REPORT TO CONGRESS

NEW NEEDS ASSESSMENT OF THE URBAN INDIAN HEALTH PROGRAM AND THE COMMUNITIES IT SERVES

(25 U.S.C. § 1654)

Prepared as provided in House Report 111-180 (2009)
Urban Indian Health Program

Submitted to the United States Congress

U.S. Department of Health and Human Services
Indian Health Service

Table of Contents

Executive Summary

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 Indian Health Service (IHS) carries out this authority through contracts with, and grants to, Urban Indian Organizations (UIO). 25 U.S.C. §§ 1652-1653. Since its initial passage, amendments to the IHCIA have strenghthened Urban Indian Health Programs (UIHP)[1] by expanding Agency contract and grant authorites to include direct medical services, alcohol and substance abuse services, mental health services, human immunodeficiency virus (HIV) prevention and treatment services, and health promotion and disease prevention services.

The IHS contracts nationwide with qualifying UIO, which are defined by the IHCIA at 25 U.S.C. § 1603(29) as 501(c)(3) non-profit organizations controlled by an urban American Indian/Alaska Native (AI/AN) board of directors. These IHS-funded programs support primary care clinics and outreach and referral programs that provide culturally appropriate services addressing the unique social, cultural, and health needs of American Indians and Alaska Natives residing in urban areas.

This needs assessment, required by H. Rept. No. 111-180, p. 145, entitled, *New Needs Assessment of the Urban Indian Health Program and the Communities it Serves*, provides estimates of the current health status and health care needs of the urban AI/AN populations residing in urban centers. Current examples describe how UIO assist the public and private health care entities in providing services to urban American Indians and Alaska Natives, and assisting urban American Indians and Alaska Natives with utilizing these health services resources. The report also defines gaps between unmet health needs and resources available for the urban AI/AN populations.

[1] Unless otherwise indicated, references throughout this report to UIHP are intended to include a total of 43 UIO that the IHS funds under the IHCIA, including: (a) 33 UIHP that receive contracts and/or grants under 25 U.S.C. §§ 1652-1653; (b) 2 UIHP that are considered IHS Service Units per 25 U.S.C. § 1660b; and (c) 8 UIHP formerly funded under the NIAAA Programs that continue to receive funding under 25 U.S.C. § 1660c.

A. Introduction

This needs assessment, entitled, *New Needs Assessment of the Urban Indian Health Program (UIHP) and the Communities it Serves*, is prepared as provided in House Report (H.R. Rept. No. 111-180), p. 145: "From within the increase provided, the Service is directed to conduct a new needs assessment of the urban Indian health program and the communities it serves." This report addresses the UIHP needs assessment described under 25 U.S.C. § 1654 and makes recommendations based on that assessment.

B. Background, History, and Study Conducted for this Report

1. Background and History

The Indian Health Service (IHS) is an Agency within the United States Department of Health and Human Services (HHS). The Agency's principal mission is to provide primary health care for American Indians and Alaska Natives throughout the United States. *See* S. Rep. No .102-392, at 2-3 (1992), *as reprinted in* 1992 U.S.C.C.A.N. 3943.

The IHS's authority to provide health care services to American Indian and Alaska Native (AI/AN) people derives primarily from two statutes. The Snyder Act, 25 U.S.C. § 13, is a general and broad statutory mandate authorizing the IHS to "…expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians," for the "relief of distress and conservation of health." 25 U.S.C. § 13; *See also* 68 Stat. 674 (transferring the health-related functions of the Snyder Act from the Department of Interior to Health, Education, and Welfare, the predecessor of HHS). The IHCIA, 25 U.S.C. §§ 1601-1683, establishes numerous programs specifically created by Congress to address particular Indian health initiatives, such as alcohol and substance abuse treatment, diabetes prevention and treatment, medical training, and 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, Urban Indian Organizations (UIO). 25 U.S.C. §§ 1652-1653. Since its initial passage, amendments to the IHCIA have strengthened UIHP by expanding the IHS's contract and grant authorities to include direct medical services, alcohol and substance abuse services, mental health services, human immunodeficiency virus (HIV) prevention and treatment services, and health promotion and disease prevention services.

Under the authority of the IHCIA, the IHS contracts nationwide with qualifying UIO, which are defined by the IHCIA at 25 U.S.C. § 1603(29) as 501(c)(3) non-profit organizations controlled by an urban American Indian and Alaska Native board of directors. These IHS-funded programs support primary care clinics and outreach and referral programs that provide culturally appropriate services addressing the unique social, cultural, and health needs of AI/AN people residing in urban areas.

An "Urban Indian" eligible for services, is defined by the IHCIA as any individual who: (1) resides in an urban center, which is any community that has a sufficient urban Indian population with unmet health needs to warrant assistance under Title V of the IHCIA, as determined by the Secretary of HHS; and (2) meets one or more of the following criteria: (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; (B) is a descendant, in the first or second degree, of any such member described in (A); (C) is an Eskimo, Aleut, or other Alaska Native; (D) is a California Indian; (E) is considered by the Secretary of the Department of the Interior to be an Indian for any purpose; or (F) is determined to be an Indian under regulations pertaining to the IHS UIHP that are promulgated by the Secretary of HHS. 25 U.S.C. § 1603(3), (13), (27), (28).

1. Study Conducted for this Report

IHS Study of Urban Indian Health Needs

The 2010 United States Census (Census) reported 78 percent of American Indians and Alaska Natives reside in urban centers.[2] To better understand the urban AI/AN population, the IHS conducted a new Urban Indian Health Needs Assessment (UIHNA) to assess the health status and health care needs of AI/AN people who live in urban areas. The UIHNA is the basis for this needs assessment.

The study used a mixed methods approach to estimate the morbidity and mortality of urban American Indians and Alaska Natives, the availability of health resources, and the gap between available and needed resources for the urban AI/AN population. The health status of the urban AI/AN population was determined by examining epidemiological data available from the Centers for Disease Control and Prevention (CDC) and the National Vital Statistics System. Data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) was analyzed to determine the prevalence of risk behaviors such as smoking and alcohol consumption. The health needs of the urban AI/AN population were determined based upon stakeholder engagement and examination of existing data. Site visits and stakeholder interviews were conducted with all 43 IHS-funded UIHP and local UIO or AI/AN leaders in 17 potential new sites. The site visit data were complemented by an analysis of secondary data related to health resources for urban AI/AN populations. These data included the U.S. Census Bureau's American Community Survey for demographic, income, and health care coverage information; UIHP utilization and patient profile data as reported to the IHS; and other archival data provided by the individual communities. The study occurred between September 2010 and August 2012.

[2] The American Indian and Alaska Native Population. U.S. Census Bureau. Accessed January 12, 2012, at: http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf

Study Population

The study population included AI/AN people residing in 43 Metropolitan Statistical Areas (MSA)[3] where the IHS-funded UIHP are located. For a list of current IHS-funded UIHP, please see Appendix 1. Also included in the study population were AI/AN people in the 17 MSA with the largest AI/AN populations that currently do not have UIHP. For a list of these MSA, please see Appendix 2. For the purposes of this report, data from the 17 MSA was examined to assess the health status and health needs of urban AI/AN populations.

Data Collection

Quantitative data on infant mortality was compiled from the CDC National Vital Statistics System (NVSS), in collaboration with the Urban Indian Health Institute (UIHI). In addition, prevalence data from the CDC's BRFSS was analyzed to assess risk behaviors and preventive health practices that can affect health status among the study population. Qualitative data was also collected through engagement of UIHP. Site visits and interviews were conducted with all 43 IHS-funded UIHP. Among the 17 potential new sites included in the study, site visits and successful contact was made with local AI/AN leaders or UIO in all but four cities.

Data was collected to determine the health care resources available to these populations. The IHS relied upon data available through the Census Bureau's American Community Survey[4] for demographic, income, and health care coverage information; UIO utilization and patient profile data as reported to the IHS; and other archival data provided by the individual communities. The IHS UIHP 2013 Uniform Data System (UDS) report, a core set of information for reviewing the operation and performance of the 33 UIHP that receive contracts and/or grants under 25 U.S.C. §§ 1652-1653, was an integral component of the examination of data for the 33 UIHP.[5] The UDS provides a snapshot of the 33 UIHP patient demographics, services provided, clinical indicators, utilization, costs, and revenues.

Relying on the data from these resources, this needs assessment of the UIHP and the communities they serve led to a wide range of findings and insights about the health needs and health resources of American Indians and Alaska Natives who live in urban communities. Recent federal initiatives, such as meaningful use of a certified electronic health record, health information exchange, health insurance reform, and related initiatives may lead to more accurate information for future health assessments and result in improved outcomes.

[3] The Office of Management and Budget defines a Metropolitan Statistical Area as a geographical region with a relatively high population density at its core and close economic ties throughout the area.
[4] American Community Survey. U.S. Census Bureau. Accessed January 20, 2015, at: http://www.census.gov/acs/www/
[5] The UDS Report may be obtained by contacting the Director, IHS Office of Urban Indian Health Programs.

Data Limitations

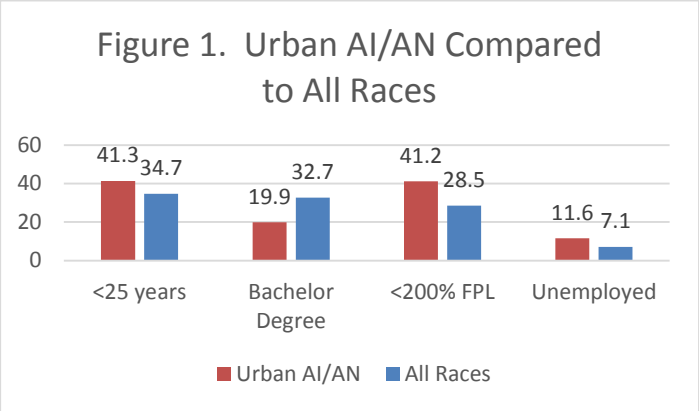
Limitations of the national datasets included problems with racial misclassification data, sampling in small populations, and access to information at various geographic levels. The dispersion and mobility of urban AI/AN populations throughout the MSA complicates the collection of health data.

C. Program Requirements and Study Results

1. Estimate the Population of Urban Indians Residing in Urban Centers who are or could be Recipients of Health Care or Referral Services

The 2010 Census reported that 78 percent of all American Indians and Alaska Natives resided in urban centers and that 72.3 percent (3.8 million) of the 5.2 million Americans Indians and Alaska Natives in the United States live in MSAs. Compared to the 2000 Census, these data suggest that the proportion of AI/AN people residing in urban communities is increasing.[6]

The urban AI/AN population experiences socioeconomic disparities with respect to age, education, income, and employment. Figure 1. Urban AI/AN compared to All Races identifies, Urban American Indians and Alaska Natives, when (41.3 percent of urban AI/AN people are below 25 years of age compared to 34.7 percent of the all races population) and less educated (only 19.9 percent of urban AI/AN people aged 25 years or older attain a bachelor's degree compared to 32.7 percent of the all races population).

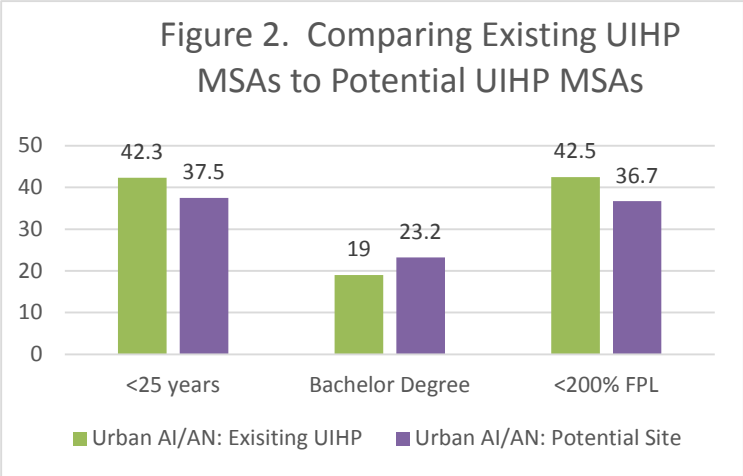


Urban AI/AN people have lower incomes, with 41.2 percent of urban AI/AN people with incomes under 200 percent of the Federal Poverty Level (FPL) compared to 28 percent of all races from the same MSA. Across the MSA examined, 11.6 percent of urban AI/AN people are unemployed compared to 7.1 percent of all races.[7] (Figure 1).

[6] The American Indian and Alaska Native Population. U.S. Census Bureau. Accessed January 12, 2012, at: http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf

[7] American Community Survey. U.S. Census Bureau. Accessed January 20, 2015, at: http://www.census.gov/acs/www/

Comparing urban AI/AN people from the MSAs with existing 43 IHS-funded UIHP to the 17 potential new MSA sites, urban American Indians and Alaska Natives from the existing UIHP are younger (42.3 percent compared to 37.5 percent below the age of 25), have lower levels of educational attainment (19 percent compared to 23.2 percent of adults 25 years of age or older hold at least a bachelor's degree), and have lower incomes (42.5 percent compared to 36.7 percent below 200 percent of the FPL). (Figure 2).



Of the 1.39 million American Indians and Alaska Natives living in MSAs with existing UIHP, 84,900 AI/AN people relied on services provided by the 33 UIHP and the 2 Urban IHS Service Units in 2013. By adding services to meet the full needs of the AI/AN people currently served by IHS-funded UIHP, and establishing UIHP in potential new MSA sites, the number of AI/AN people served will increase and improve access to health care services.

2. Estimate the Current Health Status of Urban Indians Residing in Urban Centers

American Indians and Alaska Natives who live in urban centers present a unique morbidity and mortality profile. Leading health care conditions for urban American Indians and Alaska Natives are substance abuse, heart disease, cancer, infant mortality, accidents and external causes, diabetes, and cerebrovascular disease. During the period under review, these conditions were also listed as contributing causes of death. Compounding the issues, the data from the study have shown that urban American Indians and Alaska Natives are less likely to access preventive care, do not have culturally competent options, and do not have adequate health insurance coverage.

Substance Abuse

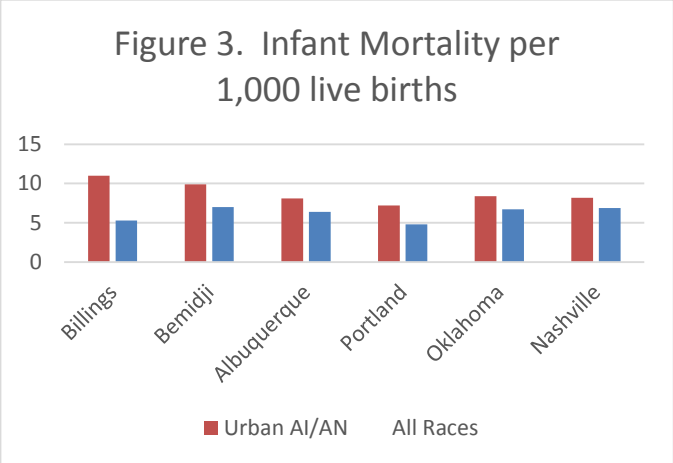
Alcohol-induced death rates are 2.8 times greater for urban AI/AN people than all races in urban areas. All regions, with the exception of east coast cities, show dramatically higher rates for urban AI/AN people than all races in urban areas who live in the same communities. Specific regions have higher alcohol-induced mortality for urban AI/AN people than all races: the IHS Billings Area is 4 times greater; the IHS Phoenix Area is 6 times greater; the IHS Tucson Area is 6.7 times greater; and the IHS Great Plains Area has a 13.4 times greater rate of mortality for urban AI/AN people compared to all races in the same MSA.[8]

[8] Centers for Disease Control and Prevention (CDC), National Vital Statistics System (NVSS). Accessed January 20, 2015 at: http://www.cdc.gov/nchs/nvss.htm

Chronic Disease
Urban AI/AN populations have greater mortality for chronic disease compared to all races in urban areas. For urban AI/AN people, diabetes death rates are 1.2 times greater, chronic liver disease death rates are 2.1 times greater, and tuberculosis death rates are 2 times greater than all races in urban areas.[9]

Infant Mortality
Nationally, infant mortality is higher among urban AI/AN people compared to the urban all race population. For every 1,000 live births among urban AI/AN people, there are 7.8 infant deaths, compared to 6.4 infant deaths per 1,000 in the urban all race population in the same MSA.

There are specific IHS Areas where infant mortality disparity is particularly significant among urban AI/AN people compared to the all race population: Billings (11.0 vs. 5.3); Bemidji (9.9 vs. 7.0); Albuquerque (8.1 vs. 6.4); Portland (7.2 vs. 4.8); Oklahoma (8.4 vs. 6.7); and Nashville (8.2 vs. 6.9).[10] (Figure 3). Adding to the high infant mortality risk, the birth rate for women under the age of 20 years is significantly higher for urban AI/AN women, at 16 births per 1,000 population, as compared with all races in urban areas, at 9 births per 1,000 population.[11]



Suicide
Urban AI/AN youth are at greater risk for suicide. Death rates from suicide among urban AI/AN populations was 13.0 per 100,000 population, compared to the all races rate of 9.2 per 100,000 population.[12]

HIV-related Mortality
Urban AI/AN people have higher rates of HIV-related mortality in certain MSA. In the IHS Bemidji Area, which includes Minneapolis, Duluth, Milwaukee, Shell Lake, Chicago, and Detroit, the HIV mortality rate is 5 percent for urban AI/AN people compared to 2.3 percent for all races in the same urban areas. In the IHS Albuquerque Area, which includes Albuquerque, Denver, and Colorado Springs, the HIV mortality rate is 4.3 percent for urban AI/AN people as compared to 2.3 percent for all races in urban areas. In the IHS Portland Area, which includes Seattle, Portland, and Spokane, the HIV mortality rate is 7 percent for urban AI/AN people and 2.2 percent for all races in the 3 MSAs.[13]

[9] Ibid.
[10] Ibid.
[11] Centers for Disease Control and Prevention, National Vital Statistics System (NVSS). Accessed January 20, 2015 at: http://www.cdc.gov/nchs/nvss.htm
[12] Ibid.
[13] Ibid.

Health Risk Behaviors

Urban AI/AN people are more likely to engage in health risk behaviors. Urban AI/AN people are more likely to report heavy or binge drinking compared to all races, and urban AI/AN people are 1.7 times more likely to smoke cigarettes. Urban AI/AN people more often view themselves in poor or only fair health status (22.6 percent) compared to all races (14.7 percent) reporting as fair/poor. A higher percentage of urban AI/AN people report they are obese (31.3 percent) than do all races in urban areas (25.0 percent).[14] Accidents and external causes of death rates are 1.4 times greater for urban AI/AN people than all races in urban areas.

Preventive Health Care

Urban AI/AN people are less likely to receive preventive care. Urban AI/AN males are less likely to report having received preventative screenings compared to all races, including prostate cancer screening (49.5 percent vs. 54.5 percent) and colorectal cancer screening (55.8 percent vs. 64 percent). Urban AI/AN women, compared to women of all races living in urban communities, are less likely to receive mammograms (70.3 percent vs. 80.5 percent) and cervical cancer screenings (79.2 percent vs. 84.3 percent). More than 35 percent of urban AI/AN people report no dental visits.[15]

Inadequate Health Insurance

American Indians and Alaska Natives lack health insurance coverage in urban centers where IHS-funded health services are provided. In 35 MSA with an UIHP, 23.5 percent of AI/AN people report no health coverage, public or private. In those same 35 MSA, 48.8 percent of AI/AN people report they have private insurance, compared to potential new MSA sites identified in Appendix 2, where 57.3 percent of AI/AN people report they have private insurance coverage. More than half (56.4 percent) of the AI/AN patients who used UIHP in 2010 lacked any form of health insurance. Only 19.7 percent of all American Indians and Alaska Natives living in an MSA without any IHS program report they have no health coverage. UIHP play an important role in the safety net and attract a disproportionate share of those without alternate resources.

Culturally Appropriate Health Care

Culturally appropriate health care is a key factor contributing to the quality of health among urban AI/AN people. UIHP report that their AI/AN communities are unanimous in their belief that culturally appropriate care is necessary to establish trusting and long-lasting relationships with AI/AN patients and their families and key to impacting health.

3. Estimate the Current Health Care Needs of Urban Indians Residing in Urban Centers

The current status of health care among urban AI/AN people points to an overall need to increase access and improve health care quality for this population. This UIHNA has identified three systemic needs that will have the greatest impact on overall quality improvement.

a. Integrate Behavioral Health Programs

[14] Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System. Accessed January 20, 2015 at: http://www.cdc.gov/brfss/

[15] Ibid.

Integrated, culturally sensitive behavioral health programs are vital to reduce the prevalence of lifestyle-related mortality and morbidity in urban AI/AN people. Increased integration of behavioral health programs and integration of behavioral health and primary care is needed to improve the health status of urban AI/AN people.

b. Improved Infrastructure and Capacity
Improved infrastructure and capacity for UIHP are necessary to: 1) maintain or increase the number of urban American Indians and Alaska Natives receiving services; 2) maintain or increase third-party revenue; and 3) provide good customer service and continuous quality improvement of care. Meaningful use of certified systems is likely to increase revenue that can be focused on unmet needs of urban AI/AN people.

c. Explore Potential New Sites
The health care needs in the 33 UIHP, 2 Urban IHS Service Units, 8 former National Institute on Alcohol Abuse and Alcoholism (NIAAA) Programs, as well as other potential new sites, warrant further health care services. Of 17 potential new sites examined, 4 sites demonstrate strong community leadership, local support, and active efforts to develop health care programs for urban AI/AN people.

4. Identify All Public and Private Health Services Resources within Urban Centers which are or may be Available to Urban Indians

Urban American Indians and Alaska Natives reside in cities with access to a variety of existing health resources. These resources include local county health departments, Community Health Centers (where available), private physicians, hospitals, urgent care centers, and university medical centers. The range of integrated services includes assessment and evaluation, individualized and collaborative service planning, individual and group counseling, case management services, parenting support, parent-child development services, physical health, and mental health services.

5. Determine the Use of Public and Private Health Services Resources by Urban Indians Residing in Urban Centers

Through collaboration, coordination, and referrals to public and private health services, UIHP have increased urban AI/AN population access to, and use of, public and private health services resources. For example, the American Indian Health and Services, in Santa Barbara, California, collaborates with the Santa Barbara County Health Department, Neighborhood Clinics, Cottage Health System, Santa Ynez Tribal Health, and CenCal Health to meet the needs of urban AI/AN population people in California. Health services include collective after hours medical doctor call center for patients, continuity of care and electronic access for patients, identifying high-risk patients, and medication management. The Helena Indian Alliance (HIA) in Helena, Montana, partners with the Behavior Health Unit, Veterans Administration (VA) Hospital Fort Harrison, Montana, and refers eligible urban AI/AN people to the hospital for services that Veterans need, but the HIA is unable to provide.

Also, several UIHP partner with the local University Medical Center and provide medical students high quality meaningful clinical rotation opportunities and experience. These medical providers often return to work for the UIHP that provided their clinical rotation opportunity.

6. Assisting Such Health Services Resources in Providing Services to Urban Indians

Many UIHP develop and implement Memorandums of Agreement (MOA) with local public and private health services organizations to refer urban AI/AN people for health and specialty care services. The UIHP provide public and private health care entities with training and technical assistance to understand AI/AN cultures and cultural practices used by urban AI/AN people. Examples of cultural practices include sweat lodges, smudging, traditional medicine men, powwows, drum groups, and AI/AN language. These traditional cultural practices are important for health, as well as dealing with grief and emotional issues such as traumatic experiences.

Specific examples of the collaboration between UIHP and health services resources located in the same urban center include:

- Urban Inter-Tribal Center of Texas (UITCT) in Dallas, Texas, refers patients without insurance who are facing specialized medical treatment and/or hospitalization to county hospitals within the Dallas-Fort Worth Metroplex. The UITCT has a strong working relationship with Parkland Health and Hospital System, the only public tax-supported health and hospital system in Dallas County. AI/AN Veterans needing hospital treatment or specialty care are referred to the local VA hospital.
- Fresno American Indian Health Project (FAIHP) in Fresno, California, has Memorandums of Understanding (MOUs) with local health providers that enable FAIHP public health nurses to assist clients with accessing care and maximize health care resources. The public health nurses triage client requests for paid referral services to ensure the appropriate level of care. The FAIHP also has two active MOUs that allow clients to access licensed mental health professionals as needed.

7. Assisting Urban Indians in Becoming Familiar with and Utilizing Health Services Resources

Most UIHP are well-integrated into the communities they serve and have established linkages and partnerships with local social service agencies, governments, hospitals, universities, and provider networks to ensure increased access to health services for urban AI/AN patients. The UIHP provide information about health services to local urban AI/AN people via newsletters, AI/AN community gatherings, and telephone calls for assistance. For example, North American Indian Alliance (NAIA) in Butte, Montana, provides information about Medicare prescription enrollment to NAIA consumers through the monthly newsletter and provides individualized support to elders to enroll. NAIA also holds anonymous HIV/Acquired Immune Deficiency Syndrome (AIDS) screening days two times a year, posting flyers, as well as advertising the event in the monthly newsletters.

8. Provide Basic Health Education, Including Health Promotion and Disease Prevention Education, to Urban Indians

Several examples of health education, including health promotion and disease prevention education, provided to urban AI/AN people by IHCIA-funded UIHP include:

- South Dakota Urban Indian Health (SDUIH) in Pierre, South Dakota, distributes Patient Wellness Handouts at the end of health care visits and also uses of the Patient Compact to help patients become more involved with self-managed care.
- Seattle Indian Health Board in Seattle, Washington, provides health promotion/disease prevention programs (e.g., diabetes management, tobacco prevention, immunizations, nutrition counseling, and breast and cervical cancer screening) to prevent costly medical procedures among its patient population. Clinical quality data in the form of health outcomes is often shared with consumers and the community by posting information in the clinic, at community events and in published reports.
- Every year, the UITCT hosts and participates in multiple internal health fairs and external community outreach events to distribute health promotion/disease prevention educational materials. Also, all patients that visit the UITCT receive ongoing publications related to health promotion and disease prevention. The waiting room is equipped with a 32-inch flat panel television provided by Accent Health that engages patients while they wait, providing health education through a wide range of healthy lifestyle topics – everything from diet and exercise to disease prevention and self-management.
- First Nations Community Healthsource (FNCH) in Albuquerque, New Mexico, partnered with other entities such as the University of New Mexico (UNM) Pathways Program and others to educate the community about FNCH's hours of operation and services.

9. Identify Gaps between Unmet Health Needs of Urban Indians and the Resources Available to Meet Such Needs

Unmet Health Needs

While some progress has been made, urban AI/AN populations face gaps between the three systemic needs listed in section 3 above (integrate behavioral health programs, improved infrastructure and capacity, and explore potential new sites), and existing health services resources.

Unmet health and social needs of urban AI/AN populations include access to prescription medicine, specialty care, and dental services. Adding or expanding dental and pharmacy services, and improving the quality of care through accreditation or establishment of patient-centered medical homes would narrow the gap of unmet health needs.

Integration of culturally sensitive behavioral health programs is vital to reducing the prevalence of lifestyle-related mortality and morbidity in urban AI/AN people. UIHP are integrating behavioral health programs, but health care providers need resources to expand efficient and effective integration practices. UIHP and former NIAAA Programs have recognized the need for more mental health and substance abuse counselors to adequately address the co-occurring disorders commonly exhibited in AI/AN people in need of substance abuse treatment.

UIHP also reported the need for more age- and gender-appropriate resources for substance abuse treatment; while male American Indians and Alaska Natives can encounter wait times for treatment admission up to 6 months, treatment options available for youth, women, and women with children can be even longer. Some of the best treatment programs for AI/AN youth, women, and women with children are administered by the 43 UIHP. These programs have culturally appropriate initiatives to reduce obesity, prevent diabetes and its complications, and reduce risk factors related to heart disease and cancer. Efforts to target behavioral or lifestyle changes offer the best hope for impacting the major health challenges of the urban AI/AN populations.

Changing demographics challenge the existing UIHP. To meet patient demands, UIHP need to hire more providers (preferably AI/AN health professionals) and increase clinic hours to meet patient needs. Clinic space needs to be expanded or modified to provide a broader range of services such as dental and pharmacy services. New satellite clinic locations are needed within the urban center to make services accessible to urban AI/AN people who migrated away from previous community centers.

The IHS and UIO will use the new IHS Policy for "Conferring with Urban Indian Organizations" (implemented on September 22, 2014) to collaborate and ensure that the health care needs of the urban American Indians and Alaska Natives are addressed. This could involve identifying an accurate level of funding need and developing a strategy to prioritize and secure resources to meet urban AI/AN health needs.

Resources Available to Meet the Needs of Current IHS-Funded UIHP

The existing UIHP and former NIAAA Programs may enhance their ability to meet unmet health needs through updated business models. UIHP health care providers may move more aggressively to develop more effective and efficient business models that address broader healthcare needs, described in sections 1 and 2 above, and improve potential for reimbursement of services. For example, with enhanced, cost-based reimbursement rates, such programs could maximize their billing opportunities as Federally Qualified Health Centers.

UIHP have taken advantage of opportunities to expand health coverage under the Patient Protection and Affordable Care Act (Public Law 111-148). The planned expansion of Medicaid estimated providing coverage for over 96,000 urban American Indians and Alaska Natives living at or below 138 percent FPL in the 33 UIHP and 2 Urban IHS Service Units. In 2012, the potential increase in primary care revenues was estimated at just under $85 million. In the 17 potential new sites, Medicaid expansion was estimated to

provide coverage to over 20,000 urban American Indians and Alaska Natives, translating to nearly $18 million of additional primary care Medicaid revenue. In addition, there are nearly 140,000 uninsured American Indians and Alaska Natives in 35 urban centers that currently receive IHS funding between 139 percent and 400 percent of the FPL who have the option to purchase subsidized insurance through the state and federal marketplace. Issues remain, however, because many states have not expanded Medicaid. Eleven UIHP and 11 potential new sites are located in federally facilitated or Partnership Marketplace states that have not adopted Medicaid expansion.

UIHP leverage IHS funding to expand resources. For every dollar invested by the IHS, 33 of the 43 UIHP generate an additional $1.84 from third-party coverage, patient self-pay, and other public or foundation fundraising. These funds help improve and expand services to urban AI/AN people, and continued efforts to improve collections may result in expanded services targeted at unmet health needs.

Resources Available to Meet Needs in Additional Sites – Exploring New Site Expansion

Program expansion across urban communities has occurred organically. Entrepreneurial efforts by UIHP have successfully expanded health services to urban AI/AN populations into other cities and locations, often financing these efforts with patient-generated revenue. This is a proven successful model for site expansion. Examples include Nebraska Urban Indian Health Coalition, Inc. in Lincoln, Nebraska, which now serves Omaha, Nebraska, and Sioux City, Iowa; and Native American Health Center in Oakland, California, which has expanded to provide services in San Francisco, Richmond, and six school-based sites in the Bay Area.

There are opportunities to increase access to health services within the existing cities, such as Los Angeles, which has the second largest urban AI/AN population in the United States, by increasing access points. This could be accomplished by funding satellite expansion with grantees, teaming with community health centers, or identifying other providers reaching the target population to form partnerships or collaborations.

Among the 17 potential new sites with no UIHP, contacts in 13 sites indicated there is no formally organized group actively seeking to establish UIHP. Only four sites have strong community organization, leadership, and local support, and these sites are actively developing health care services for urban AI/AN populations: Cleveland, Ohio; Fayetteville/Lumberton, North Carolina; Houston, Texas; and San Antonio, Texas.

Appendix 1 – Current UIHP: 33 UIHP, 2 Urban IHS Service Units, and 8 Former NIAAA Programs

33 UIHP: 25 U.S.C. §§ 1652-1653

Full Ambulatory (21)

American Indian Health and Family Services	Detroit, MI
American Indian Health and Services[1]	Santa Barbara, CA
Denver Indian Health and Family Services	Denver, CO
First Nations Community HealthSource[2]	Albuquerque, NM
Gerald L. Ignace Indian Health Center	Milwaukee, WI
Helena Indian Alliance	Helena, MT
Hunter Health Clinic[2]	Wichita, KS
Indian Health Board of Billings	Billings, MT
Indian Health Board of Minneapolis[2, 3]	Minneapolis, MN
Indian Health Center of Santa Clara Valley[2, 4]	San Jose, CA
NATIVE Project[5, 6]	Spokane, WA
Native American Community Health Center[2, 4]	Phoenix, AZ
Native American Health Center	Oakland, CA
Native Americans for Community Action	Flagstaff, AZ
Native American Rehabilitation Association of NW[2, 5]	Portland, OR
Nebraska Urban Indian Health Coalition[5]	Omaha, NE
Sacramento Native American Health Center[4]	Sacramento, CA
San Diego American Indian Health Center[6]	San Diego, CA
Seattle Indian Health Board[2, 4]	Seattle, WA
South Dakota Urban Indian Health[4]	Pierre, SD
Urban Inter-Tribal Center of Texas	Dallas, TX

[1] Accredited Patient Centered Medical Home (PCMH)
[2] Receives HRSA Community Health Center 330 Funding
[3] Accredited by The Joint Commission (TJC)
[4] Accredited by the Accreditation Association for Ambulatory Health Care (AAAHC)
[5] Accredited by Commission on Accreditation of Rehabilitation Facilities (CARF)
[6] Working towards AAAHC Accreditation

Appendix 1 – Current UIHP: 33 UIHP, 2 Urban IHS Service Units, and 8 Former NIAAA Programs – continued

33 UIHP: 25 U.S.C. §§ 1652-1653 – continued

Limited Ambulatory (6)

American Indian Health Services of Chicago	Chicago, IL
Indian Family Health Clinic	Great Falls, MT
Nevada Urban Indians	Reno, NV
North American Indian Alliance	Butte, MT
United American Indian Involvement	Los Angeles, CA
Urban Indian Center of Salt Lake	Salt Lake City, UT

Outreach and Referral (6)

American Indian Community House	New York, NY
Bakersfield American Indian Health Project	Bakersfield, CA
Fresno American Indian Health Project	Fresno, CA
Missoula Indian Center	Missoula, MT
Native American Lifelines of Baltimore and Boston	Baltimore, MD
Tucson Indian Center	Tucson, AZ

2 Urban IHS Service Units: 25 U.S.C. § 1660b

Indian Health Care Resource Center of Tulsa[4]	Tulsa, OK
Oklahoma City Indian Clinic[4]	Oklahoma City, OK

8 Former NIAAA Programs: 25 U.S.C. §1661c

Ain Dah Ing	Shell Lake, WI
American Indian Council on Alcoholism	Milwaukee, WI
Friendship House Association of American Indians[5]	San Francisco, CA
Juel Fairbanks Halfway House	St. Paul, MN
Kansas City Indian Center	Kansas City, MO
Minnesota Indian Primary Residential Treatment Center	Sawyer, MN
Native Directions[5]	Manteca, CA
Thunderbird/Wren Halfway House	Duluth, MN

[4] Accredited by the Accreditation Association for Ambulatory Health Care (AAAHC)
[5] Accredited by Commission on Accreditation of Rehabilitation Facilities (CARF)

Appendix 2 – Potential New Sites, Metropolitan Statistical Areas with Highest AI/AN Populations not served by IHS, Tribal, or Urban Indian Health Program (I/T/U)

Atlanta-Sandy Springs-Marietta, GA
Austin-Round Rock-San Marcos, TX
Cincinnati-Middletown, OH
Cleveland-Elyria-Mentor, OH[1]
Colorado Springs, CO
Fayetteville-Lumberton, NC[1]
Houston-Sugar Land-Baytown, TX[1]
Memphis, TN
Nashville-Davidson-Murfreesboro-Franklin, TN
Orlando-Kissimmee-Sanford, FL
Oxnard-Thousand Oaks-Ventura, CA
Philadelphia-Camden-Wilmington, PA-NJ-DE
Richmond, VA
San Antonio-New Braunfels, TX[1]
St. Louis, MO
Virginia Beach-Norfolk-Newport News, VA
Washington-Arlington-Alexandria, DC-VA-MD

[1] Site demonstrates strong community leadership, local support, and active efforts to develop health care program for urban American Indians and Alaska Natives.