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

February 22, 2024

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

Dear Representative Grijalva:

I am pleased to provide you with the *Urban Indian Organization Infrastructure Study Report to Congress Fiscal Year 2023*. This report was prepared by the Indian Health Service and is being submitted pursuant to the Consolidated Appropriations Act, 2021(Pub. L. No. 116-260), Explanatory Statement for Division G.

This report summarizes the infrastructure study for the 41 facilities run by Urban Indian Organizations to address the needs of American Indian and Alaska Native people living in urban communities.

I hope you find this information helpful.

Sincerely,

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Enclosure

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

February 22, 2024

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

Dear Vice Chair Murkowski:

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The Honorable Brian Schatz
Chairman
Senate Committee on Indian Affairs
United States Senate
Washington, DC 20515

Dear Chairman Schatz:

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Washington, DC 20201

February 22, 2024

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

Dear Chairman Westerman:

I am pleased to provide you with the *Urban Indian Organization Infrastructure Study Report to Congress Fiscal Year 2023*. This report was prepared by the Indian Health Service and is being submitted pursuant to the Consolidated Appropriations Act, 2021(Pub. L. No. 116-260), Explanatory Statement for Division G.

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REPORT TO CONGRESS

URBAN INDIAN ORGANIZATION INFRASTRUCTURE STUDY
FISCAL YEAR 2023
(Public Law No. 116-260)

U.S. Department of Health and Human Services
Indian Health Service
Office of Urban Indian Health Programs

Submitted to the United States Congress

Table of Contents

I. EXECUTIVE SUMMARY

The Consolidated Appropriations Act, 2021 (Pub. L. No. 116-260) (hereinafter "the Act") was enacted on December 27, 2020. The Act provided the Indian Health Service (IHS) with a total Fiscal Year (FY) 2021 appropriations of $6.4 billion. The Joint Explanatory Statement for Division G for the Act designated funds to conduct an infrastructure study for facilities run by Urban Indian Organizations (UIOs).

A national Urban Indian-specific infrastructure report has never been conducted, and this study is the first step towards addressing the most critical deficiencies faced by UIOs, as well as the formulation of a comprehensive cost and action plan. Currently, there is no IHS funding appropriated specifically for Urban Indian Organization facility construction.

In response to the Act, the IHS engaged a private-sector contractor to prepare a comprehensive infrastructure study using current and projected data, in conjunction with stakeholder input, to establish each Urban Indian Organization's future service plans. These reports outline the necessary operational and facility resources needed for each Urban Indian Organization to provide appropriate services to their Urban Indian population. Although the reports do not represent the views of the IHS or the United States (U.S.) Department of Health and Human Services (HHS), and the IHS has not adopted the reports, the IHS elected to treat the reports as a significant collection of useful data points for the particular purpose of discussing and evaluating the infrastructure needs of UIOs. Since each Urban Indian Organization has the ability to provide services outside the scope of their contract with the IHS with non-IHS funding, some of those activities may be included in the descriptions, data, and estimates contained in these reports. Nothing in these reports is an acknowledgment by the IHS that any particular activity is within the scope of an Urban Indian Organization's contract with the IHS, or that any service area beyond what is defined by the individual Urban Indian Organization's contract with the IHS is otherwise approved by the IHS.

This report establishes future facility needs for the majority of the 41 existing UIOs and estimates the operational resources needed to serve each Urban Indian Organization Service Area's future Urban Indian[1] population. The report also includes, but is not limited to the following:

- Current and projected Urban Indian Organization active user population.
- Current, potential, and projected service line market share and demand.
- New points of care, new services, and expansion of existing services.
- Existing and projected staffing and cost of operations.
- Existing and projected square feet by service line by planned service area.
- Description of the Urban Indian Organization's existing facility, age, and condition.

[1] The term "Urban Indians" is the term used by the Indian Health Care Improvement Act (IHCIA) and defined in the statute for purposes of eligibility for services at IHS-funded UIOs.
https://uscode.house.gov/view.xhtml?req=(title:25%20section:1603%20edition:prelim)

- Current maintenance and improvement needs.
- Total square feet projected for current points of care.
- Cost analysis for expansion and replacement.
- Identification of priority needs for services, staff, and space.

A summary of major takeaways and insight from the study conducted includes the following:

Service Area and Population
Urban Indian Organizations are presently providing services to approximately 28 percent of the American Indian and Alaska Native (AI/AN) population to be within the Medicare Advantage[2] network adequacy criteria by 2032.[3]

Healthcare Demand
Twenty-three of the UIOs, under their Federally Qualified Health Center (FQHC) designation, provide care to their surrounding non-Urban Indian communities. While many locations serve non-Urban Indian patients, 79 percent of the primary care forecasted demand outlined in this study is based on the demand of the local Urban Indian population.

New Services
While some UIOs intend to remain solely dedicated to their mission of providing services primarily addressing substance use disorder, the majority of UIOs aspire to be a medical home providing culturally appropriate services dedicated to improving the wellness of their patients and communities. New services planned are predominantly ambulatory.

Several UIOs have included regional outpatient specialty care services in their vision for the future that would meet their local population's needs.

Staff
According to 2021 data, UIOs have a total staff count of 3,420 Full-Time Equivalents (FTEs). To fulfill the 2032 vision of services for Urban Indians, UIO FTEs need to grow to 6,275, an increase of 78 percent. For overall patient service demand, the number of FTEs would need to grow to 8,083.

Operational Budget
The 2032 operating budgets for the UIOs will need to grow to $1.37 billion to meet their future plans[4] to serve their Urban Indian communities. If the IHS Office of Urban Indian Health Programs (OUIHP) were to fully support efforts by UIOs to achieve their 2032 vision to support

[2] Centers for Medicare & Medicaid Services - *Medicare Advantage Network Adequacy Criteria Guidance*, January 10, 2017. https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf

[3] Note that this data point may or may not align with the urban center defined in any particular Urban Indian Organization's contract with the IHS.

[4] Note that any particular Urban Indian Organization's future plans may or may not be within the scope of what is legally authorized to be carried out via a contract with IHS under Title V of the Indian Health Care Improvement Act.

their Urban Indian communities, the Urban Indian health funding provided annually would need to increase by 1,270 percent.

Facility Requirements[5]

To provide the space necessary to meet the UIOs' 2032 vision of service for their Urban Indian population, an additional 2.75 million building gross square feet (BGSF) is required. To acquire the needed additional square feet, an influx of capital for facility design and construction of $2.95 billion is required. To replace the entire inventory of Urban Indian Organizations' space would require $4.4 billion.

Table 1. Summary of Reported Urban Indian Organization Infrastructure Improvement Needs

10-Year Period – Calendar Year 2022 through Calendar Year 2032

Current Estimated Percent of Future Urban Indians Served by UIOs	Additional FTEs	Additional Operational Funding	Additional Building Gross Square Foot	Capital Investment
28%	**6,275**	**$1.37 Billion**	**2.75 Million**	**$2.95 Billion**

Resources Needed for 2032 Service Vision (Urban Indians Only)

II. BACKGROUND

The Indian Health Care Improvement Act (IHCIA) establishes numerous programs specifically created by Congress to address particular Indian health issues, including Urban Indian health. Through the IHCIA, Congress "establish[ed] programs in urban centers to make health services more accessible to Urban Indians." 25 U.S.C. § 1651. The IHS carries out this authority through contracts with, and grants to, UIOs. 25 U.S.C. §§ 1652-1653. The IHS, on behalf of the HHS Secretary, provides oversight of the grants and contracts to UIOs, with the purpose of making health services more accessible to Urban Indians. The IHCIA, as amended, states the policy of the federal government is "to ensure the highest possible health status for Indians and Urban Indians and to provide all resources necessary to effect that policy" and to "raise the health status of Indians and Urban Indians."

The IHS OUIHP was established in 1976 to make healthcare services more accessible to AI/AN people living in urban areas. The IHS contracts with 41 qualifying UIOs, which are defined by the IHCIA at 25 U.S.C. § 1603(29) and are non-profit organizations controlled by an Urban Indian board of directors. These IHS-funded programs support primary care clinics, outreach and referral programs, and residential and outpatient substance use disorder treatment centers that provide culturally appropriate services addressing the unique social, cultural, and health

[5] The estimates for the required space were completed by a private-sector contractor, thus the IHS cannot confirm that the costs for construction follow the standard estimating practices for IHS healthcare facility construction projects.

needs of American Indians and Alaska Natives residing in urban areas. The UIOs define their services based on the population, health status, and documented unmet health needs of the Urban Indians in the communities they serve. The UIOs provide healthcare services for Urban Indians who do not have access to the resources offered through IHS-operated or tribally operated healthcare facilities because these individuals do not live on or near a reservation.

Until recently, IHS funding awarded to UIOs could only be used for construction activities necessary in order to meet or maintain accreditation standards of The Joint Commission pursuant to 25 U.S.C. § 1659. However, in 2021, the Infrastructure Investment and Jobs Act, Public Law No. 117-58, amended this authority to authorize the IHS to make funds available for renovations to facilities or construction or expansion of facilities, including leased facilities.

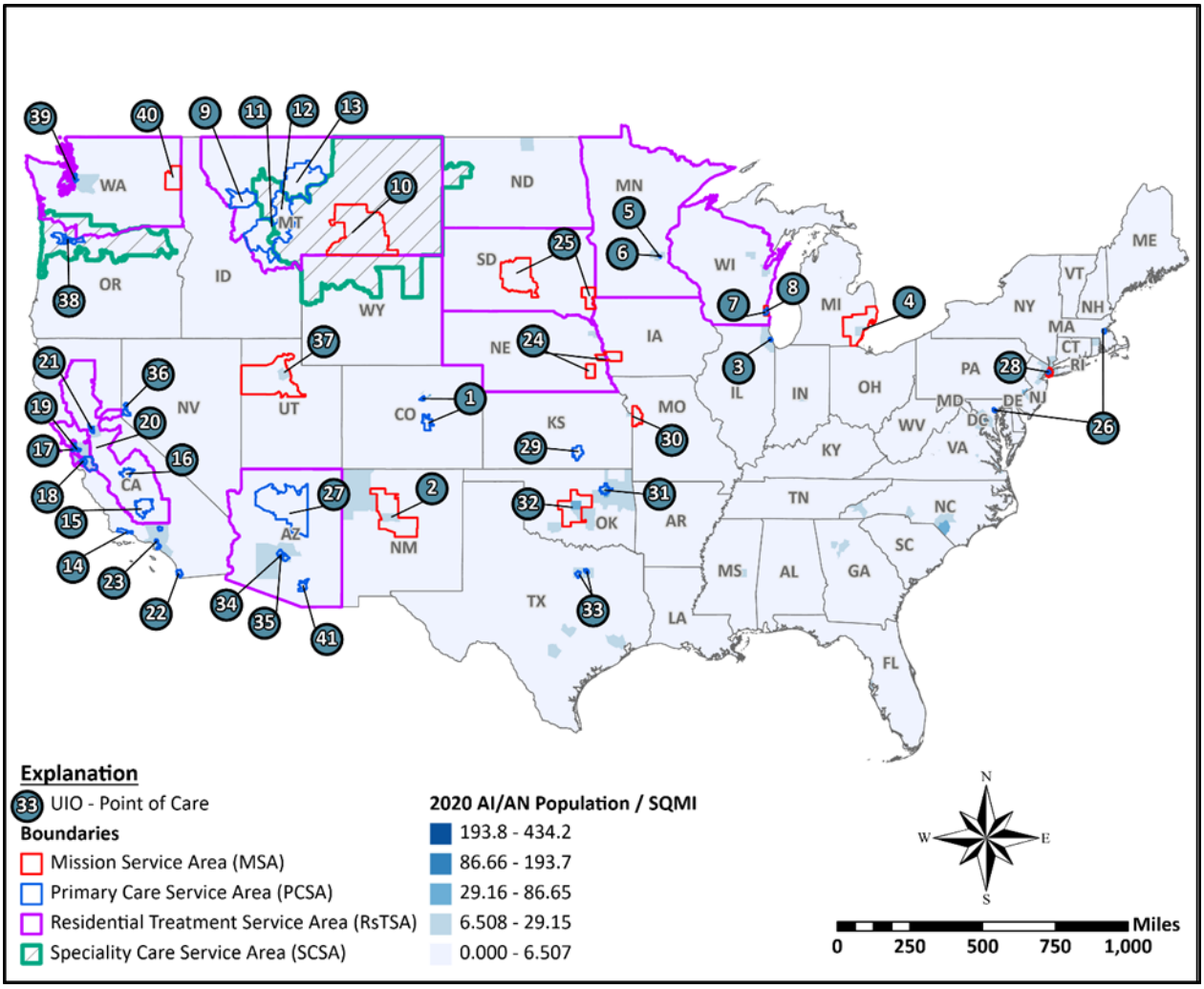
According to the IHS Uniform Data System for Calendar Year 2021,[6] UIOs provided 696,229 health care visits for 70,388 American Indians and Alaska Natives living in urban areas. The UIOs provide a range of services to Urban Indian people, from facilitating access to healthcare to directly providing primary, dental, mental, and other healthcare services. The UIOs manage four types of programs defined by service model and capacity: 1) full ambulatory care, 2) limited ambulatory care, 3) outreach and referral, and 4) residential and outpatient substance use disorder treatment. Definitions for the four types of UIOs are as follows:

> **Full Ambulatory Care**: Outpatient services providing direct medical care to the population served for 40 or more hours per week.
>
> **Limited Ambulatory Care**: Programs providing direct medical care to the population served for less than 40 hours per week.
>
> **Outreach and Referral**: Programs providing case management of behavioral health counseling and education services, health promotion/disease prevention education, and immunization counseling, but not direct medical care.
>
> **Residential and Outpatient Substance Use Disorder Treatment**: Programs providing residential and outpatient substance abuse treatment, recovery, and prevention services.

[6] Indian Health Service, *Urban Indian Organization, National Uniform Data System Summary Report – 2021*. https://www.ihs.gov/urban/national-data-reporting/

National Urban Indian Organization Map

Figure 1 Shows a Map Depicting Locations of the 41 Urban Indian Organizations and AI/AN Population



<u>Urban Indian Organization Name Key</u>:

1. Denver Indian Health and Family Services, Inc. (ASA)
2. First Nations Community HealthSource (MSA)
3. American Indian Health Service of Chicago, Inc. (ASA)
4. American Indian Health and Family Services of SE Michigan, Inc. (MSA)
5. Indian Health Board of Minneapolis, Inc. (DAPCSA)
6. Juel Fairbanks Chemical Dependency Services (RsTSA)
7. American Indian Council on Alcoholism, Inc. (MSA)
8. Gerald L. Ignace Indian Health Center, Inc. (ASA)
9. Butte Native Wellness Center (ASA)
10. Helena Indian Alliance (ASA)
11. Indian Family Health Clinic (ASA)
12. American Indian Health and Services (ASA)
13. Bakersfield American Indian Health Project (ASA)

14. Fresno American Indian Health Project (ASA)
15. Friendship House (RsTSA)
16. Indian Health Center of Santa Clara Valley (ASA/DAPCSA)
17. Native American Health Center (ASA)
18. Native Directions (RsTSA)
19. Sacramento Native American Health Center, Inc. (ASA)
20. San Diego American Indian Health Center (ASA)
21. United American Indian Involvement, Inc. (ASA)
22. Nebraska Urban Indian Health Coalition, Inc. (MSA/RsTSA)
23. South Dakota Urban Indian Health (MSA)
24. All Nations Health Center (ASA)
25. Billings Urban Indian Health and Wellness Center (MSA/SCSA)
26. Native American Lifelines of Baltimore and Boston (ASA)
27. Native Americans for Community Action (ASA)
28. New York Indian Council (ASA)
29. Hunter Health (ASA)
30. Kansas City Indian Center (MSA)
31. Indian Health Care Resource Center of Tulsa (ASA)
32. Oklahoma City Indian Clinic (MSA)
33. Texas Native Health (ASA)
34. Native American Connections, Inc. (RsTSA)
35. Native Health (ASA)
36. Nevada Urban Indians, Inc. (ASA)
37. Urban Indian Center of Salt Lake (MSA)
38. Native American Rehabilitation Association of the Northwest (DAPCSA/RsTSA/SCSA)
39. Seattle Indian Health Board (ASA/RsTSA)
40. The NATIVE Project (MSA)
41. Tucson Indian Center (ASA)

Map Notes:

1. ASA: Access Service Area
2. MSA: Mission Service Area
3. RsTSA: Residential Treatment Service Area
4. Primary Care Service Area (PCSA)
5. DAPCSA = Dartmouth Atlas Primary Care Service Area

III. METHODOLOGY

To assess each UIO's infrastructure ability to meet their population's future needs, a process was established that would be responsive to the Urban Indian Organization's future market opportunity, stakeholder input, and the IHS resource planning standards for services, staff, and space. Market opportunity is defined within the context of this report, as the percentage of the user population from a specific community or service area that is expected to be served at a facility for a specific discipline.

To commence the project, two national kick-off teleconference meetings with the UIOs were conducted to communicate the purpose, schedule, data required, and anticipated final product. Three planning teams were established to cover all 41 UIOs and an initial site visit schedule was coordinated.

Data Collection and Site Visits
Prior to the site visits, each UIO received a data and information request. The data request included multiple data elements, both historical and current, including strategic plans, patient origin by zip code, workload by zip code for medical/dental/behavioral health, workload by service line, existing staff and facility information, leadership and department questionnaires, and financial statements.

From April 2022 through June 2022, site visits were conducted with 40 of the 41 UIOs. All UIOs' points of care were visited to assess site and building condition and validate department gross square footage. In addition to the facility assessment, stakeholder interviews were conducted with UIO executive and department leadership to gain a deeper understanding of each UIO's current operations and planning efforts, as well as their initial 10-year vision for their organization. During interviews, the organizational and service line leaders provided specific insight as to the category of service lines (both clinical and non-clinical) that might be needed to best serve their community.

Service Area, Potential Patient Population, and IHS User Population
Two standardized service areas were outlined per organization, including a Mission Service Area (MSA) and an Access Service Area (ASA). The MSAs were unique per organization and defined by each Urban Indian Organization during the data-gathering phase. As an example, the Urban Indian Center of Salt Lake (UICSL) chose as their future planning efforts, Salt Lake, Tooele, Davis, and Weber Counties as their identified MSA. This would allow UICSL to set goals of capturing demand and anticipate AI/AN population growth within the MSA by 2023. The ASAs are defined by the UIO county's Medicare Advantage network adequacy criteria for primary care (e.g., Large Metro/5 miles/10 minutes). Some UIOs with multiple points of care for primary care have multiple ASAs. The access disparity between the MSA and the ASA occasionally resulted in additional new ASAs being planned. The UIOs also added larger service areas specifically for their desired Residential Treatment Service Area (RsTSA) and Regional Specialty Care services (SCSA). Note that these service areas may or may not align with the urban center as defined in any particular UIO's contract with the IHS.

The potential patient population included the total number of existing patients, existing, and future Urban Indian populations, existing non-Urban Indian Medicaid and total populations within these service areas, and the IHS user population for the local county and communities. The potential Urban Indian population to serve was identified as the census count of AI/AN individuals who reside solely within these service areas.

The forecasting methodology for the 2032 healthcare demand was driven by population projections within each of these service areas. Two methodologies were considered when determining the Annual Growth Rate (AGR), including the Environmental Systems Research Institute, Inc. (ESRI) AGR and Historical AGR. The ESRI methodology is an industry standard for U.S. demographer forecasts of future population. This methodology is derived from census information and specifically addresses anticipated population growth between 2022 and 2027. The Historical AGR methodology relies on the change in census population between 2010 and 2020.

Establishing the Vision - Healthcare Demand and Service Modeling

Together, the service area and population data enabled the contractor to model service line market opportunity by patient population group (Urban Indian, non-Urban Indian Medicaid, all non-Urban Indian). The contractor conducted planning with UIOs modeling two scenarios with each scenario having its own service area, optional growth rate, and baseline market share assumption. The scenarios revealed the market opportunity by demonstrating a service line's healthcare demand and a number of sustainable key characteristics. Various utilization and throughput benchmarks were used to formulate 2032 workload forecasts and key characteristics. The first teleconference concluded with the UIOs having established their service area (ASA or MSA), growth rate, future services, market share, and the resulting healthcare demand, or workload.

Resourcing the Vision

Once the future service vision and demand and key characteristic capacity were established, the process moved forward using standard IHS resource planning approaches. The Resource Requirements Methodology (RRM) was used for staffing and projected future operational budgets. The Health Systems Planning (HSP) tool was used for planning purposes.

Staff

During the early UIO collaborations, the contractor confirmed existing staffing models. To establish each UIO's future vision and staffing requirements, existing staffing models were forecasted, industry standards were considered, and compared to RRM staffing. An initial future staffing plan was shared with the Urban Indian Organization, reviewed, and edited for publication.

Operational Budget

Using the accepted RRM process and the final staffing plan established above, operational budgets were established for the UIO's future vision of services. This process is based on the

number of FTEs planned, an average IHS Area's locality salary and benefit costs, and a factor for other operational costs.

Facility Requirements
The UIO's future vision of services, workload, and staff as developed above were then directly inputted into the HSP software to establish the required future facility space requirements.

Priority Development
The last part of the planning effort is the identification of the UIO's gaps between their vision of their future and their present situation. Thoughtful prioritization of these gaps leads to an actionable plan.

Capital Investment Budgeting
To establish the UIO's capital investment requirements, the study established a construction and total project budget estimate cost per square foot for four different building types. Per each UIO's vision, the study assigned a building type and its associated costs, then adjusted the cost depending on the location of the UIO. The midpoint of construction costs for all estimates was established for November 2026.

IV. POPULATION SUMMARY

For this study, the 32 UIOs that supplied primary care patient data reported delivering care to approximately 138,114 unique Urban Indian patients per year. This Urban Indian patient population represents 28 percent of the estimated 493,797 AI/AN-only population to be within the Medicare Advantage primary care access standard to the respective Urban Indian Organization by 2032. Recognizing that the 493,797 AI/AN-only population that may use this point of care, it does not include the census estimates of AI/AN +1 other race, AI/AN +2 other races, AI/AN +3 other races populations and represents the most conservative count of local market opportunity. For this study, only The NATIVE Project in Spokane, Washington, defined their future opportunity with the AI/AN +1 other race population count.

The 32 UIOs also serve an additional 116,210 local, unique, non-Urban Indian patients annually, as well as approximately 31,100 unique Urban Indian patients from outside their service area. For instance, in Denver, Colorado, and Dallas, Texas, where there are no IHS facilities within 90 miles, more than 50 percent of patients who reside in those locations travel from beyond their designated service area to access care at an UIO facility.

As the UIOs are eligible for FQHC open access designations, meaning healthcare can be provided to Urban Indian and non-Urban Indian populations, 23 of the 32 UIOs provide care to non-Urban Indian patients in their surrounding communities. Services available to non-Urban Indian patients may or may not improve the revenue opportunities and sustainability.

Medicare Advantage Access Standards establish a reasonable driving distance and travel time planning expectation for a multitude of services and for every county in the U.S. This standard

was used to establish a reasonable reach or market area for each Urban Indian Organization's primary care planning. These primary care travel times vary by location, from five miles or 10 minutes in our most urban settings (New York City, New York; Los Angeles, California; San Francisco, California; Boston, Massachusetts), to 60 miles and 70 minutes in Flagstaff, Arizona. A similar catchment market area was defined for Residential planning or Specialty Care planning, but this was more typically based on direct conversation with the Urban Indian Organization, not an access standard.

Like access standards, annual Urban Indian population growth rates are variable, depending on the locale. Within the study, the annual growth rates varied from a low of 0.02 percent in Pierre, South Dakota, to 8.1 percent in Chicago, Illinois. Most growth rates fall between 0.5 percent and two percent. Two growth rates were considered by UIOs. The first was the most recent local ESRI projection for American Indians and Alaska Natives, from 2022 to 2027 annualized and extended to 2032, or the second, the historical change in American Indians and Alaska Natives between the 2010 and 2020 census. For example, in Chicago, Illinois, and other states with growth rates exceeding two percent, such growth rates at UIOs were typically the result of the Urban Indian Organization choosing the historical census rate.

Each Urban Indian Organization's contract with the IHS designates a service area, many of which are based on a local county or counties. County sizes vary substantially across the U.S. For the purpose of this study, some UIOs chose the IHS-designated service area as their planning area, and others chose to base their planning area on the Medicare Advantage Access Standard. Regardless of their choice, the growth forecast and market share modeling determine the envisioned workload to be provided in their future plans.

As mentioned earlier, UIOs offering adult and/or adolescent residential treatment may have a much larger service area and are typically specified by the UIO. Their Service Area Urban Indian populations are identified in the table that follows. For instance, the Friendship House Service Area is based on all the counties in the San Francisco Bay Area, while the Native Directions, Inc., Three Rivers Indian Lodge in Manteca, California, includes all the counties of the Central Valley of California.

While not offering residential treatment programs, Oklahoma City Indian Clinic, Oklahoma, and Indian Health Care Resource Center of Tulsa, in Oklahoma, are pursuing specialty care services for a larger regional service area. While the Native American Rehabilitation Association in Portland, Oregon, provides both adult and adolescent residential treatment to the five local county metropolitan areas and beyond, it also seeks to provide specialty care to a larger regional service area. The Billings Urban Indian Health and Wellness Center in Billings, Montana, also studied a larger regional service area. These regional studies only included Urban Indian populations in their consideration.

Table 2 – The Population Summary provides an overview of the UIO's Urban Indian unique patients, non-Urban Indian patients, patients from outside their service area (OTSA), their

growth rate, their local access standard, and the number of projected Urban Indian patients in 2032 in their ASA, MSA, and RsTSA.

TABLE 2 - POPULATION SUMMARY

URBAN INDIAN ORGANIZATION NAME - SERVICE AREA	2021 Urban Indian Unique Patients	2021 Total Unique Patients	2021 Urban Indian Patients from OTSA	Urban Indian Annual Growth Rate (AGR)	Access Standard (miles/ min)	2032 Urban Indian Pop w/in Access Standard	2032 Urban Indian Pop w/in MSA	2032 RsTSA Urban Indian (Only if Used)	NOTE
Albuquerque Area									
Denver Indian Health & Family Services - Colorado Springs	-	-	-	1.35%	10/15	7,527	7,527	-	1
Denver Indian Health & Family Services - Denver	3,540[3]	4,074[2]	2,098	1.40%	5/10	10,998	43,557		
First Nations Community Healthsource - Albuquerque	3,379[3]	13,505[2]	1,933	1.80%	10/15	38,903	73,849		
Bemidji Area									
American Indian Health Service of Chicago	903[3]	3,154[2]	393	8.10%[4]	5/10	31,227	174,275		
American Indian Health & Family Services of SE MI Inc. - Detroit	291[3]	1,049[2]	198	1.21%	5/10	2,629	16,052		
Indian Health Board of Minneapolis	3,661[3]	7,216[2]	1,965	0.66%	N/A	N/A	5,714		
Juel Fairbanks Chemical Dependency Services - St. Paul	-	-	-	0.48%	N/A	N/A	73,120	73,120[5]	6
American Indian Council on Alcoholism, Inc. - Greenfield	61	65	10	0.82%	N/A	N/A	8,192		
Gerald L. Ignace Indian Health Center - Milwaukee	-	-	-	1.01%	5/10	6,657	8,192		
Billings Area									
All Nations Health Center - Missoula	958[3]	1,114	128	1.43%	20/30	3,894	3,938		
Billings Urban Indian Health & Wellness Center	-	-	-	0.74%	20/30	8,919	17,934	72,466[5]	7
Butte Native Wellness Center	-	-	-	0.24%	30/40	938	938		
Helena Indian Alliance	693[3]	3,108[2]	112	0.96%	20/30	1,626	1,691		
Indian Family Health Clinic - Great Falls	958[3]	1,114	128	1.56%	20/30	4,931	26,473		
California Area									
American Indian Health & Services - Santa Barbara	891[3]	11,401[2]	440	2.02%	10/15	3,263	30,426		

URBAN INDIAN ORGANIZATION NAME - SERVICE AREA	2021 Urban Indian Unique Patients	2021 Total Unique Patients	2021 Urban Indian Patients from OTSA	Urban Indian Annual Growth Rate (AGR)	Access Standard (miles/ min)	2032 Urban Indian Pop w/in Access Standard	2032 Urban Indian Pop w/in MSA	2032 RsTSA Urban Indian (Only if Used)	NOTE
Bakersfield American Indian Health Project	3,615[3]	3,615	121	1.51%	10/15	13,866	21,633		
Fresno American Indian Health Project	1,180[3]	2,082[2]	217	1.17%	10/15	19,302	25,174		
Friendship House – San Francisco	-	-	-					100,166[5]	
Indian Health Center of Santa Clara Valley - Gilroy	-	-	-	1.53%	N/A	3,239			
Indian Health Center of Santa Clara Valley - San Jose	24,421[3]	25,425[2]	4,121	1.62%	5/10	7,707	25,176		
Indian Health Center of Santa Clara Valley - Silver Creek	16,019[3]	16,569	-	0.66%	5/10	9,355			
Native American Health Center - Oakland	978[3]	10,837[2]	138	0.94%	5/10	11,182	21,745		
Native American Health Center - Richmond	27	153	-	1.14%	5/10	4,729	14,314		
Native American Health Center - San Francisco	517[3]	4,356[2]	-	0.31%	5/10	6,750	6,948		
Native Directions, Inc. - Three Rivers Indian Lodge - Manteca	125	78	125	1.41%	10/15	8,655	160,098	160,098[5]	6
Sacramento Native American Health Center, Inc.	2,209[3]	18,519[2]	1,070	1.33%	5/10	6,063	20,676		
San Diego American Indian Health Center	3,061[3]	9,686[2]	1,075	1.90%	10/15	18,167	49,547		
United American Indian Involvement, Inc. - Cerritos	-	-	-	2.06%	5/10	8,224			
United American Indian Involvement, Inc. - Long Beach	-	-	-	2.22%	5/10	8,070			
United American Indian Involvement, Inc. - Los Angeles	811[3]	811	566	2.60%	5/10	33,197	213,326		
United American Indian Involvement, Inc. - Palmdale	-	-	-	2.23%	5/10	4,615			
Great Plains Area									
Nebraska Urban Indian Health Coalition - Lincoln	619[3]	1,958[2]	52	1.21%	10/15	3,084	3,098		
Nebraska Urban Indian Health Coalition - Omaha	5	44	-	1.29%	5/10	5,691	7,607	25,234[5]	

URBAN INDIAN ORGANIZATION NAME - SERVICE AREA	2021 Urban Indian Unique Patients	2021 Total Unique Patients	2021 Urban Indian Patients from OTSA	Urban Indian Annual Growth Rate (AGR)	Access Standard (miles/ min)	2032 Urban Indian Pop w/in Access Standard	2032 Urban Indian Pop w/in MSA	2032 RsTSA Urban Indian (Only if Used)	NOTE
South Dakota Urban Indian Health - Pierre	1,165[3]	2,567[2]	31	0.02%[4]	30/40	4,062	4,164		
South Dakota Urban Indian Health - Sioux Falls	1,134[3]	1,626[2]	3	1.65%	10/15	7,121	7,375		
Navajo Area									
Native Americans for Community Action - Flagstaff	3,462[3]	6,655[2]	960	0.49%	60/70	16,941	37,301		
Nashville Area									
Native American Lifelines of Boston	-	-	-	0.19%	5/10	1,261	9,752		
Native American Lifelines of Baltimore	-	-	-	0.72%	5/10	2,424	10,337		
New York Indian Council - Long Island City	-	-	-	1.06%	5/10	26,349	87,976		
Oklahoma City Area									
Hunter Health - Wichita	2,057[3]	15,813[2]	272	0.48%	10/15	6,888	6,952		
Kansas City Indian Center	-	-	-	1.29%	10/15	6,060	6,831		
Indian Health Care Resource Center of Tulsa	18,129[3]	18,129	3,002	0.60%	10/15	30,544	89,835	89,835[5]	10
Oklahoma City Indian Clinic	18,091[3]	18,091	1,122	1.22%	10/15	25,821	66,947	66,947[5]	6,7
Texas Native Health - Dallas	2,012[3]	2,057	1,708	6.07%	5/10	8,616	129,192		
Texas Native Health - Fort Worth	-	-	-	4.16%	5/10	7,061			
Phoenix Area									
Urban Indian Center of Salt Lake	-	-	-	3.81%	5/10	8,402	36,665		
Native American Connections, Inc. - Phoenix	-	-	-	0.74%	N/A	N/A	N/A	351,790[5]	8
Native Health - Central Phoenix	8,561[3]	19,665[2]	5,751	1.71%	10/15	25,272	121,700		
Native Health - Mesa	1,871[3]	2,243	542	1.36%	10/15	38,479			
Native Health – West Phoenix	1,368[3]	6,392[2]	464	1.19%	10/15	21,186			
Nevada Urban Indians, Inc. - Carson City	-	-	-	1.03%	10/15	1,678	1,641		
Nevada Urban Indians, Inc. - Reno	-	-	-	2.30%	10/15	5,559	11,596		

URBAN INDIAN ORGANIZATION NAME - SERVICE AREA	2021 Urban Indian Unique Patients	2021 Total Unique Patients	2021 Urban Indian Patients from OTSA	Urban Indian Annual Growth Rate (AGR)	Access Standard (miles/ min)	2032 Urban Indian Pop w/in Access Standard	2032 Urban Indian Pop w/in MSA	2032 RsTSA Urban Indian (Only if Used)	NOTE
Portland Area									
Native American Rehabilitation Association of the Northwest (NARA) - Portland	4,297[3]	7,924[2]	1,146	1.06%	N/A	4,697	30,099	30,099[5]	9
NARA - Wellness/Dental and Totem - Portland 2				0.55%	N/A	3,964			
NARA - Indian Health Clinic - Portland 3				1.13%	N/A	3,937			
NARA - Hillsboro				1.32%	N/A	2,625			
NARA - Gresham				0.75%	N/A	3,799			
Seattle Indian Health Board	4,528[3]	8,522[2]	1,092	1.23%	5/10	3,039	20,562	128,456[5]	
Seattle Indian Health Board - Lake City Clinic	-	-	-	0.64%	5/10	2,237			
The NATIVE Project - Spokane	2,735[3]	5,047[2]	254	0.67%	10/15	25,726	25,816		
Tucson Area									
Tucson Indian Center	-	-	-	1.01%	10/15	23,074	37,744		
	138,332	**254,664**	**31,237**			**610,230**	**1,803,705**	**1,098,211**	

NOTES

1. DIHFS Colorado Springs MSA and ASA are the same.
2. UIOs serving at least 1,000 non-Natives or 30% or more of patients are non-Native.
3. Existing UIOs offering primary care with data provided.
4. The highest and lowest annual growth rates of Urban Indians.
5. UIOs with RsTSA or Specialty Care Service Area.
6. MSA and RsTSA are the same.
7. RsTSA and Specialty Care Service Area are the same.
8. Primary Care recently initiated, same market population as Native Health.
9. Regional Specialty Care Service Area = Portland HRR = 52,641.
10. MSA serves as Specialty Care Service Area

V. DEMAND AND NEW SERVICES

While the Urban Indian population establishes an UIO's overall point of healthcare demand opportunity, 100 percent market share cannot be realistically expected to present at a point of care, nor will that demand make every service sustainable at that point of care. To create the future service vision for a point of care, access, demand, operational realities, revenues, and expenses must be considered prior to adding services to an organization's menu of offerings. The UIO's vision of future services viewed their financial realities relative to the healthcare

opportunities presented by their population's service area or areas. Service line-by-service line financial feasibility studies were not conducted as part of this study.

At the commencement of the study, the 41 UIOs were classified in accordance with the following categories of service:

- Full Ambulatory – 19 UIOs;
- Full Ambulatory, Child, Youth & Family Services, Housing & Social Service Assistance, Severe Mental Illness (SMI) and Severe and Persistent Mental Illness Services (Mental Health), Addiction Recovery, Assertive Community Treatment Team, Residential Treatment – One Urban Indian Organization;
- Full Ambulatory and Residential Treatment – Two UIOs;
- Limited Ambulatory – Seven UIOs;
- Limited Ambulatory and Outreach & Referral – One Urban Indian Organization;
- Limited Ambulatory and Residential Treatment – One Urban Indian Organization;
- Outpatient Substance Abuse – One Urban Indian Organization; and
- Outpatient Substance Abuse and Residential Treatment – Four UIOs; and Outreach & Referral – Five UIOs.

Table 3 shows the application of these categories to the multitude of service areas and points of care managed by the UIOs. While many UIOs are presently offering services beyond these categories, many others intend to reach beyond their present level of services (see New Services Note column) and/or location in their future vision. There were 10 new service areas identified for planning by the UIOs during the study, three of which were underway, and seven new service areas by the end of the study. Each of these new service areas are envisioned as Full Ambulatory.

While a few UIOs have a primary mission of residential substance use disorder treatment, the majority of UIOs emphasize primary medical care services and aspire to be the culturally appropriate medical home for their patient population and community. Presently, UIOs that offer primary care and provided data, are providing approximately 463,000 provider visits per year. The staff and resources planned are envisioned to support approximately 1,376,000 primary medical provider visits in 2032.

The $1.37 million medical visits include both Urban Indian and non-Urban Indian patients. The percentage of Urban Indian versus non-Urban Indian visits vary substantially, depending on the local community and outreach efforts.

Each UIO worked with the planning team to establish their market share goals for primary medical care visits, as well as other service lines of interest. Each UIO developed its own unique approach to its future vision, some more optimistic than others. As shown in Table 3, the present Urban Indian primary medical care market share within their service area varies from one percent to 42 percent. The 2032 goal market share for the same service area varies from one percent up to 80 percent market share. The goals for two small locations went to

100 percent market share due to long travel distances to neighboring IHS facilities. Except for these two locations, Indian Health Care Resources of Tulsa and Oklahoma City Indian Clinic, all UIO Urban Indian market share values were adjusted downwards to account for the local IHS Service Unit User Population to ensure that the UIO and the IHS were not planning for the same patient population.

Most UIOs see themselves offering a broader spectrum of outpatient services in the future to provide their patients with a one-stop shop of services. Distinctly noted, the Seattle Indian Health Board sees their future satellite locations offering only primary care, mental health, and outpatient pharmacy. Also distinctly, the Native American Health Center of Oakland intends to limit their new points of care to the services they offer today, primary care, dental, and mental health.

Two UIOs, South Dakota Urban Indian Health and Billings Urban Indian Health and Wellness Center are interested in building adult residential treatment programs for their service areas.

The Billings Urban Indian Health and Wellness Center, the Indian Health Care Resource Center of Tulsa, and the Native American Rehabilitation Association in Portland, Oregon, have included regional specialty care services in their future vision. The envisioned services are based on the demand from their local Urban Indian population. The specialty care demand forecasts do not include the non-Urban Indian population. The Oklahoma City Indian Clinic also is pursuing the regional specialty care demand while also including labor and delivery services in their planned future.

Table 3 Demand and New Services Summary identifies each UIO's Facility Type, present primary care Urban Indian and non-Urban Indian market share and demand, future primary care Urban Indian and non-Urban Indian market share and demand, and new services identified for the Urban Indian Organization's future vision. It also includes new service areas identified for planning by the UIOs.

TABLE 3 - DEMAND AND NEW SERVICES SUMMARY

URBAN INDIAN ORGANIZATION NAME -SERVICE AREA	2022 Primary Care (PC) Visits	2022 Urban Indian PC Market Share	2022 Non-Urban Indian PC Market Share	2032 Urban Indian PC Market Share	2032 Non-Urban Indian PC Market Share	2032 PC Visits	New Services Notes
Albuquerque Area							
Denver Indian Health & Family Services - Denver	0	N/A	N/A	80.00%	0.00%	23,237	1,2,3,4,5,6,9,10
Denver Indian Health & Family Services - Colorado Springs	0	N/A	N/A	80.00%	0.00%	23,237	1,2,3,4,5,6,9,10
Denver Indian Health & Family Services - Denver	8,382	8.00%	0.40%	78.00%	0.40%	38,894	3,4,5,6,9

URBAN INDIAN ORGANIZATION NAME -SERVICE AREA	2022 Primary Care (PC) Visits	2022 Urban Indian PC Market Share	2022 Non-Urban Indian PC Market Share	2032 Urban Indian PC Market Share	2032 Non-Urban Indian PC Market Share	2032 PC Visits	New Services Notes
First Nations Community Healthsource - Albuquerque	35,235	1.30%	7.80%	17.80%	7.80%	84,357	4,5
Bemidji Area							
American Indian Health Service of Chicago	2,451	2.00%	0.20%	8.00%	0.30%	11,250	2,3,4,5,6,9
American Indian Health & Family Services of SE MI Inc. - Detroit	1,324	1.20%	0.90%	78.90%	6.00%	13,471	2,5,6,8
Indian Health Board of Minneapolis	6,717	13.80%	1.60%	20.30%	2.80%	11,358	3,4,5,6,9
Juel Fairbanks Chemical Dependency Services - St. Paul	N/A	N/A	N/A	N/A	N/A	N/A	
American Indian Council on Alcoholism, Inc. - Greenfield	N/A	N/A	N/A	N/A	N/A	N/A	
Gerald L. Ignace Indian Health Center - Milwaukee	No Data	N/A	N/A	61.50%	7.00%	22,434	3,8,9
Billings Area							
All Nations Health Center - Missoula	346	2.30%	0.00%	60.00%	8.00%	11,426	2,3,4,5,6,9
Billings Urban Indian Health & Wellness Center	2,135	3.30%	0.00%	40.50%	0.00%	28,000	2,3,4,5,6,7,8,9,11,12
Butte Native Wellness Center	1,035	29.20%	0.00%	100.00%	20.00%	6,282	2,3,4,6,9
Helena Indian Alliance	4,752	20.10%	16.50%	100.00%	33.00%	13,581	2,3,4,6,9
Indian Family Health Clinic Great Falls	1,568	6.10%	2.90%	50.00%	10.00%	11,590	2,4,5,9,10
California Area							
American Indian Health & Services - Santa Barbara	20,113	12.00%	24.80%	73.90%	27.60%	29,870	5,6,8,9
Bakersfield American Indian Health Project	34	0.10%	0.00%	76.00%	0.00%	40,668	2,3,4,5,6,9
Fresno American Indian Health Project	1,683	1.10%	0.30%	55.00%	0.30%	41,963	2,3,9
Friendship House – San Francisco	N/A	N/A	N/A	N/A	N/A	N/A	
Indian Health Center of Santa Clara Valley - Gilroy	N/A	N/A	N/A	80.00%	16.00%	16,227	1,2,3,4,5,9,10
Indian Health Center of Santa Clara Valley - San Jose	49,727	2.30%	13.30%	22.00%	20.00%	65,490	3,4,5
Indian Health Center of Santa Clara Valley - Silver Creek	21,253	0.70%	5.10%	1.00%	5.10%	20,840	3,4,5
Native American Health Center - Oakland	20,114	3.30%	9.40%	25.00%	9.40%	29,489	

URBAN INDIAN ORGANIZATION NAME -SERVICE AREA	2022 Primary Care (PC) Visits	2022 Urban Indian PC Market Share	2022 Non-Urban Indian PC Market Share	2032 Urban Indian PC Market Share	2032 Non-Urban Indian PC Market Share	2032 PC Visits	New Services Notes
Native American Health Center - Richmond	N/A	N/A	N/A	25.00%	4.00%	7,488	1,2,10
Native American Health Center - San Francisco	1,902	3.40%	0.40%	20.00%	2.00%	9,965	
Native Directions, Inc. Three Rivers Indian Lodge Manteca	N/A	N/A	N/A	8.00%	N/A	2,676	1
Sacramento Native American Health Center, Inc.	16,000	1.20%	1.10%	67.50%	1.10%	60,253	4,5,6,8,9
San Diego American Indian Health Center	6,466	2.80%	0.80%	12.40%	2.60%	20,470	3,4,5,6,8,9,12
United American Indian Involvement, Inc. - Cerritos	N/A	N/A	N/A	10.00%	0.70%	4,042	1,2,3,4,6,9,10
United American Indian Involvement, Inc. - Long Beach	N/A	N/A	N/A	10.00%	0.70%	3,927	1,2,3,4,6,9,10
United American Indian Involvement, Inc. - Los Angeles	1,333	0.50%	0.00%	10.00%	0.70%	15,905	2,3,4,5,6,9
United American Indian Involvement, Inc. - Palmdale	N/A	N/A	N/A	10.00%	0.70%	2,121	1,2,3,4,6,9,10
Great Plains Area							
Nebraska Urban Indian Health Coalition - Lincoln	6,180	19.30%	8.60%	22.00%	10.00%	7,638	2,4,6,9,10
Nebraska Urban Indian Health Coalition - Omaha	N/A	N/A	N/A	20.00%	8.00%	13,752	1,2,4,6,9
South Dakota Urban Indian Health - Pierre	4,496	10.70%	0.00%	48.40%	0.00%	10,577	4,5,6,9,15
South Dakota Urban Indian Health - Sioux Falls	2,507	6.50%	2.00%	58.50%	2.00%	17,697	3,4,5,6,7,9
Navajo Area							
Native Americans for Community Action - Flagstaff	5,738	2.80%	10.40%	10.00%	29.00%	16,455	2,3,4,5,9
Nashville Area							
Native American Lifelines of Boston	N/A	N/A	N/A	79.00%	1.00%	4,712	1,2,6,9,10
Native American Lifelines of Baltimore	N/A	N/A	N/A	79.80%	2.00%	9,478	1,2,6,9,10
New York Indian Council - Long Island City	No Data	N/A	N/A	80.00%	0.00%	81,344	1,2,3,4,5,6,9,10
Oklahoma City Area							
Hunter Health - Wichita	34,370	17.10%	36.70%	38.00%	47.70%	48,729	8
Kansas City Indian Center	N/A	N/A	N/A	16.00%	0.70%	4,529	1,2,10
Indian Health Care Resource Center of Tulsa	53,033	39.80%	0.00%	58.10%	0.00%	77,550	4,8,9,11,12

URBAN INDIAN ORGANIZATION NAME -SERVICE AREA	2022 Primary Care (PC) Visits	2022 Urban Indian PC Market Share	2022 Non-Urban Indian PC Market Share	2032 Urban Indian PC Market Share	2032 Non-Urban Indian PC Market Share	2032 PC Visits	New Services Notes
Oklahoma City Indian Clinic	80,127	32.80%	0.00%	60.10%	0.00%	160,401	5,8,11,12,13,14
Texas Native Health - Dallas	8,923	6.50%	0.10%	40.00%	0.00%	21,617	3,4,5,6,9
Texas Native Health – Fort Worth	N/A	N/A	N/A	75.30%	0.00%	20,517	1,2,3,4,5,6,9,10
Phoenix Area							
Urban Indian Center of Salt Lake	No Data	N/A	N/A	13.90%	0.00%	19,598	3,5,6,9
Native American Connections - Phoenix	No Data	N/A	N/A	N/A	N/A	3,776	1,10
Native Health - Central Phoenix	13,902	8.50%	4.30%	14.20%	4.30%	21,326	3,4
Native Health - Mesa	4,238	2.80%	0.30%	14.20%	0.30%	21,747	2,3,4,9
Native Health - West Phoenix	11,696	2.60%	4.80%	14.20%	4.80%	21,789	3,4
Nevada Urban Indians, Inc., Carson City	N/A	N/A	N/A	36.00%	5.20%	3,066	1,2,6,10
Nevada Urban Indians, Inc. - Reno	835	0.80%	1.20%	47.00%	1.20%	10,860	2,4,6
Portland Area							
NARA - East Portland	4,004	13.50%	1.50%	60.10%	1.50%	11,210	3,4,9
NARA - Gresham	53	0.30%	0.00%	60.10%	1.50%	9,644	2,3,4,6,9
NARA - North Portland	4,841	42.00%	4.10%	60.10%	4.10%	6,493	2,3,4,6,9
NARA - Portland	1,402	5.00%	0.30%	60.10%	1.50%	13,079	2,3,4,6,9
NARA - West Portland	N/A	N/A	N/A	60.10%	1.50%	6,714	1,2,3,4,6,9,10
Seattle Indian Health Board	14,643	29.30%	2.60%	35.30%	3.00%	15,916	4,5,7
Seattle Indian Health Board, Lake City Clinic	N/A	N/A	N/A	35.30%	2.00%	4,505	1,6
The NATIVE Project - Spokane	9,004	4.80%	3.20%	41.30%	3.20%	45,991	3,4,5,6,9
Tucson Area							
Tucson Indian Center	N/A	0.00%	0.00%	19.80%	0.00%	17,630	1,2,3,4,6,8,9,10
	462,562					**1,375,614**	

Table 3 Notes

1. Primary Care
2. Dental
3. Eye Care
4. Physical Therapy
5. Imaging
6. Pharmacy
7. Residential Treatment
8. Specialty Care/Visiting Specialties/Traditional Healing/Alternative Medicine
9. Podiatry
10. Behavioral Health
11. Occupational Therapy
12. Speech Therapy
13. Ambulatory Surgery
14. Labor & Delivery
15. SA Transitional Care and/or Emergency Shelter

** Notated in Light Green are New Primary Care Area & Point of Contact

VI. STAFF AND OPERATIONAL BUDGET SUMMARY

The UIOs established future visions based on market opportunities, operational models, and conceptual service line financials. Each Urban Indian Organization's vision suggested that the 2032 market opportunities for their target populations provided adequate demand to sustain the services planned. The planned future vision of services may or may not require federal support to meet the designed community healthcare demand.

In 2022, the 41 UIOs received $99.9 million in IHS contract and grant funding. The amounts varied by UIO from $739,000 for the Juel Fairbanks Chemical Dependency Services in St. Paul, Minnesota, to $10 million for the Oklahoma City Indian Clinic. These funds vary by the services offered and the patients served.

While 39 UIOs provided staffing data, only 17 UIOs provided their overall operating budgets. This was due to the large variability in each UIO's capabilities to have and assemble data for planning purposes. Indian Health Service grant funding makes up 22 percent of the overall operational funding for these 17 UIOs. The total operational funds for the 17 UIOs also included other revenue sources, such as patient revenue and state and county contracts and grants, to supplement the IHS funding. The percentage of operational funding provided by the IHS can vary from a low of 12 percent at the Hunter Health in Wichita, Kansas, to over 100 percent, where programs are ramping back up with staff hiring after the COVID-19 pandemic or leadership transitions.

The highest operating costs among UIOs are staff, with salaries and benefits typically comprising 70 percent of a health clinic's operating expenses. At the time of data collection, of the 39 UIOs that provided staffing data, there were 3,420 FTEs staff positions. To fulfill the 2032 vision of services for Urban Indians, UIO FTEs need to grow to 6,275, an increase of 78 percent. For overall patient service demand, the number of FTEs would need to grow to 8,083. The combined staffing data suggests that the new Bakersfield American Indian Health Project has the biggest market opportunity as their plan reflects that they only have six percent of the staff needed for their vision. Their plan has them growing from 17 staff to 262 FTEs in 2032.

The future staffing numbers take into consideration present staffing, forecasted service demand, and the IHS's RRM. A review of the forecasted staff FTE needs were aligned with individual UIOs needs when desired. The numbers were primarily driven by the organizational outlook, depending on the relative strategic outlook of each entity's estimates of patient population future service needs.

The 2032 operating budgets of UIOs will need to grow to $1.37 billion to meet future needs of serving Urban Indians. The Oklahoma City Indian Clinic plans to meet their local primary care demand, by developing a regional specialty care center that includes ambulatory surgery, while offering 24-hour / seven days per week labor and delivery services. This Oklahoma City service growth reflects the largest 2032 operating budget increase at $154 million. The smallest 2032 operating budget increase at under $4 million would be the American Indian Council on Alcoholism, Inc. in Greenfield, Wisconsin, which plans to improve its outreach and county-wide Urban Indian behavioral services. Both programs, the Oklahoma City Indian Center and the American Indian Council on Alcoholism, Inc. are Urban Indian-only programs.

Of the 17 UIOs that provided total operating budgets, their operating budgets would need to grow from $211.2 million to $739.0 million, a 250 percent increase over the coming 10 years.

If the IHS were to fully support UIOs to achieve their 2032 visions to support their communities, the contract and grant funding provided annually would need to increase by $1.37 billion for the Urban Indian population portion and overall would need to increase by $1.81 billion to achieve their vision. Note that any particular Urban Indian Organization's future plans may or may not be within the scope of what is legally authorized to be carried out via a contract with the IHS.

Table 4 - Staff and Operational Budget Summary identifies each UIO, existing and future required staff, present IHS annual funding, FY 2022 operating budget, if provided by the UIO, and the FY 2032 operating budget needed for their envisioned 2032 future service population.

TABLE 4 - STAFF AND OPERATIONAL BUDGET SUMMARY

URBAN INDIAN ORGANIZATION NAME - SERVICE AREA	2022 Staff FTEs	2032 Staff FTEs	Staff % of Need	2022 OUIHP Contract & Grant Award	2022 Operating Budget	2022 Grant % of 2022 Operating Budget	Projected 2032 Operating Budget	2022 Grant % of 2032 Operating Budget
Albuquerque Area								
Denver Indian Health & Family Services - Denver and Colorado Springs	44	456	10%	$1,788	$ -	N/A	$70,259	0%
First Nations Community Healthsource - Albuquerque	230	620	37%	$3,924	$ -	N/A	$94,673	0%
Bemidji Area								
American Indian Health Service of Chicago	29	126	23%	$1,978	$ -	N/A	$19,774	0%

URBAN INDIAN ORGANIZATION NAME - SERVICE AREA	2022 Staff FTEs	2032 Staff FTEs	Staff % of Need	2022 OUIHP Contract & Grant Award	2022 Operating Budget	2022 Grant % of 2022 Operating Budget	Projected 2032 Operating Budget	2022 Grant % of 2032 Operating Budget
American Indian Health & Family Services of SE MI Inc. - Detroit	42	137	31%	$1,913	$ -	N/A	$21,924	0%
Indian Health Board of Minneapolis	99	115	86%	$4,777	$11,618	41%	$22,811	51%
Juel Fairbanks Chemical Dependency Services - St. Paul	22	25	NA	$739	$ -	N/A	$4,959	0%
American Indian Council on Alcoholism, Inc. - Greenfield	5	25	20%	$911	$905	101%	$3,976	23%
Gerald L. Ignace Indian Health Center - Milwaukee	75	170	44%	$2,496	$ -	N/A	$26,741	0%
All Nations Health Center - Missoula	35	110	32%	$1,690	$ -	N/A	$17,871	0%
Billings Area								
Billings Urban Indian Health & Wellness Center	32	234	14%	$2,014	$ -	N/A	$36,786	0%
Butte Native Wellness Center	12	70	17%	$1,215	$900	135%	$11,517	8%
Helena Indian Alliance	40	129	31%	$1,459	$ -	N/A	$20,702	0%
Indian Family Health Clinic - Great Falls	21	89	24%	$1,671	$ -	N/A	$14,416	0%
California Area								
American Indian Health & Services - Santa Barbara	79	227	35%	$1,628	$11,064	15%	$35,661	31%
Bakersfield American Indian Health Project	17	262	6%	$1,829	$ -	N/A	$42,442	0%
Fresno American Indian Health Project	37	249	15%	$2,123	$2,086	102%	$38,613	5%
Friendship House – San Francisco	62	62	NA	$1,196	$ -	N/A	$9,690	0%
Indian Health Center of Santa Clara Valley - Gilroy, San Jose, and Silver Creek	100	667	15%	$2,138	$ -	N/A	$104,252	0%
Native American Health Center - Oakland, Richmond, and San Francisco	279	463	60%	$2,326	$ -	N/A	$72,985	0%
Native Directions, Inc. - Three Rivers Indian Lodge - Manteca	7	31	23%	$1,413	$ -	N/A	$4,948	0%
Sacramento Native American Health Center, Inc.	192	348	55%	$2,574	$20,055	13%	$55,543	36%
San Diego American Indian Health Center	69	203	34%	$2,279	$7,222	32%	$32,515	22%
United American Indian Involvement, Inc. - Los Angeles	84	298	28%	$3,263	$10,084	32%	$45,092	22%
Nashville Area								

URBAN INDIAN ORGANIZATION NAME - SERVICE AREA	2022 Staff FTEs	2032 Staff FTEs	Staff % of Need	2022 OUIHP Contract & Grant Award	2022 Operating Budget	2022 Grant % of 2022 Operating Budget	Projected 2032 Operating Budget	2022 Grant % of 2032 Operating Budget
Nebraska Urban Indian Health Coalition - Lincoln and Omaha	51	250	20%	$1,990	$ -	N/A	$40,563	0%
South Dakota Urban Indian Health - Sioux Falls and Pierre	44	252	17%	$2,570	$4,900	52%	$40,044	12%
Native American Lifelines of Baltimore & Boston	17	151	11%	$1,084	$ -	N/A	$24,892	0%
New York Indian Council - Long Island City	UNK	459	NA	$1,211	$ -	N/A	$71,792	0%
Navajo Area								
Native Americans for Community Action - Flagstaff	73	263	28%	$1,939	$5,020	39%	$41,406	12%
Oklahoma City Area								
Hunter Health - Wichita	147	301	49%	$1,692	$14,667	12%	$46,771	31%
Kansas City Indian Center	UNK	52	NA	$750	$ -	N/A	$8,496	0%
Indian Health Care Resource Center of Tulsa	174	490	36%	$6,323	$ -	N/A	$76,623	0%
Oklahoma City Indian Clinic	321	1,197	27%	$9,966	$32,735	30%	$187,059	17%
Texas Native Health – Dallas and Fort Worth	31	268	12%	$3,282	$4,079	80%	$42,269	10%
Phoenix Area								
Urban Indian Center of Salt Lake	32	172	19%	$1,939	$ -	N/A	$26,189	0%
Native American Connections, Inc. - Phoenix	96	137	70%	$1,351	$15,500	9%	$20,603	75%
Native Health - Phoenix, Mesa, and West Phoenix	195	575	34%	$3,838	$19,248	20%	$86,823	22%
Nevada Urban Indians, Inc. - Reno and Carson City	22	174	13%	$1,585	$ -	N/A	$27,145	0%
Portland Area								
Native American Rehabilitation Association of the Northwest	325	905	36%	$2,754	$46,200	6%	$143,901	32%
Seattle Indian Health Board	180	266	68%	$5,985	$ -	N/A	$42,403	0%
The NATIVE Project - Spokane	68	316	22%	$2,112	$ -	N/A	$49,405	0%
Tucson Area								
Tucson Indian Center	32	159	20%	$2,202	$5,000	44%	$24,287	21%
Grand Totals	**3,420**	**11,503**	**29.70%**	**$99,916**	**$211,283**		**$1,808,821**	**11.70%**

VII. FACILITY REQUIREMENTS SUMMARY

Since the founding of the first UIO, these facilities have by necessity, demonstrated some of the most creative and community-focused programming for AI/AN patient populations. The type of

facilities within the current inventory of UIOs includes a former National Guard Armory, an automotive service station, an elementary school, among many others. A small portion of the existing facilities were built or holistically renovated into state-of-the-art healthcare buildings. The age of the buildings varies from recent, to more than 100 years old, with conditions ranging from good to poor.

While there are 41 UIOs included in the scope of this study, at the start of the exercise, there were 81 points of care being used to support the mission. While some UIOs have a single facility, others have multiple sites. The Indian Health Center of Santa Clara Valley in San Jose, California, has seven facilities, and the Native American Rehabilitation Association in Portland, Oregon, has 11 facilities. The supplemental spaces may be on the same block, in the neighborhood, or across town. A supplemental space might be administrative, a separate clinical service line, facility support space, or distribution of services to improve access.

This study has resulted in proposals for points of care in 10 new service areas within managing distance of an existing UIO. Typically, these new service areas are intended for high -volume, low-acuity outpatient services, like primary care and mental health. Two new locations in Los Angeles, California, and one new location in Seattle, Washington, were underway as this study commenced, with another seven arising as a result of this planning effort. The Native American Rehabilitation Association in Portland, Oregon, has envisioned five primary care points of care, while United American Indian Involvement in Los Angeles, California is envisioning four.

Of the UIOs providing facility data, 66 percent of the facility's inventory of 1.67 million gross square feet is owned by UIOs. The other 34 percent (563,000 net useable square feet) is leased. Twenty-one of the UIOs have some dependency upon leased space. The Sacramento Native American Health Center in Sacramento, California, is the most dependent on leases for its operation, as 100 percent of its 83,640 operating square feet is leased. The 11 UIOs that follow are 100 percent reliant on leases: American Indian Council on Alcoholism, Inc. in Greenfield, Wisconsin; American Indian Health Service of Chicago, in Chicago, Illinois; Gerald L. Ignace Indian Health Center in Milwaukee, Wisconsin; United American Indian Involvement, Inc., in Los Angeles, California; Billings Urban Indian Health & Wellness Center in Billings, Montana; Denver Indian Health & Family Services in Denver, Colorado; Native Americans for Community Action in Flagstaff, Arizona; South Dakota Urban Indian Health in Sioux Falls, South Dakota; Tucson Indian Center in Tucson, Arizona; All Nations Health Center in Missoula, Montana; and Native American Lifelines in Baltimore, Maryland, and Boston, Massachusetts.

The existing 1.1 million of owned building gross square feet (BGSF) meets only 21 percent of the 5.2 million BGSF need required to achieve each of the UIO's vision for 2032, with 4.4 million BGSF of this total need as a result of Urban Indian demand. The percent of BGSF need varies with each UIO, from 0 percent at locations where their entire need is presently met in leased facilities, to 93 percent at Minneapolis, Minnesota, where their three owned properties, offering distinct services at each, are scattered within a half-mile radius of each other near downtown Minneapolis.

Facility ownership improves an UIO's opportunity to improve its facilities, but ownership does not guarantee adequate space to expand or make significant changes to its facilities. Many UIOs

have acquired or are pursuing adjacent properties. It is often a challenge for UIOs to find adequate property to expand services to meet the local community healthcare demands and/or needs.

Nearly 3.5 million additional BGSF is needed to meet the overall vision if maintaining the disparate leased facilities in the inventory. Of the 3.5 million, approximately 2.75 million square feet is needed to meet the healthcare needs of Urban Indians. If the Urban Indian Organization's leased spaces were to be eliminated, an additional 563,000 square feet of new space would be needed. The Oklahoma City Indian Clinic requires the largest amount of square feet to achieve their vision.

To acquire the needed additional square feet to meet each UIO's 2032 vision, an influx of capital for design and construction of $3.85 billion will be required; $2.95 billion for the Urban Indian demand alone. To replace the entire inventory of Urban Indian Organization space would require $5.66 billion. These estimates are Total Project Budget Estimates, with a midpoint of construction established as November 2026. Land acquisition costs are not included but would certainly be required in many instances. Table 5 shows the range of Total Project Budget Estimates.

Table 5 – The Facility Requirements Summary identifies for each UIO service area the required space needs, along with the estimated total of facility capital investment that is necessary to supplement the existing space and replace it entirely.

TABLE 5 – FACILITY REQUIREMENTS SUMMARY

		Urban Indian Only SQ FT/Cost				Overall SQ FT/Cost	
Urban Indian Organization Name	Est. % Urban Indian	Needed FTEs	Needed Operating Funding $	Needed SQ FT	Capital Investment Needed	Needed SQ FT	Capital Investment Needed
Albuquerque Area							
Denver Indian Health & Family Services	99%	409	$69,672	177,942	$165,623	179,441	$167,018
First Nations Community Healthsource - Albuquerque	64%	251	$60,835	103,648	$97,520	161,300	$151,764
Bemidji Area							
American Indian Health Service of Chicago	93%	90	$18,295	53,315	$61,490	57,626	$66,462
American Indian Health & Family Services of SE Michigan Inc. - Detroit	62%	59	$13,505	28,918	$29,256	46,944	$47,493
Indian Health Board of Minneapolis	75%	12	$17,135	3,238	$3,505	4,310	$4,666

		Urban Indian Only SQ FT/Cost				Overall SQ FT/Cost	
Urban Indian Organization Name	Est. % Urban Indian	Needed FTEs	Needed Operating Funding $	Needed SQ FT	Capital Investment Needed	Needed SQ FT	Capital Investment Needed
Gerald L. Ignace Indian Health Center, Inc. - Milwaukee	70%	67	$18,820	23,893	$23,882	33,948	$33,933
Billings Area							
All Nations Health Center - Missoula	79%	59	$14,162	33,752	$33,464	42,590	$42,227
Billings Urban Indian Health & Wellness Center	100%	202	$36,786	94,882	$93,113	94,882	$93,113
Butte Native Wellness Center	58%	33	$6,638	14,247	$13,419	24,721	$23,285
Helena Indian Alliance	59%	52	$12,135	18,751	$17,662	31,988	$30,129
Indian Family Health Clinic - Great Falls	82%	56	$11,835	11,114	$10,468	13,538	$12,751
California Area							
American Indian Health & Services - Santa Barbara	34%	50	$12,044	24,602	$30,365	72,846	$89,912
Bakersfield American Indian Health Project	100%	245	$42,442	97,833	$110,014	97,833	$110,014
Fresno American Indian Health Project	98%	209	$38,000	64,835	$76,024	65,882	$77,251
Indian Health Center of Santa Clara Valley	20%	114	$20,895	42,392	$58,757	211,511	$293,161
Native American Health Center - Oakland	45%	83	$32,824	34,459	$48,023	76,621	$106,781
Sacramento Native American Health Center, Inc.	58%	91	$32,351	23,600	$27,445	40,518	$47,120
San Diego American Indian Health Center	46%	61	$14,824	35,013	$42,153	76,799	$92,460
United American Indian Involvement, Inc. – Los Angeles	83%	178	$37,430	151,645	$183,462	182,688	$221,018
Great Plains Area							
Nebraska Urban Indian Health Coalition, Inc.	40%	80	$16,277	19,558	$18,777	48,738	$46,791
South Dakota Urban Indian Health, Inc.	87%	181	$34,888	102,706	$108,130	117,883	$124,109
Nashville Area							
Native American Lifelines of Baltimore and Boston	80%	107	$19,840	52,083	$51,375	65,346	$64,458
New York Indian Council	100%	459	$71,792	168,668	$225,247	168,668	$225,247
Navajo Area							
Native Americans for Community Action, Inc. - Flagstaff	43%	82	$17,892	38,057	$37,674	88,070	$87,185
Oklahoma City Area							
Hunter Health Clinic - Wichita	22%	34	$10,253	11,106	$10,562	50,662	$48,180

		Urban Indian Only SQ FT/Cost				Overall SQ FT/Cost	
Urban Indian Organization Name	Est. % Urban Indian	Needed FTEs	Needed Operating Funding $	Needed SQ FT	Capital Investment Needed	Needed SQ FT	Capital Investment Needed
Kansas City Indian Center (Heart of Nation)	83%	43	$7,030	18,051	$17,175	21,816	$20,758
Indian Health Care Resource Center of Tulsa	100%	316	$76,623	82,646	$72,743	82,646	$72,743
Oklahoma City Indian Clinic	100%	876	$187,059	218,722	$205,792	218,722	$205,792
Texas Native Health	100%	237	$42,269	87,452	$82,282	87,452	$82,282
Phoenix Area							
Urban Indian Center of Salt Lake	100%	140	$26,189	61,400	$54,292	61,400	$54,292
Native Health - Phoenix, Mesa	72%	273	$62,272	117,977	$111,122	164,490	$154,932
Nevada Urban Indians, Inc.	89%	135	$24,196	75,850	$73,686	85,095	$82,667
Portland Area							
Native American Rehabilitation Association of the NW	87%	503	$124,791	212,868	$240,544	245,466	$277,381
Seattle Indian Health Board	60%	51	$25,382	59,495	$71,771	99,390	$119,899
The NATIVE Project - Spokane	91%	225	$44,746	76,423	$85,823	84,380	$94,758
Tucson Area							
Tucson Indian Center	100%	127	$24,287	54,262	$53,799	54,262	$53,799
Primary Care		6187	$1,326,414	2,495,401	$2,646,439	3,260,472	$3,525,831
Residential Treatment / BH		87	$41,866	256,942	$309,294	263,457	$321,884
TOTAL		6,275	$1,368,281	2,752,343	$2,955,733	3,523,929	$3,847,714

VIII. IHS HEADQUARTERS PARTICIPANTS

The study was led and overseen by members of the IHS Office of Urban Indian Health Programs (OUIHP), and the IHS Office of Environmental Health and Engineering (OEHE). Active project representatives were:

- Rose Weahkee, Ph.D. – Director, OUIHP, IHS – Headquarters;
- Rick Mueller – Deputy Director, OUIHP, IHS – Headquarters;
- Shannon Beyale – Commander, U.S. Public Health Service (USPHS), Program Management Officer, OUIHP, IHS – Headquarters;
- Debi Nalwood – Health System Specialist, OUIHP, IHS – Headquarters;
- Shawn Thomas – Health System Specialist, OUIHP, IHS – Headquarters;
- Revaline Yazzie-Tate – Health System Specialist, OUIHP, IHS – Headquarters;
- Cindy Baldwin – Health System Specialist, OUIHP, IHS – Headquarters;
- Tashina Collins – Ethics Specialist, Division of Personnel Security and Ethics, Office of Human Resources, IHS – Headquarters;

- Omobogie Amadasu, Professional Engineer (P.E.), Commander, USPHS, Division of Facilities Planning and Construction (DFPC), OEHE, IHS – Headquarters; and
- Mark Hench, P.E., Commander, USPHS, Division of Facilities Planning and Construction, OEHE, IHS – Headquarters.

The IHS appreciates each UIO's thoughtful and discerning insight and direction relative to the development of each UIO's vision and the resources needed to achieve it.

IX. GLOSSARY OF DEFINITIONS

Term	Definition
Urban Indian Population/Square Mile	This indicates the projected number of Urban Indian that will live within a square mile.
Access Service Area	A service area defined by the local Medicare Advantage primary care drive time/distance access standard to a primary care Point of Care (PoC).
Aesthetic Quality	The evaluation of the atmosphere and attractiveness of a facility's environment of care.
American Indian/Alaska Native (AI/AN) plus 1, 2, 3, etc.	A census count of individual American Indians and Alaska Natives (AI/AN), where the individual recognizes their AI/AN alone, or as AI/AN +1, +2, or +3 other races.
Annual Growth Rate (AGR)	The percent of growth per year; used to project future population growth.
Beds	The number of beds existing or anticipated to describe a facility's planned capacity.
Building Circulation and Envelope factor	A space multiplying factor to accommodate the public and service corridors, as well as the exterior envelope of a building. For a single-story building, this is 20 percent. For a multi-story building, this increases to 25 percent to allow for elevators and stairwells.
Building Gross Square Feet (BGSF)	The square feet sum of a project's built size that includes all habitable space, infrastructure system space, and the exterior walls of a facility. Usually measured in square feet and abbreviated as the BGSF. Typically used to drive the facilities cost estimate and total project budget estimate.
Capacity	Refers to the capacity that can be reasonably expected of a discipline, department, or facility given each discipline's key characteristic and the planned throughput expectations. For example, a measure of how many visits an outpatient facility can accommodate for specific services.

Term	Definition
Condition & Maintenance	The evaluation of the current state, integrity, and appearance of mechanical, electrical, and structural components required for building operations.
Construction Costs	The dollar amounts a new facility may cost to build at a particular time and in its location.
Conversion Factor (Department Circulation Space)	A space multiplying value to enlarge planned net square feet space to accommodate department corridors, walking spaces, and walls between department rooms. This factor will vary depending on the type of department function and its fire egress requirements.
Crossover	Identification of historical workload migration to and from an existing facility and surrounding facilities.
Demand	The healthcare workload, potentially anticipated from a service area population or presently provided by a discipline/facility.
Department	A specific functional organization of a healthcare organization, e.g., medicine, nursing, pharmacy, medical records, dentistry, radiology, etc. Also referred to as a service, discipline, or program.
Department Gross Square Feet (DGSF)	A planning approximation of the required area of a department, including wall and structure thickness, and corridors within the department. Usually, abbreviated as the DGSF. Department net square feet multiplied by a department conversion factor. Existing or actual DGSF can also be measured from existing floor plans, those measurements should not include electrical closets, stair towers, or air ducts within the department perimeter.
Discipline	A specific medical specialty, e.g., medicine, nursing, pharmacy, dentistry, radiology, etc. Also referred to as a service, department, or program.
Distribution of Services	A description of a how a healthcare system arranges their delivery of healthcare across a geographic area or region.
ESRI (Environmental Systems Research Institute, Inc.)	The ESRI is the global market leader in geographic information system (GIS) software, location intelligence, and mapping.
Existing Unique Patients	The number of individuals who have visited a healthcare setting over a specified period.
Full-Time Equivalent (FTE)	A staff position paid for 2,080 hours per year.

Term	Definition
Federally Qualified Health Center (FQHC)	A FQHC is a safety net provider that primarily provides services typically furnished in an outpatient clinic. A FQHC includes community health centers, migrant health centers, healthcare centers for the homeless, public housing, primary care centers, and health center program "lookalikes." A FQHC can also include outpatient health programs or facilities operated by a tribe or tribal organization, or by an Urban Indian Organization. A FQHC is paid based on the FQHC Prospective Payment System (PPS) for medically necessary primary health services and qualified preventive health services.
Gap Analysis	Compares planned assets to existing assets in an effort to identify where shortcomings exist, and future implementation efforts might be warranted.
Geographic Information Systems (GIS)	A geographic information system (GIS) is a data management framework that creates, organizes, and analyzes all types of knowledge relative to a specific position, place, or area.
Growth Vector	A quantifiable means to anticipate future growth. For example, clinic staff will need to grow because the workload is anticipated to grow in the future.
Health Systems Planning (HSP)	An IHS software used for the planning, programming, and design of health programs, staff, and facilities.
Hospital Referral Region (HRR)	The Dartmouth Atlas of Health Care label for their recognized tertiary care service area. The named service areas are defined by the zip codes from which Medicare patients typically choose the named location to access cardiothoracic and neurosurgery services.
Hospital Service Area (HSA)	The Dartmouth Atlas of Health Care label for their recognized hospital service areas. The named service areas are defined by the zip codes from which Medicare patients typically choose the named location for their emergency and inpatient care.
Indian Health Service (IHS)	The IHS, an agency within the U.S. Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives.
IHS Areas	The IHS consists of 12 large geographic and administrative units responsible for the planning, support, and provision of healthcare at IHS direct care Service Units, tribal compacted and/or contracted healthcare programs, and UIOs.

Term	Definition
Infrastructure Assessment Score	An objective total of a point of care's facility quality relative to patient access and wayfinding, organizational concept, patient treatment room size, staff workspace sizes, condition and maintenance, aesthetic quality, and patient visual and acoustic privacy.
Inventory of Space	The documentation of square feet by room, department, or facility type associated with a facility, service area or health system.
Key Characteristics (KC)	The recognized significant component of a discipline/department/service line that establishes the discipline's capacity and ability to deliver care (e.g., providers, modality, beds).
Market Opportunity	A quantification of healthcare demand for a healthcare service at a specific location and usually associated with a geographically defined catchment area.
Market Share	The planned percentage of potential total available patients or service line demand within a service area.
Maximum Workload (Max Wkld)	The year with the highest number of visits per discipline and/or service line.
Medicaid	Medicaid is a joint federal and state program, which, together with the Children's Health Insurance Program (CHIP), provides healthcare coverage to millions of low-income people, children, pregnant women, parents, seniors, and individuals with disabilities.
Medicare Advantage Access standard	By service line, the time or distance within which care should be available. A measure of network adequacy for the awarding of Medicare Advantage contracts. Publicly available for every county in the U.S., while recognizing the availability of care and urban/rural nature of that county.
Mission Service Area (MSN, Mission)	The mission service area is defined by an organization's charter, contractual agreement, or by local leadership, which helps define their healthcare responsibility.
Net Area or Net Square Feet (NSF)	The size computed by multiplying the length and width of rooms from the inside finish of walls. Also, the programmed size to deliver specific functions in a space program. Typically, abbreviated as the NSF.
Net Use-able Square Feet (NUSF)	The quantification of space associated with a lease for which rent is being paid. It is usually larger than the DGSF but smaller than the BGSF, depending on how many other tenants are sharing a building.
Operational Budget	The annual dollar amount planned for an organization to provide services.

Term	Definition
Organizational Concept	The evaluation of the overall logical and logistical design of a facility's departmental layout.
Outpatient Visits	Ambulatory healthcare encounters typically seen annually by a service line or facility. The count does not typically include inpatient services.
Outside The Service Area (OTSA)	The geographic area beyond a point of care's defined service area. Typically defined to understand the patient traveling to or migrating to the point of care.
Patient Access and Wayfinding	The evaluation of the intuitive layout of a facility of how well a patient can navigate the environment.
Patient Visual and Acoustic Privacy	The evaluation of the capacity for primary care examination rooms and behavioral health offices to provide adequate sight and sound proofing to ensure patient confidentiality.
Percent (%) of Need	The gap analysis comparison of existing assets to future required assets. The percent need of the future compared to what UIOs have today.
Planned Staff	The anticipated number and distribution of full-time equivalents (FTEs) by department and position.
Point of Care (PoC)	Location where ambulatory, ancillary, and/or cultural services are provided.
Primary Service Area (PSA)	The service area chosen by the Urban Indian Organization as their healthcare market (ASA or MSA) for planning purposes.
Population, Workload, Services, Staff, and Space (PSW).	Five facility planning metrics used to determine space utilization needs.
Residential Treatment Service Area (RsTSA)	Regional area from which a PoC anticipates receiving patients for 24-hour / 7 days per week Residential Treatment services.
Resource Requirements Methodology (RRM)	The IHS staffing methodology to define the number of staff required by discipline/department/facility in accordance with the population served and or the workload planned. The application also approximates the annual operating budget at facility opening.
Service Area	The geographic healthcare market area for which a discipline/department/service line/facility is planned. One point of care or facility can have multiple service areas, differentiated by service line. For example, primary care and residential treatment will have different service areas. This is not an IHS Service Area, or site otherwise approved by the IHS as the contractual service area.
Service Line	Ambulatory, ancillary, and preventative care disciplines, departments, and/or programs.

Term	Definition
Size of Patient Treatment Rooms	The evaluation of clinical space square feet being used for patient care.
Size of Staff Workspaces	The evaluation of service space square feet used to support patient care functions.
Space	The quantity of square feet associated with a room, department, lease, or facility.
Throughput	The amount of workload/demand a single key characteristic can be expected to schedule or see per year.
Total Project Cost Estimate	The projected dollar amount to budget for project completion. It includes construction costs, Architect/Engineer (A/E) fees, owner costs, contingencies, and taxes. It should be sensitive to timing and location. For this study, land acquisition and site due diligence are not included.
UIO Desired Scenario	The scenario relative to service area, population, population growth, service line market share and workload and planned staff chosen by the Urban Indian Organization as their future vision.
Urban Indian Organization (UIO)	The term "Urban Indian organization" means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 1653(a) of this title.
User Population	The number of American Indian and Alaska Native patients who have received care, touching any point of delivery within the IHS system over the past 3 years. These counts may or may not include Urban Indian Organization patients.

Term	Definition
Urban Indian	The term "Urban Indian" means any individual who resides in an urban center, as defined in subsection (g) hereof, and who meets one or more of the four criteria of Indians or Indian. The term "Indians" or "Indian", unless otherwise designated, means any person who is a member of an Indian Tribe, as defined in subsection (d) hereof, except that, for the purpose of sections 1612 and 1613 of this title, such terms shall mean any individual who: (A) irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member, or (B) is an Eskimo or Aleut or other Alaska Native, or (C) is considered by the Secretary of the Interior to be an Indian for any purpose, or (D) is determined to be an Indian under regulations promulgated by the Secretary.[7]
Utilization Rate	The estimated workload that an individual patient is likely to encumber annually within a healthcare system.
Visit(s)	A count of patient encounters to a specific discipline/service line/facility. Usually communicated as an annual count.
Weighted Facility Age	An organization's infrastructure age when multiple points of care of different sizes and age are part of their inventory.
Women Infants and Children (WIC)	The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) serves to safeguard the health of low-income, pregnant, postpartum, and breastfeeding women, infants, and children up to age 5, who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, including breastfeeding promotion and support, and healthcare referrals.
Workload	The healthcare demand planned for or presently provided by a discipline/service line/department. Typically communicated as an annual workload count using a unit like visits, cases, billable tests, examinations, and patient days.

[7] Office of the Law Revision Counsel, United States Code, Title 25, Chapter 18, *General Provisions, 25 U.S.C. 1603: Definitions*. https://uscode.house.gov/view.xhtml?req=(title:25%20section:1603%20edition:prelim)#1603_1