Resolution #97-170-DSB

RESOLUTION OF THE GOVERNING BODY OF THE THREE AFFILIATED TRIBES OF THE FORT BERTHOLD RESERVATION

WHEREAS, This Nation having accepted the Indian Reorganization Act of June 18, 1934, and the authority under said Act; and

WHEREAS, The Constitution of the Three Affiliated Tribes generally authorizes and empowers the Tribal Business Council to engage in activities on behalf of and in the interest of the welfare and benefit of the Tribes and of the enrolled members thereof; and

WHEREAS, The health care status of the enrolled members of the Three Affiliated Tribes is critical and falls far below regional and national statistics wherein tribal members continue to die from alcoholism, unintentional injuries, cancer, heart disease, diabetes, motor vehicle accidents, and other diseases at rates which exceed *all populations* in the United States, including *all* Indian Health Service areas; and

WHEREAS, The Tribal Business Council has undertaken certain measures to assess the health care needs of tribal members and is dedicated to improving health care for the resident, enrolled members, and that any such unmet health care needs of tribal members shall be deemed a number one priority; and

WHEREAS, The Tribal Business Council began the process of assessing the health care needs of the residents of the Fort Berthold Reservation two (2) years ago when the Tribal Business Council entered into a memorandum of Agreement with the Indian Health Service in July of 1995, for the purposes of employing a Health Planner to develop a Comprehensive Health Plan as well as to provide technical assistance to tribal staff in order to develop and improve existing tribal health programs; and

WHEREAS, The Tribal Business Council on June 17, 1997, created a Comprehensive Health Committee to analyze health care systems, including the development of health care options that will most benefit the residents of the Fort Berthold Reservation, and that such health care options has been presented to the Full Council on August 12, 1997, *(See Resolution No. 97-146-DSB)*; and

WHEREAS, It is the considered judgment of the Tribal Business Council to adopt the recommendations of the Comprehensive Health Committee that the health care needs of the residents of the Fort Berthold Reservation include the building of a new medical facility regardless of whether the Tribal Business Council decides to contract Indian

Reso # 97-170-DSB
Attachment A
1 of 9 pages

EXECUTIVE SUMMARY

There are many concerns in the area of health care as expressed by tribal members, health care professional staff, as well as, tribal council representatives. In order to address these concerns, the Three Affiliated Tribes decided to develop a comprehensive health care plan (CHP) for the Fort Berthold Community. Another factor which influenced the decision to develop a Comprehensive Health Care Plan was the anticipation of revenue from JTAC and the Four Bears Casino which could be used to supplement needs in the area of health care. To begin this process, a Health Planner was hired via a Memorandum of Agreement with the Indian Health Service to develop a Comprehensive Health Plan as well as provide technical assistance to Tribal staff on developing and improving existing Tribal Health Programs.

The methodology in developing the CHP was to begin by looking at the health care situation and assessing the the level of need as identified by the stakeholders. Information on the level of need and concerns were identified by; meeting with health system leaders in the state of North Dakota (Fall 1995 - Winter 1997), meeting with IHS Headquarters and Area personnel (Winter 1996), holding community meetings (Spring and Summer 1996), conducting a focus group (Spring 1996), conducting an IHS Employee Survey (Winter 1996), conducting a Community-Wide Health Care Survey (Fall 1996 & Winter 1997), consultant review (Spring 1996 & Spring 1997), conducting informal interviews throughout this process, and conducting a literature review (Fall 1995 - Winter 1997). Information from the aforementioned sources was compiled and summarized. Preliminary recommendations were developed with the help of health care consultants which would address the underlying causes of the issues and improve health care. The preliminary recommendations were presented to the Tribal Business Council (Spring 1997). A Comprehensive Health Committee was developed to gather additional input from the communities regarding the preliminary recommendations and to finalize a recommendation to the Tribal Business Council. In July and August 1997, community meetings were held in each segment to present preliminary recommendations and gather input from the communities on Fort Berthold. Final Recommendations were formulated for the Tribal Business Council regarding a Comprehensive Health Plan (August 1997).

Critical issues identified were as follows:

Health Status - The health status of the Native American residents of Fort Berthold is poor in comparison to the rest of the United States, and in fact, as compared to some of the other IHS areas as well. The IHS Mortality Charts show that Fort Berthold residents continue to die from alcoholism, unintentional injuries, cancer, heart disease, diabetes, motor vehicle accidents, and other diseases at rates which exceed the U.S. All Races Population and All IHS Areas Population.

The health status issues discussed above have a severe impact on Fort Berthold communities and families. Years of potential life lost for American Indians as a result of a relatively high rate of premature deaths, is 50% greater than for individuals in the general population.[1] Delivery of health care on Fort Berthold needs to be redirected toward a greater emphasis on wellness services and behaviors which will keep people well (prevention).

Quality - information from all sources indicates that quality of care is an extremely important issue to the people of Fort Berthold. Quality of care is an important factor in getting and keeping market share.

Access - there is lack of ability to access needed services whether it is direct care in the clinic or referral care to outside providers. People report that it is hard to get an appointment at the Minne Tohe Clinic, and the wait times are excessive. In addition, it is hard to get a referral if specialty services are needed. Only 26% of the User Population at the Fort Berthold Service Unit have an alternate resource, i.e. Medicaid or Private Insurance, which also lessens access to medical care other than the IHS.

Emergency Services - there is a lack of emergency services in all segments of the reservation, especially hard hit are the more isolated communities. All segments of the reservation rely on ambulance service from the closest town which result in excessive response times and ultimately may contribute to loss of lives in an emergency situation.

Management - concern was expressed about how the tribe would maintain responsibility and accountability in relation to management of health care under 638 contracting. The complex nature of the health care industry necessitates that qualified people manage the programs. Concern was expressed that the health care plan needs to be implemented and carried out.

Professional Staff - concern was expressed about getting and maintaining staff which are concerned and caring, qualified, well trained, and are allowed to practice free of political interference. Recruiting enrolled members should be a priority as well as training programs to get more qualified enrolled members.

Facilities - it has been documented currently by the Office of Planning and Legislation, and consultant review that the Fort Berthold Service Unit facility for outpatient care is inadequate. This inadequacy limits the ability to provide services and see patients. In addition, there are many cases where no facilities exist to provide needed care e.g. for inpatient treatment of alcoholism or emergency medical treatment. The need for facilities has been documented in the past by a study conducted in 1979 by Don Jennings and Associates, Inc., of Lakewood, CO, for the Three Affiliated Tribes on the Feasibility For Hospital, Extended Care and Ambulatory Care Services.

Services - a lack of services especially for elderly, mental health, children, and emergencies exists. Duplication and fragmentation result in loss of efficiency due to the mix of Federal, Tribal, and private sector services.

Funding - the level of funding for the Aberdeen Area is at 67% of the need as described by the IHS, this places constraints on services and personnel at the Fort Berthold Service Unit. Research done for this document indicates that people are concerned about the level of funding, they want assurance that the funding from the government will be maintained and preferably, increased thereby upholding the trust responsibility of the Federal government.

Input - a large are of concern expressed by people who provided input for this project was that they wanted to have a say in what happens with the health care system. They want to be involved in developing the system and making the decisions about what the future holds in relation to health care. In order to address this concern immediately, the Tribal Business Council formed a Comprehensive Health Committee to gather input in addition to the surveys, community meetings, focus group, and informal interviews which were done initially to get input regarding concerns and suggestions for health care. The Comprehensive Health Committee was given the responsibility of finalizing recommendations for the health plan which would incorporate community input.

Politics - a significant concern expressed throughout the research process for this project was that politics would adversely impact the delivery of health care, especially since the Tribe had passed a resolution to 638 Contract for health care services at the IHS Clinic.

There are numerous forces acting upon health care in general and the IHS specifically, following are some of the factors which were taken into consideration as recommendations for change in the health care system on Fort Berthold were formulated:

I. Federal Trust Responsibility to Provide Health Care to American Indians

Historically, health care has been provided to American Indians by the Federal government based upon a special government-to-government relationship between Indian tribes and the United States. This relationship is based on Article I, Section 8, of the United States Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions (1830's), and Executive Orders.[2] As the director of Indian Health Service, Dr. Michael Trujillo, states:

> "Our Indian ancestors ceded land, water, mineral rights, and forests for, among other things, health care. Many lost their lives doing so. They did so to ensure the survival and well-being of future generations of Indian people. The U.S. government committed itself to a trust responsibility and it is our responsibility to uphold that government-to-government trust relationship. The trend toward downsizing the role and responsibilities of the federal government cannot be used to diminish historic treaty and trust obligations to American Indian and Alaska Native people."[3]

II. The Indian Self-Determination and Education Assistance Act of 1976

The Indian Self-Determination and Education Assistance Act of 1976, as amended, gave new opportunities and responsibilities to the IHS and tribes in delivering care. This policy emphasizes tribal administration of Federal Indian programs, including health care. Self-Determination does not lessen the Federal treaty obligations even though many tribes have assumed the role of providing health care for their communities.[4] Thirty five to forty percent of the Federal dollars for health care are utilized by tribes who manage their own programs through a Self-Determination Contract or a Self-Governance Compact. Amendments to the Self-Determination Act also allow transfer of proportionate share of pooled resources (that amount of shared resources that

supported contracted or compacted health programs formerly operated by IHS) from IHS Area Offices and Headquarters. While the law protects the share of pooled Area Office and Headquarters dollars that remain to support health programs of noncompacting/contracting tribes, the proportionate downsizing of pooled operations, together with Federal FTE and administrative budget reductions, has resulted in reduced economies of scale in some Area and Headquarters operations. In those Areas with the highest percentage of transfer, the remaining resources may fall below a minimum critical mass necessary to sustain a fully functional support system. All these factors taken together have resulted in some gaps in some Area and Headquarters functions. Currently, the Three Affiliated Tribes have a resolution in place (#96-30-DSB) to contract with the Indian Health Service for those services, functions, and activities in the delivery of an effective health care program on the Fort Berthold Reservation. In addition, the aforementioned resolution states that the Tribe elects to receive its share of funding that the Area and Headquarters offices use in carrying out programs, services, functions and activities in the delivery of health care.

III. Health Status of Fort Berthold Residents

The health status of the Native American residents of Fort Berthold is poor in comparison to the rest of the United States, and in fact, as compared to some of the other IHS areas as well. The life expectancy at birth for both sexes is 64.9 years for the Aberdeen Area as compared to 73.2 for IHS all Areas and 75.8 for U.S. all races[5]. The IHS Mortality Charts show that Fort Berthold residents continue to die from alcoholism, unintentional injuries, cancer, heart disease, diabetes, motor vehicle accidents, and other diseases at rates which exceed the U.S. All Races Population and All IHS Areas Population.

Many of the causes of death for Fort Berthold residents are preventable but involve lifestyle changes that present a challenge to health care personnel. Alcoholism continues to be a major health and social problem and death rates are increasing. Motor vehicle accidents comprise a large percentage of the unintentional injuries which is our leading cause of death, 20% of motor vehicle accidents are alcohol related.

A very low percentage of diabetic patients on Fort Berthold have a level of control which is considered acceptable. The result of poor control is a greater incidence of complications such as dialysis.

Prevention related activities on Fort Berthold are very limited, i.e. cancer screening. This is significant because cancer is one of the leading causes of death on Fort Berthold.

The health status issues discussed above have a severe impact on Fort Berthold communities and families. Years of potential life lost for American Indians as a result of a relatively high rate of premature deaths, is 50% greater than for individuals in the general population.[6] Delivery of health care on Fort Berthold needs to be redirected toward a greater emphasis on wellness services and behaviors which will keep people well (prevention).

IV. Changing Health Care Industry

Costs of medical care continue to increase faster than the general rate of inflation. In the past, the IHS budget was augmented to compensate for rising costs. Future IHS budgets probably will not include more funds to cover rising costs and some absolute reductions in HIS' budget are possible. IHS budget discussion is extremely important considering that in fiscal year 1996, the IHS per capita health care expenditure was $1,578 compared to the U.S. civilian per capita expenditure of $3,920[7].

Sustaining full acute inpatient care capabilities in the smallest hospitals is increasingly problematic.[8] The trend nationally is for mergers, consolidations, and takeovers in order to consolidate smaller independently operated hospitals and clinics into large vertically integrated heath care systems in order to accommodate managed care, growing competition, and market shakeouts.

Managed care can be defined as systems that integrate the financing and delivery of health care services to covered individuals by means including arrangements with selected providers to furnish a comprehensive set of health care services to members; explicit credentialing standards, formal programs for on going quality assurance and utilization review; and significant financial incentives for members to use providers and procedures associated with the plan. The managed care revolution is certain to envelop thousands of Native Americans. Those covered by Medicaid will be affected first, as states contract with managed-care organizations to provide services to Medicaid recipients. Native Americans will encounter managed-care in less direct ways as well. Increasingly, IHS tribal, and urban health services will face competition from managed care organizations seeking to expand their business. Competition from managed care plans will again impose sharp budget constraints on programs.

An environment of unparalleled Federal budget reductions, transfer of many Federal programs and resources to States, decreases in discretionary programs in the Federal budget, and a strong anti-government sentiment are contributing to the health care environment. Constrained government health care spending, especially in Medicare and Medicaid, will potentially limit and/or decrease third part revenues to IHS and tribal programs. Possible new caps on payments and more restrictive eligibility requirements could reduce IHS and tribal revenues from Medicaid as well. In some cases, Indians who are eligible for Medicare or Medicaid benefits could be assigned to managed care organizations that contract with the state. Such shifts could further diminish the IHS and/or tribal user base and erode revenues, economies of scale, and financial stability.

President Clinton has proposed changes to Federal agencies and departments that would allow a 12 percent reduction of the Federal workforce over a period of 5 years.[9] The IHS has shared in the overall downsizing of the Federal workforce with a policy to absorb the reductions above the service unit level to the maximum extent practical. Some service units have realized an increase in the number of Full Time Equivalent (FTE) staffing, however, at this point in time, no FTE increases have been realized at the Fort Berthold Service Unit. Reductions of FTEs at Headquarters and Area offices have begun to tax capabilities and services. It is anticipated that the effects from FTE reductions will become more severe if further reductions occur. It is paramount during

this time of streamlining and improving the Federal government that we maintain and improve the capabilities of Tribal governments and services to Indian people.

V. Indian Health Service Division of Facilities Planning and Construction(DFPC)

The DFPC is responsible for administering the planning, design, and construction of hospitals, health centers, substance abuse treatment centers, and staff quarters as authorized by the Snyder Act, 23 U.S.C. 13; and the Indian Health Care Improvement Act (IHCIA) P.L. 94-437. Section 301 of the IHCIA, P.L. 94-437, directs the IHS to identify planning, design, construction, and renovation needs for the 10 top priority inpatient care facilities and the 10 top priority outpatient care facilities and to submit those needs through the President to the Congress. In response to this directive, the IHS developed the Health Facilities Construction Priority System (HFCPS) methodology. Under the three phase HFCPS process, the IHS solicits proposals for health facility construction and ranks them according to their relative need for construction. The highest ranking proposals are added to the Priority Lists. After projects are placed on the Priority Lists, the IHS updates its 5 year planned construction budget. That budget is updated yearly and used as the basis for funding requests. Currently, Fort Berthold is not on the Priority List for construction. Area staff indicate that the current funding for construction is very inadequate, it is anticipated that it will take 10 - 15 years of appropriations in order to finish construction of those facilities on the list. The outlook for new construction for Fort Berthold utilizing this system looks very grim.

In Public Law 101-512, "Department of the Interior and Related Agencies Appropriations Act of 1991," the Congress directed the Indian Health Service (IHS) to develop a "joint venture program to demonstrate the potential of cooperative efforts between the IHS and the tribes." The Joint Venture Demonstration Program is intended to assist those tribes and tribal organizations that wish to use tribal funds to increase the level of health care services provided to their population. Participating tribes or tribal organizations would acquire a suitable health center building that they will lease to the IHS for 20 years without cost. In return, the IHS will equip, supply, operate, and maintain the facility. Projects will be competitively selected to participate based on the need for additional space and the capability of a tribe to provide, within a specified time frame, a facility that meets the standards of the IHS Health Facilities Planning Manual (HFPM) and the IHS Resource Requirements Methodology (RRM).

Two tribes have been selected to enter this demonstration, The Confederated Tribes of the Warm Springs Reservation, Oregon and the Choctaw Nation of Oklahoma constructed facilities under this program. Indian Health Service staff at Area and Headquarters have indicated that the authorizing legislation remains valid, however, no additional appropriations have been made to fund this legislation.

Currently, Space Allocation Plan Summaries, RRMNAs, PJD Workload Projection, and construction cost estimates have been completed by the Office of Planning and Legislation at Aberdeen for the Fort Berthold Service Unit. These documents indicate that an increased amount of staffing and space are required to operate Fort Berthold health care programs. The proposal done by Aberdeen indicates a space requirement of 35, 924 square feet as compared to approximately 13,000 square feet currently occupied by the Fort Berthold Service Unit (including the new construction).

The proposed staffing requirements would be a total of 99 FTEs at a cost of $2,631,074.00 for the 50 additional staff, this would bring the total personnel costs to $5,005,769.

VI. 1992 Three Affiliated Tribes and Standing Rock Sioux Tribe Equitable Compensation Act

Beginning in 1998 the Three Affiliated Tribes will receive interest payments from an eventual 149.2 million economic recovery trust fund as compensation for the 156,000 acre taking of reservation land during the construction of the Garrison dam and Reservoir. Congress has given a broad mandate that limits the use of these moneys to "...educational, social, welfare, economic development, and other programs." The trust fund (known as JTAC funds) can be used for such purposes as economic development, education, health care improvement, or environmental management as stated by Senator Conrad in the Congressional Record on February 9, 1994. This flexibility promotes tribal sovereignty over investment choices and supports innovative program ideas. Additionally, the legislation encourages long-term investment by prohibiting the disbursement of interest payments to any member of the Tribe on a per capita basis.[10] The initial payment of JTAC funds will be a balloon payment of approximately 30 million dollars, thereafter, the yearly payment from the interest will be approximately 8-10 million dollars annually.

VII. Insurance

Blue Cross Blue Shield of North Dakota conducted a utilization study looking at a cross section of insured residents on Fort Berthold. The reason that the Health Planner requested this study from BCBSND was to get some numbers to approximate the cost of insurance so that a decision could be made regarding purchase. The three year average per member per month cost is $130. The average premium cost/month for a fully insured employer group is $165. Using the figure of $165 to calculate approximate insurance costs for tribal membership yields the following results:

$165 X 10,000 (total members) X 12months =$19, 800,000
165 X 5,000 (resident population) X 12months = 9,900,000

Looking at figures generated by this study to insure elderly, an average cost for male and female age 60 and over is $258/month. Adding a 10% administrative cost, following is an approximate cost for elderly 60 and above:

$258 X 12months X .10(admin. Cost) X 533 =$1,815,184

Looking at figures generated by this study to get an approximate cost for hospital insurance for the enrolled resident membership is:

$57 X .10 (admin. fee) X 12months X 5000 residents =$3,762,000

It becomes apparent from this study that the cost to buy insurance is very high and continually increasing.

In consideration of the issues which have been identified through the research for this project, in looking at the underlying causes, and looking at factors for consideration, the following recommendations are offered as means to address the issues and improve the health care system on Fort Berthold:

1. **OPERATIONS**
   - Enter a joint venture with the Indian Health Service under the Joint Venture Demonstration Program which is intended to assist those tribes that wish to use tribal funds to increase the level of health care services provided to their population In this manner, the IHS would be increasing the level of staffing and equipment needed to operate an expanded facility.
   - Construct a suitable health center building.
   - Lease health center building to the IHS for 20 years without cost.
   - IHS will equip, supply, operate, and maintain the facility.
   - This will require an intensive lobbying effort on the part of the Tribe in order to get the funds appropriated from Congress for this project.
   - In this manner the Tribe can be proactive in ensuring that the trust responsibility of the Federal government is upheld in providing health care for Indians.
   - Within one year reassess the plan for 638 contracting, based on funding outlook regarding the Joint Venture Project.
2. **FACILITIES**
   - Provide a new health care facility for the residents of Fort Berthold to increase the capacity to see patients and provide additional services such as twenty four hour urgent care.
   - Identify resources available for health care facility needs, cost estimates have been obtained from the Aberdeen Area IHS and from CTA Architects Engineers as a starting point.

Outpatient Facility	$13,191,300
Staffing Costs	5,005,769
Equipment Costs	3,265,900

   - Engage the services of an architectural engineering firm with health care experience and a reputation for success to do the planning, design, and construction of facility.

3. **GOVERNANCE**
   - Revise the Tribal constitution to allow for mechanisms whereby; a health board could be established that would enjoy political neutrality in the event that the tribe would decide to enter a 638 contract or a Self Governance Compact in the future.
4. **SERVICES**

- Evaluate the feasibility of an Outpatient Surgery Center, Longterm Care Facilities, Medical Inpatient Care, and an Inpatient Substance Abuse Facility utilizing the services of a health care professional.
- Develop an Emergency Medical System to work in conjunction with Urgent Care Services. Include First Responders, EMT's and Paramedics (training and staff in each segment), an ambulance for each segment, and upgrade the Geographical Information System to include 911 call capability.
- Develop health care initiatives in each community specific to community needs, i.e. upgrade the IHS facility in Twin Buttes, staffing and equipment for new health facility in White Shield. Resources would have to be identified, i.e. JTAC funds or casino funds.

5. TRANSPORTATION

Develop a reservation wide transit system to increase access to all residents and alleviate the transportation duties which adversely impact health care programs.

PROGRAM PLAN AND GUIDELINES FOR IMPLEMENTING THE JOINT VENTURE DEMONSTRATION PROGRAM DESCRIBED IN PUBLIC LAW 101-512

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE

INDIAN HEALTH SERVICE

MAY 1991

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For The

Program Plan and Guidelines for Implementing The Joint Venture Demonstration Program

PROGRAM PLAN AND GUIDELINES FOR IMPLEMENTING THE JOINT VENTURE DEMONSTRATION PROGRAM DESCRIBED IN PUBLIC LAW 101-512

INTRODUCTION AND EXECUTIVE SUMMARY

In Public Law (P.L.) 101-512, "Department of the Interior and Related Agencies Appropriations Act of 1991," the Congress directed the Indian Health Service (IHS) to develop a "joint venture program to demonstrate the potential of cooperative efforts between the IHS and the tribes." The Joint Venture Demonstration Program is intended to assist those tribes and tribal organizations that wish to use tribal funds to increase the level of health care services provided to their population. Participating tribes or tribal organizations would acquire a suitable health center building that they will lease to the IHS for 20 years without cost. In return, the IHS will equip, supply, operate, and maintain the facility.

Up to three tribes may be selected to participate in the demonstration. The Congress appropriated $1.5 million for initial Federal participation.

The IHS will use a modified version of its current Health Facilities Construction Priority System (HFCPS) to evaluate proposals of tribes wishing to participate in this demonstration. The Priority System will:

- Evaluate which of the proposals demonstrate the greatest relative need for a new or replacement facility.

- Determine which proposals are most responsive to congressional intent to complete the Joint Venture Demonstration Program in a timely manner.

Each chosen proposal must meet the criteria set forth in P.L. 101-512, and progress actively toward completion in a timely manner. Tribal participants will be required to have a Program Justification Document (PJD) and a Program of Requirements (POR) approved by the Director, IHS, by December 31, 1991, and to have full funding available by that date. Projects will be tentatively selected until they meet these deadlines. Projects that cannot meet the December 31, 1991 deadline, will be dropped from consideration. The IHS will report quarterly to the Congress on the status of this Joint Venture Demonstration Program, including the anticipated cost.

BACKGROUND

Public Law 101-512 establishes stringent criteria for participation in the Joint Venture Demonstration Program. These are addressed below:

- Up to three proposed health centers not currently on an IHS Facilities Construction Priority List may be chosen to participate in the Joint Venture Demonstration Program. Only health centers will be considered for participation in the Joint Venture Demonstration Program. The IHS defines health centers as facilities operating a minimum of 40 hours per week, staffed with a basic health care team providing services for acute and chronic ambulatory problems, and acting as a referral center to other levels of care. The minimum workload in a facility of this kind is 4,400 primary care provider visits (PCPV). A PCPV is a medical encounter with an ambulatory health care provider in one of the following categories: Medical Doctor, Physician's Assistant, Nurse Midwife, Nurse Practitioner, or Podiatrist.

- The IHS participation is limited to equipping, supplying, operating, and maintaining facilities obtained (through construction or lease) by tribes. The Congress has funded IHS participation for $1.5 million. This may not be enough to equip, supply, operate, and

maintain the chosen facilities. The IHS is to keep the Congress informed as to how far the $1.5 million will go.

- Tribal participants will provide a facility to the IHS for a minimum of 20 years under a no-cost lease. The IHS will provide no funding to construct or lease space for the facility.

Projects will be competitively selected to participate based on the need for additional space and the capability of a tribe to provide, within a specified timeframe, a facility that meets the standards of the IHS Health Facilities Planning Manual (HFPM) and the IHS Resource Requirements Methodology (RRM).

Factors Used in the Joint Venture Demonstration Program Formula

The IHS will use the Phase II formula from the HFCPS Methodology to determine the relative need for a new or replacement facility. To evaluate each tribe's capability to make and meet proposal commitments, the following factors will be used to modify the priority score generated by the HFCPS formula:

- The date the tribe commits to having a PJD and POR that the Director, IHS, can approve. These documents must meet the criteria of the IHS HFPM and RRM before they can be approved. Both the PJD and POR must be approved by December 31, 1991; proposals without an approved PJD and POR will be dropped from consideration.

- The date the tribe will fund the project with tribal resources. The availability of these funds must be properly documented. Proposals must be fully funded by December 31, 1991; those that are not will be dropped from consideration.

- The amount of funding the tribe will commit to provide on-going support to the program, if the tribe elects this option.

This is the amount the tribe will commit to equip, supply, operate, and maintain the facility with tribal resources[1].

THE FORMULA TO DETERMINE ELIGIBILITY AND PRIORITY

The formula that the IHS will use in determining a proposal's eligibility and relative need for additional space will include a score generated by the Phase II HFCPS Methodology and the additional factors described above. That formula is outlined in the following table:

Scoring Formula for the Tribe/IHS Joint Venture Demonstration Program								
Demonstration Score	=	HFCPS Score	X	Planning Completion Factor (Table D*)	X	Financial Commitment Factor (Table E*)	X	On-going Support Factor (Table F*)

* Tables D, E, and F are in Exhibit II.

IMPLEMENTATION OF THE JOINT VENTURE DEMONSTRATION PROGRAM

The IHS will implement the Joint Venture Demonstration Program by asking each Area Office to assist each interested tribe in preparing a proposal that contains the following:

- A cover sheet with signature blocks for the tribal chairman and the IHS Area Director (See Exhibit I).

- A completed IHS HFCPS Data and Computation Form for Use with the Joint Venture Demonstration Program (See Exhibit II). This form is a modified version of the form in the working draft of the HFCPS.

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[1] Tribes are not required to provide on-going support; however, those proposals which demonstrate an ability to provide this support will be ranked somewhat higher.

- A tribal resolution, stating the tribe's commitment, subsequent to a tribal referendum if required, including, but not limited to, the following:

  - Expend the necessary funds for the proposed project.

  - Provide the facility to the IHS for 20 years under a no cost lease.

- A financial summary, showing the estimated cost of the project and the tribe's ability to meet its commitments (See Exhibit III).

Each proposal will be reviewed by the appropriate IHS Area Office to ensure that the proposed facility is compatible with the Area Health Services Delivery Plan. The IHS Headquarters will review and evaluate each proposal using Phase II of the IHS HFCPS Methodology criteria and the criteria set forth in P.L. 101-512. Based on the results of the scoring formula, the IHS will choose three proposals for potential participation in the Joint Venture Demonstration Program. For each of the chosen proposals the IHS will ask the appropriate Area Office to assist the tribe in preparing and submitting the following:

- A PJD and a POR based on the IHS HFPM and RRM.

- A cost estimate using the *Indian Health Service Budget Cost Estimating System,* version 3.0.

- A financial statement indicating the tribe's capability for meeting the financial commitments made in its proposal, including commitments by financial institutions that may be assisting with funding. If funds are not available when the proposal is submitted, the financial statement must indicate how the funds will be obtained and when they will be available. Before committing support for a project, the IHS will ask that an audit be performed to confirm actual financial capability.

If no tribe is willing and able to commit funding to acquire a required facility that it would lease to the IHS without cost for 20 years, the IHS will so inform the Congress and the Joint Venture Demonstration Program will be canceled.

SCHEDULE

The proposed timeframe for the Joint Venture Demonstration Program is listed below:

- o February 13, 1991 Headquarters send the program implementation plan (this document) to Areas for Area and tribal review.
- o March 25, 1991 Each Area collates and submits comments on the program implementation plan to IHS Headquarters.
- o March 29, 1991 Each Area submits Tribal Participation Interest Forms. (See Exhibit IV.)
- o April 25, 1991 IHS Headquarters requests proposals for Joint Venture Demonstration Program participation.
- o July 15, 1991 Each Area submits tribal proposals to Headquarters.
- o August 1, 1991 IHS Headquarters submits a list of potential participants to the Congress.
- o Dec 31, 1991 Last day for approval of PJD and POR and for certification of funding availability. Tentatively selected proposals not meeting deadline will be dropped from consideration.

Exhibit I

A Proposal to Participate
In the Joint Venture Demonstration Program

Public Law 101-512
[Name of Facility] Health Center
[Location], [State]
[Month], [Year]

Proposed[1]

[*Name*] [*Title*] [*Tribe*]	[*Date*]

Recommend for Consideration

[*Name*] Director, [*Area*] Indian Health Service	[*Date*]

[1] A tribal resolution must be included in the proposal submission. It must state the tribal commitment to obtain an appropriate health facility and lease it to the IHS without cost for 20 years.

The Indian Health Service Health Facilities Construction Priority System Data and Computation Form For use as part of the Joint Venture Demonstration Program Instructions

The Health Facilities Construction Priority System (HFCPS) Data and Computation Form (Page II - 5) is designed to aid Indian Health Service (IHS) Areas and tribes in preparing proposals for consideration under the HFCPS and the Joint Venture Demonstration Program. The form permits each Area and tribe to collect and analyze the data in its proposals and may be used, with the three attached tables, to score each Phase II proposal. It and the tables are based on the HFCPS formula; however, in creating the tables, the three major factors in the formula have been bounded (i.e., they have had upper and lower limits placed on them) and normalized (i.e., they have been adjusted so each carries an appropriate weight). The form is self explanatory; however, the following instructions are provided to clarify what had to be abbreviated to fit on the form.

A. The total Primary Care Provider Visits (PCPV) projected 3 years into the future using the IHS Facility Planning Forecasting Guidelines.

B. The Required Space at a stand-alone outpatient facility is equal to the annual PCPV [A] times 2.5.

C. The age of a facility is the average age of the portions of the facility weighted by the square footage. Use the worksheet below to determine the weighted average age of the facility. All data on IHS facilities is available from the Public Health Service (PHS) Real Property Inventory. Data for tribal facilities must be documented.

Work Sheet for Determining the Weighted Average Age of a Facility

Square Footage of the Portion of the Facility	/	Total Facility Square Footage	X	Age of the Portion	=	Weighted Age of the Portion
(_____	/	_____)	X	_____	=	
(_____	/	_____)	X	_____	=	
(_____	/	_____)	X	_____	=	
(_____	/	_____)	X	_____	=	
(_____	/	_____)	X	_____	=	
(_____	/	_____)	X	_____	=	
(_____	/	_____)	X	_____	=	
				Total Weighted Average Facility age		_____

D. Existing space for IHS facilities is the total space of all *permanent* buildings as listed on the PHS Real Property Inventory. Existing space for tribal facilities is the total gross square footage of the facility's permanent space. To-scale as-built drawings must accompany proposals to consider tribal facilities. If there is no existing facility, enter 0.

E. Multiply the Base Facility value times the Location Index value to obtain the cost per square foot to replace the existing facility. The Base Facility Cost and the Location Index are found in the *IHS Budget Cost Estimating System Instruction Manual.* The Base Facility Cost is found in Table 1 for the appropriate Area. The Location Index is found in Table 3 for the appropriate Area. If the location has no listing on Table 3, use the listing for the nearest service unit.

F. For existing facilities, enter and sum the costs to correct the Facilities Engineering Deficiencies System (FEDS) deficiencies for the codes listed under item F. If no facility exists or for facilities for which no FEDS survey has been completed, enter 0.

G. For existing facilities, the Cost Per Square Foot to Repair is the total Cost to Repair [F] divided by Existing Space [D]. If no facility exists enter 0.

H. For existing facilities, the Condition Factor to be used on Table A is determined by dividing the Cost per Square Foot to Repair [G] by the Cost per Square Foot to Replace [E]. If no facility exists enter 0.

I. Determine the Adjusted Existing Space by multiplying the Age and Condition Factor (obtained from Table A) times the Existing Space [D] and subtracting that value from the Existing Space [D].

J. Obtain the Urgency of Need Factor for proposed outpatient facilities from Table B.

K. For proposed stand-alone outpatient facilities, enter the road miles to the nearest level 1, 2, or 3 emergency room. Use the most recent edition of the Rand McNally Road Atlas, if available. Otherwise use a state road map and send an original copy of the map with the application.

L. Consult Table C to get the Alternative/Isolation factor. For outpatient facilities use the road miles to the nearest Level 1, 2, or 3 emergency room [K] as the input value to Table C.

M. To determine the HFCPS Score multiply the Urgency of Need Factor [J] times the Isolation/Alternative Factor [L].

N. To determine the Joint Venture Demonstration Ranking score multiply the HFCPS Score [M] times the product of the Planning Completion Factor (Table D) times the Financial Commitment Factor (Table E) times the On-going Support Factor (Table F).

IHS Health Facilities Construction Priority System
Data and Computation Form
For Use with the Joint Venture Demonstration Program

Phase II

Location:		*Date Submitted:*	
Area Office:		*Service Unit:*	
Contact Person:		*Telephone:*	

Optional Narrative:

Location/ Tribe:	IHS Area Office	Date:
A.	Projected Primary Care Provider Visits per the IHS Facilities Planning Forecasting Guidelines.	_____
B.	Required Space for Proposed Stand-alone Outpatient Facilities (For use on Table B.) PCPV [A] X 2.5 _____ X 2.5	_____
C.	Total Weighted Average Facility Age from the table on Page II - 2	_____
D.	Existing Space (Permanent space listed on the *PHS Real Property Inventory*)	_____
E.	(See *The IHS Budget Cost Estimating System* Ver. 3.0.) Cost per Square Foot to Replace _____ X Location Index _____	_____
F.	Cost to Repair	

FEDS Deficiency	Cost	FEDS Deficiency	Cost
FEDS Code 2	_____	FEDS Code 11	_____
FEDS Code 3	_____	FEDS Code 12	_____
FEDS Code 4	_____	FEDS Code 13	_____
FEDS Code 7	_____	FEDS Code 14	_____
FEDS Code 8	_____	FEDS Code 15	_____

	Total FEDS Costs (Sum of FEDS 2,3,4,7,8,11,12,13,14 and 15).	_____
G.	Cost per Square Foot to Repair Total FEDS Cost (F) _____ Divided By / Existing Space (D) _____	_____
H.	Condition Factor (For use on Table A.) Cost per Square Foot to Repair [G] _____ Divided By / Cost per Square Foot to Replace (E) _____	_____
I.	Adjusted Existing Space (for use on Table B). Existing Space _____ - (Age and Condition Factor From Table A) (_____ X Existing Space [D] _____)	_____
J.	Urgency of Need Factor (from Table B).	_____
K.	Road miles to the nearest Level I, II, or III Emergency Room (for use on Table C).	_____
L.	Isolation/Alternatives Factor for proposed Outpatient Facilities (from Table C).	_____
M.	100 X Urgency of Need Factor [J] _____ X Isolation/Alternative Factor [L] _____ 100 X	_____
Joint Venture Demonstration Program Score		
N.	HFCPS Score (M) _____ X Planning Completion Factor (Table D) _____ X Financial Commitment Factor (Table E) _____ X On-going Support Factor (Table F) _____	_____

Table C Alternative and Isolation	
Road Miles to Other Facility	Outpatient Factor
00 - 10	1.00
11 - 15	1.00
16 - 20	1.00
21 - 25	1.05
26 - 30	1.10
31 - 35	1.15
36 - 40	1.20
41 - 45	1.25
46 - 50	1.30
51 - 55	1.35
56 - 60	1.35
61 - 65	1.40
66 - 70	1.40
71 - 75	1.45
76 - 80	1.50
81 - 85	1.50
86 - 99	1.60

Table D Planning Completion Factor Approval Date for the Program Justification Document and Program of Requirements				
Date an Approveable PJD is submitted to IHS	July 30, 1991	Sep. 30, 1991	Dec 30. 1991	After Dec. 30, 1991
Planning Document Factor	1.25	1.10	1.0	0

Table E Financial Commitment Factor				
Date the Tribe Can Fund the Project	July 30, 1991	Sep. 30, 1991	Dec. 30, 1991	After Dec. 30, 1991
Factor	1.25	1.10	1.0	0

Table F On-going Support Factor
The factor for ongoing support is 100 percent + the percent of on-going support the tribe can commit. Thus if the tribe can commit to providing 30 percent of the required support at a facility, the Factor for On-going Support would be 1.30.

Financial Statement Sheet

Build or Purchase			
Cost to Build or Purchase			Line No.
Estimated Gross Square Feet[1]		Square Feet	1
Base Facility Cost per the *IHS Budget Cost Estimating System* Table 1		Per Square Foot	2
Subtotal: Facility Cost (Line 1 X Line 2)		$	3
Site work Cost per the *IHS Budget Cost Estimating System* Table 1		per Square Foot	4
Subtotal: Site work Costs (Line 1 X Line 4)		$	5
Total Base Costs (Line 3 + Line 5)		$	6
Location Index *IHS Budget Cost Estimating System* Table 3			7
Total Estimate Cost (line 6 X Line 7)		$	8
Source of Funds to Purchase or Build		Date Available	9
Funds Available	$		10
Assets to be converted to Cash	$		11
Loans (Specify)	$		12
Grants (Specify)	$		13
Other Funding (Specify)	$		14
Acquisition by Lease			
Cost to Lease			
Estimated Gross Square Feet[1]	$	Gross Square Feet	15
Annual Lease Cost Per Square Foot	$	Per Square Foot	16
Total Annual Lease Cost (Line 15 X Line 16)			17
Source of Tribal Funds for Lease (Specify)			
		$	18
.		$	.
		$	*nn*
Total Funds for Lease (Sum of lines 18 through *nn*)			

[1] The facility gross square footage must be based on staffing generated by the IHS Resource Requirements Methodology and space allocated using the IHS Health Facilities Planning Manual.

Tribal Participation Interest Form

Area Office	Contact Person	Telephone No.

Tribe or Native Corporation	Expresses some interest in participating	Expresses no interest in participating	Has offered no comment	Tribal Contact

Reso # 97-170-DSB

Health Service, pursuant to P.L. 93-638, or whether the Governing Body determines that a joint venture demonstration project is more appropriate; and

NOW, THEREFORE, BE IT RESOLVED, The Tribal Business Council hereby accepts the report of the Comprehensive Health Committee, which recommends the entering into of a Joint Venture Demonstration Project with the Indian Health Service, which said report is atttached and incorporated herein as "Attachment A".

BE IT FURTHER RESOLVED, The Tribal Business Council hereby authorizes the Chairman, Treasurer, and Financial Advisor to seek funding for the construction of a new medical facility from all potential sources.

CERTIFICATION

I, the undersigned, as Secretary of the Tribal Business Council of the Three Affiliated Tribes of the Fort Berthold Reservation, hereby certify that the Tribal Business Council is composed of 7 members of whom 5 constitute a quorum, 7 were present at a Regular meeting of duly called, noticed, convened, and held on the 12th day of August, 1997; that the foregoing Resolution was duly adopted at such Meeting by the affirmative vote of 4 members, 3 members opposed, 0 members abstained, 0 not voting, and that said Resolution has not been rescinded or amended in any way.

Dated this 12th day of August, 1997.

Dayton Spotted Bear
Secretary, Tribal Business Council

ATTEST:

Chairman, Tribal Business Council