

**COMMENTS and RESPONSES on the PROPOSED  
HEALTHCARE FACILITIES CONSTRUCTION PRIORITY SYSTEM  
7/10/2004**

**General Health Facilities Construction Priority System Comments:**

- 1. Although the aim is to have a single scoring system for all projects, consider that there may need to be scoring differences based on project categories and the need for additional categories (new, replacement, JV, SAP, etc.).**

Response: Although the scoring criteria is similar for all healthcare facilities the system recognizes that specific categories are necessary to compare similar type facilities in similar congressional funding categories

- 2. Why are there several different priority lists and not one consolidated list as recommended by the Needs Assessment Workgroup?** Response: The projects have been divided into separate list so that they will reflect like facilities and current congressional funding categories.
- 3. How does IHS propose to present the total unmet health and facilities need to Congress?** Response: The information gathered in the Area Health Services and Facilities Master Plans (AHSFMP) will be coordinated and made available for the IHS Unmet Health and Facilities Need Report.
- 4. How will the determination be made for Primary Service Areas (PSA) that have projects that will only include health facility improvements and not need additional staffing/operating resources?** Response: All facilities need will be identified under this methodology. The HFCPS, a construction funding allocation program, does not evaluate or prioritize the IHS global need for staffing and operation resources. However, it is addressed as a part of the process of planning the requirements for specific high priority facilities. It does not appear that they would score high on the priority list; however there may be eventual consideration for such projects with an Area Facilities Priority list. (See White Paper entitled "IHS Area Level Priority List Funding" on the Office of Environmental Health and Engineering (OEHE) website) At present there is no separate funding category which includes this type project.
- 5. How is an existing hospital divided up when it serves multiple PSAs?** Response: All workloads and specialty department sizes are determined during the Program Justification Document (PJD) development with the Health System Planning Process (HSP). The HSP, based on the services plan for the IHS Area, determines "Population Catchment Area" (identified by communities) to determine workloads and sizes for each specialty department. This will ensure proper sizing of all facilities and avoid double counting of user populations. Each PSA would have the proper size ambulatory care Health Center based on their user population. The same user population would also be included for the specialty and inpatient services not provided in the local Health Center.
- 6. What is being done to improve the coordination between OEHE and the Area Planners and to improve the participation and input opportunities for the planners in the Mater Plan and Facilities Priority System processes?**

Response: An ad hoc monthly teleconference was held with the Planners and Area

Facility Engineers during the summer 2003 and since then members of Division of Facilities Planning and Construction/OEHE have participated in the planner's monthly teleconference and will continue to do so in 2004. Planners will review and comment on all future drafts of these systems.

**7. Why are the Dental and RYTC facilities left out of the proposed HFCPS?**

Response: At present the methodology does not fit well with all the referenced facilities programs and the Dental program currently has their own funding authority. The needs associated with these facilities will be reflected in the AHSFMPs.

**8. Congress indicated that the review of the priority system should consider specific issues. While some of the issues were considered – others were not. There are no bonuses in the priority system for those projects that can reduce their costs by using modular construction. Or bonuses for projects that result in very small increases to the operating budgets, or that use alternate funding resources.**

Response: IHS does not feel that modular construction is appropriate for permanent Healthcare Facilities. Renovation projects with small increases in operating budgets are being considered as the main type of project for the Area Priority List (see White Paper on OEHE website) and the alternate funding resources are considered under the Innovation Criterion of the Healthcare Facilities Construction Priority System (HFCPS).

**9. Tabulating Final List for Project Funding – There really should be a team (that) works with tribes that do not have adequate resources to do good HealthCare planning at the development stage of these projects. Also, few Areas have planning staff. Areas with an adequate planning staff will obviously be at an advantage. Having a team consisting of planners from area offices may (for no nefarious reasons) result in a skewed process. Can we expect a fair system.**

Response: Area staff, including planners and facility engineers have developed minimum criteria for tribes that choose not to participate in the formal AHSFMP process. This effort will go a long way to assuring that all tribes, regardless of resources, produce data that will be fair and comparable for competing on the HFCPS.

**10. Does the proposed process favor the IHS facilities in that they are the oldest and in need of the greatest repairs?**

Response: On individual cases only; e.g., a Tribe that has no facility would also rate high in the Facility Deficiency Criterion.

**11. Allow flexibility in the scoring system so that it can be adjusted as we cycle through the years. A five year cycle seems sensible. During the intervening years, adjustments can be made with adequate consultation and discussion.**

Response: The Tribal Consultation Process should produce many ideas for improving the HFCPS and the five year cycle has been included to allow Tribes and PSAs the opportunity to develop innovations and revisions that will improve efficiencies and scores. Any changes in the scoring process under consideration would include Tribal Consultation prior to adoption.

**12. The proposed criteria and system only address replacement of facilities. It does not allow for existing facilities that are in critical need of a major expansion/renovation/modernization (the 20 to 40 million price range) but can't compete with those facilities needing total replacement. These types of**

- existing facilities warrant consideration for one time construction and equipment funding, as well as additional staffing positions, to meet the demands of the eligible population.** Response: This problem has surfaced in recent years at a few PSAs in Indian Country and to date has been handled on an individual basis, e. i., emergency funding, combination of third party reimbursements, M&I funds, etc. At present it is hoped that new funding, possibly through an Area Priority List (see white paper on OEHE website) that targets these types of facility needs would be a reasonable solution to the problem.
- 13. A scoring method to consider is one that is supported by the user pop. report 650 that already exists. It is the total # of Indians registered over the last 3 yrs., compared to the total # active in the last 3 yrs. HRSA also has a formula for access to care to determine medically underserved communities eligible for health center funding. It is a comparison of # providers in a given service area per total population. This information is published in the Federal Register.** Response: The User Population of each PSA is a major part of the Supportable Space Calculation.
- 14. Is it the intention that this methodology be applied to the other new construction programs? At one time there was talk about one priority list for all new construction programs.** Response: As stated above, although the scoring criteria is similar for all healthcare facilities the HFCPS methodology recognizes that specific categories are necessary to compare similar type facilities and in specific congressional funding authorizations, e. g., there are categories for Hospitals, Health Centers, etc.
- 15. Would this methodology allow a stand-alone dental facility?** Response: Dental facilities would be prioritized in a category with other dental facilities and at present there exists a separate funding authority for stand alone dental facilities. The Dental departments would also be included in the healthcare facility for each PSA.
- 16. The IHS plan needs to have an overall standardization to create uniformity among all 12 Areas. The uniformity will generate an equal opportunity for all Areas to get on the new priority listing. Without uniformity, comparisons of the facilities between Areas will be extremely difficult and HQs will be left trying to come up with a priority list out of the end of results.** Response: The Healthcare Facilities Validation Committee will have the responsibility to develop procedures for validating all data in Phase II and using the same procedures for all PSAs/facilities that are competing for a funding priority list.
- 17. Is there a clear definition of IHS supportable space? This listing should be included in the Master Plan guidelines. Are all the 12 Areas going to be looking at Wellness Centers, EMS or CHR programs outside a healthcare facility?** Response: Phase I and II of the HFCPS will use either the IHS Supportable Space Formula or the HSP, without deviations and the Small Ambulatory Care Facility Criteria, depending on Tribal Consultation Comments, and for the second question, the health services plan of the AHSFMP should include these programs as appropriate.
- 18. If the current health care facilities on the priority list are grandfathered in, the Agency will have approximately 20 years worth of new construction in**

- the priority system. Why is IHS expending a lot of money at 12 Areas to have a plan in place by 2004?** Response: Congress has asked IHS, in consultation with the Tribes to revise and recommend improvements in the current facilities priority system. Also, the AHSFMP is a keystone for IHS health care planning and for compiling data on the Total Unmet Healthcare Facilities Need in Indian Country.
- 19. Was the timing and cost of implementation presented to the Facilities Appropriation Advisory Board (FAAB), or was it just for the establishment of the policy and procedure?** Response: Because AHSFMP and HFCPS involve major planning issues the FAAB was involved. Also, it has been over 10 years since IHS completed a comprehensive master planning effort.
- 20. Is it good policy to expend \$2-5Million in 02-03 for Area Master Plans where the current system has a 10 year unfunded need/list of unfunded but approved projects?** Response: Congress has directed IHS, in consultation with the Tribes to revise and make recommendations for improvements in the current facilities priority system. Also, the AHSFMP is a keystone for IHS healthcare planning and for compiling data on the Total Unmet Healthcare Facility Need in Indian Country.
- 21. The proposed Scoring Basis proposes to exclude facilities of less than 1000 SM (10,764 Sq. Ft).?How many communities will this exclude? What if a Treaty Tribe elects that their Primary Service Area is a location of less than 500 individuals?** Response: IHS does not limit size of PSAs, however IHS requires that facilities under approximately 1200 sm with an approximate user population of 1300 (the break point between a full-time and part-time facility) need to establish sustainability with a business plan. Refer to IHS Small Ambulatory Care Facility Criteria which has been specifically developed for facilities 1200 m<sup>2</sup> and smaller.
- 22. Is the highest priority to provide every user a basic level of care or does the proposal tends to support existing infrastructure without addressing need to restructure existing health delivery modalities?** Response: The goal of the priority system is to provide facility resources supporting basic medical care in the most efficient and effective manner to the PSAs demonstrating the greatest need on a national level, also considering the limited resources available to IHS.
- 23. Can the proposed planning and selection process meet the TEST or same CRITERIA as if this were HUD/FDA/EPA/ or DHHS announcing in the Federal Register a new proposed regulation?** Response: Because of differing goals and missions the response is that IHS is following all the policies and procedures required when developing and instituting new policy such as the HFCPS.
- 24. Will the public process and development of the implementing plan withstand critical LEGAL test or challenges which will be raised by those not considered or not selected for consideration to second phase?** Response: The HFCPS is a competitive process that has been reviewed and molded to accommodate comments and recommendations of the IHS and the ultimate customers, Tribes, PSAs, etc. and therefore is considered a fair and

reasonable effort to establish healthcare facility construction priorities in Indian Country.

- 25. Where is the “Agency Business Plan?”** Response: There is no Agency Business Plan for the IHS healthcare facilities program. Business plans are required for PSAs of 1300 user population and smaller; i.e., facilities that do not support a fulltime primary care provider. A plan most appropriate for IHS is the long range or strategic plan and the annual total need for healthcare facilities in Indian Country. The AHSFMP and HFCPS are most important to the healthcare facilities planning for IHS.
- 26. If Congress is truly looking for the Indian Health Service to provide a new approach to the Priority System, why have we agreed to only fund “replacement facilities” and not look at the merit of expanding and renovating existing structures to fulfill the need of a POR/PJD? This would allow any appropriated funds to be applied to more programs and Tribes. I know the Advisory Committee had recommended pursuing an Area Share of funds as well as those retained at Headquarters but this has not been fully accepted by HQ as of this date.** Response: The IHS recognizes that there is a need for renovation funds that could be managed at the Area Level. At present there is no funding authorization available. A white paper has been developed delineating many of the facts and issues involved in an Area Facilities Renovation Priority List. This white paper is available at the OEHE website at [.from the facilities group at IHS headquarters.](#)
- 27. If IHS does pursue an Area Share of Congressionally appropriated funds, I feel the buildings/programs produced by this funding should receive operating funds just as the replacement funds. If IHS does not pursue the operating funds for an Area sponsored expenditure of appropriated funds, M&M funds will need to provide the operating funds created by the expansion of programs and space. I have not seen any financial analysis that indicates our M&M collections per user is equal to the amount provided through Congressional funding of operations. The IHS must always seek Congressional appropriations of staff and operating funds for increases to programs or face serious deficits in operation budgets that increasingly rely upon M&M collections.** Response: The IHS recognizes that there is a need for renovation funds that could be managed at the Area Level. At present there is no funding authorization available. IHS concurs with the need to establish systems to effectively collect and use third party payments to augment health services and facilities programs.
- 28. We like the structure of the basic formula and how the five parts of the Score are added together instead of multiplied. For this type scoring system, it is easier to see how one part of the scoring directly affects the other portions of the formula. This proportionally graded criteria is lost if the parts were to be multiplied together.** Response: Agree
- 29. Each IHS area is considerably different from other areas of the Indian Health Service. It will be almost impossible to devise a priority system that does not favor one IHS area over another and likewise discriminate against the least favorable areas. It may be more palatable to all areas to ensure**

- some mixture of projects that would ensure some parity between areas. One suggestion is to have each Area compose its own priority list and have the ranking on this area list play into the scoring of the overall IHS list. Points could be given as to how high the construction projects score within the area. The number one ranked projects would get added points in the national ranking system; as would number two and three, etc. Or maybe just the highest three. Response: The five criteria and weighting were studied and formulated by the Needs Assessment Workgroup, the FAAB and IHS staff. The results are now contained in the HCFCPS methodology and additional changes to scoring methods will not be considered until all commentary from the Tribal Consultation Process is received and systematically analyzed.
- 30. And to follow on to the idea above, each number one ranked project of each area could be ranked nationally to form the first twelve on the national list and then each second ranked project could be scored nationally to form the next twelve, etc. This method would ensure parity between areas even if the projects of one area were much larger in scope and cost than another area.** Response: Refer to response for comment 29, above. One weakness of this suggestion may be that certain PSAs with higher unmet needs would be funded behind many PSAs with lesser unmet needs.
- 31. Develop an internal “beta” test team of planners, medical staff, engineers, Tribal reps, and attempt to test or tear apart the assumptions. If the process or data methods can not withstand critical internal debate; than it is too early to release even a draft proposal?** Response: The five criteria and weighting were studied, debated and formulated by the Needs Assessment Workgroup, the FAAB and IHS staff. In addition, all facets of IHS staff have participated in numerous conference calls and meetings focused on the AHSMP and the HFCPL methodology. This document alone contains over ninety individual questions dealing with the HFCPL methodology and after two years of development, commentary and revisions it is ripe for Tribal Consultation.
- 32. We need to think of the impacts of this system five and ten years from now. What staff and functions will be available to control this? Are we going to penalize the Tribes in an Area because there is not adequate staff to collect and validate data?** Response: The proposed system will have the ability to be updated on the five year basis. The strategy behind this considers several important issues. Resources to collect and validate data will be an IHS responsibility to promote fairness for all participants. The final priority funding list would need replenishing at about five or so years depending on congressional appropriation. This would mean that the new candidates from the total Facility Needs Assessment Process would have to be drawn from the total list much earlier than 5 years to allow time for validation final prioritization.
- 33. Why is the list going to stand for five years? The workgroup recommended an annual review similar to the SDS system. At five years it’s not going to be any better than it is now! Once a project received planning the \$ it would in the pipeline and become part of the 5 year plan. Until then the list could be adjusted.** Response: Annual update and validation of the list is resource

intensive and probably unnecessary. The Final Priority Funding List no longer needs updating as those facilities will remain on the final list until funded. This is projected to take a minimum of 5 years. At some time before that a new list will be established from the Phase I List. There is no problem with updates when service areas or services delivery change and when new Federally recognized Tribes become part of the system. A close look at the scheduling of the lists shows that the updating would have to begin possibly a year prior to the 5 year date to provide time for Phase II validation and final prioritization. Annual updates of services and facilities data is encouraged to keep the Master Plans current.

- 34. This looks like there will be only one national list. What happened to the Area level project list for those that don't want the staffing package? This was a key component to the process so that each area would receive something every year instead of all of the resources going to a few projects on the national list.** Response: The IHS recognizes that there is a need for renovation funds that could be managed at the Area Level. At present there is no funding authorization available. A white paper (see OEHE website) has been developed delineating many of the facts and issues involved in an Area Facilities Renovation Priority List.

#### **Self Determination and Tribally Owned (Title I and Title V) Comments:**

- 35. Those tribes which built facilities without IHS assistance will not qualify for federal dollars because they have new facilities (compared to older IHS facilities). By default is this a fair process?** Response: It is recognized that Tribes/PSAs with newer facilities will score lower than Tribes/PSAs with older or no facilities. Congress and Federal Programs do not allow retroactive funding; therefore it does not seem this specific situation can be remedied by the HFCPS.
- 36. When the instructions say the Tribe must provide data that is compatible and contain the information needed for the Priority System Criteria, the Agency needs to be cautious in that we are not treating the I/T/U the same. If a Tribe has elected to take their shares of the Facilities Program at the Area and HQ, they are not required to participate in the FEDs database. Does the Agency plan to accept their deficiency data for an existing facility in the format they use? Do we require them to run an HSP and RRM if they are not a residual function or will they be able to have an A&E firm do a master plan for a new facility and how do we deal with the differences in size and function?** Response: In consideration of commentary received on the draft HFCPS, IHS is committed to assist and help the 638 and Title V Tribes to include services and facilities data in the AHSFMP and to compete for the IHS facilities construction funds. Area staff, including planners and facility engineers, is developing minimum criteria for tribes that choose not to participate in a formal master planning process, but will provide data to be included in the AHSFMP. This effort will help to assure that all Tribes/PSAs are included in the HFCPS.
- 37. It is unfair to Title V Tribes that have recently completed health facilities with substantial amounts of their own funds to now compete in a priority**

- system with older, run down facilities?** Response: It is recognized that Tribes/PSAs with newer facilities will score lower than Tribes/PSA with older or no facilities. Congress and Federal Programs do not allow retroactive funding; therefore it does not appear that the HFCPS can provide relief for this situation.
- 38. A tribal facility that does not participate in a Facility Condition Assessment will not have BEMAR (FEDS) reported in a similar fashion as those that do (or perhaps not at all). Since this is not a residual function, will a tribe be allowed to provide BEMAR (FEDS) data from their source and in their format?** Response: Tribal data will be accepted and will be adjusted for format and compatibility during the master planning process and Phase I of the HFCPS. As an open policy, IHS will offer technical assistance to achieve compatibility with the Facility Engineering Deficiency System (FEDS) and preserve fairness among all Tribes and PSAs for data intended for the HFCPS.
- 39. It is unfair for the Title V Tribes to have to report FEDS deficiencies and ICD-9 codes in order to compete on the Priority list. It was also suggested that a chart be developed indicating the Title V Tribes that now report FDS data to OEHE and ICD-9 codes to the IHS National Patient Information Reporting System (NPIRS)?** Response: There is no intention to impose an unnecessary burden on the 638 or Title V Tribes but the Priority System must have comparable data to produce replicable scores for all PSAs nationwide. As an open policy, IHS will offer technical assistance to achieve compatibility with the FEDS system and preserve fairness among all Tribes and PSAs for data intended for the HFCPS.
- 40. How will the proposed priority system interface or address current or in-place PL 93-638 Title I and V agreements?** Response: IHS will work with the Tribes to adjust agreements and to accommodate the completion of AHSFMPs and provide data for the HFCPL methodology.
- 41. We need to revisit the factors we are using to establish a priority system. The Master Plan and BEMAR (FEDS data) are not residual. The Tribes have taken their shares and are responsible for condition surveys and upkeep of their buildings. The system needs to allow for equitable input into the system in order to compare apples to apples.** Response: There is no intention to impose an unnecessary burden on the 638 or Title V Tribes but the Priority System must have comparable data to produce replicable scores for all PSAs nationwide. As stated previously, IHS will offer technical assistance to achieve compatibility with the HFDS/FEDS system and preserve fairness among all Tribes and PSAs.

#### **Facilities Deficiency Criteria Comments:**

- 42. I strongly urge the use of the supportable space formula in the equation in lieu of HSP to make it objective rather than subjective. The HSP is a good planning tool; however, it has its drawbacks: (1) much of the space is out-of-template and it would be difficult to maintain objectively in determining out-of-template space, (2) sometimes workload barely over a threshold will force a larger template, and (3) it would be a lot of work to prepare a proper HSP**

- for every PSAs. Response: The IHS Supportable Space Formula and the HSP are both being considered for calculating the required space, see answer 17 above.
- 43. Why allow a non-existent building to score higher than an existing building? Every application should have equal standing. Every existing IHS funded program has an existing building. It may not be Federal or Tribal but may be owned by a third party through Contract Health Services.** Response: A PSA may not have a healthcare facility, a recently recognized Tribe, for instance. It is certainly reasonable that a PSA with no existing facility for primary healthcare should receive the maximum score for Facilities Deficiency. It is noted that lease buildings used for healthcare will also count as existing space.
- 44. One concern here is that a service area without a facility may not show a condition or deficiency factor. Clearly, a service area with no facility (that can otherwise justify one) should score maximum points in a Facility Deficiency Score.** Response: Agree, the Facility Deficiency Criterion is structured to do that.
- 45. Under the Building Condition Cf, which BEMAR (FEDS) deficiencies are “deficiency types that are related to healthcare?” Clearly some of the deficiency codes have much larger impact on healthcare than others. I suggest you weight the deficiency code categories giving more weight to say patient care, program deficiencies that you do to those like plant management & grounds.** Response: Agree, the FEDS categories related to healthcare are now identified in the HFCPS methodology.
- 46. The workgroup report stated that if the cost to repair was greater than 75% of the replacement cost then the facility would be replaced. The condition factor should reflect that by being equal to 1 at 75% of the replacement cost.** Response: Agree, this is now incorporated into the HFCPS methodology.
- 47. The criteria assumes that old is bad, which may not always be the case. The Building Factor provides a higher value for an old facility when an older facility may be in great condition but just not as functional as a new facility.** Response: The age factor was studied and debated by the Needs Assessment Workgroup, the FAAB and IHS staff. The proposed application is felt to be the fairest way to reflect facility age and additional changes will not be considered for this criterion until receipt of commentary from the Tribal Consultation Process.
- 48. How is building age determined? Date building commissioned? Or date built by BIA? Or date which building was first used for healthcare? (In older buildings used many years for other purposes the date could vary widely.)** Response: Use the IHS Real Property Inventory (RPI) acquisition date or beneficial occupancy date when first used as a healthcare facility, or equivalent if tribally owned.
- 49. The replacement cost has to be adjusted by area. The cost of construction varies widely across the country. The BEMAR (FEDS) estimates are local estimates therefore the replacement cost/m<sup>2</sup> should be based on the same adjustment factors.** Response: All estimates will be checked using the IHS Facilities Budget Estimating System which includes location and escalation factors.

**50. There appears to be discrepancies in the in the following BEMAR guidance documents, which one should be used for the FEDs scoring?**

<http://www.oehe.ihs.gov/hb/pdf/07302.pdf>

<http://www.oehe.ihs.gov/hb/pdf/07301.pdf> Response: Both documents are being revised to clear up the discrepancies.

**51. Are we building in an incentive to let deficiency cost increase for particular buildings to build up the FEDS prior to putting a facility on the priority list.**

Response: While it is conceivable that this practice could occur it would not be a sound facilities policy. There are funds distributed each year based on a FEDS plan and to gamble and indefinitely delay projects runs the risks of major costly repairs with no guarantee of new facility funds and an increasing unobligated balance for the M&I account.

#### **Health Resources Indicator Comments:**

**52. What is the history of use of the ACG within IHS or with any other public health agency. Private sector models don't usually capture preventive health needs very well. How much data entry will be required to use the ACG or will it be compatible with RPMS? If data entry is not only costly but introduces errors during data entry? Who will cover costs? Does the patient population referred to above mean only those that currently seek health care from IHS or all those in the service area with a health care need? The ACG needs to be available for use before any commitment to use it can be made. Availability in 2005 is not acceptable. The area recommends the health status indicator similar to what is currently used in LNF rather than one of the unknown validity.**

Response: The FAAB has also recommended that IHS use the LNF - FDI for the Health Resources Indicator Criterion or three health related factors from the LNF data for a health status indicator (these are the Population in excess of 55 years age, the Poverty Index and the Poor Health Status Index). The system use should be determined after Tribal Consultation comments are received.

**53. We do not understand the basis or computation of the "Health Indicator" criterion; however if it is as comprehensive and analytical as described, we feel it should be weighted with a higher number of points. Construction and health care program funding should be directed toward the neediest communities.** Response: Refer to Answer 52.

**54. Is there a Health Services Deficiency consideration? If new funds for health services are to be distributed as a result of New Construction or Joint Venture funds, there should be a determination or consideration of some sort regarding the level of services (people, RRM, providers, etc.) related to the need for services (Health Status). This would be a health services deficiency consideration. A new facility built to HSP guidelines (regardless of who funded it) will not be effective unless there are people there to deliver the services. Funding of service deficiencies would amount to putting the resources where they are most needed or effective. The HSFMP will ultimately identify deficiencies in the health services. Should this not be**

**considered in the priority scoring system?** Response: Refer to answer 52 for the Health Resources/Indicator to be considered for the priority system and in addition, the AHSFMPs are compiling services and facilities data that will be used in the HFCPS.

**Access to Care Comments:**

- 55. The guidelines need to define the concept of “alternate facilities” and how they are to be located. Because health-care facilities are not all the same, and do not provide the same services or combination of services, the location of an “alternate facility” is a question.** Response: The alternate facilities access definition used for the HFCPS is the distance to the nearest Level I, II, or III Emergency Room (IHS or other) from the existing or proposed health facility. The basic concept is that any patient always has access to emergency treatment at an emergency room where their condition will be treated and stabilized for transportation to another healthcare facility of their choosing.
- 56. What is the definition of the “nearest outpatient facility or emergency room”? Is it the nearest facility that has the capacity to serve the entire population, part of it, or just nearest regardless?** Response: The alternate facilities access definition is the distance to the nearest Level I, II, or III Emergency Room (IHS or other) from the existing or proposed health facility.
- 57. The guidelines should be more specific on what to do if access to services depends on ferry services or air taxi. How is that considered if it only applies to a small portion of services? Or only a small portion of patients?** Response: Any access to the primary care provider that is not by road would receive the maximum score. This would be applied to the location of the nearest ambulatory care facility in the PSA for the community of record. If a portion of the population does not have road access to the PSA healthcare facility or the closest Level I, II, or III emergency room they would receive the maximum score and be averaged in with the remainder of the PSA user population.
- 58. Assumption is that some patients may have to commute 2 hours (via air or highways or ferry system) to get to an adequate size facility to obtain quality inpatient care (like many regions of the US)?** Response: The system is not considering credit or points for distances to inpatient or tertiary care. Rare or complex referrals requiring inpatient care may range throughout the country.
- 59. Do we have a good definition of public transportation? Tribal health program transportation plans should not be considered public unless they meet the definition of public. There are tribal programs that transport a limited amount of patients to and from a limited number of appointments. These efforts should not serve penalize a facility and health delivery program.** Response: The public transportation portion has been eliminated because of the difficulty in defining and measuring it.
- 60. This must be clearly defined with examples. Are you referring to buses, taxis, CHR transport, charter aircraft, etc.? How does the availability relate to the ability of the individual to pay for the service.** Response: The public

transportation portion has been eliminated because of the difficulty in defining and measuring it.

- 61. The current guideline suggests that “Mapquest” (a free internet utility) will be the only recognized choice for calculating distances. This is not the software used by contractor who has already completed a Master Plan for Phoenix Area and is in the process for Billings Area. While the use of the internet available product may save some costs, it severely limits the ability of Planners to full use of mapping software. A Microsoft product is available that provides accurate measurement of distances plus the advantage of setting the travel time for various road types and calculating precise point to point distances and travel times. Since this product only costs approximately \$250, is there any reason that each Area Office could not purchase the product and expand the flexibility in the planning of facilities? In addition to the obvious advantages, this software package has some GIS capabilities that would also be useful including embedded 1990 and 2000 Census data and the ability to incorporate GPS data.** Response: This suggestion has merit and Microsoft Streets and Trips Software is being adopted for use in all AHSFMPs.
- 62. In our Master Plan Tribal Leaders Meeting, the issue was brought up that the proposed weighting criteria does not address access problems. Although it is somewhat referenced under “Documented Barriers”, the consensus is that it does not allow for the workload factor used in determining need. A more appropriate term may be “potential workload lost through access problems”. In summary, this means that a PSA workload may be shortened because, historically, they have low workload because of inability for users to get into the system to see a provider. They will not rank out as high as a facility that is funded a higher per capita level and has been able to accommodate more of its eligible users.** Response: The suggestion may have some merit but it is extremely difficult to measure for all the PSAs. At present the “Barriers to Service” criterion is considered subjective and will only be used for Phase II scoring in the HFCPS, after validation.
- 63. The PJD already has established criteria for 30 minutes to an outpatient facility. Why not use existing criteria rather than creating new ones? We recommend deleting any reference to road type as being irrelevant to travel time?** Response: A clear objective measure of distance will be used from the Microsoft Streets and Trips software mentioned above.
- 64. What if the location is next to another major health care provider (tribal or non-tribal)? Is this tribe disadvantaged in the formula and what would be the “position of the Secretary?”** Response: Issues such as this would be documented and adjacent PSAs would be identified in the services plan in the AHSFMP.
- 65. What is the definition of the “nearest outpatient facility or emergency room”? Is it the nearest facility that has the capacity to serve the entire population, part of it, or just nearest regardless?** Response: The alternate facilities access definition is the distance to the nearest Level I, II, or III Emergency Room (IHS or other) from the existing or proposed PSA health facility location.

**66. What if the nearby facilities are not accepting any new patients? How do we verify and evaluate the information? What health care delivery criteria substantiate favoring smaller facilities?** Response: With the alternate facilities access definition, no patient in the country can be refused emergency treatment at an emergency room, the first question is moot. Validation will be performed only in Phase II of the HFCPS. The Type/Size of Facility Criterion was instituted by the Needs Assessment Workgroup to help favor smaller ambulatory facilities.

#### **Type/Size of Facility Comments:**

**67. Consider recent developments in health care practices as they evolve. As an example: IHS practices have, to some extent, discouraged the development of new hospitals in favor of replacement with outpatient facilities while CMMS has encouraged development and continuity of small rural hospitals through the Critical Access Hospital (CAH) program (Rural Hospital Flexibility Act of 2000)** Response: It is because of changes in the health care industry that IHS has focused on ambulatory care. Also, as a safeguard for isolated areas, IHS has evolved the alternative rural hospital concept for large isolated health centers. These health centers are authorized to include a Level III emergency and urgent care unit, short stay sub acute nursing unit and a low risk birthing center.

**68. Exception to the 10,000sm limit? We would all like exceptions here and there. The exception should not overly burden the entire funding structure. If we are to allow exceptions, there should be an escape mechanism or limit built in to each and every exception (years, dollars, project, etc.). We don't recommend exceptions: however, if done, they should not be set in stone, institutionalized, done at the expense of other areas, and/or maintained from cycle to cycle without review and scrutiny.** Response: The five criteria and weightings were studied and formulated by the Needs Assessment Workgroup, the FAAB and IHS staff. The results are now contained in the HFCPS methodology and additional revisions to the criteria and their respective weightings will not be instituted until all commentary from the Tribal Consultation Process is received and systematically analyzed.

**69. In the algorithms in the example there are no changes in the slope of the formula at 3000 & 10,000 as stated in the narrative. It only changes at 1000, 6000, and 20,000 in the example.** Response: This conflict has been corrected and the initial slope change will take place at 1200 m<sup>2</sup> rather than 1000 m<sup>2</sup> and subsequently at 6000 m<sup>2</sup> and 20,000 m<sup>2</sup> respectively.

#### **Innovation Comments:**

**70. Is there a way to reward Tribes that propose plans to renovate existing facilities that result in major construction costs savings as compared to proceeding with a new replacement facility?** Response: It is possible to claim

- innovation points by reducing the construction costs by reusing a significant portion of the existing facility.
- 71. How about innovation points for those that are carrying greater percentages of operational costs, perhaps based on the Disparity Index.** Response: The LNF – FDI index is being considered as the Health Resources Indicator Criterion and would not be appropriate for an innovation score also.
- 72. Do the proposed criteria allow Tribes to count other federal funds (USDA Grants, Denali Commission, HUD, HHS, etc.) like special appropriations as not part of the IHS appropriations or state aid?** Response: Yes
- 73. Four of the “Innovation” elements reward tribes that have been able to work closely with local, state, and non-IHS organizations. However, if this is the case, that tribe would benefit from reducing its needs for the IHS funds and specifically construction funding. What about tribes that have not been able to negotiate agreements with local, state, and non-IHS organizations? Why are they penalized? Their need is not reduced.** Response: This criterion was included to reward innovation and is not intended to penalize Tribes. There are many other innovation opportunities available to all Tribal and PSA healthcare programs.
- 74. Since IHS cannot easily apply for or receive outside funds that might be seen as augmenting our appropriated funds this criteria clearly favors 638 or compacting Tribes and is viewed as an “adverse effect” on direct service Tribes. How will this be documented and what will be accepted? This criterion appears to be very subjective.** Response: Each innovation claim will be validated in Phase II by the Healthcare Facilities Validation Committee using the same approval standards.
- 75. The “Innovation” portion of the score should not penalize tribes that cannot possibly meet the standard set. We have small tribes that cannot possibly work in partnership with other tribes because of the physical distance between our tribes. Because the point is not possible, it ends up to be a point against the tribe applying.** Response: The Health Care Delivery Programs located in Indian Country present many opportunities for innovation regardless of size or location of the program.
- 76. Most Grants or loans from others have 1-2 years deadlines so what is creditable one year to gain points may not be valid by the time a project is in final PSD/PJD phase or even close to real time?** Response: A good point, the time delays cited are realistic and would make this type of innovation difficult to realize.
- 77. What is a Regional Partner, since every PSA or tribe has referrals to somewhere on a regional basis?** Response: A referral itself does not qualify, however a program that involves several specialties; e. g., where the IHS PSA handles all Audiology patients and the Regional Clinic handles all the Eye Care patients resulting in efficiencies that reduce costs for both health programs is innovative. This type of Regional Partner would qualify as an innovation.

#### **Scoring and Validation Comments:**

- 78. How will data be validated and who has the financial and technical resources to validate data?** Response: The proposed IHS Healthcare Facilities Validation Committee will have the sole responsibility of validating all data in Phase II of the HFCPS. They will be provided resources to secure additional planning and technical expertise for the important data validation effort.
- 79. I suggest the scores be based on 1000 points rather than 100. There potentially will be too many ties if you base it on 100.** Response: This is sound reasoning and has been adopted for the HCFCPS.
- 80. We continue to reward the haves and exclude the have-nots. If our goal is to get health care to as many AI/AN as possible, we need to reward the risk takers and innovators. This process does not do that. The factor with the greatest weight is the Facility Deficiency; it should be Health Need and Innovation.** Response: The five criteria and weightings were studied and formulated by the Needs Assessment Workgroup, the FAAB and IHS staff. The results are now contained in the HCFCPS methodology and additional revisions to the criteria and their respective weightings will not be instituted until all commentary from the Tribal Consultation Process is received and systematically analyzed.
- 81. The major driver should be health need not space or FEDS. Just because a building is old and not well maintained, does it mean that it has the greatest need?** Response: See response for comment 80, above.
- 82. The major driver should be health need not space or FEDS. Just because a building is old and not well maintained, does it mean that it has the greatest need.** Response: See response for comment 80, above.
- 83. The determination to replace space for health programs should be decided by Health Indicators and the not deficiencies for the existing structure. The largest weighting is for a facility's score and not Health Indicators. I feel Health indicators should have the largest weight and a Facility Deficiency Score to be much less.** Response: See response for comment 80, above.
- 84. The "Access to Care" and the "Facilities Type/Size" portions should be a smaller portion of the total.** Response: See response for comment 80, above.
- 85. The Construction Priority System should be based on health care needs and not building needs. We should focus on new construction and not resign ourselves to accept a no-growth status. For this reason, we think that the "Health Status" factor should have a larger part of the total score. 20% is not large enough to allow the health need factor to lead the construction needs.** Response: See response for comment 80, above.
- 86. The "Facilities Deficiencies" affecting an existing facility should play a smaller part in the overall score. In fact this factor is not important at all unless the current facility is being demolished and replaced during construction. I think that the developers assumed that the priority system should ideally be used to replace old run-down clinics and hospitals that frustrate our facilities engineers. However a scoring system that did this well would not serve as a viable scoring system for other needs.** Response: See response for comment 80, above.

- 87. We need to look at the points we are assigning to the different factors. The most important factor is the actual health needs of the population served by the proposed facility. That makes Criterion 2 the most important and it should have the most weight.** Response: See response for comment 80, above.
- 88. If Data is from a tribe or Tribal Contractor, are all computing the data and using the same basis to develop the outcomes? What if the Tribe comes up with prices not based on a national cost estimating system recognized within the building industry?** Response: The facilities and planning staffs will provide technical assistance to assure that the data is compatible with the various IHS data bases. All estimates will utilize parameters contained in the IHS Facilities Budget Estimating System (FBES) such as locality indexes.
- 89. In the “Facilities Deficiency” factor, we feel the age portion of the equation is given too much weight. In the example, the age portion of the space discount. Af, for the averaged weighted age of 26.85 years, amounted to twice that of the condition portion, Cf, even though the building is in poor condition. Note: Buildings with an FCI score of over 10% are considered in poor condition. We are not sure how the formulas were developed but it appears that the developers expected the building to degrade linearly from 10 through 90 years of age. However as engineers, we cannot assume that the value and age of the building has a direct and linear relationship with the quality of services delivered within.** Response: See response for comment 80, above.
- 90. We feel the “Isolation” factor is weighted too heavy and will prove difficult to measure. It is difficult to measure the access difficulties that concern each and every patient for each and every home. We also feel this public transportation issue is weighted too heavy. Most places don’t have bus service to the clinic and will receive full score for this section. The few places that do have bus service will be penalized, but the bus service may be feasible for only a small portion of the service area. It would be easy to spend more than 30 minutes on buses if a transfer is necessary; thus making it impractical. And what about Indian communities that provide van pickup service? Under the definitions set in this package, this would not qualify for public transportation, but is more convenient and a more practical free service in many cases.** Response: See response for comment 80, above. Also, the public transport portion of the isolation factor has been eliminated, in part due to the problems raised above.
- 91. Our concern with the “Type of Facility” criterion is centered on how the HSPBA is determined. As mentioned earlier, this is a term that needs better definition. Is it possible for a tribe that has more than enough facilities space overall to score a large HSPBA if considering a chosen set of communities needing a chosen set of limited services.** Response: All required space for a PSA will be calculated in Phase I and II of the HFCPS using the latest IHS User Population data (also refer to Answer 17). As for the second question, the PSAs and communities will be identified by the services plan in the AHSFMP and will be checked in the IHS data bases for accuracy to avoid double counting or other manipulation.

