2022 Active User Population: 1,355

Chugachmiut provides community health aide services in Chenega Bay, Nanwalek, Tatitlek, and Port Graham. Only the Chugachmiut communities of Seward and Valdez are on the road system. The remaining five communities can only be reached by air or water transport. The Ilanka Health Center in Cordova is staffed by two mid-level practitioners and operates through an agreement between Chugachmiut and the Native Village of Eyak. The Valdez Native Tribe subcontracts with Chugachmiut to purchase contract outpatient, pharmacy, dental, and hospital services.

Copper River Native Association

- Principal Medical Services Facility: Robert Marshall Building Clinic
- Number of Tribes Served: Six Tribal communities
- IHS 2022 Active User Population: 882

The Copper River Native Association (CRNA) provides healthcare to the villages of Cantwell, Gakona, Glennallen, Gulkana, Kluti-Kaah), and Tazlina. The CRNA provides community health aide services in the Clinics. All CRNA communities are connected by road system to Anchorage. The CRNA Robert Marshall facility provides the full range of primary care to the CRNA members.

Mt. Sanford Tribal Consortium

- Principal Medical Services Facility: Chistochina Health Clinic and Mentasta Clinic
- Number of Tribes Served: Five Tribal communities
- IHS 2022 Active User Population: 58

Mt. Sanford Tribal Consortium provides community health representatives, alcohol, mental health, and contract health services to the Native residents of Chistochina, Mentasta,

Nabesna, and Slana. All villages are connected by the Richardson Highway to the Mt. Sanford village clinics.

Kenaitze Indian Tribe

- Principal Medical Services Facility: Dena'ina Wellness Center
- Number of Tribes Served: Alaska Native people on the western Kenai Peninsula
- IHS 2022 Active User Population: 4,060

The Kenaitze Indian Tribe (KIT) serves Alaska Native people who live on the western Kenai Peninsula between Point Possession and Kasilof including Cooper Landing, Kenai, Nikiski, Soldotna, and Sterling. All Kenaitze communities are located on the Sterling Highway and are connected by road to Anchorage. The KIT operates Dena'ina Health Clinic in Kenai providing primary outpatient, behavioral, diabetes control, and health education services.

Ketchikan Indian Community

- Principal Medical Services Facility: Ketchikan Indian Community Tribal Health Clinic
- Number of Tribes Served: Ketchikan and Saxman Indian Communities
- IHS 2022 Active User Population: 2,375

The Ketchikan Indian Community (KIC) Tribal Health Clinic provides acute and chronic medical, dental, pharmacy, and behavioral health services. The KIC has a wellness presence, focused on diabetes and offer essential preventive services such as cancer screening, tuberculosis screening, and diabetes screening.

Tanana Chiefs Conference

- Principal Medical Services Facility: Chief Andrew Isaac Health Center
- Number of Tribes Served: 42 Interior Alaska communities
- IHS 2022 Active User Population: 14,820

The Tanana Chiefs Conference provides a wide array of health services including: Diabetes Care, Immunizations, Obstetric Care, Orthopedics, Pediatrics, Radiology, Women's Health, Dental, and Vision to Alaska Native people residing in Interior Alaska.

Council of Athabascan Tribal Governments

- Principal Medical Services Facility: Yukon Flats Health Center in Ft. Yukon
- Number of Tribes Served: Seven Tribal communities
- IHS 2022 Active User Population: 999

The Yukon Flats Health Center is operated by the Council of Athabascan Tribal Governments (CATG) under P.L. 93-638, Title V. The Yukon Flats Health Center is a Community Health Center that provides primary medical, 24-hour emergency, dental, and referral services. The Yukon Flats Health Center provides healthcare to the communities of Arctic Village, Beaver, Birch Creek, Canyon Village, Circle, Venetie, and Fort Yukon.

Tribes and Tribal Organizations that Serve an Individual Tribe Where Their Principal Medical Facility is a Clinic

- Principal Medical Services Facility: Village clinics within their respective communities
- Number of Tribes Served: 17 Tribal communities
- Most of these Title I and Title V compacts have clinics serving their Tribal communities.

Akiachak Native Community

- IHS 2022 Active User Population: 816

Chickaloon Native Village

- Services managed by SCF
- IHS 2022 Active User Population: 13

Chitina Traditional Village Council

- Services managed by SCF
- IHS 2022 Active User Population: 47

Cook Inlet Tribal Council

- Clare Swan offers Brief Outpatient, Outpatient and Intensive Outpatient services to individuals struggling with substance abuse.
- Utilizing a therapeutic "Village of Care" model, the Recovery Journey program is a 12-bed residential unit at the Ernie Turner Center.

Fairbanks Native Association

- The U.S. Department of the Interior owns the land and leases it to Tanana Chiefs Conference, which holds responsibilities for the building, maintenance, etc. The Fairbanks Native Association operates the Graf residential treatment program under a 638 contract with Tanana Chiefs Conference.
- IHS 2022 Active User Population: 9,210

Karluk IRA Tribal Council

- IHS 2022 Active User Population: 26

Knik Tribal Council

- Services managed by SCF

Metlakatla Indian Community

- Principal Medical Services Facility: Annette Island Health Center
- Number of Tribes Served: Metlakatla Indian Community
- IHS 2022 Active User Population: 1,341

The Annette Island Health Center provides acute and chronic medical, dental, pharmacy, optometry, and behavioral health services, and offers essential preventive services such as cancer screening, TB screening, diabetes screening, prenatal care, and health education.

Native Village of Eklutna

- Services managed by SCF

Native Village of Eyak

- IHS 2022 Active User Population: 400

Native Village of Kwinhagak

- IHS 2022 Active User Population: 1,167

Ninilchik Traditional Council

- IHS 2022 Active User Population: 614

Seldovia Village Tribe

- IHS 2022 Active User Population: 702

St. George Traditional Council

- IHS 2022 Active User Population: 49

Tanana IRA Native Council

- IHS 2022 Active User Population: 158

Valdez Native Tribe

- IHS 2022 Active User Population: 259

Yakutat Tlingit Tribe

- IHS 2022 Active User Population: 363

Alaska Tribal Health System Health Facilities Unmet Needs

Figure 11: 2021 Facility Type and Unmet Need

Facility Type	Maintenance & Improvement Unmet Need	New & Replacement Space Unmet Need
Clinics	$ 261,000,000	$1,622,000,400
Regional Hospitals	191,000,000	372,000,000
Alaska Native Medical Center	7,000,000	822,000,000
IHS Expanded Authorities Facilities	0	1,584,000,000
ATHS Health Facility Need	**$ 459,000,000**	**$ 4,400,000,000**

Historically Provided IHS Active Services

The ATHS has a statewide network of over 200 health facilities:

- 171 village clinics
- 27 regional clinics
- Six regional hospitals
- One tertiary care medical center (ANMC)

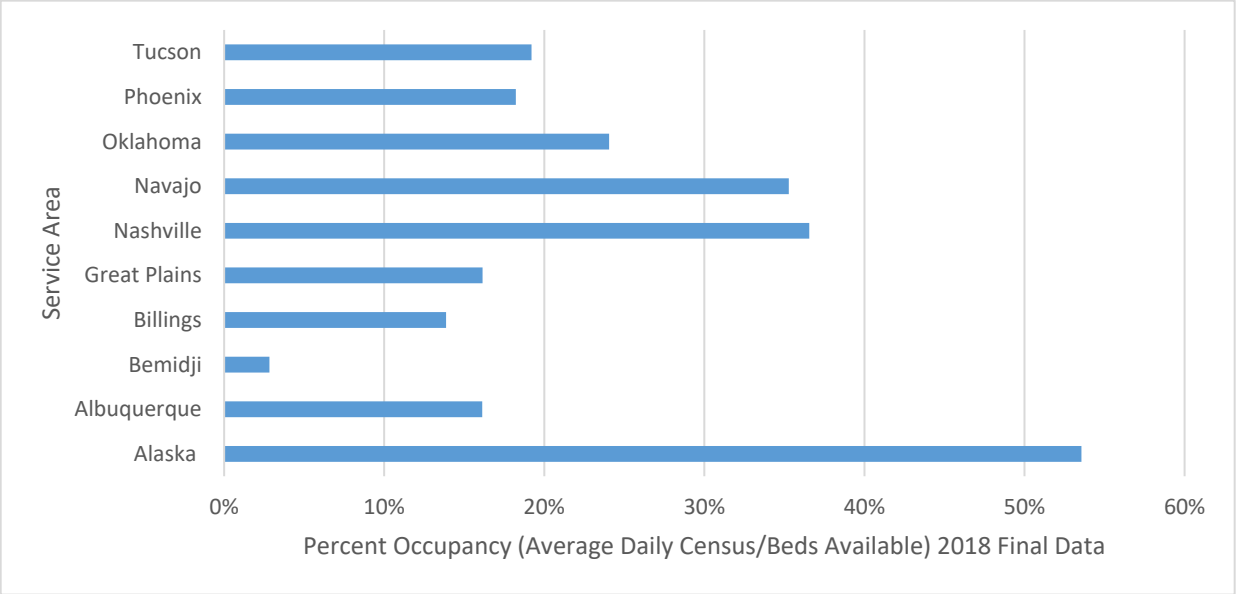
The ATHS has been fortunate to have three of their regional hospitals (Bethel, Nome, and Utqiaġvik,) replaced or expanded in recent years. Remaining inpatient facilities range from 21 to 64 years of age, with Anchorage, Dillingham, Kotzebue, and Sitka's inpatient facilities delivering services from undersized and often outdated facilities, severely restricting healthcare services delivery. Sitka was selected in 2020 to participate in the IHS Joint Venture Construction Program (JVCP), but will continue using the exiting 64-year old hospital for the next several years while the replacement is being designed and built.

In 2016, the IHS reported that the ATHS had 2.8 million square feet of existing space in the ATHS healthcare facilities and an unmet need for new and replacement space of $2.8 billion. As of 2020, there are three million square feet of existing space. Using the IHS 2021 healthcare facilities unmet needs report preparation methodologies, a 2021 unmet need of 2.5 million square feet of new and one million square feet replacement space is required, with an estimated cost of $4.4 billion. This is an increase in unmet need of almost 60 percent over the last five years. With a projected need for 5.5 million square feet of healthcare facility space, only 55 percent of clinical space required is available for the current AI/AN active users served by the ATHS. This is especially evident in ANMC where the daily adult inpatient load has, at times, exceeded 100 percent during FY 2019, requiring patient diversion to purchased/referred care and long wait times in the emergency department (ED) as a result of bed availability limitations.

The national IHS/Tribal Health System has five medical centers, including ANMC. The IHS FY 2018 Hospital Inpatient Statistics for IHS and Tribal Hospitals reports an average daily patient load (ADPL) for ANMC of 75.5 percent. For the other four medical centers, the combined ADPL is 31.1 percent, well less than half the ANMC utilization. By a large margin, ANMC has the highest ADPL for all hospitals and medical centers in the IHS/Tribal Health System. The ANMC has continued to see a high utilization of inpatient units. The Medicine and Surgery units are most impacted. They comprise the 92 adult beds of ANMC's 173 total beds. Today, the ANMC adult ADPL is over 100 percent and continues to rise.

The ATHS regional hospitals also have an average 31 percent higher utilization that than other 50 bed or less hospitals in the national IHS/Tribal Health System. To deliver the best modern medical care, facilities must be sized to the populations they serve and designed to optimize the medical services and procedures provided.

Figure 12: Average Percent Patient Occupancy of IHS and Tribal Hospitals by Service Area



[4]

The benefits of high-quality healthcare are only realized when Alaska Native people can readily access the healthcare facilities that provide the appropriate covered services. The ATHS facility sites offer the only feasible source of healthcare access for many Alaska Native people, who experience low health status compared to many non-Native populations.

Challenges for the facilities of the ATHS include:

- Adequacy for current and future health treatment needs.
- Undersized space capacity for populations served.
- Increase in specialized medical care needs.

Alaska Native people often choose culturally competent service providers when they have a choice; therefore, high utilization of Tribal health facilities is expected to continue. The majority of existing facilities are undersized for the populations currently served.

All totaled, the Alaska health facilities unmet need for services historically provided by the IHS under their active authorities is $2,815,200,000.

[4] Source: FY2018 IHS OPHS Report on Hospital Inpatient Statistics

Estimates for Expanded Authority Health Care Facilities

The IHS has not yet completed its assessment of new healthcare facility types included in the reauthorization of the Indian Health Care Improvement Act (IHCIA). These service categories have not been historically provided through the IHS healthcare network. These specific service types require corresponding unique facility types.

Because the IHS has not funded facilities for these types of services, it has not yet planned and sized these types of facilities. The IHS's facility planning and design methodology does not include criteria for such services yet; however, development planning criteria are currently underway.

The IHS conducted a preliminary assessment of facility needs for services by surveying priorities of Tribes in 2015. The survey listed a range of healthcare facility types, available under both active and expanded authorities. Survey respondents ranked the top five healthcare facility needs for their communities. The five priority expanded authority service types for Tribes are as follows:

- Inpatient Mental Health and Inpatient Alcohol Substance Abuse treatment.
- Long-Term Care Facilities:
  - Clinical - Primarily engaged health-related care (Skilled Nursing Facility) (Rehabilitation after hospitalization, Nursing Facility, Alzheimer's, cognitive delays, or other disabilities special care).
  - Non-Clinical – Primary focus on Activities of Daily Living (ADLs). Custodial Care (Residential Care Adult Day Care, board, "group," independent and assisted living homes and communities that provide incidental medical care).
- Specialty Care Center: Cardiology, Orthopedics, Urology, Ophthalmology, Podiatry, Bone Mineral Density, Chemotherapy, Dermatology, and Otolaryngology.
- Dialysis.

The IHS identified a scope of needs for five types of expanded authority facilities ranked highly by Tribes. In the absence of official IHS planning criteria for these facility types, the IHS used averages from industry standards along with disease burden health data published by other agencies to develop basic estimating criteria. These criteria were used to estimate unmet need for the top five priority facility types in the FY 2016 IHS and Tribal Health Care Facilities' Needs Assessment Report to Congress. These preliminary estimates will be revised as official IHS planning criteria for these types of facilities are established.

In total, the Alaska health facilities unmet need for expanded authority services included in the 2010 IHCIA Reauthorization, but not historically provided by the IHS is $1,584,300,000.

Figure 13: 2021 Alaska Health Facility Unmet Needs Space and Cost Calculations Summary Table

IHS Active Authorities			IHS Expanded Authorities		
T/TO	New and Replacement Space (ft²)	Unmet Facilities Need ($)	**Facility Type**	New Space (ft²)	Unmet Facilities Need ($)
Annette Island Service Unit	-	$-	Clinical Long Term Care	599,400	$693,500,000
Akiachak Traditional	5,000	4,600,000	Non-Clinical Long Term	266,600	308,500,000
Alaska Native Medical	833,400	821,700,000	Dialysis Center	91,800	117,600,000
Aleutian Pribilof Islands	7,700	12,400,000	Regional Specialty Care	203,000	272,800,000
Arctic Slope Native Assoc.	66,000	177,100,000	Inpatient Behavioral Health	165,900	191,900,000
Bristol Bay Area Health	132,000	211,700,000			
Council of Athabascan Tribal Governments	5,800	7,000,000			
Chitina Traditional Council	-	-			
Chugach	33,900	50,200,000			
Copper River Native	23,300	37,400,000			
Eastern Aleutian Tribes	26,600	41,500,000			
Eyak	15,600	23,200,000			
Fairbanks Native Assoc.	-	-			
Kodiak Area Native Assoc.	76,600	123,000,000			
Karluk IRA	1,500	2,400,000			
Ketchikan Indian	18,400	19,300,000			
Kenaitze Indian Tribe	40,600	40,700,000			
Kwinhagak	-	-			
Maniilaq Assoc.	71,000	205,800,000			
Mt. Sanford Tribal	3,300	5,300,000			
Ninilchik Traditional	3,300	4,300,000			
Non-Tribal Ownership	19,300	194,000,000			
Norton Sound Health Corp.	1,900	3,000,000			
Native Village of Eklutna	353,300	333,000,000			
Southcentral Foundation	129,300	148,400,000			
SouthEast Area Regional Health Consortium	1,500	2,400,000			
St. George	2,000	3,200,000			
Seldovia Village Tribe	123,400	143,300,000			
Tanana Chiefs Conference	9,200	14,100,000			
Tanana Tribal Council	1,100	1,800,000			
Tyonek, Native Village of	300	400,000			
Valdez Native Tribe	-	-			
Yakutat Tlingit Tribe	195,600	184,000,000			
TOTAL	**2,200,900**	**$2,815,200,000**	**TOTAL**	**1,326,700**	**$1,584,300,000**
ALASKA AREA TOTAL		**~ 3,530,000 ft²**			**~ $ 4,400,000,000**

1. T/TO submitted planning documents were used for ANMC space and cost, and SCF space.
2. For buildings with current JVCP & SAP awards, IHS assumes they have zero new space unmet need (e.g. CATG – Arctic Village, Chugachmiut – Seward, Kwinhagak, Ninilchik – renovation space only, TCC – Tok, SEARHC, Yakutat, and YKHC)
3. North Slope Borough clinics attributed to ASNA

Maintenance and Improvement

Facility aging has increased costs and risks associated with maintenance and repairs. This trend has been accelerated as maintenance and repair deficiencies could not be fully corrected because the maintenance and improvement budget was insufficient. The current reported Alaska backlog of essential maintenance, alteration, and repair (BEMAR) is $228 million. There is concern that this number is under reported by facility managers due to the limited amount of funding available for such projects.

When a facility is unable to keep up with maintenance needs, the risk of failure increases. For example, to balance the budget, informed decisions are routinely made to defer maintenance to save money. When the building equipment suddenly stops working, the consequent financial damage and lost productivity results in being many times greater than the cost the facility would have incurred had it not deferred maintenance.

In alignment with industry best practice, a sustainable IHS Maintenance and Improvement (M&I) program is estimated by IHS at 6.4 percent of eligible building replacement value (CRV) for maintenance, repair, and renovation of medical facilities. Within the IHS M&I system, 1.2 percent is currently allocated to routine/non-routine maintenance, 2.2 percent to deferred maintenance, and three percent to major renovation. For the ATHS building inventory, that equates to $112.2 million annually. The FY 2020 funding for Alaska M&I was $23.6 million, 21 percent of best practice. This results in an annual shortfall of $88.6 million. Adequate funding is essential to ensure functional healthcare facilities that meet building/life safety codes, conform to laws and regulations, and satisfy accreditation standards.

The IHS Supported Tribal Health Facility Construction in Alaska over the Last Five Years

There are three IHS construction programs that provide new and replacement healthcare facilities:

1. **New Construction**: Under this option, the IHS provides funding to plan, design, construct, and equip the healthcare facility and to staff, operate, and maintain the completed facility. Priority is based on a list of facilities established in 1993. No new facilities have been added to this list for 30 years[5]. Of the 27 original projects, seven remain to be funded. At the current funding level for this program, Tribes will continue to be locked out of this opportunity for at least another 8 to 10 years. The last Alaska facility on this list was the Samuel Simmonds Memorial Hospital in Utqiaġvik; it was completed in 2013.

2. **Joint Venture Construction Program**: Under this option, the participating Tribes have resources outside of the IHS appropriations. They provide planning, design, equipment,

[5] 25 U.S.C. 1631(c)(1)(D)

and construction funding, and lease the facility to the IHS at no cost for 20 years. The IHS then provides funding to staff, operate, and maintain the completed facility. A new list of participating Tribes is established via competitive application every three to five years. Tribes with resources wait eagerly for each opportunity; Tribes are prepared to fully-fund the cost of planning, design, equipment, and construction. However, despite the project cost savings to the Federal Government, the selection of projects is very limited. Over the last five years, Alaska has submitted 15 eligible applications resulting in five awards or 33 percent of all JVCP projects. Additional appropriations would allow the IHS to further leverage Tribal resources and improve care throughout the IHS healthcare network.

3. **Small Ambulatory Program**: Under this option, the IHS provides planning, design, and construction funding up to a cap of $2 million for each project. The participating Tribes then provide funding to staff, operate, and maintain the completed facility. A new list of participating Tribes is established via competitive application every three to five years. Only Tribes with other resources can participate. The cap on IHS construction funds limits these projects to very small facilities or requires a Tribe to augment project funding in addition to providing the staffing. In Alaska, more than 60 percent of construction funding was also provided by participating Tribal organizations.
   Since 2016, Alaska [Small Ambulatory Program] funding totaled $31.2 million ($12.3 million Federal and $18.9 million Tribal), with seven facilities completed or in progress. For JVCP, the Tribes committed $527.9 million in project funding, with four facilities completed or in progress.

Figure 14: Completed ATHS Health Care Facilities as of August 2020

Completed Facilities						
Facility	Location		Year Completed	Federal Funding	Tribal Funding	Space
Ninilchik Village Tribe	Ninilchik, AK	SAP	2019	$ 568,661.00	$ 931,339.00	2,819
Norton Sound Health Corporation	Shishmaref, AK	SAP	2020	$ 2,000,000.00	$ 4,379,634.00	5,200
Yakutat Health Center	Yakutat, AK	JV	2020		$ 9,600,000.00	10,900
Yukon Kuskokwim Health Corp	Kongiganak, AK	SAP	2020	$ 2,000,000.00	$ 528,000.00	2,711
			Total	$ 4,568,661.00	$ 15,438,973.00	21,630
Facilities Currently Under Construction						
Facility	Location			Federal Funding	Tribal Funding	Space
Tanana Chiefs Conference	Tok, AK	SAP		$ 2,000,000.00	$ 11,297,000.00	11,968
Yukon Kuskokwim Health Corp	Bethel, AK	JV			$ 236,585,499.00	252,392
			Total	$ 2,000,000.00	$ 247,882,499.00	264,360
Facilities Currently In Design						
Facility	Location			Federal Funding	Tribal Funding	Space
Chugachmiut Outpatient	Seward, AK	JV			$ 15,000,000.00	14,164
Chugachmiut Tatitlek Renovation	Tatitlek, AK	SAP		$ 1,731,339.00		2,592
Council of Athabascan Tribal Governments	Arctic Village, AK	SAP		$ 2,000,000.00	$ 1,503,134.00	2,257
Native Village of Kwinhagak (YKHC	Quinhagak, AK	SAP		$ 2,000,000.00	$ 215,024.00	2,800
Southeast Alaska Regional Health Consortium	Sitka, AK	JV			$ 266,744,937.00	230,627
			Total	$ 5,731,339.00	$ 283,463,095.00	252,440
HHS NEF Awards from IHS						
Facility	Location		Year Awarded	Federal Funding	Tribal Funding	Space
Alaska Native Medical Center Expansion	Anchorage, AK	NEF	2019	$ 14,000,000.00		252,291
			Total	$ 14,000,000.00	$ -	252,291
Grand Totals				Federal Funding	Tribal Funding	Space
				$ 26,300,000.00	$ 546,784,567.00	790,721

Capital Funding Options

This report outlines the funding options available to replace, expand, and/or renovate ATHS health facilities, and describes the advantages, disadvantages, and obstacles of each funding option.

In accordance with Congressional direction in 25 U.S.C. § 1631(c)(l)(D), priority of certain projects is protected, and requires the IHS to first allocate appropriated Health Care Facilities Construction funds to construct projects on the Priority List, which means the IHS would not be able to fund replacement of ATHS facilities until all Priority List facilities were complete and the ATHS facilities appeared in a subsequent Priority List. It is important that all current projects on the Priority List be completed before considering new projects. The funding options considered by the IHS and the ATHS include the following:

Appropriated Health Care Facilities Construction Funds – IHS facilities appropriations are the primary funding source for new or replacement healthcare facilities. See the New Construction option in the previous section for more information.

Joint Venture Construction Program - The JVCP is for projects in which T/TOs construct or acquire an appropriately sized facility and, in return, the IHS agrees to request appropriations from Congress for operating and maintaining the healthcare facility. See the JVCP option in the previous section for more information.

Small Ambulatory Program: Under this option, the IHS provides planning, design, and construction funding. See the SAP option in the previous section for more information.

Maintenance and Improvement & Backlog of Essential Maintenance and Repair - The ATHS currently receives approximately $40 million annually in M&I and BEMAR funds through funding agreements and project funding agreements for M&I eligible facilities. These funds are only available for the maintenance and repair of existing eligible facilities and not for new space.

Repair by Replacement Program - The IHS repair-by-replacement (RBR) program utilizes M&I funding to federally-owned buildings for which the cost to replace a building is more cost-efficient than renovating it. The intent of RBR is to alleviate maintenance and repair deficiencies in smaller, usually older or temporary, buildings in the most economical way. The RBR is not intended for replacing existing large complex buildings nor circumventing the Health Facilities Construction Priority System or the Quarters Construction Priority System. The M&I funds are used to replace an existing building when replacement is demonstrated to be more cost-effective than renovation. An RBR project provides funding to construct a new facility that is the same size plus or minus 10 percent of the facility being replaced. The RBR program does not provide funding for additional staffing. The ATHS M&I eligible facilities are typically not good candidates for this program because they are undersized and require significant additional space from which to deliver healthcare services.

Special Appropriation from Congress – Unique appropriations for constructing facilities. Examples:

- The Affiliated Tribes Health Facility Compensation Act, P.L. 108-437, 118 STAT. 2623, constructed the Elbowoods Memorial Health Center with congressional funding through the Army Corps of Engineers.
- The American Recovery and Reinvestment Act of 2009 funded IHS healthcare facility construction.

Nonrecurring Expenses Fund: The Consolidated Appropriation Act of 2008, Division G, Section 223, permits HHS to transfer unobligated balances of expired discretionary funds from FY 2008 and onward into the Nonrecurring Expenses Fund account to be used for capital acquisitions, including facilities infrastructure.

U.S. Department of Housing and Urban Development Section 242 - The Office of Health Care Programs within the U.S. Department of Housing and Urban Development administers the Section 242 Mortgage Insurance for Hospitals program. The program provides credit enhancement commitments (insurance against losses) for health facility replacement, remodeling, and expansion-including purchase of existing facilities, modernization, and equipment.

The U.S. Department of Agriculture Rural Development Community Facilities Program - The U.S. Department of Agriculture makes and guarantees loans to develop "essential community facilities," which include clinics, ambulatory care centers, hospitals, rehabilitation centers, and nursing homes, in rural areas and towns with populations of up to 20,000. These loans may be used to construct, enlarge, or improve healthcare facilities.

The Health Resources and Services Administration - The Health Resources and Services Administration's Federal Office of Rural Health Policy, has resources that may be applicable, including "Critical Access Hospital Replacement – "The Manual"." The Agency also oversees the Health Center Loan Guarantee Program which can reduce the costs of financing needed for capital projects at existing health center awardees.

Tribally-Funded - The ATHS has funded millions of dollars in small improvement and repair throughout the system. However, the ATHS cannot independently fund a major replacement project given the amount of capital required. However, the ATHS may be able to work with partners to secure funding from another source. Examples follow: (1) with the Denali Commission, the ATHS provided over $150 million to replace over 100 aging village clinics that were varying states of disrepair; (2) The Bureau of Indian Affairs (BIA) Indian Loan Guarantee Program helps Tribal borrowers secure business financing on commercially reasonable terms. Borrowers must have 20 percent equity in the project being financed and the project must benefit the economy of a reservation or Tribal service area. The BIA indicated that the largest loan to date has been $35 million but loan requests for between $60 and $80 million are currently being considered; and (3) In the future, another possibility for the ATHS is to use the authorities of 105(*l*) leasing as an assurance of financial stability when qualifying for a private sector construction loan, once a clear and sustainable funding source is established by the IHS.

Alaska Municipal Bond Bank Authority - The Alaska Municipal Bond Bank Authority (AMBBA) is a public corporation that aids in financing capital improvement projects, such as schools, water and sewer systems, and public buildings. The AMBBA generates funding by selling bonds on the national market and using the proceeds to purchase bonds from authorized borrowers within the state. Administratively supported by the Alaska Department of Revenue, a board of five directors determines the Bank's actions, such as setting interest rates and approving loans.

Public Law 85-151, 71 Stat. 370 as amended at 42 U.S.C. § 2005 et seq. - This Public Law authorizes funds available to partially fund the construction of a hospital that serves Indians and non-Indians.

Summary of New and Replacement Space Submitted by ATHS Organizations

Eight of the 35 ATHS T/TOs submitted planning documents that outline their highest priority projects. Summaries of the eight ATHS T/TO submissions are included below.

Alaska Native Tribal Health Consortium – Alaska Native Medical Center

The ANTHC is a nonprofit Tribal Health Organization designed to meet the unique health needs of AI/AN people living in Alaska. In partnership with the AI/AN people that we serve and the Tribal Health Organizations of the Alaska Tribal Health System, ANTHC provides world-class health services. The work includes tertiary inpatient and outpatient specialty medical services at the ANMC, wellness programs, disease research and prevention, rural provider training, and rural water and sanitation systems

The 2013 ANMC Master Services Plan evaluated current and future population trends, in addition to the future needs for medical services. The plan identified that ANMC was less than half the size it needs to be. This additional space requirement was also identified in the Alaska Area Master Health Plan completed in 2006. Since the opening of the hospital, ANMC has explored many master planning options for expansion to meet the space needs. The landscaping and parking area to the north and east of the hospital is the clearest available area of expansion for inpatient services.

The ANMC is currently operating in excess of its capacity and experiencing severe inpatient space limitations. As shown in Figure 15: *Patient Bed Occupancy Over Time – Adult Med/Surg* graph, since May 2019 the occupancy rate has exceeded the available bed capacity as staff have held patients in non-inpatient spaces such as the ED, until medical or surgical inpatient beds became available. A projection for 1993 anticipated that the current ANMC replacement facility would provide 86,450 outpatient visits on an annual basis. In FY 2019, ANMC provided over double this estimate with 185,130 outpatient visits. The ANMC service population is currently 177,345 and expected to increase to 232,203 by 2030. Inpatient admissions and outpatient specialty visits are at an all-time high. The ANMC is in desperate need of more space to provide crucial healthcare services for AI/AN people.

Figure 15: ANMC Patient Bed Occupancy over Time

The ANTHC is currently engaged in the development of a Project Justification Document (PJD) and a Program of Requirements (POR) for the ANMC North Tower project. This project fits into the 'Group Two' of the overall ANMC Health Facility Master Plan, which focuses on in-patient adult bed expansion. Below is a summary table of the Masterplan Groups to provide the overall perspective of ANMC's unmet need, highlighting the overall $797.8 million in facility construction and remodel needs. When escalated by three percent to 2021, this number becomes $821.7 million.

The ANMC North Tower planning is based on the healthcare needs of the growing Alaska Native population. The project uses the calculated historical 32 percent population growth rate from 2004 to 2017 to inform the needs of the ANMC clinical needs in the year 2030. An aging factor is added to the population to more accurately represent service needs for the hospital in 2030. Included in Appendix A of this report are the pre-conceptual planning documents for the ANMC North Tower project. The project's 95 percent POR//PJD cost estimate is $344.3 million but will continue to be refined with the continued project development. The POR/PJD is expected to be completed by the end of 2020.

Figure 16: ANMC Facility Master Plan Cost Summary

Project Group	Project	Area	Project Cost	Funding Source	Cumulative Cost of Group	Total Cumul. Cost
GROUP 1	Parking North of Hospital		$ 20.3 M	FTA Grant	$ 20.3 M	
	Patient Housing	202 rooms	$ 50.0 M	State of AK	$ 70.3 M	
	ANMC Inpatient Renovations	55,300	$ 34.7 M	ARRA+ANTH	$ 105.0 M	
	Specialty Clinic Campus Renovations	139,682	$ 35.8 M	ANTHC	$ 140.8 M	
	ANMC Clinic Remodels	19,600	$ 2.8 M	ANTHC	$ 143.6 M	
	ANMC Clinic Remodels	52,500	$ 3.3 M	ANTHC	$ 146.9 M	
	Progressive Care and CCU Addition	6,800	$ 13.3 M	ANTHC/311	$ 160.2 M	
					$ 160.2 M	**$ - M**
GROUP 2	Surface Lot H		$ 1.5 M		$ 1.5 M	
	North Tower Addition & ANMC Remodel	326,719	$ 315.1 M	TBD+NEF	$ 316.6 M	
	North Tower Structured Parking	195,000	$ 27.7 M	TBD+NEF	$ 344.3 M	
					$ 344.3 M	**$ 344.3 M**
GROUP 3	Campus Infill and Remodels	179,400	$ 108.0 M	TBD	$ 108.0 M	
	Specialty Clinic Structured Parking	162,500	$ 20.7 M	TBD	$ 128.7 M	
					$ 128.7 M	**$ 473.0 M**
GROUP 4	Large East Addition & ANMC Remodel	327,300	$ 315.7 M	TBD	$ 315.7 M	
	Large East Structured Parking	64,300	$ 9.1 M	TBD	$ 324.8 M	
					$ 324.8 M	**$ 797.8 M**

Footnotes:

1. Cost are escalated to 2020 dollars
2. Large East Addition includes New 217,500 SF, Remodel 109,800 SF, Parking 64,300 SF. Cost estimate based on North Tower $/sf

Bristol Bay Area Health Corporation

Incorporated in Appendix B is the BBAHC Long Term Care Needs Assessment, Business Plan & Facilities Master Plan Update, Final Report dated August 31, 2017.

The BBAHC Kanakanak Hospital - Dillingham Campus Master Plan has been updated to incorporate a new two-story addition to the existing Hospital, and a new staff housing building with eight two-bedroom units. The two-story addition to the hospital includes the relocation and replacement of physical therapy, audiology, pre-maternal quarters, and boarders' quarters. The staff housing is planned uphill and west of the hospital, north of Berrypicker's Lane.

Figure 17: BBAHC Projects Cost Estimate
This master plan update outlines two projects for the campus of the following scope and costs:

Project Description Building Gross	Square Feet	Budget Estimate
1. Two Story Hospital Addition: Quarters; Physical Therapy and Rehabilitation; Audiology	13,603 SF	$ 6,829,934
2. Staff Quarters: (8) 2-bedroom units	10,241 SF	$3,584,235

The Kanakanak Hospital Executive Team has identified the two-story hospital addition as their priority project, with the new staff housing project following the completion of the addition. If funding and construction capacity are available both projects could be pursued simultaneously.

The scope of the master plan does not address the overall need of the facility, the age of the existing hospital or the needs of the user population by 2030, consequently the IHS Health System Planning (HSP) runs were used as the basis for BBAHC unmet needs summarized in this report.

Council of Athabascan Tribal Governments

Incorporated in Appendix C is the Council of Athabascan Governments FY 2019 SAP application for Arctic Village.

The proposed project will replace the existing clinic with a new replacement building in Arctic Village. The new approximately 2,500-square foot clinic will be designed and equipped with piped water and sewer services and will incorporate the latest features of healthcare design. The existing 1,310-square foot clinic was not constructed to healthcare standards, and a code and condition survey conducted in 2001 found numerous deficiencies. The clinic has no running water or piped sewer. The clinic was constructed in about 1990 as a converted log cabin.

Care is provided by a Community Health Aide The Community Health Aide/Practitioner is able to provide basic health services including diagnosing and treating minor illnesses and injuries, working with other itinerant providers (physician, physician assistants, nurse practitioners and Behavioral Health Aides and a mobile dentistry program).

Figure 18: Arctic Village clinic Project Cost Estimate

Item	Task Description	Cost
a	Administrative and legal expenses	$ 5,000
b	Site acquisition	$ -
c	Planning (including NEPA determination)	$ 15,000
d	Design	$ 84,667
e	Engineering services	$ 80,000
f	Construction inspection	$ 130,
g	Site work	$ 100,
h	Demolition and removal	$ -
i	Construction	$2,400,000
j	Equipment	$
k	Miscellaneous or other (Utilities)	$ 70,000
l	**Subtotal (Sum of items "a" thru "k")**	**$ 3,184,667**
m	Project contingency (10 percent)	$
	Total project costs (Sum of items "l" and "m")	**$ 3,503,134**

Kodiak Area Native Association

Incorporated in Appendix D is the KANA Health Center Facility Expansion Concept Report. KANA is planning to redevelop the Alutiiq Enwia Health Center in Kodiak, Alaska to address space and programmatic needs affecting Behavioral Health, Medical, and Dental programs. KANA intends to pursue a JVCP agreement with the IHS to ensure the future sustainability of the facility expansion. With the user population expected to increase to 7,000 by 2031, building additional space at this facility will help KANA better serve the current population and prepare for the future. To alleviate these constraints, additional space is needed for:

- Clinical space to accommodate current services that lack space
- Offices
- Administrative support
- Mechanical support
- Storage (pharmaceuticals, durable medical equipment)

Based on current user population and projected population increases, the IHS HSP software recommends that KANA facilities should total 117,554 square feet to properly serve the 2030 design population. The three-page concept paper provided insufficient basis for space and cost projections, and consequently IHS HSP runs were used as the basis for the KANA unmet needs summarized in this report.

Maniilaq Health Corporation

Incorporated in Appendix E is the Maniilaq Association Facility Master Plan 2018 – 2028 (FMP).

The Maniilaq Association is a non-profit corporation recognized under section 501(c) (3) of the Internal Revenue Code of 1972 as amended. The Maniilaq Association is a rural health, social, and Tribal services provider with a budget in excess of $80 million annually, and more than 500 employees. It is the largest single employer within the Northwest Arctic.

The MHC has identified six priority projects under their 2018 to 2020 immediate needs:

- Priority #1- MHC Building Automation System Replacement - Phase 1-Construction
- Priority #2- Employee Housing-Phase 1, 16 units
- Priority #3- Lake Street Boiler Room Upgrade.
- Priority #4- Putyuk Double Wall Fuel Tank.
- Priority #5- MHC Space Utilization Study - Allied Health Building.
- Priority #6- Demolition of Duplexes- Pursuant to new housing (#2 above).

Facility Need Priority- Mid-Range - 2021 to 2023

The MHC identified eight projects as a part of their mid-range priority needs. See Appendix A of the FMP for details.

Facility Need Priority- Long Range - 2024 to 2028

The MHC has identified eight projects as their long-range priority needs. See Appendix A of the FMP for details.

The focus of the FMP was primarily quarters, and renovation. Due to the limited scope of the facilities master plan, the IHS HSP runs were used to better estimate total Maniilaq facilities unmet needs.

Southcentral Foundation

Incorporated in Appendix F is the SCF 2018 Master Plan.

The SCF is an Alaska Native-owned, nonprofit healthcare organization serving nearly 65,000 AI/AN people living in Anchorage, Matanuska-Susitna Borough, and 55 rural villages in the Anchorage Service Unit. Incorporated in 1982 under the Tribal authority of Cook Inlet Region, Inc. (CIRI), Southcentral Foundation is the largest of the CIRI nonprofits.
The SCF vision is a Native Community that enjoys physical, mental, emotional, and spiritual wellness; its mission is to work together with the Native community to achieve wellness through health and related services. The organization has developed and implemented comprehensive health-related services to meet the changing needs of the Native community enhance culture and empower individuals and families to take charge of their lives.

The plan is a roadmap for development that addresses short-term goals now in progress, and provide a long-range vision that enhances the SCF vision and mission, as summarized below:

Alaska Native Health Campus

- Develop expansion strategies to meet needs, balanced with budgetary considerations.
- Update the coordinated campus plan and identify collaborative opportunities and challenges.
- Guide future plans to meet short-term clinical needs.

Mat-Su Valley Campus

- Develop expansion strategies to meet needs, balanced with budgetary considerations.
- Create a coordinated campus plan and identify collaborative opportunities and challenges.
- Guide future plans to meet short-term clinical needs.

Anchorage Off-Campus Facilities

- Document existing sites, opportunities, and challenges.
- Identify potential community partnerships.

Anchorage Service Unit (future)

- Document existing sites, opportunities, and challenges.
- Identify potential community partnerships.

The plan presents the current and future healthcare needs of the AI/AN population in the southcentral region of Alaska. Through asset optimization, the SCF will achieve sustainable operations, responsible growth, and enhanced Customer-Owner wellness. The plan recommends a path forward that utilizes existing space and vacant land to its fullest potential. Additionally, it recommends redevelopment of underutilized property as part of the long-range development plan in Anchorage and the Matanuska-Susitna Valley.

Figure 19: SCF Anchorage Service Unit Cost Estimate

Description	Current Space (ft^2)	2025 Total Space (ft^2)	New Space (ft^2)
Behavioral Health Services	73,773	171,308	97,535
Dental Services	74,684	81,079	6,395
Medical Services	166,260	217,978	51,718
Executive and Tribal Services	22,320	47,727	25,407
Office of the President	17,977	16,888	-
Organizational Development	28,024	23,147	-
Native Hospital	3,000	7,000	4,000
Totals	**386,038**	**565,127**	**185,055**

SouthEast Alaska Regional Health Consortium

Incorporated in Appendix G is the SEARHC draft PJD for the Mt Edgecumbe Hospital JVCP, May 2018. The Project Summary Document space and cost data were not used in this report, as buildings with JVCP awards are assumed by the IHS to have no unmet need.

The SEARHC is a non-profit health consortium established in 1975 under the provisions of the Indian Self-Determination and Education Assistance Act (P.L. 93-638). Contracting with IHS began in 1976 with SEARHC assuming operation of the Community Health Aides Program. In

1982, the IHS Juneau Clinic, now Ethel Lund Medical Center, was also assumed by SEARHC. The MEH was assumed from the IHS in 1986.

The SEARHC is headquartered in Juneau, Alaska. The MEH, the flagship of the Consortium, is located in Sitka, Alaska, 93 air miles southwest of Juneau and 591 air miles southeast of Anchorage. Sitka is located on the outer coast of Alaska's inside passage on Baranof Island, a largely unpopulated land mass of 1,607 square miles. The 2015 Census shows 36 percent of Sitka residents are Alaska Natives, and 64 percent are non-Native. The community anticipates a total projected 2030 population of 8,760, and a 2030 IHS beneficiary user population of 3,895.

The MEH is the only Native full-service health provider in Sitka and on Baranof Island, offering a wide variety of needed primary, secondary, social, and traditional healthcare services. The MEH not only serves the needs of Sitka Natives, but also the referral needs of 19,920 largely rural Natives dispersed across the southeast portion of the state – a number projected to grow to 22,491 by 2030. Service delivery is based on a "tiered referral care model" with remote village clinics providing primary care services in their local facilities and referring specialty/higher levels of care to either Juneau or Sitka. Inpatient needs are referred to MEH in Sitka. Services not provided at MEH are referred out of the region to ANMC in Anchorage or other out-of-area or out-of-state care, Seattle being the nearest.

Services have grown significantly over the past 75 years since the current hospital opened, as population and demand for healthcare increased, and delivery of care has changed. To meet the projected 2030 demand for inpatient/outpatient services, the MEH will require replacement.

The Alaska Area Health Services Master Plan and the MEH FMP call for primary care, emergency care, specialty/diagnostics care, birthing, medical acute care, pediatrics and surgical acute care, and transitional care. However, the existing facility, built in 1943, is inadequate, inflexible, and unable to support the quality and quantity of projected services.

The new MEH will house primary care in a modern and efficient space, consolidating services presently located at two different points of care, one of which is off campus. Co-locating all outpatient services to the new facility will:

1. Allow outpatient services to grow
2. Improve patient care
3. Increase service efficiencies between outpatient and inpatient services

In addition, the new MEH Acute Care Nursing Unit will be built to meet the projected volumes and functional requirements for inpatient services. Services will be provided at the facility by MEH staff.

The new outpatient clinic will house primary, behavioral, specialty, dental, eye, audiology, and alternative care. The new inpatient unit will house acute care, labor and delivery/nursery, surgery, medical supply, clinical engineering, facility management, property and supply, information management, communications, employee facilities and dietary services. Located in between, facilitating efficient shared access by inpatient and outpatient services, will be imaging, pharmacy, rehab, lab, emergency, and the clinical decision unit.

The project will be located on the 30.11 acres of the present MEH campus. Alternative project locations in Sitka are not possible due the unavailability of land, driven by the community's unique coastal location, road system restrictions, and minimal available land between the water of Sitka Sound and the mountains of Tongass National Forest.

The PJD is intended to justify and detail the replacement of the MEH by the IHS. This document proposes SEARHC and the IHS enter into a JVCP agreement wherein SEARHC builds a new facility and renovates their existing facilities while IHS agrees to request funds from Congress in their annual appropriations to support the corresponding additional department related staff funding. The POR guides the architect in project design.

The PJD presents to the IHS for their consideration a program of services for a replacement of the existing, aging MEH, in Sitka, Alaska, with a modern, fully equipped 25-bed Critical Access Primary Care Acute Care Hospital. An additional 76 quarters for new staff are also included. The new Critical Access Primary Care Acute Care Hospital will improve access to healthcare for all the communities served by SEARHC.

Authorized IHS supported healthcare services include primary care, eye care, specialty care, audiology, dental care, emergency services, diagnostic imaging, laboratory, refrigerated space for the temporary storage of bodies, pharmacy, rehabilitation services, respiratory therapy, surgery, behavioral health, clinical decision unit/infusion/observation, clinical engineering, acute care, labor and delivery/nursery, hospitalists, public health nursing, health education, wellness center, community health representatives, environmental health, administration (Hospital and Regional Support), business office, human resources, performance improvement, health information management, information technology, Purchased/ Referred Care, security, dietary, facility management, medical supply, alternative medicine, communications, planning and development, short-term housing, medical nutrition services, employee facilities, public facilities, education and group consulting, housekeeping and linen, and property and supply. Telemedicine will extend care for service lines as appropriate.

The programmed size of the completed project is 353,753 Building Gross Square Feet (BGSF): 230,627 BGSF for the Critical Access Primary Care Acute Care Hospital (outpatient and inpatient services) and 123,126 BGSF for 76 quarters. The total estimated cost for this project is $267 million: $221 million for the healthcare facility and $46 million for staff quarters. The project is envisioned to be completed in one phase. Phase I will consist of the completion of the new hospital (outpatient and inpatient services) and completion of the new quarters.

Based on projected 2030 design staffing levels, it is estimated that 534 Full Time Equivalents (FTEs) will be needed at the completion of Phase I. An estimated additional 11 FTEs will be needed to maintain newly constructed quarters, bringing the total requirement to 545 FTEs. The IHS will request staffing funds based on 85 percent of the Resource Requirements Methodology (RRM) validation for the date of Phase I completion minus the prorated amount of the existing 73 FTEs.

Yukon-Kuskokwim Health Corporation

Incorporated in Appendix H is the YKHC Hospital PJD.

This active JVCP project is YKHC's highest priority project. Approved by the IHS, the PJD provides for an addition/alteration of the existing Yukon-Kuskokwim Delta Regional Hospital (YKDRH) expands ambulatory care services and replaces the existing acute care nursing unit and labor and delivery, and the addition of more supporting staff quarters in Bethel, Alaska.

The new clinic and acute care nursing unit proposed for design and construction, will be located on the existing hospital site and will meet projected inpatient and outpatient clinic and ancillary support needs. The proposed hospital renovation will provide for a behavioral health clinical decision unit, and emergency department along with ancillary services. The entire project will materially aid the achievement of the IHS mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. Together, the new primary care clinic, acute care nursing unit and renovated hospital will improve access to care for all the communities served by YKHC.

The programmed size of the completed healthcare project is 264,638 BGSF, consisting of 178,138 BGSF for the new Primary Care Clinic and Acute Care Nursing Unit and Labor and Delivery and 86,500 BGSF for the renovated hospital building. The current total estimated cost for this project is $287 million for the healthcare facility and $20 million for staff quarters. The project is envisioned to be completed in three phases. Phase I will consist of the completion of the new Clinic Building (floors one and two). Phase II will be the new Acute Care Nursing Unit, Labor and Delivery, C-Section Suite, eye care, audiology, and respiratory therapy (floor three). Phase III will consist of the renovation of the Hospital.

Based on projected 2025 design staffing levels, it is estimated that 429 FTEs will be needed at the completion of Phase I, 108 FTEs at the completion of Phase II and the remaining 358 FTEs at the end of Phase III (895 FTE total). The IHS will request staffing funds based on 85 percent of the RRM validation for the date of the Phase I completion minus the prorated amount the existing FTEs of 103 (based on the percentage 214 total existing FTE). The IHS will repeat the RRM validation process at the completion of Phase II minus the amount of 26 existing FTEs. The IHS will repeat the RRM validation process at the completion of Phase III minus the remaining amount of 86 existing FTEs.

PORTION OF PROJECT	PROFESSIONAL FEES	CONSTRUCTION	OTHER COSTS	TOTAL
Health Care Facility	$25,261,000	$190,950,000	$61,845,847	$287,056,847
Staff Quarters	$1,064,768	$15,684,632	$3,544,753	$20,294,153
Project Total	$26,325,768	$206,634,632	$65,390,600	$298,351,000

Figure 20: YKHC Project Cost Estimate

This YKHC joint venture project is under active construction and nearing completion. The IHS practice for facilities with active JVCP agreements is to assume there is no remaining unmet need upon completion of the project. Consequently, the unmet need for YKHC Regional Hospital summarized in this report is zero.

Unmet Needs Methodology Overview

The ATHS total unmet health facilities needs represent the amount of facility space needed to support the efficient delivery of modern healthcare services to IHS beneficiaries. This is presented together with the total and annual maintenance, repair, modernization, and new construction costs necessary to sustain that space. This report was prepared following 2021 IHS and Tribal Health Care Facilities' Needs Assessment Report methodology except as noted in this section.

The report shows assessed need, which is an estimate of need for planning level use. Every project, once it is actually funded is subject to refined planning, risk assessment, input from integrated project teams, approvals (Tribe, IHS, local, state, participating agency, etc.), environmental clearances, and strict acquisition and project management requirements that can result in scope, budget, and schedule adjustments.

The FY 2021 IHS and Tribal Health Care Facilities' Needs Assessment Report preparation methodology:

1. Currently the services provided are integrated into the Web-based HSP process for the eligible population. The HSP is a computer database program developed for the IHS specifically to aid in the design of health facilities. Based upon the expertise of experienced IHS personnel and the historical record of previously-constructed health centers and hospitals, a statistical model was created utilizing population numbers and demographics. The model was used to determine certain criteria, such as the appropriate numbers of exam rooms, dental chairs, size of pharmacy, etc. to be allocated to provide care for a specific population. It then determines a proposed size for such a facility with department-by-department breakdowns. These services include ambulatory, ancillary, preventive, inpatient, outpatient behavioral health, and support services. Over time, the HSP is updated, enhanced, and expanded to include new services.

2. Eligible services not yet fully deployed are also included in the total unmet needs estimate. These services include specialized healthcare facilities, such as inpatient behavioral health and alcohol substance abuse, long-term care, dialysis, and regional outpatient specialty care facilities. The IHS has not yet completed planning criteria for space and staff for all potential expanded authority services included in the IHCIA. In the absence of an official IHS planning criteria for these facility types, the IHS new construction cost estimating system and locality factors were used to establish unit costs. Space needs were identified using Facility Guidelines Institute recommendations, averages of industry practices, and health data published by other agencies.

The FY 2021 report's estimated cost and space requirements were determined using the same approach and data sources (updated) as in previous reports, with the exception that Facility Guidelines Institute recommendations for space were added to provide an incremental increase in accuracy of estimates for programs where HSP criteria were not available.

1. The amount of existing program space within each service unit (SU) was taken from the Health Facilities Data System (HFDS). The HFDS is a database with records for each building in the SU along facility parameters including size, age, and use.

2. The estimated total amount of required space each SU should have to deliver current programs to the IHS's user-population was taken from approved planning documents or detailed master plans when they existed and were current. Otherwise, the estimated amount of needed space was calculated with the HSP process. The HSP can calculate a minimum facility size needed for the 2018 user population or a design space sized for future capacity based on an estimated future population. The IHS uses a design population estimated for 10 years in the future. For this report, the 2030 population is based on 1.92 percent annual population growth.

3. The space shortage or amount of space the SU project(s) needs are the difference between the existing program space and the required program design space.

4. Simple assumptions were consistently applied to the rate of renovation, replacement, or reuse triggered by age and/or size:
    - Any project that touches a building over 30 years old will replace the entire building.
    - Any project that adds more than twice the existing space will replace the entire facility.
    - Renovations are required to upgrade existing building under 30 years of age. This ensures non-replaced space continues to meet or exceed code and Joint Commission standards. These expenses are added into the overall scope of need in the maintenance and improvement line item. Major renovation is estimated to cost 42.5 percent of respective building construction cost.

5. Construction costs are from the IHS Facilities Budget Estimating System (FBES). The FBES is a database system used by IHS to estimate construction costs using different rates for inpatient, outpatient, and office/other construction, along with a location factor multiplier to account for geographic construction cost differences.

Alaska Report Methodology Additions

This report utilizes the same methodology that is being used in the 2021 report preparation with construction cost estimates (revised to 2021 unit costs) with the following adjustments:

1. The 2021 national report prep methodology assumed an average national annual user population increase. This report used the Alaska specific IHS OPHS annual Alaska Native user population increase projection of 2.44 percent, resulting in a 2030 design Alaska user population of 232,003, including a 65+ population of 22,022.

2. The IHS SU in Alaska are no longer utilized, as the program is now carried out by T/TO. HSP calculations were done by T/TO.

3. The Denali Commission clinic space criteria was used for T/TO's with active user populations of less than 500, as the IHS has no space criteria for facilities that small.

4. The IHS location factors were used in all communities for which they were available. Communities without location factors used the location factor of similar adjacent communities with factors.

5. Six Alaska T/TO's operate health facilities in remote communities with no other available healthcare services. This resulted in Alaskan Native user populations being augmented 3.4 percent to account for active authority non-beneficiary workload.

6. This report calculated a statewide value for each of the five types of new expanded authority facility. The eight historical IHS SUs are replaced by the health programs of 35 T/TOs. In the absence of the IHS planning criteria, user population thresholds are not available, and a statewide population calculation methodology was selected rather than the T/TO by T/TO approach.

New and Replacement Space/Cost Tables

Figure 21: 2030 Alaska Active Authority New and Replacement Space Calculation by T/TO

T/TO	Replacement Space (FT^2)	New Space (FT^2)	Unit Cost ($/$FT^2$)	Cost of New and Replacement Space ($)
Annette Island Service Unit	-	-	-	$-
Akiachak Traditional Council	1,841	3,159	$918	$4,590,000
Alaska Native Medical Center	364,200	469,219	$986	821,734,000
Aleutian Pribilof Island Assoc.	4,887	2,847	$ 1,606	12,417,760
Arctic Slope Native Assoc.	24,509	41,470	$ 2,684	177,077,890
Bristol Bay Area Health Corp.	126,896	5,055	$ 1,605	211,740,958
Council of Athabascan Tribal Govts.	4,736	1,026	$ 1,218	$7,019,354
Chitina Traditional Council	-	-	-	$-
Chugach	10,925	22,947	$ 1,483	50,219,709
Copper River Native Assoc.	2,153	21,119	$ 1,606	37,365,065
Easter Aleutian Tribes	24,531	2,049	$ 1,561	41,495,619
Eyak	3,606	11,970	$ 1,490	23,214,083
Fairbanks Native Assoc.	-	-	-	-
Kodiak Area Native Assoc.	3,315	73,286	$ 1,606	122,990,852
Karluk IRA	614	886	$ 1,606	$2,408,400
Ketchikan Indian Community	-	18,392	$ 1,051	19,333,890
Kenaitze Indian Tribe	-	40,627	$ 1,001	40,659,664
Kwinhagak	-	-	-	-
Maniilaq Assoc.	25,058	45,908	$ 2,900	205,766,512
Mt. Sanford Tribal Consortium	1,604	1,697	$ 1,606	5,299,036
Ninilchik Traditional Council	3,284	-	$ 1,296	4,256,234
Norton Sound Health Corp.	8,600	10,668	$ 10,066	193,956,590
Native Village of Eklutna	-	1,897	$ 1,606	3,046,179
Southcentral Foundation	63,023	290,308	$942	332,982,165
SouthEast Area Regional Health Consortium	127,025	2,304	$ 1,147	148,388,010
St. George	1,324	176	$ 1,606	2,408,400
Seldovia Village Tribe	398	1,602	$ 1,606	3,211,200
Tanana Chiefs Conference	49,783	73,586	$ 1,162	143,337,731
Tanana Tribal Council	9,225	-	$ 1,534	14,146,942
Tyonek, Native Village of	-	1,096	$ 1,606	1,759,469
Valdez Native Tribe	-	289	$ 1,526	440,427
Yakutat Tlingit Tribe	-	-	-	-
Yukon-Kuskokwin Health Corp.	186,474	9,091	$941	183,989,460
Total	**1,048,010**	**1,152,674**		**$ 2,815,255,601**

*Note: ANMC replacement space is existing space that requires remodeling as part of the ANTHC Facilities Master Plan.

Figure 22: Alaska Statewide Expanded Authority New Space Calculation by Facility Type

CLINICAL LONG TERM CARE ANALYSIS

BED CALCULATION					COST CALCULATION				
Based on Centers for Medicare & Medicaid Services Data					Based on FGI Study for Space & Alaska Area Data for Cost				
Population 65 and Over	# of Beds per 1000 People 65 and Over[6]	Total # of Beds	Existing Facility Factor	Estimated # Beds Needed	Unit Cost Facility per SF	Locality Factor (LF)	Cost to Construct per SF with LF	Total SF	Total Cost Clinical LTC
22,017	38.6	850	25%	637	$650	1.78	$1,157	599,417	$693,525,469

NON-CLINICAL LONG TERM CARE ANALYSIS

BED CALCULATION					COST CALCULATION				
Based on Centers for Medicare & Medicaid Services Data					Based on FGI Study for Space & IHS Data for Cost				
Population 65 and Over	# of Beds per 1000 People 65 and Over	Total # of Beds	Existing Facility Factor	Estimated # Beds Needed	Unit Cost Facility per SF	Locality Factor (LF)	Cost to Construct per SF with LF	Total SF	Total Cost Non-Clinical LTC
22,017	25	550	40%	330	$650.00	1.78	$1,157	266,640	$308,502,480

DIALYSIS CENTER

STATION CALCULATION					COST CALCULATION				
AI/AN Population	Estimated User Rate	Estimated Users	# of Patients per Station	Total # of Stations	Locality Factor	Cost per Station	Construction Cost	Cost per SF	Estimated Total SF
232,003	0.42%	974	3	325	1.78	$203,352.00	$117,639,132	$1,282	91,791

REGIONAL SPECIALTY CARE CENTER

SF Calculation					COST CALCULATION		
AI/AN Population	Estimated User Rate	Estimated Users	sf per User	Total SF	Unit Cost per SF	Locality Factor	Total Cost of Specialty Care Facilities
32,003	25%	58,001	3.5	203,003	$755	1.78	$272,815,228

INPATIENT Behavioral Health

SF Calculation					COST CALCULATION		
AI/AN Population	Average User / IBH Facility	Number of Facilities (Rounded)	Facility Size (sf)	Total SF	Cost to Construct per SF	Locality Factor	Total Cost of Inpatient Behavioral Health
32,003	33,000	7.0	23,700	165,900	$650	1.78	$ 191,946,300
					Alaska Area Expanded Authority Total		**$1,584,428,609**

[6] Nursing Home Data Compendium 2015 Centers for Medicare & Medicaid Services