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Urban health program strategic planning report.

American Indian Health Care Association.

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URBAN HEALTH PROGRAM STRATEGIC PLANNING REPORT

AMERICAN INDIAN HEALTH CARE ASSOCIATION

DEVELOPED FOR:

INDIAN HEALTH SERVICE
5600 Fishers Lane
Rockville, MD 20857

DEVELOPED BY:

AMERICAN INDIAN HEALTH CARE ASSOCIATION
245 East Sixth Street, Suite 499
Saint Paul, Minnesota 55101
(612)293-0233
FAX(612)293-9148

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PURPOSE AND SCOPE

The rapidly changing health care delivery environment requires continued adaptation and change if an organization is to survive and fulfill its mission. Strategic planning is concerned with the decisions that must be made for the entire organization for the long-term. The Indian Health Service Urban Health Program, and the individual urban Indian health programs, are at a critical juncture as health care reform is developing for the future. In August 1991, the Indian Health Service published the Indian Health Service Executive Reference Guide on Strategic Planning[1]. This report applies the Strategic Planning and Management Model to the Urban Indian Health Program. Although it sets forth the entire steps of the strategic planning model, it is more accurately a progress report through the first eight steps of the strategic planning model. Subsequent analysis should then continue the process for steps 9 through 11.

BACKGROUND AND HISTORY

Most American Indians lived on or near reservations prior to the early 1950s. During the 1950s, the Bureau of Indian Affairs instituted a relocation program that sought to help and encourage American Indians find employment and obtain education in nearby cities. During this transitional period, many American Indians experienced health related problems, poor societal and individual identities, and high unemployment. Unlike their reservation counterparts, urban Indians did not have access to federal health care services offered by the Bureau of Indian Affairs and later, the Indian Health Service.

Because of their unfamiliarity with mainstream health care systems and inability to afford such health care, many urban Indians did not have access to nor use health care services. American Indian leaders organized small volunteer clinics that operated on a part-time basis to alleviate this health problem. These small volunteer clinics provided health care services that were responsive to the cultural and economic concerns of the urban Indian population.

In 1966, Congress appropriated approximately $300,000 to the Indian Health Service to operate a clinic for urban Indians living in Rapid City, South Dakota. Six years later, Congress appropriated $150,000 to the Indian Health Service to conduct a study of urban Indian health problems in Minneapolis, Minnesota. This study, funded in 1972, evolved into an outreach program to help urban American Indians gain access to and use available health services in Minneapolis. In fiscal

[1] Indian Health Service Executive Reference Guide on Strategic Planning, Indian Health Service/PHS/DHHS. August 1991.

years (FY) 1973 through 1976, Congress appropriated additional monies to the Indian Health Service to fund other urban Indian health programs in San Francisco and Los Angeles, California; Seattle, Washington; Oklahoma City, Oklahoma; and Dallas, Texas. These initial programs proved that urban Indians would use health care services if such services were culturally sensitive, accessible, available, and affordable.

In 1976, Congress passed the Indian Health Care Improvement Act (P.L. 94-437) to address the deficiencies in health between American Indians and the general population. Title V of the Indian Health Care Improvement Act provided for funding and a mechanism by which new urban Indian health programs could develop direct health services and strengthen relationships with existing community and social service programs. The Indian Health Service has been an advocate for urban Indian health and administers the Urban Health Program through its Headquarters and Area offices.

STRATEGIC PLANNING MODEL

According to the Strategic Planning and Management Model, "strategic planning is the continuous process of making present risk-taking decisions systematically and with the greatest knowledge of their futurity; organizing systemically the efforts needed to carry out these decisions; and measuring the results of these decisions against their expectations through organized systematic feedback . . . strategic planning does not deal with future decisions; it deals with the futurity of present decisions" (p.36).

Strategic planning decisions differ from tactical or operational decisions because they are rare, consequential, and precursive. They occur infrequently and without precedent; they commit substantial resources and make significant commitment to a course of action; and they set precedents for other future actions and lessor decisions. Strategic planning decisions are inherently risky, in that the future is unknown, and are made for the long-term. As applied in this report, the Strategic Planning and Management Model is broken down into the following twelve steps:

1. Charter Development
2. Mandate Analysis
3. Mission Statement
4. Internal Environmental Scanning
5. External Environmental Scanning
6. Strategic Issues Analysis
7. Strategic Policy Agenda
8. Strategic Objectives
9. Program Formulation

10. Budget Formulation
11. Budget Execution
12. Evaluation and Control

METHODOLOGY

Preliminary discussions were conducted with Indian Health Service (IHS) staff[2] and
urban Indian health program directors to help define data, issues and process. A national urban Indian health strategic planning seminar was planned to bring interested participants in the Urban Health Program together. Using a delphi group process, participants at the national urban Indian health strategic planning seminar in January 1993 identified those internal strengths and weaknesses and external threats and opportunities as set forth in Tables 3 through 6. Once these strengths, weaknesses, opportunities and threats were identified, listed and collated, a follow-up questionnaire was sent to all the urban Indian health program directors; each director was asked to rank these according to what he or she thought was most important. A review of various urban Indian health reports was completed and an initial list of issues was developed. An initial draft of the plan was developed and disseminated to the urban Indian health program directors, board members, and IHS Area Urban Coordinators attending a national training seminar in November 1993. Additional issues and comments were received from those participants and incorporated into the report.

APPLICATION OF THE MODEL

Charter

Since 1977, the urban Indian health program directors, individually and through the American Indian Health Care Association, have developed recommendations and assisted the Indian Health Service (IHS) in planning for, and improving, health care for urban American Indians. The Urban Health Program of the IHS has solicited urban Indian health program directors' recommendations, convened working groups and sponsored conferences to identify critical issues and better plan health services for American Indians residing in urban centers.

In fiscal year 1990, the IHS Director established strategic planning as an IHS objective. Then, in fiscal year 1992, the IHS Urban Programs Branch and the

[2] Associate Director, Office of Planning, Evaluation, and Legislation; Director, Division of Clinical and Preventive Services; Director, Division of Program Evaluation and Policy Analysis; Chief, Special Initiatives Branch; Chief, Urban Health Program Branch; Chief, Demographic Statistics Branch; and the Delivery Order Officer.

Program Evaluation Branch developed a delivery order with the American Indian Health Care Association to, among other tasks, begin application of the IHS strategic planning model to the Urban Health Program. A strategic planning seminar was held in the early spring of 1993 to review the strategic planning process with the directors of the individual urban Indian health programs and IHS staff, to review the strategic planning mandate, and to initiate the internal and external scanning process. Conference participants included thirty representatives from the urban Indian health programs and five representatives from the Indian Health Service. Two days of workshops and seminars were provided defining the strategic planning process, developing consensus on the need for and value of strategic planning, formulating the planning steps and specific tasks and individuals to be involved, and implementing the initial steps of the process.

Mandate

The Indian Health Care Improvement Act, as amended (P.L. 94-437), is critical to urban Indian health programming. Title V of the legislation authorized federal government support for urban health programming and established this programming as a discrete budget activity within the Indian Health Service. Under Title V, Congressional appropriations for the Urban Health Program have increased from $6,858,000 in FY 1978 to $21,544,500 in FY 1993. Title V also gave the Indian Health Service the authority to establish, fund and develop new programs so that urban Indian health needs could be documented and services planned for meeting those needs. This Act also provided authority to enable urban Indian health programs to improve access to health care and to provide direct health care services. This was a notable departure from the earlier pilot programs that focused on only providing outreach and referral services.

The Indian Health Care Improvement Act, specifies the criteria for awarding and renewing contracts to urban Indian health programs. This law requires the Indian Health Service to develop procedures to ensure contract compliance and performance, and requires reports to Congress on urban Indian health status, services, and unmet needs. The Indian Health Care Improvement Act also established the Urban Programs Branch Office as the organizational unit within the Indian Health Service responsible for planning and oversight of the provisions of this law.

The Indian Alcohol and Substance Abuse Prevention and Treatment Act, as amended (P.L. 99-570), also specifies the criteria for awarding and renewing grants to the urban Indian health programs. In passing this law, Congress stated that alcohol and substance abuse is the most severe health and social problem facing Indian tribes and people today. According to this Act, "Indian tribes have the primary responsibility for protecting and ensuring the well-being of their

members." In the Omnibus Drug Act of 1988, Section 2202 was added to the Indian Alcohol and Substance Abuse Prevention and Treatment Act which defines "urban Indian" and adopts the same meaning found in the Indian Health Care Improvement Act. Section 2202 also authorized grant monies for the provision of direct services, treatment and rehabilitation services, and school and community-based education substance abuse prevention programs for urban Indians. This program authority was subsequently included in the 1992 amendments to the Indian Health Care Improvement Act.

In addition to legislative requirements, additional regulatory guidance is contained in CFR 42-36.35, October 1, 1988. The regulations define the urban Indian health program activities, contracting, and reporting requirements. The legislation and regulations define the parameters in which the Urban Health Program will operate and have been drafted into a program guidance manual section for the IHS Urban Health Program. The draft manual section has not been formal approved at this time.

Mission

The role of the IHS Urban Health Program is:[3]

1. To assure that, within available resources, a comprehensive program of health services is accessible to urban Indians;

2. To support community programs to prevent alcoholism and substance abuse;

3. To support community programs to promote health promotion and disease prevention, immunization, mental health, and child abuse prevention and treatment services; and,

4. To assure that within those resources, eligible patients or clients, regardless of age or sex, have access to and are provided with high quality health care services.

As stated in the 1976 Indian Health Care Improvement Act, the goal of IHS is to "elevate the health status of American Indians and Alaska Natives to the highest possible level, matching or exceeding health status indicators in the general population." The IHS Urban Health Program has two general goals:[4]

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[3] Indian Health Service Manual, Chapter 19: Urban Health Program (draft).

[4] *Ibid.*

1. To elevate the health status of urban American Indians and Alaska Natives to the highest possible level.

2. To assist the urban Indian organizations to establish and improve health services designed to meet the needs of the urban Indian community.

These general goals are to guide the IHS Urban Program Branch in the administration and oversight of the Urban Health Program. The IHS Urban Program Branch also has two general objectives:[5]

1. To provide assistance in the development of a comprehensive, effective health services delivery program with emphasis on health promotion and disease prevention.

2. To provide assistance in the development of a comprehensive, effective network of local community resources for the delivery of ambulatory health care services.

The customers of the Urban Health Program are those urban American Indians residing in urban centers currently served by urban Indian health programs who do receive services from the urban Indian health program. The potential customer base would also include those urban American Indians residing in urban centers with an urban Indian health program who do not currently receive services from the urban Indian health program, as well as urban American Indians residing in urban centers which do not have an urban Indian health program. At the present time, the unserved population is larger than the served population, principally do to lack of funding.

By consensus, the mission of the IHS Urban Health Program is to raise the health status of urban American Indians to the highest possible level. This mission statement has been used by the IHS Urban Health Program and the urban Indian health programs for many years.

Internal Environmental Scan

Review of Historical Performance

Since their beginning, urban Indian health programs have provided both outreach and referral, and direct comprehensive services depending on the availability, accessibility, and affordability of mainstream health services. The urban Indian health programs have developed and implemented a reporting system; developed

[5] *Ibid.*

and initiated AIDS education and prevention activities; initiated alcohol and substance abuse prevention, treatment, rehabilitation and education programs; continued to strengthen their perinatal programs; continued to improve linkages and cooperation with other local agencies; decreased administrative costs; and have expanded services while remaining cost effective. Four programs have received JCAHO accreditation.

Urban Indian health programs have improved the health status of urban Indians as substantiated by high immunization compliance rates, pap smear compliance rates, hypertension and diabetes follow-ups. These current accomplishments and activities have been documented elsewhere.

Past and Current Funding

Indian Health Service (IHS) funding has had a positive affect on the health status of urban American Indians. One of the most evident and important effects of Indian Health Service funding has been the stability it has given to urban Indian health programs. Where urban Indian health programs were once small voluntary clinics that often operated on a part-time basis, Federal IHS funding added legitimacy and viability to these programs. Increased funding of the IHS Urban Health Program Title V has allowed the programs to operate more effectively and to leverage other funding resources.

The amount of IHS funding appropriated for the Urban Health Program has increased from $150,000 in 1972 to $21,544,500 in 1993. This funding trend is shown in Figure 1 and Table 1.

Figure 1: Level of Funding for the IHS Urban Health Programs

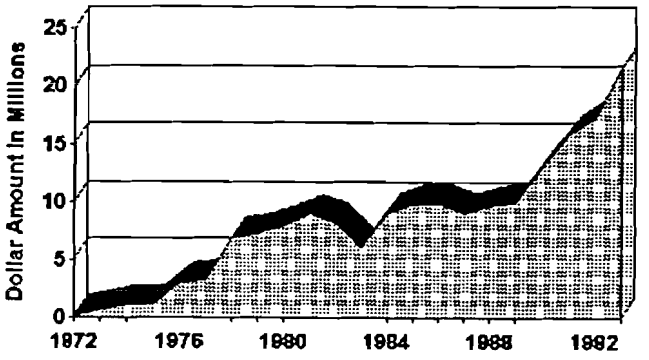

Table 1: Level of Funding for the IHS Urban Health Programs

Fiscal Year	Dollar Amount
1972	150,000
1973	600,000
1974	1,100,000
1975	1,132,000
1976	2,920,000
1977	3,280,000
1978	6,858,000
1979	7,270,000
1980	8,000,000
1981	8,900,000
1982	8,160,000
1983	6,000,000
1984	9,000,000
1985	9,800,000
1986	9,800,000
1987	9,000,000
1988	9,624,000
1989	9,962,000
1990	13,049,000
1991	15,770,000
1992	17,195,000
1993	21,544,500

The impact of this increase can be misleading for two reasons. First, the American Indian population in urban areas has steadily been increasing so that today over 50 percent of the American Indian population live in urban areas. Second, the cost of medical care has risen dramatically. For instance, between 1978 and 1988, the cost of medical care had nearly doubled.

At present, the urban Indian health programs receive grant funding to supplement their base contract funding under Title V; the programs receive funding for AIDS prevention, health promotion and disease prevention, alcohol and substance abuse treatment and prevention, mental health and immunization services.

Although the urban Indian health programs receive Title V funding, often this is insufficient. Many programs do not have another stable source of funding. Fee-for-service revenue is sporadic and unreliable. Therefore, the small programs must rely on increased and sustained support from the Indian Health Service (IHS), since much of the non-IHS funding is so unreliable and competitive. The urban Indian health programs that provide direct health care services are eligible for reimbursement from Medicare and Medicaid; however, the small urban Indian health programs that only provide outreach and referral services can not receive Medicare, Medicaid, or other third party payments.

Table 2 presents the funding received by the urban Indian health programs for the years 1984 through 1992 from all sources. Other than the IHS, the largest amount of funding is received from Medicaid; followed by Section 330 of the Public Health Services Act, county funding, the WIC program, state funding, other federal funding and third party payments (insurance) respectively.

Table 2: Receipts by Source and By Year: In Dollars

PROGRAM	1984	1985	1986	1987	1988	1989	1990	1991	1992
Section 330	1,595,143	1,799,380	1,514,152	1,633,990	1,878,210	1,902,107	2,293,193	2,542,121	2,439,869
MCH	294,233	294,206	179,181	97,063	105,190	102,621	130,415	66,581	137,996
Title X	108,502	0	0	0	0	67,416	57,664	58,044	10,406
WIC	645,979	808,921	839,253	834,983	894,866	893,754	1,343,070	1,480,373	1,752,872
IHS (Title V)	7,928,531	9,135,867	8,575,619	8,288,670	7,727,789	8,123,771	8,250,231	9,968,102	8,553,176
IHS (Other)	929,533	782,137	1,515,918	1,682,494	1,956,148	1,189,456	1,483,840	2,090,886	2,758,603
Other Federal	1,217,482	438,775	373,784	191,211	671,082	1,138,743	1,705,672	1,818,206	1,352,075
Medicare	97,154	92,030	127,458	93,220	144,291	240,385	109,420	186,151	221,420
Medicaid	590,478	963,576	880,570	1,178,370	980,657	1,086,023	814,370	2,364,198	3,525,523
Title XX	16,533	2,102	0	31,214	0	60,014	41,466	41,511	29,252
3rd Party	546,390	894,217	1,071,184	1,155,809	695,465	874,427	931,058	1,105,060	1,158,711
Patient Collections	980,502	1,017,571	1,155,483	583,152	504,153	782,167	663,021	621,484	698,100
State	1,139,454	1,442,691	1,269,125	1,267,121	1,152,475	1,636,047	2,259,405	3,175,507	1,358,592
County	508,967	550,583	679,289	566,205	440,055	889,433	1,523,687	1,498,538	1,877,718
City	144,671	330,010	132,594	189,743	421,753	435,402	427,228	376,881	628,879
Other	774,286	704,008	682,510	913,759	535,032	1,109,501	6,053,270	1,950,334	959,918
TOTAL	17,517,838	19,206,074	18,991,445	18,709,002	18,208,353	20,531,267	24,280,122	29,343,849	27,487,110

Internal Strengths

In analyzing the internal environment of the Urban Health Program, three major factors were examined: organizational structure, culture, and resources. Organizational structure includes authority, responsibilities, and functions within both the IHS system and the urban Indian health programs. Culture is the pattern of beliefs, expectations and values within both IHS and the urban Indian health programs. Resources consist of financial, operational and human resource capabilities within both IHS and the urban Indian health programs. If these and other factors allow the Urban Health Program to achieve its mission and objectives then they are strengths. If these factors prevent or impede the Urban Health Program from achieving its mission and objectives then they are weaknesses. Strengths should be nurtured and encouraged and weaknesses controlled so that the Urban Health Program mission and objectives can be attained.

A list of strengths was collated and then these were sent to the urban Indian health programs. Table 3 displays the strengths of the urban Indian health programs as ranked by the urban Indian health directors.

Table 3: Internal Strengths

Category	Rank
Program history and longevity	1
Retaining good provider staff	2
Addressing alcohol and lifestyle problems	3
History of expanding base funding	4
Program flexibility and adaptability	5
Professionalism of program staff	6
The program directors' experience	7
Knowledge of patient's culture/finances	8
Creating community responsive programming	9
The program directors' expertise	10
Networking with other community programs	11
American Indian Health Care Association	12
Experienced with non-fed capital funding	13
Experienced in developing intervention models	14
Congressional support for the programs	15
Experience tracking mobile population	16
Data gathering and reporting experience	17
Knowledge of capitated/prepaid system	18
Experience in quality assurance and JCAHO accreditation	19
Understanding and compliance with CLIA/OSHA regulations	20
Good relationship with community boards	21

Internal Weaknesses

The urban Indian health program directors also developed and ranked those identified organizational, cultural and resource weaknesses as identified in Table 4.

Table 4: Internal Weaknesses

Category	Rank
Insufficient training for community boards	1
Insufficient funds for capital projects	2
Lack of coordination between IHS and the programs	3
IHS's failure to adequately support the programs	4
Lack of regional funds	5
Have technical expertise but no funding to share it	6
Staff burnout as result of being underpaid and overworked	7
High turnover rate of executive directors	8
Mismanagement by few programs impacts on all	9
Hard to recruit and retain good staff	10
AIHCA's lack of visibility at the national level	11
AIHCA's lack of funds to hold regular board meetings	12
Excessive contract/grant reporting requirements	13
IHS Area Office staff unfamiliar with contract/grant reporting	14

The urban Indian health programs have many valuable internal strengths resulting from 20 years of history and experience in developing responsive services or their communities. The internal weaknesses frequently require joint action and attention by both the IHS and the individual urban Indian health programs. The IHS funding has provided the base upon which the urban Indian health programs have built increasing funding and other resources. The Urban Health Program has developed additional programs to meet community needs and has historically increased the numbers and types of services provided to local urban Indian communities.

External Environmental Scan

External environmental scanning is the analysis of variables that are outside the Indian Health Service and that are not typically within the short-term control of management. This external environment can be further divided into the task environment and the societal environment.

The task environment includes those factors that are affected by the major operations of the Indian Health Service. Such factors include, but are not limited to: urban Indian health programs, regional and national organizations, and urban American Indian communities. The societal environment includes more general forces; ones that do not directly touch the short-term activities of the IHS Urban Health Program but do influence its long-term decisions. These include, but are not limited to: political-legal forces, economic and technological-medical forces.

The process of external environmental scanning produces a list of opportunities and threats. External opportunities are short or long-term variables that allow the IHS Urban Health Program to achieve its objectives. External threats are short or long-term variables that prevent or impede the IHS Urban Health Program from achieving its objectives.

Opportunities

Table 5 presents a ranked listing of external opportunities as developed and reviewed by the urban Indian health program directors. Directors were asked to rank those opportunities that allow the urban Indian health programs to better serve their Indian patients.

Table 5: Ranking of External Opportunities

Category	Rank
Development of the urban program branch office within IHS	1
An increasing urban Indian population	2
Eligibility for greater funding	3
New IHS director	4
Clinton health care plan	5
Health care reform	6

Threats

Table 6 presents a ranked listing of external threats. Urban Indian heath program directors developed and ranked those short or long-term threats that prevented the urban Indian health programs from serving and helping their Indian patients.

Table 6: External Threats

Category	Rank
Decreasing funds and cost containment	1
Possibility that some urban programs may not survive	2
Programs need minimum base funding	2
Health care reform	3
Perceived competition with Tribes	4
Lack of understanding/communication between IHS and states	5
Inefficiency of some IHS Area Offices	6

This report has addressed the initial steps of the strategic planning process. Internal and external environmental scanning has resulted in a list of strengths, weaknesses, opportunities and threats. Building upon the internal and external scans, strategic issues, strategic policy, and strategic objectives were then defined.

Strategic Issues Analysis

In completing a strategic issues analysis, strategic or fundamental policy questions affecting the IHS Urban Health Program mandate, mission and values were identified and examined. These included fundamental issues affecting service mix, levels, and benefits; client eligibility for services and service utilization; linkages and agreements; cost accounting, financing, and funding methods; grant and contracting policies; organizational effectiveness and efficiency; and others.

Strategic issues analysis categorized issues into the four areas of health status issues, organizational issues, administrative issues, and human resources issues. Within these areas, specific issues are:

Health Status Issues

- Reduce Preventable Deaths
- Increase Health Assessment/Education Activities
- Study Defined Benefit Package
- Improve Quality Assurance/Outcomes Management Plans
- Increase Access to Care

Organizational Issues

- IHS Organizational Analysis
- Direct Grants With Headquarters
- Local Networking
- Relationship With Regional Health Alliances
- Develop Data Processing Capabilities

Administrative Issues

- Develop Forward Funding Budget
- Federally Qualified Health Center (FQHC)
- Support Urban Grants/Contracts
- Training and Technical Assistance
- Simplify Grant/Contracting Process
- Innovative Demonstrations

Human Resources Issues

- Increase Provider Recruitment
- Human Resource Development Training
- Director Retention
- Provider Training
- Executive Training

Health Status Issues

Reduce Preventable Deaths

Can the Urban Health Program reduce preventable deaths among American Indians? Urban American Indians show mortality rates from some causes as high or higher than the general population.[6,7,8,9] The goal of the Indian Health Service, to raise the health status of American Indians to the highest possible level, requires reducing mortality rates for urban American Indians. Failure to address this issue will prohibit the IHS from accomplishing the goal of improving health status to the highest possible level.

Increase Health Assessment/Education Activities

Can the Urban Health Program increase health assessment and health education activities for American Indians? A recent health appraisal report indicates that urban American Indians score high on many behavioral risk factors, contributing to increased preventable morbidity and mortality.[10,11] Failure to address this issue will result in increasing morbidity and mortality rates and increased costs of care to treat essentially preventable illnesses.

Study Defined Benefit Package

Can the Urban Health Program design a fundable benefit package for urban American Indians? The types of services available to American Indians vary between urban Indian health programs depending on the amount and availability of funding to the program.[12,13] Federal health care reform proposes a standard

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6 *Epidemiological Report: Ten Leading Health Problems of Urban American Indians,* American Indian Health Care Association, 1993.

7 *National Uniform Epidemiological Statistical Data and Analysis Report,* American Indian Health Care Association, 1989.

8 *Urban Indian Health Comparative Analysis Report,* American Indian Health Care Association, February 1991.

9 *Urban Indian Infant Mortality Report,* American Indian Health Care Association, July 1993.

10 *Assessment of the Health Risks of Urban Indians in Selected Urban Centers,* American Indian Health Care Association, 1993.

11 *Healthy Traditions: The Health Risk Appraisal Project for Urban American Indians,* American Indian Health Care Association, 1990.

12 *Comparison of Governmental Funding Sources for Urban Indian Health Programs,* American Indian Health Care Association, March 1991.

13 *Urban Indian Health Program Minimum Service Package,* American Indian Health Care Association, August 18, 1987.

benefit package for all Americans, and many states are taking the initiative to define standard sets of health care benefits to be delivered to various patient populations. To meet the goal of the IHS of raising the health status of American Indians to the highest possible level and the mission of the IHS Urban Health Program to assure that comprehensive health care services are accessible to urban American Indians, differences in benefits available in different urban centers should be addressed. Failure to address this issue will continue the differential access to services for American Indians dependent upon their city of residence.

Improve Quality Assurance/Outcomes Management Plans

Can the Urban Health Program improve quality assurance and outcomes management programs in urban Indian health programs? Four of the urban Indian health programs have received Joint Commission on the Accreditation of Health Care Organizations (JCAHO) accreditation. Others are in the process of preparation for accreditation review.[14] Two of the tenets of health care reform are improved quality assurance and increased outcomes management and monitoring. Urban Indian health programs must be prepared to participate in these areas under both national and state health care reform proposals currently being developed. Failure to address this issue could leave the urban Indian health programs behind as health care reform continues to develop.

Increase Access to Care

Can the Urban Health Program increase access to care for urban American Indians? The urban Indian health programs currently provide health services to American Indians in 41 urban centers. There remains an additional 18 urban centers with a significant urban American Indian population that currently do not receive services.[15,16,17,18,19] Approximately one half of the urban Indian population

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[14] *Identification of Urban Indian Health Programs Pursuing JCAHO Accreditation,* American Indian Health Care Association, 1989.

[15] *Evaluation of the Health Care Needs of Urban Indians in Areas Served and Unserved Under Title V of the Indian Health Care Improvement Act,* American Indian Health Care Association, November 1992.

[16] *Urban Health Program Consensus Statement: IHS Round Table Meeting,* Indian Health Service/PHS/DHHS, July 18 - 19, 1990.

[17] *Assessment of the Health Care Needs of American Indians/Alaska Natives Living in Cities Not Served by Urban Indian Health Programs,* American Indian Health Care Association, 1992.

[18] *Potential Sites: Urban Centers Unserved by an Urban Indian Health Program,* American Indian Health Care Association, February 1991.

[19] *Evaluation of Potential Site Locations for New Urban Indian Health Care Programs,* American Indian Health Care Association, September, 1989.

resides in areas not served by an urban Indian health program. To meet the goal of the IHS and the mission of the IHS Urban Health Program, one half of the urban Indian population cannot be without accessible health care. Failure to address this issue will decrease the likelihood that this goal and mission will be accomplished.

Organizational Issues

IHS Organizational Analysis

Can the Urban Health Program meet the organizational needs of the urban Indian health programs? The urban Indian health programs report many areas needing improvement in the support and assistance provided by the IHS Urban Health Program and the IHS Area Offices.[20] The first objective of the Urban Health Program is to provide assistance in the development of the urban Indian health system. The second objective is to provide assistance in the development of community resources for the delivery of ambulatory health care services. Failure to adequately provide the needed support and assistance to meet the organizational needs of urban Indian health programs could jeopardize the entire Urban Health Program.

Direct Grants With Headquarters

Can the Urban Health Program award all funding to urban Indian health programs through direct grants with IHS Headquarters? The 1993 amendments to the Indian Health Care Improvement Act provide for use of either contracts or grants for funding urban Indian health programs.[21] Many of the urban Indian health programs have indicated a preference for the grant mechanism to fund programs because of its reduced administrative burden and reporting requirements. The IHS Urban Health Program contracts are differentially administered and supported by the IHS Area Offices.[22] Centralization of grant administration IHS Headquarters would increase consistency of grant administration and reduce the administrative burden of contracts. Failure to address this issue will reduce the opportunity to provide consistent grants administration, policy development, and uniform application of IHS Urban Health Program guidelines.

Local Networking

Can the Urban Health Program assist the urban Indian health programs in increasing networking with local organizations? The urban Indian health programs have been encouraged by the IHS to continue and increase networking with local

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[20] *Management and Administrative Capabilities of the Indian Health Service Urban Indian Health Program,* American Indian Health Care Association, August 1992.

[21] P.L. 102-573.

[22] *Management and Administrative Capabilities of the Indian Health Service Urban Indian Health Program,* American Indian Health Care Association, August 1992.

organizations to improve access to health care for urban American Indians.[23,24] Both of the objectives of the Urban Health Program include "provide assistance in the development of a comprehensive, effective network of local community resources." Potential changes in the way health care will be organized and delivered, will encourage increased cooperation and integration with local health care delivery networks. Those programs which do not, may not be able to participate in an increasingly managed care environment.

Relationship With Regional Health Alliances

Can the Urban Health Program increase urban Indian health program relationships with regional health alliances? The proposed national health reform envisions large regional health alliances through which the public will receive their health care. Health care providers will have to participate in a regional health alliance to receive patients and payments for their services. The IHS/tribal/urban system of health care delivery will probably have to participate in some manner with, or as, a health alliance. Urban Indian health program participation and collaboration in development of such a system may be crucial for their continued survival.

Develop Data Processing Capabilities

Can the Urban Health Program and the urban Indian health programs develop comprehensive data processing capabilities? The Urban Health Program requires the urban Indian health programs to report aggregate financial and service data on a semi-annual basis.[25] Data on individual patient services, costs, and patient demographic information is not currently available to the Urban Health Program for planning or reporting purposes.[26,27] The increasingly integrated health care delivery system requires increasingly detailed and comprehensive data available to plan and report health care services delivery and results. Failure to develop comprehensive data processing and reporting capabilities, specific to each program, will place urban Indian health programs at a severe disadvantage in a managed care environment.

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[23] *Feasibility of Linking Urban Indian Health Programs and Community Health Centers,* American Indian Health Care Association, 1989.

[24] *Information and Referral Activities in Urban Indian Health Programs,* American Indian Health Care Association, August 1989.

[25] *Urban Common Reporting Requirements (UCRR) Instruction Manual,* American Indian Health Care Association, June 1993.

[26] *A National Evaluation of Urban Indian Health Programs' Client Base and the Conditions for Which Patients Are Seen,* American Indian Health Care Association, August 13, 1993.

[27] *Assessment of the Health Care Needs of American Indians/Alaska Natives Living in Cities Not Served by Urban Indian Health Programs,* American Indian Health Care Association, 1992.

Administrative Issues

Develop Forward Funding Budget

Can the Urban Health Program develop and benefit from forward funding budgeting? The IHS essentially develops its budget estimates and justification without benefit of urban Indian health program input. Urban Indian health programs typically must react to budgets and funding requests only after the IHS sends the request and justification to the Congress. Greater coordination and cooperation between the IHS and the urban Indian health programs would produce a realistic annual budget estimate, funding request, and justification that could be supported by both the IHS and the urban Indian health programs. Forward funding budgets for future years' funding needs would tie annual budgets to progress toward specific goals or objectives, such as the Year 2000 Health Objectives for the Nation. Failure to address this issue will continue the practice of budget development without input from the urban Indian health programs actually delivering the services, without concern for future budgetary periods, and unrelated to attaining defined objectives.

Federally Qualified Health Centers

Can the Urban Health Program support development of urban Indian health programs as Federally Qualified Health Centers? The urban Indian health programs will become eligible as Federally Qualified Health Centers (FQHC) effective January 1, 1994.[28] This status will require additional reporting requirements and place additional developmental requirements on urban Indian health programs, but will also allow them to recover actual cost-based reimbursement for medicaid services. Some urban Indian health programs may need training and technical assistance to meet these additional developmental and reporting requirements. Failure to address this issue will cost urban Indian health programs increased revenue and potential participation in managed care medicaid programs.

Support Urban Grants/Contracts

Can the Urban Health Program commit to full support of the urban Indian health program grants and contracts? Many of the urban Indian health programs do not believe that the IHS fully supports the Urban Health Program.[29] Two internal weaknesses of the Urban Health Program are lack of coordination between the IHS and the urban Indian health programs and the failure of IHS to adequately support the urban Indian health programs. There appears to be a significant variance between the Urban Health Program mission and objectives to support programs and provide assistance, and the perception of the urban Indian health programs.

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[28] *Omnibus Budget Reconciliation Act of 1993.*

[29] *Finalization Report: IHS Chapter 19, IHS Urban Health Program Branch Office,* American Indian Health Program, August 1993.

Lack of perceived support will hamper efforts toward coordination between the IHS and the urban Indian health programs.

Training and Technical Assistance

Can the Urban Health Program meet the training and technical assistance needs of the urban Indian health programs? About one half of the urban Indian health programs rated the technical assistance provided by IHS as less than adequate.[30] Because of geographic isolation from other Indian health programs and cultural and programmatic differences from other mainstream health care providers locally, specific technical assistance and training by the IHS is desired by most urban Indian health programs. Training for contract and grant compliance and reporting, program development, and health services administration frequently are requested. Because of changes in staff and programming, this training and technical assistance must routinely be scheduled and provided, especially for the benefit of new executive directors. Inadequate training and technical assistance will inhibit development of a comprehensive, quality health care system for urban American Indians.

Simplify Grant/Contracting Process

Can the Urban Health Program act to simplify the grant and contracting process for the urban Indian health programs? Urban Indian health programs frequently cite the numerous reporting and compliance requirements imposed by IHS contracts (and grants to a much lesser extent).[31] Simplification of the contracting and grant requirements will free urban Indian health program time and resources to be devoted to program operations. Current contracting requirements hampers the efficiency of urban Indian health programs.

Innovative Demonstrations

Can the Urban Health Program encourage and support innovative urban Indian health demonstration projects? Many urban Indian health programs are participating in managed care systems.[32] The urban Indian health programs in Tulsa and Oklahoma City are examples of demonstration projects transcending the differences between urban and tribal health programs. Health care reform will also encourage innovative and collaborative solutions to health care delivery. Failure to support innovative demonstrations to meet the health care delivery needs of urban Indian health programs may leave some programs unable to adapt to a changing health care delivery marketplace.

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[30] *Management and Administrative Capabilities of the Indian Health Service Urban Indian Health Program,* American Indian Health Care Association, August 1992.

[31] *Ibid.*

[32] *Experiments in Efficiency: Case Studies of Urban Indian Health Programs and Managed Care Systems,* American Indian Health Care Association, february 1991.

Human Resources Issues

Increase Provider Recruitment

Can the Urban Health Program increase provider recruitment for the urban Indian health programs? The second ranked internal strength of the urban Indian health programs is retention of good provider staff. The problem is in recruitment of provider staff, which will probably become more difficult with the increasing emphasis under managed care toward primary care providers. Well qualified primary care physicians are critical in a managed care environment. Without primary care providers, urban Indian health programs will not be able to compete in a managed care environment and cannot adequately serve their patient population.

Human Resource Development Training

Can the Urban Health Program meet the human resource development training needs of the urban Indian health programs? Insufficient board training, staff burnout, director turn over, and difficulty in recruitment and retention of staff are all cited as internal weaknesses of the urban Indian health programs. To meet the Urban Health Program objective "to provide assistance in the development of a comprehensive, effective health services delivery program" will necessitate that the urban Indian health programs have available training to further develop their human resource programs. Failure to improve human resource development programs in urban Indian health programs will contribute to the present internal weaknesses previously listed.

Director Retention

Can the Urban Health Program improve retention of directors by the urban Indian health programs? One of the internal weaknesses of the urban Indian health programs is the high turn over rate of executive directors. In some years the turn over rate exceeds 33 percent. Two of the internal strengths of the urban Indian health programs are the experience and the expertise of the executive directors. Clearly it is important to retain executive directors with experience and expertise. Poor management is routinely cited as a principal reason for failure of health care organizations in general. Failure to address this issue will result in continued high turn over rates of urban Indian health program executive directors.

Provider Training

Can the Urban Health Program meet the provider training needs of the urban Indian health programs? Provider training opportunities are associated with recruitment and retention of provider staff. A part of the mission of the Urban Health Program is to assure that patients are provided with high quality health care services. To meet the IHS goal of elevating the health status of American Indians to the highest possible level will require well trained and experienced provider staff. Failure to meet the training needs of urban Indian health program providers will leave the

urban Indian health programs less than adequately prepared to increase health status, provide quality care, and improve provider recruitment and retention.

Executive Training

Can the Urban Health Program meet the executive management training needs of the urban Indian health programs? Urban Indian health programs continue to need executive development and training for their top management staff.[33] Comprehensive executive training has not been made available to urban Indian health programs by the IHS in the past. One of the Urban Health Program internal weaknesses is mismanagement within a few of the urban Indian health programs. The ever changing and complex business environment of health care delivery necessitates periodic management development training and education for urban Indian health program executive staff. Without continuing executive training, urban Indian health program management will not be competitive in tomorrow's health care delivery system.

[33] *Management and Administrative Capabilities of the Indian Health Service Urban Indian Health Program,* American Indian Health Care Association, August 1992.

Strategic Policy Agenda

Once the strategic issues were identified and listed, they were evaluated according to their strengths, weaknesses, opportunities and threats (S.W.O.T.s). The evaluative process resulted in a strategic policy agenda. There were five questions that were answered sequentially. The five questions were:

1. What are the practical alternatives, "dreams," or "visions" that might pursued to address each strategic issue?

2. What are the barriers to realizing these alternatives, dreams or visions?

3. What major proposals might be pursued to achieve these alternatives, dreams, or visions and what barriers can be overcome?

4. What major actions using current resources must be taken within the next year to implement the major proposals?

5. What specific steps must be taken within the next six months to implement the major proposals and who is responsible for their implementation?

The strategic policy agenda process was formalized into the strategic objectives.

Strategic Objectives

The strategic objectives were the end results of the strategic planning process. These strategic objectives provide a means for translating the broad strategic action agenda into specific concrete actions. Strategic objectives must be quantifiable and doable. The also must be integrative, precursive, substantive, and definitive.

Quantifiable: It must be objectively stated and measurable.

Doable: It must be consistent with the legislative mandate, it is something that IHS or the urban Indian health programs can accomplish, and sufficient resources are available to succeed.

Integrative: It integrates external and internal values in pursuit of an organization's mission.

Precursive: It set precedents for program and management policies, and subsequent objectives.

Substantive: It commits substantial resources and involves substantial leadership by the highest levels of management.

Definitive: It provides clarity of direction and is the source of specific operational objectives and targets.

NATIONAL URBAN STRATEGIC OBJECTIVES

Health Status

By the Year 2000, the Urban Health Program will reduce urban American Indian and Alaska Native mortality and morbidity rates as specified in the report "Healthy People 2000: National Health Promotion and Disease Prevention Objectives" and measured by a formal health status monitoring/behavioral risk factor surveillance system.

Organizational

By the Year 2000, IHS and urban Indian health programs will plan, develop, and implement policy to restructure/reorganize the IHS, which requires IHS to delegate all authorities over planning, administration, budget, and operations to the most organizationally effective unit or office based upon utilization review of resource efficiency and patient satisfaction.

Administrative

By the Year 2000, the IHS and urban Indian health programs will plan, develop, and implement a managed care delivery system that provides defined benefits and equitable distribution of resources for benefits/services as measured through needs assessments, utilization review and outcomes management, quality assurance and patient satisfaction.

Human Resources

By the Year 2000, the Urban Health Program will have a human resource development program to improve recruitment, increase retention, and provide a career development program resulting in a highly qualified, well-trained, motivated, satisfied, and stable workforce at all levels of the Urban Health Program.

NATIONAL URBAN TACTICAL OBJECTIVES

HEALTH STATUS

STRATEGIC OBJECTIVE:

By the Year 2000, the Urban Health Program will reduce urban American Indian and Alaska Native mortality and morbidity rates as specified in the report "Healthy People 2000: National Health Promotion and Disease Prevention Objectives" and measured by a formal health status monitoring/behavioral risk factor surveillance system.

TACTICAL OBJECTIVES:

Reduce overweight to a prevalence of no more than 30 percent among urban American Indians and Alaska Natives.

Reduce cigarette smoking to a prevalence of no more than 20 percent among urban American Indians and Alaska Natives.

Reduce deaths among urban American Indians and Alaska Natives caused by unintentional injuries to no more than 66.1 per 100,000 American Indians and Alaska Natives.

Reduce diabetes-related deaths among urban American Indians and Alaska Natives to a prevalence of no more than 48 per 100,000 American Indians and Alaska Natives.

Reduce deaths among urban American Indian and Alaska Native men caused by alcohol-related motor vehicle accidents to a prevalence of no more than 44.8 per 100,000 American Indian and Alaska Native men.

Reduce deaths among urban American Indians and Alaska Natives caused by motor vehicle crashes to no more than 39.2 per 100,000 American Indians and Alaska Natives.

Reduce cirrhosis deaths among urban American Indians and Alaska Natives to no more than 13 per 100,000 American Indians and Alaska Natives.

Reduce suicides among urban American Indian and Alaska Native men to no more than 12.8 per 100,000 American Indian and Alaska Native men.

Reduce homicides among urban American Indians and Alaska Natives to no more than 11.3 per 100,000 American Indians and Alaska Natives.

Reduce the infant mortality rate among urban American Indians and Alaska Natives to no more than 8.5 per 1,000 live births.

Increase to at least 90% the proportion of pregnant urban American Indian and Alaska Native women who receive prenatal care in the first trimester of pregnancy.

Increase to at least 90% the proportion of urban American Indians and Alaska Natives who have received, at a minimum within the appropriate interval, all of the screening and immunization services and at least one of the counseling services appropriate for their age and gender as recommended by the U.S. Preventive Services Task Force.

Increase to at least 90% the proportion of urban Indian health program patients receiving at least an annual health assessment.

Increase to at least 90% the proportion of urban Indian health programs providing health education activities in at least five health areas.

Increase to 100% the proportion of direct service urban Indian health programs which have a quality assurance/outcomes management process meeting JCAHO standards.

ORGANIZATIONAL

STRATEGIC OBJECTIVE:

By the Year 2000, IHS and urban Indian health programs will plan, develop, and implement policy to restructure/reorganize the IHS, which requires IHS to delegate all authorities over planning, administration, budget, and operations to the most organizationally effective unit or office based upon utilization review of resource efficiency and consumer satisfaction.

TACTICAL OBJECTIVES:

Increase to 100% the proportion of IHS authorities which have been delegated to the most appropriate organizational level.

- planning, administration, budget, operations

Increase to 100% the proportion of IHS funding received by urban Indian health programs through grants with IHS headquarters.

Increase by 70% the proportion of urban Indian health programs who are participating in a local network.

- consortiums, alliances, affiliations

Increase to 100% the proportion of urban Indian health programs which have entered into a relationship with a regional health alliance.

Increase to 90% the proportion of urban Indian health programs reporting satisfactory data processing capabilities to meet their, and the Urban Health Program, analysis and reporting needs.

- FQHC, health care reform, state, local, managed care

ADMINISTRATIVE

STRATEGIC OBJECTIVE:

By the Year 2000, the IHS and urban Indian health programs will plan, develop, and implement a managed care delivery system that provides defined benefits and equitable distribution of resources for benefits/services as measured through needs assessments, utilization review and outcomes management, quality assurance and patient satisfaction.

TACTICAL OBJECTIVES:

Develop a forward funding budget process with full participation by the urban Indian health programs within one year.

Increase to 90% of the eligible urban Indian health programs which participate in the Federally Qualified Health Center program.
- cost accounting, information processing

Increase to 90% the proportion of urban Indian health programs reporting satisfaction with the contact and grant support provided by IHS.

Increase to 90% the proportion of urban Indian health programs reporting satisfaction with the training and technical assistance provided by the IHS.

Increase to 90% the proportion of urban Indian health programs reporting satisfaction with the IHS grant and contracting process.

Increase the number of innovative demonstrations supported by the Urban Health Program by 50%.

Increase access to care so that there is an urban Indian health program in urban centers in which at least 75% of the urban American Indians reside.

Increase access to care so that urban Indian health program patients receive an appointment within 1 day for acute and chronic conditions and within 5 days for less urgent conditions.

Complete a study a defined benefit package available through all urban Indian health programs within one year.
- universal coverage, IHS wrap around provisions

HUMAN RESOURCES

STRATEGIC OBJECTIVE:

By the Year 2000, the Urban Health Program will have a human resource development program to improve recruitment, increase retention, and provide a career development program resulting in a highly qualified, well-trained, motivated, satisfied, and stable workforce at all levels of the Urban Health Program.

TACTICAL OBJECTIVES:

Reduce the average annual rate of separation from the IHS Urban Health Program to no more than 15% of clinical staff and 10% of administrative staff.

- Develop and implement a career benefits package.

Increase by 10% the number of American Indians/Alaska Natives working at all professional and non-professional levels in the Urban Health Program.

Decrease to an average of no more than 60 days the time from recruitment to selection of applicants for clinical positions.

- Extend grant obligation pay-backs to urban programs.

Increase to 80% the proportion of urban Indian health program who have had staff attend human resource development training within the last year.

Increase to at least 80% the proportion of urban Indian health program provider staff who have attended continuing education within the last year.

Increase to at least 80% the proportion of urban Indian health program executive directors who have more than one year in their present position.

Increase to at least 80% the proportion of urban Indian health programs which have had executive staff attend training within the last year.

- FQHC, health care reform, expansion, new regulations

CONCLUSION

This report has applied the Indian Health Service Strategic Planning Model to the Urban Health Program. It has summarized and reviewed the strategic planning process, the charter, mandate and mission of the Urban Health Program. It has compiled and listed the internal strengths and weaknesses and external opportunities and threats as viewed by participants within the Urban Health Program.

Based on the previous steps and in consultation with the Urban Health Program participants, strategic issues to the survival of the Urban Health Program were defined. Through a policy analysis and participant input and feedback, strategic objectives for the Urban Health Program have been developed. Various tactical objectives have been developed for each strategic objective. Consensus has been continually sought through Indian Health Service and urban Indian health program participation in the strategic plan development at two seminars and repeated surveys and mailings.

This plan should be reviewed and evaluated once more at a national seminar involving the IHS Urban Programs Branch staff, the IHS Area Urban Coordinators, and representatives from each urban Indian health program. Once this plan has been reviewed and accepted, the final steps in the strategic planning process of program formulation, budget formulation and budget execution should be completed in close consultation with the urban Indian health programs.

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APPENDIX

URBAN INDIAN HEALTH DIRECTORS' RECOMMENDATIONS

The following are recommendations compiled from urban Indian health program directors and others over the last ten years for improving health services to urban American Indians. Some of the recommendation may have been implemented, some are beyond the abilities of the IHS, some may no longer be relevant, and some may have not yet come to pass.

1. Language should be added to Title I, Section 102(b)(1) to include urban Indian health programs as preferential applicants for health career recruitment awards.

2. Allow programs the flexibility to determine their service population based on their experiences and data. IHS Area/Program personnel and urban Indian health program directors should establish a method to determine the service population.

3. Revise language requiring grants instead of contracts. In 1990, the law was amended to allow for either contracts or grants.

4. Include language, similar to tribal contractors, that allows one year carry-over of unspent contract funds.

5. Allow urban programs to be eligible for commission corps placement and IHS research funding.

6. Amend the law to allow for urban Contract Health Services funding so that urban Indian health programs have the resources to pay for outside referrals.

7. Extend the Federal Tort Claims Act to cover urban Indian health programs.

8. Funding for data systems should be adequate and timely to insure beneficial reports and feedback to the Individual programs, as well as to IHS.

9. Amend P.L. 94-63, to change the criterion for designation of an area as a MUA (medically undeserved area) so that the urban Indian health programs can take advantage of MUA funding. At present, there is a criterion that "at least 51% of a Community Health Center's patients reside in a designated MUA. The smallness of the Indian population relative to white and other ethnic populations within our cities, and the fact that urban Indians are located in pockets throughout urban areas rather than in any one concentrated area, mitigates against the attainment of this criterion by Indian organization[s] that would otherwise be eligible for MUA funds" (Rhoades, 1984, pp 7-8).

10. Centralize the Funding and Reporting Requirements in Headquarters.

11. The Urban Program Office in Headquarters must be given more staff if it is going to set uniform policies, standards and contracts and oversee and monitor compliance with the law. The IHS should hire health analysts to work in the Area Offices. The health analyst should provide technical assistance to urban Indian health programs, and coordinate services among the several state and local health agencies.

12. Headquarters should give Area Offices a written directive allowing them to waive annual competitive bidding for Title V funding if programs meet their contractual obligations.

13. That no monies be withheld unless the programs receive a written notice of the amount and reason for withholding.

14. All "other-use" Title V monies (travel expenses) should be designated and controlled by one central agency.

15. Development of a formal procedure that would insure continuity and quality of care to Indian patients regardless of geographic residence (reservation v urban), or tribal affiliation.

URBAN ROUND TABLE RECOMMENDATIONS

In 1990, the Indian Health Service sponsored the Urban Round Table Meeting in Rockville, Maryland. The following strategic issues were discussed.

1. Expanding the Data Base for Urban Health: There is a need to strengthen the knowledge base about services provided to and by urban Indians under the current program. There is a lack of adequate data to measure the effectiveness of services and its impact on the status of urban Indian health.

2. Delivering Services to Non-Indians: Urban Indian health programs which seek alternate resources to match their IHS support are often placed in the position of also serving non-Indians. There is no formal policy by IHS on serving non-Indians in the urban health setting.

3. Medical Malpractice Costs: Medical malpractice has become unaffordable for many urban health programs, especially for prenatal and obstetrical care. Some programs have eliminated needed services due to the cost of malpractice insurance.

4. The New Federalism: The move towards a "New Federalism", or contracting federal Indian funds to tribal governments, does not consider potential impact on urban Indian health care.

5. Patient Billing: Many urban programs have established "patient billing systems," primarily in response to alternative funding sources. IHS area offices have conflicting views on the whether to allow these billing systems.