INDIAN HEALTH SERVICE
OFFICE OF URBAN INDIAN HEALTH PROGRAMS
STRATEGIC PLAN

2017-2021

This Strategic Plan was drafted by the Indian Health Service Office of Urban Indian Health Programs with the assistance of the National Academy of Public Administration

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

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Acronyms and Abbreviations

ACA	Patient Protection and Affordable Care Act
Academy	National Academy of Public Administration
APP	Annual Performance Plan
AI/AN	American Indian/Alaska Native
CCUIH	California Consortium for Urban Indian Health
CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IDCS	Integrated Data Collection System
IHCIA	Indian Health Care Improvement Act
IHM	Indian Health Manual
IHS	Indian Health Service
FMAP	Federal Medical Assistance Percentage
GPRA	Government Performance and Results Act
GPRAMA	GPRA Modernization Act
MSA	Metropolitan Statistical Area
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NCUIH	National Council of Urban Indian Health
NDW	National Data Warehouse
NIHB	National Indian Health Board
O&R	Outreach and Referral
OMB	Office of Management and Budget
OUIHP	Office of Urban Indian Health Programs
RPMS	Resource and Patient Management System
SAMHSA	Substance Abuse and Mental Health Services Administration
TANF	Temporary Assistance for Needy Families
UDS	Uniform Data System
UIHI	Urban Indian Health Institute
UIO	Urban Indian Organization
VA	Department of Veterans Affairs

Introduction: Overview of the Indian Health Service, the Office of Urban Indian Health Programs, Urban Indians, and Urban Indian Health

Pursuant to the Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242, 2568 (2015), the Indian Health Service (IHS) has developed this strategic plan for the Office of Urban Indian Health Programs (OUIHP). The strategic plan was developed by contracting with the National Academy of Public Administration (Academy) and conferring with Urban Indians.

Overview of the IHS and OUIHP

The Indian Health Service (IHS) is the principal Federal health care provider and health advocate for American Indian and Alaska Native (AI/AN) people, and its Mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. The provision of health services to members of federally recognized Tribes grew out of the special Government-to-Government relationship between the Federal Government and Indian Tribes. This relationship is recognized in the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations, and executive orders. The IHS provides a comprehensive health service delivery system that includes three mechanisms:

(a) the direct provision of health care services to American Indians and Alaska Natives by the IHS;

(b) the provision of health care services to AI/AN people through contracts and compacts with Indian Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act; and

(c) the award of contract and grant funding to Urban Indian Organizations (UIOs) that are providing services to American Indians and Alaska Natives living in urban areas, or "Urban Indians."[1] Building on authority in the Snyder Act (25 U.S.C. § 13), the Indian Health Care Improvement Act (IHCIA) explicitly authorizes the last mechanism.

The IHS, on behalf of the Secretary of Health and Human Services (HHS), 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."[2] Non-profit UIOs, with Urban Indian-controlled boards, provide primary medical care and public health case management outreach and referral services in urban areas for Urban Indian beneficiaries. The 2010 United States Census reported that 78 percent of the 5.2 million American Indians and Alaska Natives reside in

[1] The term "Urban Indians" is being used because it 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 Urban Indian organizations.

[2] 25 U.S.C. § 1602(1) (emphasis added).

urban areas.[3] The total number of American Indians and Alaska Natives in the IHS service population is about 2.2 million. Historically however, less than 1 percent of the funding provided by the Federal government for health care services for American Indians and Alaska Natives goes to grants and contracts for services to Urban Indians.

The IHCIA also directed the establishment of an office within the IHS to provide central oversight of the programs and services authorized by the IHCIA and to carry out the IHCIA provisions relating to Urban Indian health. The IHS established the OUIHP at IHS Headquarters to carry out these duties. The OUIHP, working with the IHS Area Offices and other Headquarters program offices, oversees the program under which the IHS currently awards contracts and grants to 42 UIOs that provide health care services to Urban Indians.

While the UIOs are diverse in geographic area, size, services offered, and funding strategy, they share a commitment to providing culturally competent health care to a population that is impacted by socioeconomic disparities, including lower incomes, higher unemployment, and lower levels of educational attainment. The Urban Indian population experiences greater rates of substance abuse, chronic disease, infant mortality, HIV mortality, and suicide as compared to all races from the same Metropolitan Statistical Areas (MSAs). UIOs "play an important role in the safety net and attract a disproportionate share of those without alternative resources."[4]

Culturally competent care is particularly important in an urban environment where Indian culture may be absent in the daily lives of many Urban Indians. The UIOs, then, provide an important connection to Indian culture. This cultural sensitivity may encourage Urban Indians to seek needed health care they would otherwise avoid and to continue treatment when needed because it is provided in an environment that makes them feel accepted, appreciated, and comfortable. Many illnesses that are common in the Urban Indian population, such as diabetes, require continual monitoring and care for successful treatment. Care in a trusted and supportive environment can be critically important to positive outcomes.

Performance of the mission regarding Urban Indian health significantly depends on the efforts of the OUIHP working in unison with UIOs on a wide range of issues. These include ensuring that the resources are available to fund UIOs in their efforts to provide health care services to Urban Indians and that the IHS Area Offices and Service Units engage the OUIHP and UIOs on matters that impact Urban Indians. The ability of UIOs to deliver health care

[3] U.S. Census Bureau, 2010 Census Brief: The American Indian and Alaska Native Population: 2010, at 12-13 (Jan. 2012) (hereinafter 2010 Census Brief), *available at* http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf. The Census count is based on self-reporting and likely includes Indians who are members of federally recognized Tribes, those who are members of state recognized Tribes, and others who identify themselves as Indians.

[4] Indian Health Service, Report to Congress: New Needs Assessment of the Urban Indian Health Program and the Communities it Services at 10 (Mar. 31, 2016) (hereinafter New Needs Assessment), *available at* https://www.ihs.gov/urban/includes/themes/newihstheme/display_objects/documents/ReportToCongressUrbanNeedsAssessment.pdf.

services also relies on key partnerships with other Federal agencies, as well as states, local governments, insurers, and foundations that fund UIOs; non-profit organizations that provide advocacy, timely information, technical assistance, and training; and Tribes, which in some cases, operate health care programs that may partner with or receive referrals from UIOs.

Some UIOs provide health care for non-Indian individuals using non-IHS funds,[5] and they may also receive funds from other Federal agencies, including, for example, the Health Resources and Services Administration (HRSA). Obtaining funds from such other resources may enable the UIOs to expand their capacity, increase other revenue streams, and provide a broader array of services to Urban Indians. All IHS funds received by Urban Indian health programs must be used to treat Urban Indians.

Background on Urban Indians and Urban Indian Health

Historically, most AI/AN individuals resided on reservations in remote rural areas. Census Bureau data shows that only 8 percent of the AI/AN population lived in cities in the 1940s.[6] In the 1950s and 1960s, under the Federal government's Termination policy and Indian Relocation program, many AI/AN individuals and families were relocated to urban centers with the promise of job training and placement, temporary housing, health care, and other types of assistance to support them as they adjusted to the urban environment. This program, together with poor living conditions on the reservations and the attraction of greater opportunities in cities, led to a dramatic shift in the AI/AN population to urban areas. According to the 1970 Census, 38 percent of AI/AN people lived in urban areas. Significant demographic shifts occurred since then, and according to the 2010 Census, 78 percent of the AI/AN population in the U.S. resided in urban areas.[7]

Advocacy efforts in the late 1960s drew public attention to the poor health status of the Urban Indian population and their unique cultural and health needs.[8] In the early 1970s, Congress provided funding for an assessment of Urban Indian health needs in Minneapolis and for the establishment of pilot programs to address Urban Indian health in target cities of the Relocation program, such as Tulsa, Oklahoma; Seattle, Washington; and San Francisco, California. These efforts aimed to identify access barriers to health services for Urban Indians and the value of culturally appropriate health services. Information collected from the study and pilot programs raised awareness of the unmet health needs of Urban Indians.[9]

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[5] By law, IHS funds can only be used to pay for services provided to Urban Indians who are eligible for such services under the IHCIA.

[6] Williams, Timothy, *Quietly, Indians Reshape Cities and Reservations*, New York Times (Apr. 13, 2013), *available at* http://www.nytimes.com/2013/04/14/us/as-american-indians-move-to-cities-old-and-new-challenges-follow.html?_r=0.

[7] 2010 Census Brief, at 12-13.

[8] Indian Health Service, Indian Health Manual (IHM), Part 3, Chapter 19, *Urban Indian Health Program* § 3-19.1(B), *available at* https://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p3c19.

[9] Ibid.

In 1976, Congress passed the IHCIA. Since its initial passage, the IHCIA was amended several times and, in 2010, was permanently reauthorized as part of the Patient Protection and Affordable Care Act (ACA).[10] The IHCIA, as amended, removes limits on where UIOs can expand programs, which were previously limited to the urban center[11] where the UIO was located, provides access to goods and services available to Federal agencies, allows IHS-funded UIOs to access the Federal employee life and health insurance benefits for their employees, and authorizes the HHS Secretary to donate excess or surplus property to UIOs and to allow UIOs to use HHS facilities.[12]

The IHCIA, as amended, also requires that the IHS confer with UIOs to the maximum extent practicable.[13] Confer means engagement in an open and free exchange of information and opinions leading to mutual understanding and comprehension and emphasizing trust, respect, and shared responsibility.[14] The IHS, including the OUIHP, has utilized the confer process to seek input from UIOs on Urban Indian health matters and published a confer policy in the *Indian Health Manual* (IHM).[15]

As of January 2017, the IHS awards grants and contracts to 42 UIOs. A complete listing is in Appendix C. Thirty-three of the UIOs receive awards under 25 U.S.C. §§ 1652-1653; these UIOs manage three types of programs defined by service model and capacity, which includes outreach and referral, limited ambulatory, and full ambulatory, as follows:

- Outreach and Referral (O&R): Six IHS-funded UIOs are outreach and referral programs, which do not offer direct medical/dental services to patients, but coordinate access to health care services provided by outside providers. Some O&R programs provide mental health, substance abuse, health education, and traditional medicine services.
- Limited Ambulatory care: IHS funds six limited ambulatory UIOs. These programs provide direct medical services for less than 40 hours per week.[16] Limited ambulatory programs do not have onsite dental care, pharmacies, or radiology services.
- Full Ambulatory care: 21 full ambulatory care UIOs serve nearly 90 percent of total Urban Indians who get care under grants and contracts awarded by the IHS. These

[10] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10221, 124 Stat. 119, 935 (2010), codified at 25 U.S.C. § 1601 *et seq*.
[11] The term "Urban center" is defined in the IHCIA at 25 U.S.C. § 1603 (27) as "any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under subchapter IV, as determined by the Secretary." The urban centers selected for current awards were determined by IHS based on an assessment of need and based upon the factors described in the applicable regulation, located at 42 C.F.R. § 136.351.
[12] 25 U.S.C. §§ 1647b, 1652, 1660g.
[13] 25 U.S.C. § 1660d(b).
[14] 25 U.S.C. § 1660d(a).
[15] IHM, Part 5, Chapter 26, *Conferring with Urban Indian Organizations*, *available at* https://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p5c26.
[16] Ibid.

> UIOs provide direct medical services for 40 hours or more per week, offer comprehensive services, and in some cases have their own pharmacies, labs, radiology, and dental care.[17]

Seven additional UIOs receive awards from the IHS pursuant to 25 U.S.C. § 1660c to manage residential alcohol and addiction treatment programs that were formerly funded by the National Institute for Alcohol Abuse and Alcoholism (NIAAA). Finally, two Urban IHS service units in the state of Oklahoma are "hybrid" programs that are awarded and funded pursuant to 25 U.S.C. § 1660b.

The IHS's fiscal year (FY) 2017 budget for Urban Indian health, which funded the 33 UIOs that received awards under 25 U.S.C. §§ 1652-1653, was $47.6 million. The two hybrid UIOs in Oklahoma that are also considered IHS service units are among the programs funded in the Hospitals and Health Clinics line item of the IHS budget. The seven former NIAAA awardees are among the programs funded in the Alcohol and Substance Abuse line item of the IHS budget.

As discussed previously, many UIOs significantly leverage IHS funding with third-party coverage, patient self-pay, partnerships with Tribes and Tribal consortia, and other public funding, or foundation fundraising. Some UIOs also receive HRSA funding through the Health Center Program, which requires that they serve a diverse clientele, including non-Indians.

[17] Department of Health and Human Services, Indian Health Service, Summary of Performance Based on 2013 Uniform Data System (UDS) Data, at 4 (Calendar Year 2013), Prepared by John Snow, Inc.

Methodology and Stakeholder Engagement

To inform the development of the Office of Urban Indian Health Programs Strategic Plan, the IHS contracted with the Academy. The OUIHP guided plan development, while the Academy collected and organized relevant information and data to assist in plan development. The OUIHP emphasized that goals and strategies should be developed in collaboration with UIOs and not be top-down, one-size-fits-all. The OUIHP also emphasized the importance of respect for the role of UIOs in the framework of Indian health care that includes IHS, Tribal, and Urban (I/T/U) programs, their need for flexibility to meet local community health needs, and their status as nonprofit entities that operate in a business-like manner. Lastly, the OUIHP stressed an appreciation for UIO innovation and creative approaches for operating in a complex and demanding environment.

A Panel of Academy Fellows was formed to guide the project, which brought expertise in health care, including public health, strategic planning, and general government management. An additional Panel member is a practicing physician with extensive background in Indian health care issues and is an enrolled member of an Indian Tribe.[18] The Panel guided the Academy's professional staff in planning and executing a customized framework for development of the OUIHP's strategic plan over the eight-month engagement with the IHS.[19]

From April through October 2016, the Academy project team conducted extensive outreach and conferred with UIOs. Interviews were conducted with the following: Executive Directors or Chief Executive Officers of most IHS-funded UIOs; officials within IHS (including Area urban coordinators); congressional staff; the National Council of Urban Indian Health (NCUIH); U.S. Department of Veterans Affairs (VA); Substance Abuse and Mental Health Services Administration (SAMHSA); HRSA; Centers for Medicare & Medicaid Services (CMS); California Consortium for Urban Indian Health (CCUIH); National Institutes of Health (NIH); and the National Indian Health Board (NIHB). In-person confer sessions were held in San Diego, California, and Seattle, Washington; one confer session was held via teleconference; and there were three informational teleconferences. The Academy's project team also conducted three site visits at UIOs. Letters were sent to UIOs that do not currently receive funding from the IHS, inviting input on the plan, a *Federal Register* Notice was issued to solicit public comment, and responses were sent back to the entities that provided input. The Academy created a website that was operational throughout the engagement and posted information about the project, including the strategic planning framework, stakeholder engagement plan, updates about the project, and e-mail and telephone numbers to invite

[18] National Academy of Public Administration, Work in Progress, Indian Health Service, Office of Urban Indian Health Programs, Strategic Planning for Urban Indian Health Programs, *available at* http://www.napawash.org/images/UIHPWorkinProgressFinal0605.pdf.

[19] National Academy of Public Administration, Strategic Planning Framework for Academy Project with the Office of Urban Indian Health Programs, *available at* http://www.napawash.org/images/Strategic_planning_framework_Final.pdf.

stakeholder input.[20] Appendix B lists the individuals and organizations that the Academy included in stakeholder outreach.

Confer sessions and outreach efforts identified an array of important goals and objectives for Urban Indian health. In discussions with UIOs, they also identified challenges constraining their ability to effectively deliver, improve, or expand services. The strategic plan includes objectives and strategies to address the goals that: (a) stakeholders commonly identified as most important to the performance of the IHS's mission with regard to Urban Indian health; and (b) the IHS through the OUIHP, has the authority and resources to address, at least in part, within a 5-year period. For informational purposes, Appendix A provides the Academy's review of the major challenges it identified through the planning process, including those not included in the plan.

[20] National Academy of Public Administration, Indian Health Service, Office of Urban Indian Health Programs, Strategic Planning for Urban Indian Health Programs, *available at* http://www.napawash.org/programs/indian-health-service-resources.html.

Strategic Plan
2017-2021

Mission: Improve access to high quality, culturally competent health services for Urban Indians.[21] The Indian Health Service (IHS), Office of Urban Indian Health Programs (OUIHP) carries out this mission in support of the broader IHS mission: "to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level."

Vision: Together with our valued Urban Indian Organization (UIO) partners, the IHS strives to develop health care solutions that fit the diverse circumstances of Urban Indians and their communities, while ensuring accountability. The IHS seeks to support currently IHS-funded UIOs in their efforts to improve capacity to serve Urban Indians and to lay the groundwork to serve Urban Indians in other communities.[22]

Guiding Principles:

- Unity of purpose among the IHS and UIOs to actively improve access to culturally competent, quality care for Urban Indians.
- A strong confer process to ensure high levels of collaboration and communication.
- Meaningful and effective partnerships with national organizations, other Federal agencies, states, health care providers, Tribes, insurers, and non-profit organizations to leverage Federal funds for Urban Indians.
- A mutual understanding of the importance of modernizing and reforming to improve health care programs and of integrating behavioral health with primary care.
- Measurable outcomes through results-driven approaches and data utilization to establish transparency and accountability with regard to the health care services provided by UIOs to Urban Indians.
- Activities conducted in a manner that is fair and inclusive.

Goals and Objectives: Performance of the mission depends on the coordinated and committed efforts of the IHS and UIOs, particularly UIOs receiving IHS funding. This understanding of mission performance is reflected in the two overarching goals of this strategic plan.

Goal One is to support currently IHS-funded UIOs in their efforts to address the key challenges they identified for improving and expanding their capacity to provide access to quality, culturally competent health services for Urban Indians.

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[21] The term "Urban Indian" is defined in the IHCIA. 25 U.S.C. § 1603(28); s*ee also* § 1603(13) (identifying the four criteria referenced in paragraph 28), (27) (defining Urban center).

[22] Serving Urban Indians in other communities is subject to the Secretary's designation of which urban centers warrant assistance, 25 U.S.C. § 1603(27), as well as the availability of appropriations and the Secretary's allocation of available appropriations.

Goal Two is to build the administrative capacity of the OUIHP, for example, to establish performance-based oversight within the IHS, as well as for the IHS-funded UIOs and to transition administration of the former National Institute on Alcohol Abuse and Alcoholism (NIAAA) awards.

Under these two overarching goals, the strategic plan encompasses a range of actions intended to advance seven strategic objectives. Actions may be undertaken directly by the OUIHP and/or in partnership with others, including IHS Headquarters senior leadership, IHS Area Offices and service units, UIOs, other organizations that receive IHS funding, other Federal agencies, Tribes, states, and others. This plan assumes the involvement of the awardee of the Urban Indian Education and Research Organization Cooperative Agreement (hereinafter "Cooperative Agreement").

GOAL 1: SUPPORT CURRENTLY IHS-FUNDED UIOS IN EFFORTS TO ADDRESS THE KEY CHALLENGES THEY IDENTIFIED FOR IMPROVING AND EXPANDING ACCESS TO CARE FOR URBAN INDIANS

Objective 1.1: Support UIOs' efforts to diversify funding and increase third-party reimbursements to ensure UIO sustainability.

Strategy: Provide technical assistance to Congress regarding extension of 100 percent Federal Medical Assistance Percentage (FMAP) to UIOs.

Strategy: Provide technical assistance to UIOs seeking funding/reimbursements, including assistance with:

- Assessing the feasibility of entering into care coordination agreements in order for 100 percent FMAP to apply to services provided by UIOs, in accordance with CMS guidelines.
- Demonstrating eligibility for reimbursement from funders and insurers;
- Negotiating agreements with the Department of Veterans Affairs (VA) to enable billing the VA for eligible care delivered to veterans;
- Identifying grant opportunities and resources to support grant writing; and
- Navigating the accreditation process.

Measure: Increased number of UIO reimbursement agreements with the VA; Increased number of accredited UIOs; Increased number of grant applications submitted by UIOs.

Objective 1.2: Support UIO efforts to attract and retain skilled, culturally competent health services providers.

Strategy: Pursue opportunities to facilitate the use of both the IHS and the HRSA National Health Service Corps scholarship and loan repayment programs to meet the unique recruitment needs of UIOs.

Strategy: Support for increased capacity for recruitment, credentialing, and privileging of licensed professionals.

Measure: Increased number of UIO service providers participating in the IHS and HRSA recruitment programs; increased UIO capacity to recruit, credential, and privilege licensed providers.

Objective 1.3: Increase awareness and actively seek support for the health care needs of Urban Indians.

Strategy: Continue working with other parts of IHS and other HHS agencies on the opportunities for UIOs to advance health care goals and initiatives and work with these agencies to facilitate UIO involvement in these goals and initiatives, as authorized, including access to funding and other resources.

Strategy: Provide UIOs with the knowledge and tools needed to participate effectively in the IHS confer processes to the maximum extent practicable.

Strategy: Support UIO efforts to build partnerships with Tribes.

- Continue efforts to improve the collection of data on the Tribal affiliation of patients served by UIOs, to help communicate the role of UIOs in serving Tribal communities, and to facilitate productive working relationships with Tribes.
- Improve the understanding and awareness by Tribal representatives of the different funding resources used by UIOs.

Strategy: Establish an ongoing process to identify and prioritize challenges that limit access to health care by Urban Indians and develop strategies to overcome or mitigate challenges.

- Support efforts to develop and interpret community health needs assessments.
- Provide guidance and support to UIOs to identify and access local, state, and federal resources available to UIOs and to Urban Indians to break down barriers to access to care.

Measure: Increase in collaboration within IHS and HHS to advance UIO health care goals and initiatives; Increased number of UIO-Tribal partnerships.

Objective 1.4: Strengthen the capacity of UIOs to work as a community to improve knowledge sharing.

Strategy: Assess options for strengthening networking among UIOs, such as facilitating the development of online communities of interest, to help meet technical assistance needs (e.g., allowing new UIO staff to tap the knowledge of more experienced staff in the community).

Measure: Increase the number of OUIHP technical resources available for UIOs; Increased UIO peer-to-peer assistance.

GOAL 2: INCREASE OUIHP'S ADMINISTRATIVE CAPACITY

Objective 2.1: Build capacity for the OUIHP to transfer administration of the former NIAAA awards.

Strategy: Develop a plan for the transition of administration of the former NIAAA awards.

Strategy: Take steps to integrate UIOs receiving former NIAAA awards into OUIHP policies, procedures, funding allocations, and the program monitoring and assessment system (discussed under Objective 2.2 below) and, as appropriate, adapt elements of the system (e.g., reporting requirements and annual on-site program reviews) to reflect the distinctive features of the former NIAAA awardees.

Measure: Approval by IHS Director of plan for transition of former NIAAA programs into the OUIHP; Accomplish changes in administration (process and policy) of the OUIHP to accommodate former NIAAA programs.

Objective 2.2: Lay the groundwork for performance-based oversight, both within the IHS and for the IHS-funded UIOs.

Strategy: Improve the quality and relevance of the data collected regarding health care services and program outcomes provided to Urban Indians by IHS-funded UIOs and the needs for improving access to health care for Urban Indians, including the Uniform Data System (UDS), Integrated Data Collection System (IDCS), and Government Performance and Results Act (GPRA) and GRPA Modernization Act (GPRAMA):

- Automate the UDS and IDCS reporting process and provide related training to UIOs.
- Review UDS and IDCS reporting requirements for possible changes needed to reflect distinctive services provided by UIOs, including the former NIAAA awardees.
- Take steps to help UIOs use UDS and IDCS data to improve performance (to replace efforts formerly conducted under a contract).

Strategy: Improve the consistency, usefulness, and efficiency of onsite program reviews:

- Explore options to help improve consistent, high quality program reviews and timely corrective actions, such as the feasibility of centralizing responsibility for onsite program reviews in OUIHP.
- Examine onsite program review requirements and processes for opportunities to ensure they reflect the circumstances of different UIO types, including former NIAAA awardees.
- Examine the program review process to identify opportunities to reduce the burden on UIOs (e.g., automation of paper processes).

Strategy: Standardize contract requirements for UIOs nationwide to enable monitoring program performance against a common baseline.

Strategy: Improve the transparency of the budget process and the transparency and accountability for funds allocated to Urban Indian health.

- Explore options for incorporating a budget-specific conferring session in the IHS budget process.
- Increase transparency for funds allocated in the IHS budget to Urban Indian health, such as identifying amounts for OUIHP and IHS Area Office administration, for technical assistance and information technology support, and for the contracts, grants, and cooperative agreement(s) awarded.
- Develop a standard methodology for allocating changes in base program funding levels, whether increases or decreases within the Urban Indian health program.

Measure: Increase in reporting automation; increase training events; development of a formula to determine distribution of funding.

Objective 2.3: Leverage OUIHP staff capacity by maximizing partnerships and resources. Ensure the IHS has available staff to perform the roles of OUIHP and support the IHS mission regarding Urban Indian health.

Strategy: Leverage capabilities of the IHS, other Federal agencies, the Cooperative Agreement awardee, and the Urban Indian community.

- Work collaboratively with other IHS offices (e.g., the Loan Repayment Program) and HHS agencies (e.g., SAMHSA, HRSA, etc.) where missions, goals, and authorities overlap.
- Actively manage the Cooperative Agreement to supplement OUIHP staff capacity in specified task areas, including public policy; research and data; training and technical assistance; education, public relations, and marketing.

Measure: Increase in OUIHP collaboration with other IHS offices and HHS agencies; increase training of OUIHP staff.

Implementation of the strategic plan is subject to the availability of resources and applicable Federal law, including the IHCIA. Nothing in the strategic plan creates a right of action against the Federal government, including HHS and the IHS, for failure to implement any portion of the strategic plan. Finally, implementation of the strategic plan is part of the overall mission of the IHS to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level, which aligns with the HHS Strategic Plan.

Appendix A: Challenges Identified Through Stakeholder Outreach

Note: Appendix A and the challenges identified were prepared by the National Academy of Public Administration's (Academy) based on the Academy's interaction with Urban Indian Organizations (UIOs) and other stakeholders interested in the development of the Office of Urban Indian Health Program's (OUIHP) strategic plan. The information is provided by the Indian Health Service (IHS) as an appendix to the OUIHP strategic plan for informational purposes and should not be attributed to the IHS.

An important focus for the planning effort was to identify challenges faced by the OUIHP and UIOs in their efforts to improve and expand access to quality health services for Urban Indians. To that end, the Academy conducted extensive outreach with UIOs and other stakeholders. During that process, UIOs and others identified a set of challenges that they face, which are summarized below. Not all aspects of these challenges are addressed by the strategic plan and, at least in some instances, may be beyond the IHS's ability or authority to address. However, to the extent appropriate and feasible, these challenges translated into goals and strategies intended to facilitate resolution of challenges. At the end of each section, the locations within the strategic plan of related strategies are noted.

Awareness, Recognition and Support: A key feature of culturally competent health care for Urban Indians is the integration of behavioral and mental health, an area of emerging emphasis throughout the health care community. UIO Executive Directors and Chief Executive Officers believe that the IHS has provided integrated health care since its inception and should be a leader and educator for other agencies as they begin to adopt this model of care. Program performance metrics used to inform external stakeholders about the results of IHS programs and reporting systems should appropriately document this model of care.

UIOs are working within their states and local communities to advocate for increased understanding and support for their programs. Efforts undertaken by the OUIHP and the National Council for Urban Indian Health (NCUIH) to formulate policy options and assist UIOs to advance opportunities within allowable processes directly supporting expansion of access to health care for Urban Indians.

A significant role for the OUIHP is education about the role of the UIOs and improving the integration of Urban Indian considerations in IHS policies and procedures and across the Department of Health and Human Services (HHS). An important strategy for increasing awareness and support for the Urban Indian health is the increased use of the confer process. As advocates for Urban Indian health care, UIOs believe this process can expand their involvement and will inform and educate states, local governments, Tribes, and others.

The strategic plan identifies opportunities for ongoing work by the OUIHP to educate and inform about Urban Indian health and to identify challenges that limit access to health care. There are also challenges related to implementation of new authorities under the 2010 IHCIA reauthorization, including facilities renovation, the requirement to confer with UIOs, expanded authority for UIOs regarding behavioral health, multi-drug abuse treatment, and

infectious and communicable disease services, community health representatives, and health information technology. (See Goal 1, Objective 1.1, 1.3.)

Resource and Patient Management System (RPMS): RPMS is the IHS information technology system used to gather, analyze, manage, and report on administrative and clinical health care information. The IHS describes RPMS as the "foundation of the Indian health information technology support system."[23] UIOs have expressed concerns related to the efficiency and functionality of RPMS, indicating that it is difficult for them to use for third-party billing and maintaining electronic health records. For these reasons, some UIOs have opted to use commercial systems instead of RPMS. Data reported by UIOs that use commercial systems is not verifiable and this has been a problem for reporting performance results.

The IHS is implementing a solution to allow for the collection of performance data from RPMS and commercial systems and is collecting this information in its consolidated National Data Warehouse (NDW). The NDW is intended to allow the IHS to collect, store, and analyze data "regardless of the platform or application." As a result, the NDW allows data from RPMS and non-RPMS sources to accurately and effectively report on integrated data.[24] UIOs have a continuous demand for health information technology training and technical assistance relating to the use of RPMS and other reporting systems. Related training and technical assistance are services provided by IHS Area offices.

Outreach and Referral UIO programs indicate that they are not able to report their activities in a manner that allows their performance to be captured and reported. These stakeholders expressed concern that certain measures, as currently used, do not accurately reflect performance based on the type(s) of services being provided. The OUIHP has taken steps to address this challenge regarding program data reporting (i.e., Uniform Data System) and has developed a short- and long-term strategy that will enable the automated collection of information from UIOs (including those that use commercial systems) and a methodology for national and Area level reporting.[25] (See Goal 2, Objective 2.2.)

Coordination: Many UIOs receive funds from multiple Federal, state, and local agencies. Some primary care sites are Community Health Centers funded by HRSA, at least one UIO receives grant funds from the SAMSHA for alcohol and drug addiction start-up, and outreach and referral UIOs receive funding from HHS's Temporary Assistance for Needy Families (TANF) program. For the UIOs that receive funds from multiple Federal entities, they indicated that there are different application, reporting, and site-review requirements, imposing a significant workload and administrative burden on the UIOs that have small staffs. Receipt of funds from multiple agencies means reporting of financial and patient care information via multiple reporting systems with differing requirements. UIOs encouraged the Federal program administrators to work together to better align these different requirements. (See Goal 1, Objective 1.3, and Goal 2, Objective 2.3.)

[23] Indian Health Service, Resource and Patient Management System (RPMS), https://www.ihs.gov/RPMS/.
[24] Indian Health Service, National Data Warehouse, https://www.ihs.gov/ndw/.
[25] Indian Health Service, National Data Warehouse, https://www.ihs.gov/ndw/.

Eligibility: UIOs report that they sometimes have difficulty getting benefits for their clients from other Federal agencies because of a lack of familiarity with IHS programs or the eligibility of Urban Indians. Interaction with the Department of Veterans Affairs (VA) concerning care for individual Urban Indian patients was specifically noted, as was admission to the VA Choice program. UIOs also indicated that some Federal grant programs may not be available to them because of the lack of clear direction on whether Urban Indians, in addition to Tribes and Tribal organizations, are included in the program authority. UIOs also report difficulties obtaining benefits for patients from private insurers because they are unfamiliar with Urban Indian health programs. The UIOs report mixed success getting these issues resolved. (See Goal 1, Objective 1.1.)

Recruitment and Retention: UIOs explained that they compete with multiple other Tribal, commercial, and private entities for medical and administrative staff and are disadvantaged because they do not have the resources to offer top salaries, and sometimes because their facilities lack the equipment, location, and number of staff that would make them more attractive employers. UIOs also report practicing a preference for hiring Indians to ensure culturally competent care and are competing for a small pool of trained medical professionals who are American Indians and Alaska Natives. UIO Executive Directors and Executive Officers indicated that much of their medical staff remain in their jobs because of a strong personal commitment to serving the Urban Indian community, but that it remains very difficult to retain staff who have multiple opportunities that may afford higher compensation and better working conditions. Recruitment and retention is routinely identified as a challenge.

IHS programs that offer student loan repayment and scholarships to providers serving at UIOs are a positive aid to recruiting and retaining medical staff. Yet, UIOs believe that some of the programs have eligibility requirements and extensive application processes that sometimes limit the ability of providers working at UIOs to utilize them. For example, they have stated that no such programs exist to address the challenge of attracting and retaining administrative staff that perform many of the tasks relating to eligibility determinations and third-party billing. (See Goal 1, Objective 1.2.)

Finally, UIOs indicate that recruitment and retention of board members is sometimes problematic, because these are volunteer positions that require time and commitment. Experience as a member of a board and training are significant factors in maximizing board functionality and the members may not have the time or opportunity for adequate training. This is an area for greater NCUIH engagement.

Administrative Capacity: UIOs expressed the concern that effective performance within the IHS is challenged by variability in the levels of communication and coordination among the IHS Area offices that provide technical assistance and support to UIOs. IHS Area office urban coordinators are tasked with providing technical assistance, support and oversight of contracts to UIOs and perform these functions as one component of a diverse set of responsibilities. UIOs have explained that, understandably, in this dynamic environment there is inconsistency in the administration of contracts and in the manner in which site reviews are conducted. For example, UIOs expressed concern that site review results are not

always shared with the UIOs in a timely fashion, which delays their ability to take corrective action based on the findings from the site visits. (See Goal 2, Objective 2.2.)

Transparency of Funding Allocations: UIOs receive funding from the IHS through contracts and grants. Historically, the annual budget justification materials presented to Congress present a summary of the allocations by IHS Area office, rather than by UIO. UIOs indicated that an important component of their ability to communicate and educate about Urban Indian health includes communication of levels and sources of funds to support Urban Indian health. They believe that a presentation in the annual budget of amounts allocated to individual UIOs could further this aspect of educating others and help them in their efforts to leverage resources and expand access for Urban Indian health care. (See Goal 2, Objective 2.2.)

Diversify Funding and Increase Third-Party Billing: A common theme throughout the interviews and confer sessions was the potential for UIOs to improve access to health care services with increased funding. For example, there is a need for increased funding for program expansion to new urban centers. Many UIOs indicated that they leverage funding they receive from IHS through third-party billing, grants from other Federal, state, and local entities and foundations, and a myriad combination of other sources. Tribal leadership consistently demonstrates support for increased federal funding levels for Urban Indian health programs to serve their Tribal members who reside away from their Tribal communities. UIOs often provide the only affordable, culturally competent health care services available in these urban areas. (See Goal 1, Objective 1.1.)

Facilities: UIOs explained that their ability to improve access to health care for Urban Indians relies, in part, on having adequately sized and equipped facilities. Some UIOs have outgrown their space and lack the resources to expand to meet the demand for services, while some have facilities in need of updating and repairs. For others, gentrification has displaced Urban Indian communities to other neighborhoods, leading to transportation challenges for Urban Indian patients. To meet patient care goals, UIOs have largely self-financed the necessary relocation, modernization, and facility expansion costs. In addition, implementing authorities[26] regarding facilities renovation is a program challenge.

Building Communities of Interest: UIOs explained that they already leverage resources to maximize their resources and identified the need for more technical assistance with the use of RPMS, third-party billing, eligibility determinations, and other issues. They also indicated that communities of UIOs work collaboratively on a regional basis to facilitate information sharing and with partner organizations, including NCUIH, the California Consortium for Urban Indian Health (CCUIH), and the Urban Indian Health Institute (UIHI), but there is not a national mechanism to more broadly and consistently share expertise and assistance. (See Goal 1, Objective 1.4.)

[26] 25 U.S.C. § 1659.

National Institute on Alcohol Abuse and Alcoholism (NIAAA) Transition: In 2016, the IHS made the decision to transfer administration of the former NIAAA awardees from the Alcohol and Substance Abuse Program to OUIHP. UIOs expressed concerns about the transfer, which will necessitate policy and process changes that will require the attention of OUIHP and is a significant workload. (See Goal 2, Objective 2.1.)

Appendix B: Individuals and Organizations Interviewed by the National Academy of Public Administration

Note: Appendix B includes the National Academy of Public Administration's (Academy) list of individuals and organizations that it interviewed. The Academy indicated that the Titles and positions listed are accurate as of the time of its initial contact with the Indian Health Service's (IHS) Office of Urban Indian Health Programs (OUIHP).

The Academy Panel and project team met with numerous stakeholders through formal interviews, meetings, and confer sessions.

Indian Health Service (IHS)

Calderon, Beverly – Disease Prevention Coordinator, California Area, IHS

Fowler, Elizabeth – Deputy Director for Management Operations, Headquarters, IHS

Herne, Mose – (Former) Director, Division of Planning, Evaluation, and Research, Headquarters, IHS

Joe, Nadine – Contract Specialist, Tucson Area, IHS

Leach, Diane – Coordinator, Government Performance and Results Act (GPRA), Headquarters, IHS

LaMere, Jennifer – Community Health Representative and Area Urban Coordinator, Oklahoma City Area, IHS

Levchuck, Leonda – Public Affairs Specialist, Headquarters, IHS

Mueller, Rick – Public Health Advisor, OUIHP, Headquarters, IHS

Moore, Sherriann – (Former) Acting Director, OUIHP, Headquarters, IHS

Notah, Genevieve – Area Urban Coordinator and Director of Planning, Navajo Area, Headquarters, IHS

Pattea, Sandra (RADM) – (Former) Deputy Director for Intergovernmental Affairs, Headquarters, IHS

Patterson, Amy – Public Health Analyst and National GPRA Support Team Member, California Area, IHS

Perez, Cynthia – Information Technology Specialist, Albuquerque Area, IHS

Redgrave, Bryce – Executive Officer, Billings Area, IHS

Riggio, Steve – Area Urban Coordinator, California Area, IHS

Taylor, Palmeda – Area Urban Coordinator, Nashville Area, IHS

Vogel, Lucie – Principal Planner, Division of Planning, Evaluation, and Research, Headquarters, IHS

Weld, Patrick – Program Evaluator, Division of Planning, Evaluation, and Research, Headquarters, IHS

Beyale, Shannon – Health Information Specialist, OUIHP, Headquarters, IHS

Urban Indian Organizations (UIOs)

Aguilera, Natalie – Director, Human Resources, Native American Health Center, Inc. (Oakland, CA)

Bear Don't Walk, Marjorie – (Former) Executive Director, Indian Health Board of Billings, Inc. (Billings, MT)

Belcourt, Ernestine – Executive Director, Indian Family Health Clinic (Great Falls, MT)

Bernal, Jacob – Executive Director, Tucson Indian Health Center (Tucson, AZ)

Billy, Jerimy – Executive Director, United American Indian Involvement, Inc. (Los Angeles, CA)

Black, Scott – Executive Director, American Indian Health & Services (Santa Barbara, CA)

Bradburry, Helen – Clinic Director, Urban Inter-Tribal Health Center of Texas (Dallas, TX)

Bruised Head, LeeAnn – Executive Director, Missoula Urban Indian Health Center (Missoula, MT)

Bulfer, Joseph – Executive Director, San Diego American Indian Health Center (San Diego, CA)

Clark, Gerald – Chief Financial Officer, Native Americans for Community Action, Inc. (Flagstaff, AZ)

Darcy, Cindy – Consultant, Seattle Indian Health Board (Seattle, WA)

Eisonage, Toni – Compliance Officer, Native Directions, Inc. (Manteca, CA)

English, Donald – Associate Chief Executive Officer, Bakersfield American Indian Health Project (Bakersfield, CA)

Feimer, Amy – Chief Executive Officer, Hunter Health Clinic (Wichita, KS)

Flaker, Doug – (Former) Director, San Diego American Indian Health Center (San Diego, CA)

Forquera, Ralph – (Former) Director, Seattle Indian Health Board (Seattle, WA)

Gibson, Judy – Chief Financial Officer, Indian Health Care Resource Center (Tulsa, OK)

Gress, Betty – Board Chairperson, Denver Indian Health and Family Services, Inc. (Denver, CO)

Guerrero, Britta – Executive Director, Sacramento Native American Health Center, Inc. (Sacramento, CA)

Harrison, Charlene – Site Director, Native American Health Center, Inc. (Oakland, CA)

Hudson, Joshua – Board Member, Native American Lifelines (Baltimore, MD, and Boston, MA)

Ironmaker, Jr., Robert – Director, Indian Health Board of Billings (Billings, MT)

Jimmerson, Shawn – (Former) Executive Director, Urban Indian Center of Salt Lake (Salt Lake City, UT)

Keeler, Donna – Executive Director, South Dakota Urban Indian Health, Inc. (Sioux Falls, SD)

Larson, Byron – (Former) Director, Urban Indian Health Institute, Seattle Indian Health Board (Seattle, WA)

Lauth, Fred – Board Member, Seattle Indian Health Board (Seattle, WA)

Lee, Roger – Board Member, Seattle Indian Health Board (Seattle, WA)

Lessard, Kerry – Executive Director, Native American Lifelines (Baltimore, MD, and Boston, MA)

Little Cloud, Robert – Board Member, Native American Health Center, Inc. (Oakland, CA)

Lodge, Toni – Executive Director, N.A.T.I.V.E. Project (Spokane, WA)

Lucero, Esther – Executive Director, Seattle Indian Health Board (Seattle, WA)

Maddox, Adrienne – Chief Operating Officer, Denver Indian Health and Family Services, Inc. (Denver, CO)

Martinez, Eugene – Associate Executive Officer, United American Indian Involvement, Inc. (Los Angeles, CA)

McCabe, Merin – Consultant, American Indian Health and Services (Santa Barbara, CA)

McPherson, Jess – Fiscal Manager, Native American Lifelines (Baltimore, MD, and Boston, MA)

Mercer, Jackie – Chief Executive Officer, Native American Rehabilitation Association of the Northwest, Inc. (Portland, OR)

Moisa, Yolanda – Chief of Staff, Native American Rehabilitation Association of the Northwest, Inc. (Portland, OR)

Murillo, Walter – Chief Executive Officer, Native American Community Health Center (Phoenix, AZ)

Noel, Leah – Executive Assistant, Indian Family Health Clinic (Great Falls, MT)

Nutter, Delbert – Chief Executive Officer, Denver Indian Health and Family Services, Inc. (Denver, CO)

Price, Darby – Board Member, Native American Health Center, Inc. (Oakland, CA)

Polk-Primm, Donna – Chief Executive Officer, Nebraska Urban Indian Health Coalition, Inc. (Omaha, NE)

Randolph, Curtis – (Former) Chief Executive Officer, Native Americans for Community Action, Inc. (Flagstaff, AZ)

Reeves, Janet – Executive Director, Nevada Urban Indians, Inc. (Reno, NV)

Rivera, Michael – Chief Executive Officer, Native American Professional Parent Resources (Albuquerque, NM)

Rosette, Maureen – Chief Operating Officer, N.A.T.I.V.E. Project (Spokane, WA)

Ruiz, Jennifer – Executive Director, Fresno American Indian Health Project (Fresno, CA)

Salcido, Arnie – Executive Director (Acting), North American Indian Alliance (Butte, MT)

Sangster, Deanna – Health Service Administrator, Native Health (Phoenix, AZ)

Scott, Kennith – Executive Director, American Indian Health Service of Chicago, Inc. (Chicago, IL)

Sechelle, Orville – Board Member, Seattle Indian Health Board (Seattle, WA)

Skeeter, Carmelita – Chief Executive Officer, Indian Health Care Resource Center (Tulsa, OK)

Son-Stone, Linda – Executive Director, First Nations Community Health Source (Albuquerque, NM)

Sparck, Aren – Government Affairs Officer, Seattle Indian Health Board (Seattle, WA)

Sunday-Allen, Robyn – Chief Executive Officer, Oklahoma City Indian Clinic (Oklahoma City, OK)

Tatum, Dan – Executive Director, Bakersfield American Indian Health Project (Bakersfield, CA)

Tetnowski, Sonya – Chief Executive Officer, Indian Health Center of Santa Clara Valley (San Jose, CA)

Tuomi, Ashley – Executive Director, American Indian Health & Family Services of Southeastern Michigan, Inc. (Detroit, MI)

Valadez, Ramona – Executive Director, Native Directions, Inc. (Manteca, CA)

Waukau, Jesse – Board Treasurer, Gerald L. Ignace Indian Health Center, Inc. (Milwaukee, WI)

Waukazoo, Martin – Chief Executive Officer, Native American Health Center (Oakland, CA)

White, Tressie – Executive Director, Helena Indian Alliance (Helena, MT)

Willson, Joyce – Board Secretary, Seattle Indian Health Board (Seattle, WA)

Willson, Lee – Board Member, Seattle Indian Health Board (Seattle, WA)

Wise, Laverne – Board and Community Liaison, Seattle Indian Health Board (Seattle, WA)

Young, Angela – Chief Executive Officer (Acting), Urban Inter-Tribal Center of Texas (Dallas, TX)

California Consortium for Urban Indian Health (CCUIH)

Barnett, D'Shane – Consultant (San Francisco, CA)

Marden, Jyl – Executive Director (San Francisco, CA)

Talaugon, Sabine – Director of Programs (San Francisco, CA)

National Council of Urban Indian Health (NCUIH)

Crevier, Francys – Policy Analyst and Congressional Liaison (Washington, DC)

Del-Villar Bermudez, Alejandro – Director, Development and Applied Social Technology (Washington, DC)

Fowler, Kimberly – Director, Technical Assistance and Research Center (Washington, DC)

Smith, Maurice – (Former) Executive Director (Washington, DC)

Young, Ryan – Coordinator, Technical Assistance and Research Center (Washington, DC)

National Indian Health Board (NIHB)

Delrow, Devin – Director, Federal Relations (Washington, DC)

Department of Veterans Affairs

Birdwell, Stephanie – Director, Office of Tribal Government Relations (Washington, DC)

Capra, Gina – Director, Office of Rural Health, Veterans Health Administration (Washington, DC)

Substance Abuse and Mental Health Services Administration (SAMHSA)

Beadle, Mirtha – Director, Office of Tribal Affairs and Policy (Rockville, MD)

Other

Munjanattu, Cherian – Financial Services Specialist, Washington State Department of Social and Health Services (Pullman, WA)

Nelson, Lonnie – Assistant Professor, Washington State University Partnerships for Native Health (Pullman, WA)

Parron-Ragland, Delores – (Former) Associate Director for Special Populations, National Institute of Mental Health (Washington, DC)

Scucci, Tony – Senior Governance Consultant, BoardSource (Portland, ME)

Congress

Benjamin, Darren – Subcommittee on Interior, Environment and Related Agencies, Appropriations Committee, U.S. House of Representatives (Washington, DC)

Appendix C: Urban Indian Organizations Funded by the Indian Health Service

The following list includes Urban Indian Organizations (UIOs) that currently receive funding from the Indian Health Service (IHS) under Title V of the Indian Health Care Improvement Act (IHCIA). The list identifies the UIOs by the type of service(s) provided and identifies the location of each IHS-funded UIO.

Full Ambulatory (21), Funded under 25 U.S.C. §§ 1652-1653

American Indian Health and Family Services of Southeastern Michigan, Inc.
4880 Lawndale Street
Detroit, MI 48210

American Indian Health and Services
4141 State Street
Santa Barbara, CA 93110

Denver Indian Health and Family Services, Inc.
1633 Fillmore Street GL1
Denver, CO 80206

First Nations Community HealthSource
5608 Zuni Road SE
Albuquerque, NM 87108

Gerald L. Ignace Indian Health Center, Inc.
930 West Historic Mitchell Street
Milwaukee, WI 53204

Helena Indian Alliance
501 Euclid Avenue
Helena, MT 59601

Hunter Health Clinic
2318 East Central Avenue
Wichita, KS 67214

Indian Health Board of Billings (Closed as of May 2, 2017)
1127 Alderson Avenue No. 1
Billings, MT 59102

Indian Health Board of Minneapolis, Inc.
1315 East 24th Street
Minneapolis, MN 55404

Full Ambulatory (*continued*)

Indian Health Center of Santa Clara Valley
1333 Meridian Avenue
San Jose, CA 95125

The NATIVE Project
1803 West Maxwell Avenue
Spokane, WA 99201

Native American Community Health Center
4041 North Central Avenue
Phoenix, AZ 85102

Native American Health Center
2950 International Boulevard
Oakland, CA 94601

Native Americans for Community Action
2717 North Steves Boulevard, Suite No. 11
Flagstaff, AZ 86004

Native American Rehabilitation Association of the Northwest
1776 Southwest Madison
Portland, OR 97205

Nebraska Urban Indian Health Coalition, Inc.
2240 Landon Court
Omaha, NE 68102

Sacramento Native American Health Center, Inc.
2020 J Street
Sacramento, CA 95811

San Diego American Indian Health Center
2602 1st Avenue
San Diego, CA 92103

Seattle Indian Health Board
611 12th Avenue South #200
Seattle, WA 98144

South Dakota Urban Indian Health
711 North Lake Avenue
Sioux Falls, SD 57104

Full Ambulatory (*continued*)

Urban Inter-Tribal Center of Texas
1261 Record Crossing Road
Dallas, TX 75235

Limited Ambulatory (6), Funded under 25 U.S.C. §§ 1652-1653

American Indian Health Service of Chicago, Inc.
4081 North Broadway
Chicago, IL 60613

Indian Family Health Clinic
1220 Central Avenue
Great Falls, MT 59401

Nevada Urban Indians, Inc.
6512 South McCarran Boulevard, Suite A
Reno, NV 89509

North American Indian Alliance
55 East Galena Street
Butte, MT 59701

United American Indian Involvement, Inc.
1125 West 6th Street, Suite 103
Los Angeles, CA 90017

Urban Indian Center of Salt Lake
120 West 1300 South
Salt Lake City, UT 84115

Outreach and Referral (6), Funded under 25 U.S.C. §§ 1652-1653

American Indian Community House (The IHS has elected not to renew this contract. The current IHS contract ended on June 30, 2017).
39 Eldridge Street, 4th Floor
New York, NY 10002

Bakersfield American Indian Health Project
1617 30th Street
Bakersfield, CA 93301

Fresno American Indian Health Project
1551 East Shaw Avenue, Suite 139
Fresno, CA 93710

Outreach and Referral (*continued*)

Missoula Urban Indian Health Center
830 West Central Avenue
Missoula, MT 59801

Native American Lifelines of Baltimore and Boston
106 Clay Street
Baltimore, MD 21201

Tucson Indian Center
160 North Stone Avenue
Tucson, AZ 85701

Urban IHS Service Units (2), Funded under 25 U.S.C. § 1660b

Indian Health Care Resource Center of Tulsa
550 South Peoria Avenue
Tulsa, OK 74120

Oklahoma City Indian Clinic
4913 West Reno Avenue
Oklahoma City, OK 73127

Former National Institute on Alcohol Abuse and Alcoholism (NIAAA) Awardees (7), Funded under 25 U.S.C. § 1660c

Ain Dah Ing, Inc.
704 North River Street
Spooner, WI 54801

American Indian Council on Alcoholism, Inc.
2240 West National Avenue
Milwaukee, WI 53204

Friendship House Association of American Indians, Inc. of San Francisco
56 Julian Avenue
San Francisco, CA 94103

Juel Fairbanks Chemical Dependency Services
806 North Albert Street
St. Paul, MN 55104

Former NIAAA Awardees (*continued*)

Kansas City Indian Center
600 West 39th Street
Kansas City, MO 64111

Minnesota Indian Primary Residential Treatment Center, Inc.
P.O. Box 66
Sawyer, MN 55780

Native Directions, Inc.
13505 South Union Road
Manteca, CA 95336