Evaluation of IHS Mid-Level Providers

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ANALYSIS OF POPULATION AND DEMOGRAPHIC TRENDS OF AMERICAN INDIANS AND ALASKA NATIVES (AI/AN) POPULATIONS

FINAL REPORT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service • Indian Health Service
ANALYSIS OF POPULATION AND DEMOGRAPHIC TRENDS OF AMERICAN INDIANS AND ALASKA NATIVES (AI/AN) POPULATIONS

FINAL REPORT

PRESENTED BY:

NATIVE AMERICAN CONSULTANTS, INC. (NACI)
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Prepared under Contract Number 282-91-0056, Delivery Order Number 7
August 1994

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

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Analysis of Population and Demographic Trends of American Indians and Alaskan Natives (AI/AN) Populations...

Final Report to Indian Health Service

Presented by

Native American Consultants, Inc.
725 2nd Street, N.E.
Washington, DC 20002

August 15, 1994

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INTRODUCTION

1.0 Background

Native Americans who leave the reservation and migrate to urban areas face many challenges. While on the reservation, they are a member of a community in which everyone lives at basically the same economic level. As a member of the majority, a Native American residing on the reservation is able to rely on the security of the extended family and housing assistance. The structure of Tribal governments also value the opinion of the individual and provides tribal members with a voice in the community.

Native Americans leave their reservations mainly to improve their economic situation. Those who leave are usually young, single, and have achieved an above average level of education. Transition to urban life puts strains on traditional Indian culture. Those who come to the cities encounter a physical environment, social organization, interpersonal behavior, attitudes, values, and sometimes even language that are foreign to what they have known. The traditional source of support, the extended family, may be undermined or totally lacking. The sense of community, with family and elders to pass traditional ways on to children, is often disrupted; people may live in isolation from each other. (Indians in Minnesota, 82)

This feeling of isolation is increased by the stigma that is often attached to leaving the reservation. Those to stay on the reservation often feel abandoned by those leaving for an urban environment. Many AI/AN’s who return to the reservation have difficulty readjusting to reservation life. Those AI/AN’s who choose to reside in urban areas are forced to deal with the additional stresses of trying to locate affordable, adequate health care services.

“A complicated and often devastating barrier for the American Indian, in addition to difficulties of access for services, is their own reluctance to request or use human resource or social services because they are not used to asking non-relatives for assistance. This aversion caused by inner conflicts reflects their feelings of powerlessness and ineffectiveness in making demands on human support systems. General fear and distrust of these agencies, institutions and bureaucracies, prevents many urban Indians from requesting assistance in crisis situations.

This feeling of incompetence and inadequacy represents a massive psychological barrier that is further reinforced by non-Indians who cannot identify with the plight of American Indians in the area.” (John Belindo) Culturally sensitive health care is essential to combat this mistrust of agencies offering health care to AI/ANs.

The health care situation for AI/ANs varies widely throughout the United States. Some urban areas offer extensive facilities through the Indian Health Service (IHS), or other health care providers. Other urban centers have no options for AI/AN health care at all. This disparity seems to have no relationship with the American Indian populations in these urban centers. In other words, urban areas that have a higher AI/AN population are no more likely to have adequate health care options than areas with much smaller Indian populations.
2.0 Methodology

2.1 Site Selection

The following six sites were selected for study:

**Baltimore, Maryland** - This site was chosen because it has a large AI/AN population, based in an urban setting. Currently, the urban Indian health program only provides alcohol and drug counseling and referral programs and AIDS awareness programs. There is no health care delivery component available at this center.

**Denver, Colorado** - The Indian health program at this site is being restructured. Currently, the center offers only outreach and referral services.

**Las Vegas, Nevada** - This site was chosen because it has both a large urban AI/AN population and a small reservation based population within close proximity.

**Minneapolis, Minnesota** - This site was chosen because the urban Indian health program located in Minneapolis is a Federally Qualified Health Center (FQHC).

**Phoenix, Arizona** - This site was chosen because its urban Indian health program provides mid-level health care services. The urban health center is also very closely associated with the IHS hospital located in Phoenix. It is also a FQHC.

**Portland, Oregon** - This site was chosen because the urban Indian health program at this site is newly reopened, and had only been operating at its current location for nine months at the time of this study.

2.2 Study Framework

2.2.1 Data Collection

A series of meetings was held to discuss and clarify contract requirements, roles and responsibilities of Urban Health Program staff at IHS Headquarters. At this time, it was decided that, due to time and budget constraints, the study would be limited to six selected metropolitan areas. A thorough and exhaustive compilation of related data sources and materials was gathered with the help of IHS urban Health Program staff. Intermittent discussions were held regarding the approach and direction of the study. Workplans and preliminary study outlines were discussed and amended.

The Contractor used two types of data collection. First a review of existing data sources was conducted. After the existing information was reviewed, the Contractor conducted six site visits and collected new data from each of the sites.
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The Contractor used two types of data collection. First a review of existing data sources was conducted. After the existing information was reviewed, the Contractor conducted six site visits and collected new data from each of the sites.
2.2.1.1 Review of Existing Data Sources

The Contractor conducted a review of existing data sources including: 1990 Census, IHS Population Projections, and Birth Rate and Mortality Rate information supplied by IHS. Proposed National Health Care Reform (Clinton Version), was reviewed along with other available information relating to national health reform. A literature search of relevant reports and studies was conducted. A complete listing of existing data sources reviewed can be found in Appendix A.

2.2.1.2 Collection of Data from Six Selected Sites

The 1990 census data provided the only comprehensive and accessible data base on the Urban American Indian population. Although over 50% of all American Indians live in urban areas, there is an assumption that health care is provided to the entire population by the IHS. However, limited resources allow the IHS to fund only some urban centers and large percentages of urban Indians are not served by IHS or any other health care agency or facility. Although all Federally recognized Native Americans are legally eligible for health care, that care is not geographically available in many urban areas. For example, Native Americans in Las Vegas are required to travel as far as Phoenix to receive IHS health services. As a result, the IHS has limited data available for served and unserved populations other than for Mortality, Infant Death, Age and Sex data.

The type and quality of data varies widely between different sites. The six cities studied represent all levels of reporting efficiency. For example, the Minneapolis health center collects the highest level of data. Centers in Baltimore, and Portland had virtually no demographic data available on their clients.

The Contractor conducted a review of data compiled at each of the six sites. This review included information collected from discussions with urban center personnel, IHS personnel (Headquarters and Area Office), personnel of State and local agencies (city and county), as well as representatives from community resource agencies, universities, and local charitable organizations.

Rather than designing a conventional survey instrument, NACI chose to use the guided conversational technique and therefore developed a Discussion Points Instrument (see Appendix B). This approach permitted a more relaxed, personal, method for establishing a rapport with Center personnel. Using a one interviewer approach, the NACI interviewer was able to collect information in a conversational manner.

A second innovative technique used by NACI was the “walk-through.” This process involved actual role playing of a new client entering the Center. During this process samples of client paperwork were examined. The NACI interviewer also collected all relevant background information on the center, including brochures, related studies, needs assessments conducted by the center, and summary data provided by area health facilities and state census offices.
2.2.2 Data Analysis

Demographic data collected from the six sites was analyzed according to completeness and accuracy. The information available was often incomplete, inaccurate, and unsupported. The methods for data collection utilized by the various urban centers was not uniform and as a result, much of the data collected was non-comparable. Since much of the available data from the sites was unusable, the 1990 Census became the main source for demographic information and projections.

2.2.2.1 Population Estimates

For the purposes of this study, the population estimates of unserved AI/ANs in the six selected sites was calculated using the following formula:

\[
\text{TOTAL RURAL AND URBAN AMERICAN} + \text{RURAL AND URBAN AI/AN SERVED BY IHS, RESERVATIONS} = \text{UNSERVED AI/AN POPULATION}
\]

2.2.2.2 Demographics

The method used to update and validate trends of unserved American Indian population for the six selected sites was based on elements determined as factors affecting the probability of receiving comprehensive health care. These data elements include:

**AGE** - The assumption is made that the very young and very old have a higher necessity for health care.

**SEX** - The assumption is made that households that are headed by females are more likely to be without health care.

**HOUSEHOLD INCOME** - The assumption is made that as household income increases the probability of that family receiving adequate health care also increases.

**EDUCATION** - The assumption is made that a higher level of education is positively related to income, and therefore the level of health care.

**HOUSEHOLD VEHICLE** - The assumption is made that families with no transportation are more likely to forgo preventive health care because of transportation difficulties. There is also a correlation with employment, since lack of transportation also limits employment opportunities.

**INSURANCE** - The assumption is made that those who are not insured through some outside source are less likely to seek out preventive health care.

**NUMBER OF PEOPLE LIVING IN HOUSEHOLD** - The assumption is made that households with more members are less likely to receive adequate health care.
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\[
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\]

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**NUMBER OF PEOPLE LIVING IN HOUSEHOLD** - The assumption is made that households with more members are less likely to receive adequate health care.
3.0 Resource Requirements

The 1990 Census population projections for the year 2000, estimate a significant increase in the AI/AN population at each of the six sites. The following table shows a breakdown of the estimated percentage increases in population for these cities.

<table>
<thead>
<tr>
<th>Site</th>
<th>Current Population</th>
<th>Projected Population (Year 2000)</th>
<th>Percentage of Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baltimore</td>
<td>6,653</td>
<td>7,745</td>
<td>17%</td>
</tr>
<tr>
<td>Denver</td>
<td>13,784</td>
<td>15,553</td>
<td>12%</td>
</tr>
<tr>
<td>Las Vegas</td>
<td>6,939</td>
<td>7,745</td>
<td>17%</td>
</tr>
<tr>
<td>Minneapolis</td>
<td>24,338</td>
<td>32,685</td>
<td>34%</td>
</tr>
<tr>
<td>Phoenix</td>
<td>38,017</td>
<td>53,503</td>
<td>40%</td>
</tr>
<tr>
<td>Portland</td>
<td>13,603</td>
<td>16,216</td>
<td>19%</td>
</tr>
</tbody>
</table>

In order to determine the resources required to adequately serve this population, the Contractor first calculated the per user and per occurrence costs incurred at each urban Indian center. From this number the average number of visits per individual was determined. Using these costs, the resources required to maintain the current level of service were determined for the increased population.

The regional average costs per individual were calculated from statistics provided by the U.S. Department of Health and Human Services. These figures are national personnel health care per capita expenses according to geographic distribution. A per user, per occurrence cost was calculated from this information.
<table>
<thead>
<tr>
<th>Site</th>
<th>Cost per Occurrence</th>
<th>Cost per User</th>
<th>US Per Person Annual Average Cost *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baltimore</td>
<td>unknown</td>
<td>unknown</td>
<td>1,253</td>
</tr>
<tr>
<td>Denver</td>
<td>$188</td>
<td>$643</td>
<td>1,253</td>
</tr>
<tr>
<td>Las Vegas</td>
<td>$413</td>
<td>unknown</td>
<td>1,253</td>
</tr>
<tr>
<td>Minneapolis</td>
<td>$41</td>
<td>$498</td>
<td>1,253</td>
</tr>
<tr>
<td>Phoenix</td>
<td>$25.50</td>
<td>$89</td>
<td>1,253</td>
</tr>
<tr>
<td>Portland</td>
<td>$591</td>
<td>$921</td>
<td>1,253</td>
</tr>
</tbody>
</table>

* Data supplied by the U.S. Department of Health and Human Services.

Once the cost per user, and per occurrence was determined, the expense involved in increasing the percentage of the total population receiving adequate health care was calculated at 10% intervals. The resource requirements associated with this increase in service are shown in the following table.

<table>
<thead>
<tr>
<th>Site</th>
<th>Current Percentage Served</th>
<th>Increase of 10%</th>
<th>Increase of 20%</th>
<th>Increase of 30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baltimore</td>
<td>0%</td>
<td>665</td>
<td>1,330</td>
<td>1,995</td>
</tr>
<tr>
<td>Denver</td>
<td>3%</td>
<td>1,844</td>
<td>3,222</td>
<td>4,601</td>
</tr>
<tr>
<td>Las Vegas</td>
<td>0%</td>
<td>694</td>
<td>1,388</td>
<td>2,082</td>
</tr>
<tr>
<td>Minneapolis</td>
<td>32%</td>
<td>10,253</td>
<td>12,688</td>
<td>15,121</td>
</tr>
<tr>
<td>Phoenix</td>
<td>57%</td>
<td>25,658</td>
<td>29,459</td>
<td>33,261</td>
</tr>
<tr>
<td>Portland</td>
<td>4%</td>
<td>2,281</td>
<td>3,642</td>
<td>5,002</td>
</tr>
<tr>
<td>Site</td>
<td>Current Percentage Served</td>
<td>Increase of 10%</td>
<td>Increase of 20%</td>
<td>Increase of 30%</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------</td>
<td>-----------------</td>
<td>----------------</td>
<td>-----------------</td>
</tr>
<tr>
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<td>665</td>
<td>1,330</td>
<td>1,995</td>
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<td>4,601</td>
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<tr>
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<td>694</td>
<td>1,388</td>
<td>2,082</td>
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<td>3,642</td>
<td>5,002</td>
</tr>
</tbody>
</table>
4.0 Population Estimates of Unserved AI/ANs in 6 Selected Urban Sites

4.1 Site Findings

4.1.1 Baltimore Site Findings

At the time the site visit was made the breakdown of funding was not available. The budget was approximately $189,000. The source of this money was the State of Maryland, Bryan White AIDS funding, and IHS drug and alcohol treatment money.

4.1.1.1 Background - Baltimore

Native Americans began their migration into the city of Baltimore in the early 1940's, the majority migrating from North Carolina. The numbers of urban Indians in Baltimore have increased greatly in the past fifteen years, and appear to be on the rise each year.

Many Baltimore urban Indians come from rural or farming backgrounds. By tradition, they tend to bond together for protection, socialization and security. Consequently, the southeast section of Baltimore has the largest concentration of Native Americans.

The majority of Baltimore urban Indians come from large families, and in general have suffered from economic and educational deprivation. Also, because of religious belief in self-denial and discipline, these Native Americans come the city unprepared for the trials and difficulties of urban living. In addition to the problems of acclimating to metropolitan life, the Baltimore urban Indian must compete with non-Indians with whom he or she may be skeptical of and slow to become involved.

The urban Indian differs from other American who migrate to cities in that the former comes to escape desperate conditions on the reservations while the latter seeks new opportunities in the urban environment. The traffic, congestion and other pressures endured in city life are not familiar to Native Americans and would likely be exchanged happily for economic security back home.

Faced with the problems of urban living, most Native Americans do not know where to turn for help and are intimidated by government agencies and bureaucracies. Pride may also inhibit many from asking for assistance. In the end, many urban Indians rely on their own nuclear family and other Indian contacts to resolve problems.

Finally, strong Indian culture and tradition keeps the urban Indian from succumbing to the confusion and hardships of living in the city, however, many of these same qualities keep them from seeking outside help.
4.1.1.2 The Baltimore American Indian Center

The Baltimore American Indian Center was founded in 1968 to assist Native Americans living in the Baltimore Metropolitan area. Among the many other functions, the center provides direct relief and services to Native Americans through financial assistance and support services. Through its many programs, it strives to help urban Indians understand and appreciate their unique culture while bridging the gap between them and their non-Indian neighbors. Finally, the Center provides outreach services to help make existing services and programs work for the urban Indian Community.

Specific Programs at the Baltimore American Indian Center include:

- Community Services and Housing
- Adult Basic Education
- Day Care
- Native American Senior Citizens Program
- Native American Youth Program
- AIDS Prevention
- Community Alcohol Services, Indian Program

4.1.1.3 Population Estimates of Unserved AI/ANs in Baltimore

\[6,5636,6 + 0 = 6,653\]

4.1.1.3.1 Difficulties in Obtaining Data

Although the cites visited in Baltimore do not qualify as a health facility nor are they bona fide Urban Centers, difficulty is encountered in collecting data from clients. For example, there is resistance on the part of clients and staff who might be suspicious of how the data might be used or there is fear that admitting one is Native American might jeopardize their ability to get quality health care. The manual system of data collection is cumbersome and there is no budget for expensive computers, software and assistance for setting up computer databases. Also, there were no figures/data available for local evaluation of needs assessment. Finally, there is the misclassification of Native Americans by receptionists since there is a reluctance to ask specific questions regarding race. Consequently, clients who appear to be Hispanic may be Native American but will be recorded as Hispanic.
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4.1.1.3 Population Estimates of Unserved AI/ANs in Baltimore

\[6,563 + 6 = 6,653\]

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4.1.2 Denver Site Findings

4.1.2.1 Background - Denver

There are almost 13,000 American Indians living and working in the Denver-Boulder metropolitan area. This population is made up of Sioux, Navajo, Cheyenne, Kiowa, and Kickapoo, among others. This highly mobile population is concentrated near and in the downtown area, although there is no uniquely "Indian" community.

The mission of the Denver Indian Health and Family Services, Inc. (DIHFSI), is "to provide culturally services that promote health and quality of life for American Indian families and individuals." They are an outreach and referral program center, offering some contractor referral services and community outreach.

"The program provides professional instruction concerning health promotion and disease prevention through individual or group presentations. Additional services include health screenings health fairs, disseminating of health care information, parenting classes, and home visits. Program offerings are provided to the community by staff or volunteer professionals."

Currently, there is no culturally appropriate Women, Infant, and Children (WIC) program within the DIHFSI facility. Although there is a population of almost 13,000 American Indians in the Denver-Boulder urban area, the number of AI/AN mothers participating in the WIC program is minimal according to WIC Director Mr. William Eden.

This facility is not equipped to deal with the delivery of any health services in-house. As a result of the red tape involved in referrals, many primary ailments, such as children's ear aches do not receive attention.

4.1.2.2 Population Estimates of Unserved AI/ANs in Denver

\[
13,784 + 643 = 13,318
\]

4.1.2.2.1 Difficulties in Obtaining Data

The DIHFSI center has only been operating under it's current management since 1993. Due to the change in administration, much of the necessary data was not available.

4.1.3 Las Vegas Site Findings

4.1.3.1 Background - Las Vegas

The Las Vegas Indian community is split into two distinct groups (permanent & transient). The location of Las Vegas makes it a natural stopping off point for those travelling to and from the west coast and northwest regions of the United States. As a result, a large percentage of the AI/AN population are temporary residents in the Las Vegas area. Of those AI/AN's who are...
permanent residents, members of the Paiute and Moapa tribes, represent a small percentage of this population, but receive a much higher level of health care.

Las Vegas has one of the largest urban Native American populations in the country. At the same time, this community has virtually no health care options. Members of the Paiute and Moapa tribe are eligible for health care at the Paiute Community Health Center. This center’s funding comes from the IHS and is used to contract out for health services in the community. Native Americans who fall into this group are basically receiving a high level of health care attention. Native Americans who are not members of these two tribes have very limited options for attaining health care.

This region suffers from a serious image problem. Many of the health care professionals interviewed noted that Nevada and Las Vegas receives a relatively small share of money allocated nationally for Federal programs. Mr. Martin Atherton, Chief Research and Statistical Analyst for the State of Nevada, commented: “Until people realize that the State of Nevada is more than a desert with a 4 mile strip of casinos, we will continue to be overlooked by funding sources.”

4.1.3.2 Population Estimates of Unserved AI/ANs in Las Vegas

\[
6,939 + 515 = 6,424
\]

4.1.3.2.1 Difficulty in Obtaining Data

The two major AI/AN facilities in the Las Vegas area are the Paiute Community Health Center and the Las Vegas Indian Center. The Paiute Center, which is funded solely by IHS, serves members of the Paiute and Moapa Tribes. Information on this population (approximately 870 individuals), is documented by the IHS using the PCC form. All data is sent to the closest Service Unit in Schurz, Nevada on hand coded, sheets where it is entered into the RPMS system. Summary information is then provided to the Center.

Due to limited funding, this center is forced to restrict services to enrolled members of the Paiute and Moapa tribes. Children of registered members are also eligible for care. Although the information available for this population is relatively accurate, the number served in this program are very limited. Therefore the demographic information available from the Paiute Health Center is non-representative of the general population.

Unfortunately, the Las Vegas Indian Center is not related to the IHS and does not collect data in a uniform manner. This center provides various services to AI/ANs in the Las Vegas area. Since this is not a health care facility, the intake process is very limited. Anyone requesting services at this center, need only provide an Indian blood form to be deemed eligible for services. Once a person is considered eligible for the center’s programs, this is basically the extent of their intake. No health information, and only limited demographic data is collected.
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4.1.4 Minneapolis Site Findings

4.1.4.1 Background - Minneapolis

The largest Tribal representation in Minneapolis are the Chippewa and the Sioux. These two tribes account for 97% of the AI/AN population using the urban center in Minneapolis. Immigration of AI/ANs began in the 1950's. Many of these individuals moved to the urban area, started families and are now in the third generation of urban living. They are very stable in comparison to other urban Indian groups. They are strongly tied to the reservation, but do not display the typical migratory patterns. Another group living in the urban area is more mobile, and have not developed strong ties to a particular urban location.

4.1.4.2 Indian Health Board of Minneapolis

The Indian Health Board of Minneapolis (IHB) is a Federally Qualified Health Center. This facility offers the most comprehensive AI/AN health care of the six sites visited during this study. This program was established in the 1970's as a pilot program for urban Indian health. As a result, this program is very well developed in comparison to the other facilities visited. The IHS is dedicated to providing both conventional health care as well as traditional native remedies. These two schools of healing are well balanced to provide the most comprehensive, culturally sensitive care possible.

One of the most distinctive attributes of the IHB is it's funding structure. IHB has successfully solicited funding from numerous sources outside of the IHS. This fund raising effort has resulted in a very strongly funded group of health and outreach programs.

Services offered at the IHBM include:

- Primary Care Services:
- Family Planning
- Pre-Natal Care
- Preventive Dental Clinic
- Culturally Sensitive Women Infant and Children (WIC) Program
- Nutrition Education
- Secondary Services
- Screening for Children and Adults
- Acute Medical Care
- Management of Chronic Diseases
- Chemical Dependency Program
- Mental Health Providers

4.1.4.3 Population Estimates of Unserved AI/ANs in Minneapolis

\[ 24,338 + 7,820 = 16,518 \]
4.1.5 Phoenix Site Findings

4.1.5.1 Background - Phoenix

Urban Phoenix AI/ANs compare to the general population negatively. 30.6% of this population live below the poverty level. Numerous Tribes are represented in this group, including: Navajo, Hopi, Tohono O'odham, Apache, and Pima, among others. Through a combination of high birth rates and immigration, the Phoenix area has one of the fastest growing AI/AN populations in the United States.

This, very mobile population is largely employed in low-income, labor intensive work. Like many urban AI/AN population, the Native Americans in Phoenix struggle to retain their rich cultures while adapting to an urban setting. Phoenix AI/AN’s have been particularly successful in this area, maintaining strong ties to tribal traditions.

4.1.5.3 Population Estimates of Unserved AI/ANs in Phoenix

38,017 + 21,856 = 16,161

4.1.6 Portland Site Findings

4.1.6.1 Background - Portland

The Portland American Indian population includes a relatively high percentage of non-permanent residents. This is due to the location of Portland as a pass through point for travellers between the west coast, southwest, and the Alaskan Northwest. The health care situation in Portland is different from the other 5 sites.

The Oregon Health Plan (OHP), an innovative Medicaid reform plan implemented on February 1, 1994, makes the health status of Native Americans in this area unique. Since this plan was so recently introduced, it’s effect on the health status of American Indians living in the State has yet to be evaluated. Health care workers in the State of Oregon are both hopeful and apprehensive about the future. This program is considered by many to be a precursor for National Health Care Reform. As such, the existing health care facilities are jockeying for positions as a certified health care providers. This certification process is seen as a first step in becoming a health care provider for National Reform.

If Phase II of the OHP is implemented as planned in 1995, some uninsured American Indians living in the Portland area will be eligible for health care. This care, however will be non-ethnically sensitive, and therefore is opposed by many of the Native American health care providers interviewed. Since the health care situation in Oregon is so unsure, it is difficult to estimate the future needs of this population.

The Northwest Indian Health Clinic has been operating in its current location since May, 1994. Before May, 1994, the Clinic had been operating under different management for several years.
4.1.5 Phoenix Site Findings

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The Northwest Indian Health Clinic has been operating in its current location since May, 1994. Before May, 1994, the Clinic had been operating under different management for several years.
Due to financial irregularities and management problems the Clinic was closed, and the entire staff was dismissed. The current management have been operating for nine months, initially as a walk-in clinic, and now as a scheduled care facility.

The clinic delivers care to approximately 700 AI/AN clients. Beyond the number of individual patient records being kept at the clinic, the staff was unable to provide no other information on their client base. As a new Clinic, they are operating a completely manual system with no demographic collection process in place at all. They are currently researching different automation systems, including RPMS and hope to have a systems in place within six months. Although the system of data collection is not well designed the level of service received by AI/AN clients using the center is excellent. The staff’s main focus is delivering the highest level of health care possible within financial and time constraints.

One issue raised during the discussion, was an Oregon state law which requires health centers to provide an initial visit to anyone claiming to be Native American. This law is based on the premise that a patient should be allowed a period of time to produce documentation proving their status. Unfortunately, this policy is well known in the urban community, and the clinic spends a significant amount of time providing one time health care to people who are not Native Americans. Once this service has been provided, it is almost impossible to get reimbursement from state or local programs for non-eligible individuals. This law was cited several times as a major stumbling block for the Center’s financial situation.

4.1.6.2 Population Estimates of Unserved AI/ANs in Portland

\[
13,603 + 921 = 12,682
\]

4.2 Demographic Characteristics of Unserved AI/ANs in Six Selected Sites

For each site visited, NACI surveyed the same demographic characteristics; those elements that were considered to influence the level of health care received by those populations. These factors were:

**Level of Income.** NACI has determined that level of income has a direct relationship with the availability and quality of health care. Those AI/AN families who live below the poverty level, as well as those who live within 200% above the poverty level, are likely to receive little or no health care.

**Age.** The age of the population has a direct effect on the level of health care received. Those populations with a large percentage of individuals under 25 years, tend to receive a lower level of health care. Individuals who are 65 years, or older have access to numerous government run, health care programs, and therefore are unlikely to be under served.
Sex. AI/AN families with a female head of household are less likely to receive adequate health care. These families have a high probability of being unemployed, or under employed.

Education Level. NACI has determined that those individuals or families whose members have achieved a higher level of education, are more likely receive adequate health care. Conversely, those with a lower level of education are more likely to be receiving poorer quality health care.

Availability of Culturally Sensitive Health Care. Those areas with available, culturally sensitive health care options, offer a more comforting alternative to AI/AN families and individuals. Therefore, it is more likely that individuals with the option of receiving more culturally sensitive health care will have an increased level of care.

Household Vehicles. The availability of transportation is a determining factor in the level of health care received. Whether or not a family or individual owns a vehicle also affects their ability to find employment.

Number of People in Household. The urban AI/AN population has been growing significantly in the last decade. Since 1980, the population has increased to 60% of the AI/AN population. Currently, the AI/AN population is the fastest growing group in the United States. This fact, combined with the level of household income, gives this population a monetary disadvantage. This directly affects the availability of health care to this population.

Insurance. An inordinate percentage of the AI/AN population residing urban, non-reservation areas are not insured. Having insurance is the factor that most directly affects the level of health care received by an individual.
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Insurance. An inordinate percentage of the AI/AN population residing urban, non-reservation areas are not insured. Having insurance is the factor that most directly affects the level of health care received by an individual.
4.2.1 Baltimore Demographic Findings

**Population by Race Baltimore**

- White: 72%
- Black: 26%
- Other race: <1%
- American Indian, Eskimo, or Aleut: <1%
- Asian or Pacific Islander: 2%

**Baltimore Household Income**

- Income levels: $0 - $10,000, $10,000 - $20,000, $20,000 - $30,000, $30,000 - $40,000, $40,000 - $50,000, $50,000 - $60,000, $60,000 - $70,000, $70,000 - $80,000, $80,000 - $90,000, $90,000 - $100,000
Baltimore Household Income of AWAN by Age of Householder

Per Capita Income Baltimore

[Graph showing household income distribution by age of householder and per capita income for different racial groups in Baltimore.]
Baltimore Household Income of Asian by Age of Householder

Per Capita Income Baltimore

NACI
BALTIMORE EDUCATIONAL ATTAINMENT OF THE AVIAN

Graduate or professional degree 7%

Less than 9th grade 14%

9th to 12th grade, no diploma 17%

Associate degree 5%

Some college, no degree 22%

High school graduate (includes equivalency) 24%

PROJECTED AVIAN POPULATION BALTIMORE

NACI
Additional information on the Baltimore site can be found in Attachment 1.
4.2.2 Denver Demographic Findings

**Population by Race Denver**

- White: 87%
- Other Race: 6%
- Asian or Pacific Islander: 2%
- American Indian, Eskimo, or Aleut: 1%
- Black: 5%

**Denver Asian Household Income**

Income ranges from $0 to $100,000.
4.2.2 Denver Demographic Findings

**Population by Race Denver**

- White: 27%
- Black: 0%
- Asian or Pacific Islander: 2%
- American Indian, Eskimo, or Aleut: 1%
- Other race: 5%

**Denver A/AN Household Income**

Income ranges from 0 to 400,000, with bars indicating the number of households in each income bracket.
UNINSURED AIAN DENVER

DENVER INDIAN HEALTH AND FAMILY SERVICES FUNDING SOURCES
Additional information on the Denver site can be found in Attachment 2.
4.2.3 Las Vegas Demographic Findings

POPULATION BY RACE LAS VEGAS MSA

- White: 80%
- Black: 10%
- American Indian, Eskimo, or Aleut: 1%
- Asian or Pacific Islander: 4%
- Other race: 5%

AVIAN HOUSEHOLD INCOME LAS VEGAS MSA

- Less than $5,000
- $10,000 to $14,999
- $25,000 to $34,999
- $50,000 to $74,999
- $100,000 or more
4.2.3 Las Vegas Demographic Findings

**Population by Race Las Vegas MSA**

- White: 80%
- Black: 10%
- American Indian, Eskimo, or Aleut: 4%
- Other race: 5%
- Asian or Pacific Islander: 1%

**AVAN Household Income Las Vegas MSA**

Income ranges:
- $0 - $4,999
- $5,000 - $9,999
- $10,000 - $14,999
- $25,000 - $29,999
- $30,000 - $34,999
- $40,000 - $49,999
- $50,000 - $59,999
- $60,000 or more
VEHICLES PER HOUSEHOLD IN LAS VEGAS

1 OR MORE VEHICLES (89%)

AGE DISTRIBUTION LAS VEGAS

FEMALES

MALES
LAS VEGAS EDUCATIONAL ATTAINMENT OF THE AI/AN

- Bachelor's degree: 7%
- Associate degree: 9%
- Some college, no degree: 25%
- Graduate or professional degree: 4%
- Less than 9th grade: 15%
- 9th to 12th grade, no diploma: 12%
- High school graduate (includes equivalency): 20%

PROJECTED POPULATION LAS VEGAS

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Additional information on the Las Vegas site can be found in Attachment 3.
Additional information on the Las Vegas site can be found in Attachment 3.
4.2.4 Minneapolis Demographic Findings

POPULATION BY RACE MINNEAPOLIS-ST. PAUL

- American Indian, Eskimo, or Aleut: 1%
- Asian or Pacific Islander: 3%
- Black: 4%
- Other race: 1%
- White: 91%

AVIAN HOUSEHOLD INCOME MINNEAPOLIS - ST. PAUL

Income Ranges:
- $0
- $6,000
- $10,000
- $15,000
- $25,000
- $35,000
- $50,000
- $75,000
- $100,000

Income Distribution:
- $0: 3%
- $6,000: 4%
- $10,000: 6%
- $15,000: 8%
- $25,000: 9%
- $35,000: 11%
- $50,000: 10%
- $75,000: 8%
- $100,000: 7%
MINNEAPOLIS-ST. PAUL EDUCATIONAL ATTAINMENT OF THE AHAN

- Bachelor's degree: 7%
- Graduate or professional degree: 3%
- Less than 9th grade: 6%
- 9th to 12th grade, no diploma: 23%
- Associate degree: 6%
- Some college, no degree: 21%
- High school graduate (includes equivalency): 34%

PROJECTED AHAN POPULATION MINNEAPOLIS - ST. PAUL

NACI
MINNEAPOLIS-ST. PAUL EDUCATIONAL ATTAINMENT OF THE AVAN

<table>
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<td>Associate degree</td>
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<td>9th to 12th grade, no diploma</td>
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</tr>
<tr>
<td>High school graduate (includes equivalency)</td>
<td>34%</td>
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<td>Some college, no degree</td>
<td>21%</td>
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PROJECTED AVAN POPULATION MINNEAPOLIS - ST. PAUL

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Additional information on the Minneapolis site can be found in Attachment 4.
Additional information on the Minneapolis site can be found in Attachment 4.
4.2.5 Phoenix Demographic Findings

POPULATION BY RACE PHOENIX MSA

- White 60%
- Black 2%
- Other race 8%
- Asian or Pacific Islander 2%
- American Indian, Eskimo, or Aleut 3%

AVIAN HOUSEHOLD INCOME PHOENIX MSA

- $0 - $5,000
- $5,000 - $10,000
- $10,000 - $15,000
- $15,000 - $25,000
- $25,000 - $35,000
- $35,000 - $50,000
- $50,000 - $75,000
- $75,000 - $100,000
- $100,000 - $125,000
- $125,000 - $150,000
- $150,000 - $200,000
- $200,000 - $250,000
- $250,000 - $500,000
- $500,000 or more
VEHICLES PER HOUSEHOLD IN PHOENIX MSA

1 OR MORE VEHICLES 78%
NO VEHICLES 22%

PHOENIX AGE DISTRIBUTION PHOENIX MSA
Additional information on the Phoenix site can be found in Attachment 5.
Additional information on the Phoenix site can be found in Attachment 5.
4.2.6 Portland Demographic Findings

**Population by Race Portland MSA**
- White: 81%
- Black: 3%
- Asian or Pacific Islander: 4%
- American Indian, Eskimo, or Aleut: 1%
- Other race: 1%

**Household Income Portland MSA**
- Less than $20,000
- $10,000 to $14,999
- $25,000 to $34,999
- $50,000 to $74,999
- $100,000 or more
PORTLAND MSA EDUCATIONAL ATTAINMENT OF THE AVAN

- Bachelor's degree: 7%
- Graduate or professional degree: 4%
- Less than 8th grade: 7%
- 8th to 12th grade, no diploma: 19%
- Associate degree: 9%
- Some college, no degree: 26%
- High school graduate (includes equivalency): 28%

PROJECTED POPULATION PORTLAND MSA

- 1980: 15,000
- 1990: 15,000
- 2000: 25,000
PORTLAND MSA EDUCATIONAL ATTAINMENT OF THE POPULATION

- Bachelor's degree: 7%
- Graduate or professional degree: 4%
- Less than 8th grade: 7%
- 8th to 12th grade, no diploma: 19%
- Associate degree: 8%
- Some college, no degree: 25%
- High school graduate (includes equivalency): 25%

PROJECTED POPULATION PORTLAND MSA

Population: 20,000 25,000
Additional information on the Portland site can be found in Attachment 6.

4.3 Present and Future Resource Requirements of Unserved AI/ANs in Six Selected Sites

4.3.1 Resource Requirements - Baltimore

To serve 10% AI/AN in FQHC at $1,253 annually
$833,621

To serve 20% AI/AN in FQHC at $1,253 annually
$1,667,242

To serve 30% AI/AN in FQHC at $1,253 annually
$2,500,863

4.3.2 Resource Requirements - Denver

To serve 10% additional AI/AN in FQHC at $1,253 annually
$2,311,033

To serve additional 20% AI/AN in FQHC at $1,253 annually
$4,038,168

To serve additional 30% AI/AN in FQHC at $1,253 annually
$5,765,304

To increase service 10% at current levels of care
$1,185,949

To serve 20% at current levels of care
$2,072,260

To serve 30% at current levels of care
$2,958,572
Additional information on the Portland site can be found in Attachment 6.

4.3 Present and Future Resource Requirements of Unserved AI/ANs in Six Selected Sites

4.3.1 Resource Requirements - Baltimore

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To serve 10% additional AI/AN in FQHC at $1,253 annually
$2,311,033

To serve additional 20% AI/AN in FQHC at $1,253 annually
$4,038,168

To serve additional 30% AI/AN in FQHC at $1,253 annually
$5,765,304

To increase service 10% at current levels of care
$1,185,949

To serve 20% at current levels of care
$2,072,260

To serve 30% at current levels of care
$2,958,572
### 4.3.3 Resource Requirements - Las Vegas

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>To serve 10% AI/AN in FQHC at $1,253 annually</td>
<td>$869,457</td>
</tr>
<tr>
<td>To serve 20%</td>
<td>$1,738,913</td>
</tr>
<tr>
<td>To serve 30%</td>
<td>$2,608,370</td>
</tr>
</tbody>
</table>

### 4.3.4 Resource Requirements - Minneapolis

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>To serve 10% additional AI/AN in FQHC at $1,253 annually</td>
<td>$12,848,011</td>
</tr>
<tr>
<td>To serve additional 20%</td>
<td>$15,897,563</td>
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<tr>
<td>To serve additional 30%</td>
<td>$18,947,114</td>
</tr>
<tr>
<td>To increase service 10% at current levels of care</td>
<td>$5,106,392</td>
</tr>
<tr>
<td>To serve 20%</td>
<td>$6,318,425</td>
</tr>
<tr>
<td>To serve 30%</td>
<td>$7,530,457</td>
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</tbody>
</table>

### 4.3.5 Resource Requirements - Phoenix

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>To serve 10% additional AI/AN in FQHC at $1,253 annually</td>
<td>$32,149,628</td>
</tr>
<tr>
<td>To serve additional 20%</td>
<td>$36,912,628</td>
</tr>
<tr>
<td>To serve additional 30%</td>
<td>$41,676,158</td>
</tr>
<tr>
<td>To increase service 10% at current levels of care</td>
<td>$2,283,535</td>
</tr>
<tr>
<td>To serve 20%</td>
<td>$2,621,887</td>
</tr>
<tr>
<td>To serve 30%</td>
<td>$2,960,238</td>
</tr>
</tbody>
</table>

### 4.3.6 Resource Requirements - Portland

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>To serve 10% additional AI/AN in FQHC at $1,253 annually</td>
<td>$1,704,456</td>
</tr>
<tr>
<td>To serve additional 20%</td>
<td>$3,408,912</td>
</tr>
<tr>
<td>To serve additional 30%</td>
<td>$5,113,368</td>
</tr>
<tr>
<td>To increase service 10% at current levels of care</td>
<td>$1,252,836</td>
</tr>
<tr>
<td>To serve 20%</td>
<td>$2,505,673</td>
</tr>
<tr>
<td>To serve 30%</td>
<td>$3,758,509</td>
</tr>
</tbody>
</table>
5.0 Report on Management and Policy Issues

5.1 Statutory Requirements (Indian Health Care Improvement Act)

For the purposes of this contract, statutory requirements of the Indian Health Service management were addressed in this study.

A. Section 503 A of the Indian Health Care Improvement Act requires each urban health program to:
   a. Estimate the population of American Indians residing in the urban center in which such organization is situated, who are or could be recipients of health care or referral services...
   b. Assist such health services resources in providing services to urban Indians...
   c. Assist urban Indians in becoming familiar with and utilizing health services resources;
   d. Provide basic health education, including health promotion and disease prevention education, to urban Indians;
   e. Identify gaps between unmet health needs of urban Indians and the resources available to meet such needs;
   f. Make recommendations to the Secretary and Federal, State, local and other resource agencies on methods of improving health service programs to meet the needs of urban Indians,...

B. Section 503(e)(3) requires that in order to fund mental health programs, the following criteria are used to evaluate need:
   a. the size of the urban Indian population to be served;
   b. the utilization by the urban Indians of alternative resources from State and local governments for no-cost or low-cost services to the general population; and
   c. the capability of the urban Indian organization to carry out appropriate services.

C. Section 507(2) and (3) require all Urban Indian Programs submit an account of activities performed under contract and amounts and purposes for which funds were expended. Quarterly reports are required that contain:
   a. determination of the gaps between unmet urban Indian Health needs and the resources that exist to meet such needs;
   b. recommendations on methods of improving health service programs to meet the needs of urban Indians;
   c. information on activities conducted by the organization pursuant to the contract;
   d. an account of the amounts and purposes for which Federal funds were expended; and other information as requested by the Secretary of the Department of Health and Human Services.