

1990

Urban Indian health

JA Kauffman

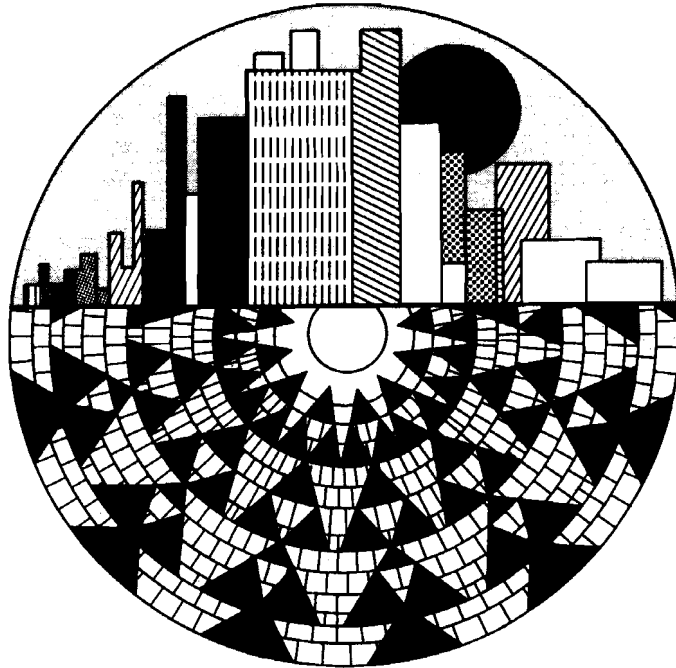
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Urban Indian Health



CONSENSUS STATEMENT
IHS Round Table Meeting
July 18 - 19, 1990



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service • Indian Health Service

INDIAN HEALTH SERVICE

URBAN HEALTH ROUND TABLE REPORT

**Rockville, Maryland
July 18 and 19, 1990**

Office of Planning, Evaluation and Legislation

**THIS REPORT IS AN INDEPENDENT STATEMENT OF THE
ROUND TABLE GROUP AND IS NOT A POLICY STATEMENT BY THE
INDIAN HEALTH SERVICE OR THE FEDERAL GOVERNMENT.**

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**Office of Planning, Evaluation and Legislation
Associate Director: Luana Reyes
Deputy Associate Director: Edward Simermeyer
Division of Program Evaluation and Policy Analysis
Director: Leo J. Nolan**

The Indian Health Service sponsored the Urban Indian Health Round Table on July 18 and 19, 1990. This report is an independent statement of the Round Table group and is not a policy statement by the Indian Health Service or the Federal Government. The Round Table was an important, topical and timely setting, experts were then provided to discuss strategies, plans and

Prior to the meeting, the Round Table Book included information on programs, an overview of programs, trends and proposed for discussion.

The format for participation of the Round Table and Legislative perspectives. IHS An

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The meeting began with the Round Table. Some topics were examined in advance of the group. The topics were set aside for these needs.

The Indian Health Service of Health (NIH) professionals in the health field. The NIH Development Conference

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PREFACE

page 1

The Indian Health Service (IHS), Office of Planning, Evaluation and Legislation, (OPEL) sponsored the Urban Round Table Meeting at the IHS headquarters in Rockville, Maryland on July 18 and 19, 1990. The purpose of the meeting was to bring together experts in health care, urban Indian community development, academia and national health policy to examine important, topical and controversial issues related to "urban Indian health". In a round table setting, experts were provided with the latest, pertinent information on each issue. The group was then provided the opportunity to discuss each issue, and to formulate recommendations, strategies, plans and a "consensus statement".

Prior to the meeting the identified experts were provided with a Briefing Book. The Briefing Book included materials on the legislative background of IHS support for urban Indian health programs, an overview of the volume and quality of services provided by urban Indian health programs, trends observed related to urban Indian health, and a summary of each of the issues proposed for discussion by the group.

The format for the Urban Round Table Meeting relied heavily on the knowledge base and participation of the experts from the field. The Indian Health Service's Office of Planning, Evaluation and Legislation specifically sought to bring together experts who could lend a variety of perspectives. IHS brought together the following perspectives on urban health:

- Urban Areas with a Large Urban Indian Health Program
- Urban Areas with a Small Urban Indian Health Program
- Urban Areas with an Indian Center but No IHS Sponsored health clinic
- Urban Areas with an Indian Substance Abuse Program but No IHS Sponsored Program
- Academicians Familiar with Urban Indian Populations and Trends
- National Health Policy for the Medically Indigent
- A Practicing Physician Involved in Urban Indian Health
- Statewide Health Care Coordination and Policy Development
- IHS Area Staff

The meeting began by seeking agreement on the specific issues to be addressed in the Urban Round Table. Some issues which appeared to be at the surface of the Urban Health arena, were examined in advance and background documentation compiled in preparation for discussion by the group. The opportunity for the group to identify additional issues was provided and time was set aside for these new issues on the agenda.

The Indian Health Service borrowed this consensus statement model from the National Institutes of Health (NIH). NIH has used this method of consensus building among health science professionals in the development of standards of care and to generate general guidance in the health field. The NIH publication, "Guidelines for the Selection and Management of Consensus Development Conferences", describes the process as:

"The creative work of the panel is to synthesize this information, along with sometimes conflicting points of view on the interpretation of these data, into a clear statement that addresses the questions posed to the panel. The answers must be as clear and accurate as possible. When consensus cannot be achieved, the statement should reflect this by noting uncertainties, options, or minority viewpoints when these exist."

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While the issues examined by the Urban Round Table were policy oriented, rather than clinical in nature, the process proved to be an effective means of bringing together a variety of perspectives and forming a statement of consensus on often times controversial topics. Clearly, the issue of adequate funding for urban health was a constant sub-issue which emerged throughout the discussion. Although, the group made some recommendations in regard to funding levels for urban health, they did not shy away from their responsibility to examine the substance of each issue on its own merits.

After examining the issues developed for the panel in advance of the round table meeting and upon adding new issues of importance to the group, the following issues were discussed by the Urban Round Table Meeting:

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 to also serve 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 toward a "New Federalism", or contracting federal Indian funds to tribal governments, does not consider potential impact on urban health care. Is there any impact? If so, will it be negative or positive?
5. **PATIENT BILLING.** Many urban programs have established "patient billing systems," primarily in response to alternate funding sources. IHS area offices have conflicting views on the allowability of billing patients under the urban health program.
6. **STATE RESOURCES.** States have a responsibility to provide health care and other assistance to populations in need, including Indian populations in their state. How can these resources be accessed?
7. **UNSERVED URBAN SITES.** Many urban Indian populations in need of health care remain unfunded by the IHS urban health program.

Experts from the panel were requested to make brief presentations on an issue. The discussion then focused on the development of "consensus statements." The purpose of a consensus statement was to accurately reflect the general position of the round table participants. A consensus statement did not require that the group reach consensus on the issue. Rather, the consensus statement described the overall position of the group, including descriptions of disagreement or dissent. The panel worked diligently toward consensus.

In addition to the panel of experts, recognition must go to Wanda Wood and Leo Nolan from the Division of Program Evaluation and Policy Analysis, for a successful meeting, and to Luana Reyes, Associate Director-OPEL, who facilitated the round table process.

The Urban Round Table review. The consensus statement on urban health care, across the various tables. The following

● The knowledge Although some urban planning documents of urban health. called the Urban Round Table related to "workload" not been an effort made specific findings problems, including collection, funding collection instrument IHS for other Indian urban health at the staff at headquarters urban health program

● The Indian evolved through it supplement the IHS this resourcefulness must be provided and more services Urban Health function Indian health programs and service programs, such as based services program

● The medical insurance premium obstetrical needs or have had to discontinue urban round table the malpractice program where services are

SUMMARY

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The Urban Round Table developed consensus statements for each of the issues prepared for their review. The group elected to add one more issue to the advance list for development of a consensus statement. This issue dealt with the need to examine and foster state involvement in urban health care. The group also developed a brief list of recommendations which they felt cut across the various issues and bolstered the overall effectiveness of their efforts on the round table. The following summarizes the consensus statements:

- The knowledge base for urban Indian health status and health care resources is lacking. Although some urban health programs have conducted excellent needs assessments and health planning documents, there is no means for these data to be aggregated to show a national picture of urban health. The IHS has implemented a common reporting system for urban programs called the Urban Common Reporting Requirements (UCRR). This instrument provides data related to "workload", but does not report diagnostic information for morbidity data. There has not been an effort to retrieve urban specific mortality data on a national basis. The round table made specific findings and recommendations to the Indian Health Service to address these problems, including a national health status report, better coordination with the States on data collection, funding for community based needs assessments, better utilization of existing data collection instruments within IHS, and eventually incorporating urban data into data collected by IHS for other Indian populations. The group stressed the severe staffing shortage focused on urban health at the headquarters level. A recommendation was made to increase the number of staff at headquarters who work on urban health issues in order to collect, analyze and report urban health program information.

- The Indian Health Service needs to address the unique service delivery model which has evolved through its urban health program. Urban programs have found other resources to supplement the IHS investment in their local communities and they should not be penalized, for this resourcefulness. A common requirement for accepting other non-IHS funds is that services must be provided to those in need, without regard to race. Urban programs can provide better and more services to Indian patients by also serving non-Indian patients in most cases. IHS Urban Health funding represents approximately 46% of the total funds supporting the urban Indian health programs. The round table called on the IHS to clarify its policy regarding urban programs and services to non-Indian patients and to assist in coordinating with other federal programs, such as the Bureau of Health Care Delivery and Assistance to protect the population based services provided through urban programs.

- The medical malpractice crisis is affecting urban health programs. Many reported insurance premiums increases of up to 500%. Programs which attempt to address prenatal and obstetrical needs of their patients are particularly hurt by the malpractice crisis. Many programs have had to discontinue services, and in some instances provide care without insurance. The urban round table recommended that the IHS conduct a national study to determine the scope of the malpractice problem among urban programs and to assess potential IHS liability in cases where services are provided without adequate malpractice coverage.

● The urban round table examined the growing trend toward tribal contracting of federal Indian dollars and the movement toward a "New Federalism" in the tribal-federal relationship. There is still much that is unknown about if and how this trend will impact Indian agencies such as the Indian Health Service and its relationship with urban Indian programs. The round table found that the potential exists for new opportunities in the relationship between tribes and urban programs. The group recommended that the IHS continue to monitor this trend and to consult with urban programs on the potential impact.

● Additional revenues are generated for urban health programs through the implementation of billing systems. Many of the alternate resources utilized by urban programs require that they implement a sliding fee billing system, which bills patients without other coverage on an ability to pay basis. Since this system is unique within the IHS structure, urban programs have received mixed reactions from IHS officials. Some programs have been advised that the billing system is not allowable, while others have received encouragement from IHS to establish and implement billing systems. The round table found that most third party reimbursers for health care will not pay for services, unless a unilateral billing system is in place and applicable to all patients. The group also noted that IHS funding does not cover the full cost of care to urban Indians, and to eliminate the revenue generated from patient billing would result in a reduction of services to Indian patients. The round table recommended that an IHS-wide policy which supports a patient billing system in urban health programs be issued.

● States have a responsibility to provide assistance to communities in need of health and social services, including Indian populations within that state. The assistance from states received by urban health programs varies from state to state. It was the finding of the group that state resources were not being utilized as much as they could, and that the Indian Health Service could do more to help gain entree into state resources for Indian communities. Specific actions were recommended which would enhance the urban health programs' use of state resources.

● While the Indian Health Care Amendments Act of 1988 provided the IHS with the authority to fund "new starts" in unserved urban Indian communities, no unserved communities have developed programs under this mechanism to date. There was a lack of guidance and information to urban Indian communities about how to proceed toward achieving Title V funding for their urban Indian community. Additionally, a lack of federal funding for urban health threatens to jeopardize existing urban programs if new starts are funded without adequate increases for this purpose. The group recommended that IHS seek additional resources to fund new starts and that a means to begin the feasibility study process in unserved communities begin. The group also recognized and endorsed the findings and recommendations of the American Indian Health Care Association study on unserved urban Indian communities.

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RECOMMENDATIONS

In addition to the specific issues previously described, the urban round table asked that the IHS consider some cross cutting recommendations which emerged through the process. Those recommendations are:

1. A central gathering point for all studies done by or about Urban Indian Health Programs should be available at IHS headquarters' Office for Planning, Evaluation and Legislation.
2. IHS should reconvene the urban round table to assess and evaluate the impact of the urban round table process, findings, and recommendations.
3. Other issues which were not addressed at the first round table meeting, but which warrant further study and the time to be examined by experts in an urban round table setting include:
 - a. Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (FAE) in urban populations needs to be better understood. More attention is needed to develop the knowledge base related to FAS/FAE assessment, services, tracking, family support systems and resources.
 - b. Acquired Immune Deficiency Syndrome (A.I.D.S.) poses a serious threat to urban Indian communities. Urban communities are at greater risk for HIV infection than other Indian communities. The population is migratory, and efforts to prevent AIDS in the Indian population nationally must focus on urban populations.
4. IHS needs to develop and disseminate informational material which describes the urban health program and answers basic questions about urban Indian health and the IHS urban program.
5. The IHS needs to increase the number of headquarters staff and amount of IHS resources focused on the issue of urban Indian health.

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URBAN HEALTH BACKGROUND

The Indian Health Service (IHS) provides health care to American Indians and Alaska Natives residing on or near federal Indian reservations or in recognized Indian communities or Alaska Villages. Services are generally limited to Indian people who are members or descendants of federally recognized tribes.

Many Indian people, today, reside off the reservation setting. The 1980 Census estimated that of the 1.7 million American Indian people identified, their residence pattern varied:

Reservations 24%
 Urban Areas 26%
 Historic Areas of Oklahoma 8%
 Alaska Native Village 3%
 Other Tribal Trust Lands 2%
 Remainder of the U.S. 37%
 (Source: U.S. 1980 Census Update on Indians, and AIHCA 1986)

Fiscal year

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The American Indian and Alaska Native population began to migrate to the cities after World War II. Around this same time, the Bureau of Indian Affairs initiated a "Relocation Program" which recruited Indian people for vocational training in urban centers. The American Indian Policy Review Commission found that over 160,000 Indians and Alaska Natives were relocated to urban centers by the BIA in the 1950's and 1960's. For the most part, Indians relocated to these target cities found themselves in poverty, with little or no support system. In the 1960's Indian community based service systems began to spring up to address the needs of Indians in urban settings.

Studies on urban Indian populations revealed that the lack of adequate health care was a serious problem for most families. Local, volunteer based community efforts began to offer limited medical care and referral to urban Indian people. The first federal funding through the Indian Health Service for urban Indian health was provided to the Indian Health Board of Minneapolis in 1972. Other health programs had been established in Seattle, San Francisco and Oklahoma City. Most urban health programs at this point depended largely on local support and volunteer health professionals. The Indian Health Service maintained that their primary beneficiaries were Indian people in reservation and Alaska village settings.

In 1976, Congress passed the Indian Health Care Improvement Act (P.L. 94-437) which was landmark legislation for all Indian health concerns, but particularly for urban populations. Title V of the legislation specifically authorized health outreach and referral and the delivery of services to Indian people in urban areas. After the passage of P.L. 94-437, there were forty-one urban Indian health centers funded under Title V. The urban health program was expanded upon in subsequent legislation passed in 1988, known as the Indian Health Care Amendments (P.L. 100-713). These amendments clarified the allowability of urban programs to provide direct health services to their patient population and strengthened the reporting and evaluation requirements for the urban health programs. Also in 1988, the Anti-Drug Law Amendments provided special language to allow urban health programs funded under Title V, to receive Alcoholism and Substance-Abuse Treatment and Prevention funding.

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In Fiscal Year 1978, after the passage of the Indian Health Care Improvement Act, the funding level for urban health programs was \$6.858 million supporting 41 programs. With the rise in health expenditures and inflation, the urban health program has suffered a net loss. The American Indian Health Care Association has calculated the medical cost index from 1978 and compared these figures to 1988 base appropriations and found that the urban health programs lost 70% of their 1978 "buying power" to inflation.

FY 1981-1990 IHS Appropriations History

Fiscal year	Appropriations		Annual Change		Cumulative Change	
	Total IHS (millions)	Urban (millions)	Total IHS	Urban	Total IHS	Urban
1981	594,119	8,900				
1982	599,645	8,160	.9%	- 8.3%	.9%	-8.3%
1983	645,583	6,000	7.7	- 26.5	8.7	-32.6
1984	770,408	9,000	19.3	50.0	29.7	1.1
1985	793,728	9,800	3.0	8.9	33.6	10.1
1986	818,194	9,800	3.1	.0	37.7	10.1
1987	841,809	9,000	2.9	- 8.2	41.7	1.1
1988	943,297	9,624	12.1	6.9	58.8	8.1
1989	1,020,106	9,962	8.1	3.5	71.7	11.9
1990	1,178,337	10,164	15.5	2.0	98.3	14.2

Courtesy of the American Indian Health Care Association

Despite this decrease in buying-power, the programs have been aggressive in their efforts to expand services. Urban Indian health programs have been able to match every IHS dollar with another dollar from alternate resources, such as federal, state, local or patient generated funding. The urban programs also created their own national organization to provide advocacy, a national voice, technical assistance and other clearinghouse functions. This organization is the American Indian Health Care Association (AIHCA). It is located in St. Paul, Minnesota and provides services to its member and other urban programs.

AIHCA has conducted many valuable studies related to aspects of the urban Indian health program. Several of those studies were integral in the analyses of the issues contained in this report and provided data for the participants of the urban round table. An annotated bibliography is included in this report which provides more information on AIHCA studies.

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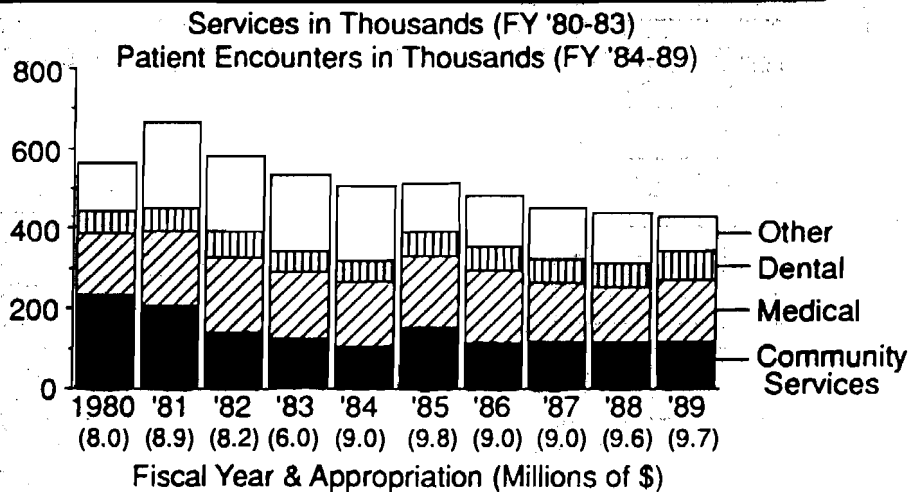
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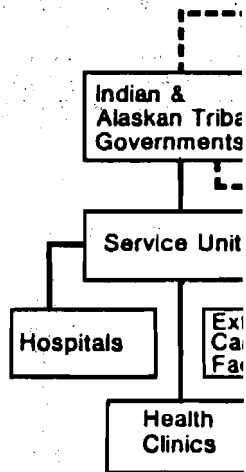
The services provided by urban Indian health programs have been monitored by the Indian Health Service in a uniform data reporting system since 1986. The "Urban Common Reporting Requirements (UCRR)" provides activity data about volume and types of services and patients. The table below shows the overall workload of the urban Indian health programs from 1980 to 1989. The total volume of services provided to urban Indians appears to be decreasing. This may be due to a variety of factors including, revised and improved data collection methods, reduction of overall projects funded under Title V and the transfer of the Oklahoma City and Tulsa clinics out of Title V to IHS Hospitals and Clinics. Underlying all these possible factors in the drop in service volume is the inability of annual funding levels to keep pace with the escalating cost of providing health services.

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Urban Indian Health Program Workload and Appropriation



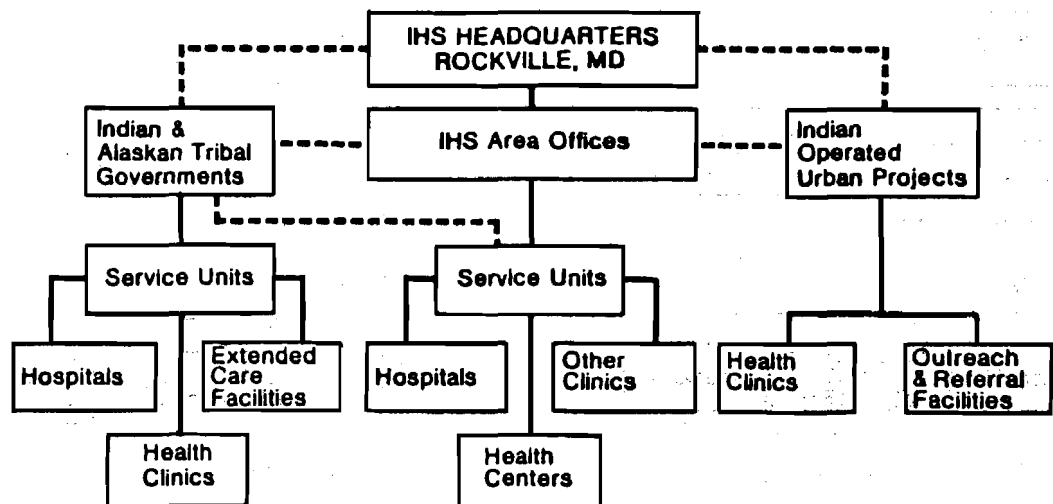
(SOURCE: Indian Health Service, 1990)



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The following organizational chart shows the placement of the urban health program in relation to the IHS delivery system. The urban health program is actually a small component of the Indian Health Service. It is a unique health delivery component and maintains representation at the headquarters level in the form of one staff person in the Office of Health Programs. Urban programs contracts are monitored by Area staff, while national guidance is provided by the headquarters office. The mission of this \$10 million program is to provide health care services to Indians and Alaska Natives residing in urban area. The urban Indian population represents up to half of the total national Indian population by some estimates.

Indian Health Service DHHS/PHS



(SOURCE: Indian Health Service, 1990)

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1. EXP

CONSENSUS DEVELOPMENT STATEMENTS

The following statements were developed by the urban round table participants. These statements best describe the position of the group for each of the issues reviewed.

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1. EXPANDING THE DATA BASE FOR URBAN HEALTH

CONSENSUS STATEMENT: *The knowledge/data base of urban Indian health programs in the IHS and in national health status data for urban Indian populations is lacking. Although a variety of information resources exist, they are often disjointed, unknown, insensitive or not specific to the data needs of urban Indians. The urban round table reached consensus that:*

- a. Headquarters staff and resources must increase to adequately address urban health.*
- b. IHS should fund and conduct a national urban Indian health status report which includes mortality and morbidity data that can be measured against other populations.*
- c. IHS needs to initiate a process to educate states about Indian specific data needs to assure accurate ethnic specific reporting by states and the National Center for Health Statistics.*
- d. Community-wide needs assessments should be conducted by urban Indian health programs on a regular basis. IHS should provide technical assistance to these programs. "Needs Assessments" should include some standard data which can be aggregated nationally, but should be focused at the needs of the local community.*
- e. Planning should begin to assure urban data can be included in the RPMS system (being instituted by IHS) without jeopardizing existing compatible data systems, including a means to conduct patient tracking among centers.*
- f. Performance measures need to account for project size, and national standards should not penalize smaller programs for that reason only.*
- g. IHS should publish urban specific data from the ATGS system.*

BACKGROUND INFORMATION:

Title V of P.L. 94-437, the Indian Health Care Improvement Act, provided specific authorization for urban Indian health programs. Congress appropriates funds to the Indian Health Service on an annual basis, categorically identifying specific programs including the Urban Health Program. The urban program has operated its programs through Buy Indian contracts with local non-profit urban Indian organizations in each of the cities it serves. These programs often leverage other state, federal, and local resources to add to IHS funds.

While most of the 34 urban health programs funded by IHS were created after the Indian Health Care Improvement Act of 1976, many of the largest and oldest urban programs predate Title V, and had developed data and reporting systems separate from the Indian Health Service. Urban health programs are also adept at raising other resources and meeting the reporting requirements of those funding agencies as well as the requirement of the Indian Health Service.

The IHS data base for urban programs is far less sophisticated and comprehensive than its data base for Indians served directly by the IHS hospitals and clinics and tribal programs. Services provided by urbans are not entered directly into the IHS data base; rather, they are reported in aggregate in a form not consistent with IHS data. Birth and mortality data for Indian people nationally includes urban Indians insofar as states and counties accurately record "race" data for Indians.

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2. DELIVERING SERVICES TO NON-INDIANS

3. MEDICAL

CONSENSUS STATEMENT: *The question of urban Indian health programs serving non-Indians surfaces often. Although IHS has recently responded to an Office of Inspector General report that defends the practice as long as the relative percentage of Indian patients is consistent with the percentage of IHS dollars in the project budget, NO policy or guidance is available on this issue. It was the consensus of the urban round table that:*

- a. *Urban Indian health programs which develop alternate resources and therefore also serve non-Indians, should not be penalized by IHS as long as they meet the percentage rule.*
- b. *IHS should issue guidance related to it's informal policy on the percentage rule, so that Areas will address the issue consistently.*
- c. *IHS should work with the Bureau of Health Care Delivery and Assistance, the National Health Service Corps, and other pertinent offices to defend urban Indian health programs with a "population based" service delivery.*

BACKGROUND INFORMATION:

The Urban Indian Health Programs which have sought other funding sources to supplement their IHS dollars have had to also accept the requirements of those funding sources, such as the prohibition of discriminating against patients based on race. The impact on programs which have pursued these other funds and accepted these requirements has varied. Some programs have been able to "target" their services at the American Indian and Alaska Native population such that a majority of their patients are still Indian. Other programs have found it difficult to keep the percentage of Indian patients above a level consistent with their relative IHS funding. Still other urban programs have opted not to accept other Federal, state or local dollars which will restrict them from serving only Indian patients, thus eliminating these resources in their effort to help Indian people in urban areas.

The Indian Health Service has been criticized by the Inspector General for allowing urban programs to serve non-Indian patients. In response to the IG's criticism, IHS maintains it is appropriate to serve non-Indians as long as the relative percentage of Indian patients served is consistent with the percentage of IHS dollars in that urban agency's budget.

CONSENSUS STATEMENT: *programs which maintain malpractice covering service coverage, choose reduce overall service problem, the urban*

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3. MEDICAL MALPRACTICE: CRISIS FOR URBAN PROGRAMS

CONSENSUS STATEMENT: *Significant hardships are experienced by urban Indian health programs which attempt to continue providing needed health care to their patients and maintain malpractice insurance. The cost of insurance and the trend of carriers to avoid covering service providers for low-income populations has forced many programs to lose coverage, choose not to secure coverage, choose to eliminate services (prenatal/obstetrical), or reduce overall services. While the group could not reach consensus on ways to address this problem, the urban round table recommends that IHS do the following:*

- a. Assess the potential liability of IHS to fund clinics which have NO insurance coverage.
- b. Conduct a national urban Indian health program study to determine the scope of the insurance crisis, including data on:
 - Number of clinics which have closed due to malpractice costs
 - Number of services eliminated due to malpractice costs
 - History of premiums paid by urban programs
 - History of claims filed and claims settled by urban programs
 - Legal analysis of extending the Federal Tort Claims Act coverage to urban Indian health programs

BACKGROUND INFORMATION:

The American Indian Health Care Association (AIHCA) conducted a survey to determine the extent to which urban programs faced a crisis in medical malpractice. It discovered that:

- Eight (8) of the 34 urban programs DO NOT carry malpractice insurance.
- Eleven percent (11%) of the clinics have been turned down for coverage.
- Over 26% of the urban programs have reduced services to cover the costs of medical malpractice
- Five percent of the programs have reduced or eliminated prenatal and obstetrical care due solely to the cost of medical malpractice
- Of the 10 largest programs, only \$3,000 has been paid out in settlements in the past five (5) years.
- Of the 10 largest programs, over \$1 million has been paid for premiums for malpractice insurance in the same five year period.
- The 34 urban programs pay a total of \$500,000 annually for medical malpractice premiums.

The Institute of Medicine released a study in 1989, showing that prenatal and obstetrical care to low-income and minority women has suffered due to the rise in medical malpractice costs and fear of lawsuits by physicians. The study recommended among other things, that clinics serving the disadvantaged be covered under the Federal Tort Claims Act. Tribal contractors under P.L. 93-638 were provided FTCA coverage after directive language was provided in the fiscal year 1988 Interior Appropriations Act. The urban health program is the only Indian service delivery system under IHS not covered by FTCA. Some argue that even with FTCA, programs would need to retain coverage.

4. THE NEW FEDERALISM: WHAT IMPACT WILL IT HAVE FOR URBAN HEALTH?

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CONSENSUS STATEMENT: *President Reagan, and later President Bush, promoted the concept contained in the "New Federalism" policy to enhance the government-to-government relationship and increase tribal administration of Federal Indian funds. The 1988 amendment to the Indian Self-Determination Act promises to clear the way for tribal government control of Federal Indian resources. Will urban Indian health programs be affected by this shift? It was the consensus of the urban round table that:*

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a. *There may be new opportunities for tribal and urban Indian health programs working together through joint ventures and the sharing of technical management skills. Urban programs have health administration skills and a management track record which could be useful to tribes. Likewise, there are many tribes with excellent health management systems and skills which can benefit urban health programs.*

b. *The issue of tribal control of Federal Indian resources is still relatively new. Many tribes are not interested in contracting away federal programs.*

c. *There may be conflicting provisions between Title V of the Indian Health Care Improvement Act and the Indian Self-Determination Act Amendments which need further review regarding these ventures.*

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d. *The round table recommends that IHS continue to monitor this issue and its potential impact on urban Indian health programs.*

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The American Indian Health Care Association contracted in 1983 for a study on "The Federal Responsibility to Provide Health Care to Urban Indians". This paper examined the continued funding of Title V programs during a time when the Indian Health Care Improvement Act had expired. In summary, it found that even without Title V, Congress headquarter authority under the Snyder Act to support urban Indian health, and indeed, Congress continued appropriating funds for urban health while Title V was no longer in effect. Once the Indian Health Care Amendments of 1988 passed, language was provided which specifically clarified that urban Indians are included in the Snyder Act authority.

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Now, a new initiative is emerging to facilitate the transfer of the administration of federal programs directly to tribes. The Senate Select Committee on Indian Affairs Special Investigations Sub-committee coined the term "The New Federalism" to encourage a move in this direction. The Indian Health Service has many programs which can be directly contracted to tribes. The Urban Indian Health Program is not one of them. The Indian Health Care Amendments of 1988 provided language which specifically restricts the eligibility to contract for urban Indian health programs to local organizations controlled by a board of "urban Indians".

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5. PATIENT BILLING POLICIES AND URBAN HEALTH

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CONSENSUS STATEMENT: Many urban health programs have established patient billing systems. Some programs have been told by IHS Area staff that this practice is unallowable, while other urban programs have been encouraged to do patient billing. Most third party payors (Medicaid, Medicare, private insurance) require that programs must have a billing system applicable to all patients if the third parties are to reimburse for services. IHS funding to urban Indian health programs does not cover the full cost of providing services to Indians in urban areas. Loss of billing revenue would reduce services to Indians. Financial screening is an important step for patient education on health costs and for assessing patient eligibility for other third party resources. Many of the other funding sources used by urban programs to provide health services to urban Indians require that they establish a sliding fee based billing system. It was the consensus of the urban round table that:

IHS must issue consistent national guidance to Area staff that patient billing is allowable for urban Indian health programs.

BACKGROUND INFORMATION:

Title V of the Indian Health Care Improvement Act, and its related amendments in P.L. 100-713, passed in 1988, are silent in regard to the restriction or allowability of billing patients on an ability to pay basis for services provided under the urban health program of IHS. Most urban health programs which have established patient billing systems have done so in response to requirements by other funding sources.

The Indian Health Service however, has played a role in establishing billing systems in some instances. The urban program in Detroit was directed by the IHS as part of its contract, to establish a billing system for third party payors and patients with the ability to pay. Other urban programs, however have been notified that their patient billing system cannot be applied to Indian patients.

The billing systems in urban health programs generate a significant amount of funding which is then programmed back into patient services. Most of the funds generated by patient billing systems come from third party payors, such as Medicaid, Medicare, and private insurers.

6. STATE RESOURCES AND URBAN INDIAN HEALTH

CONSENSUS STATEMENT: *States have a responsibility to help provide health care resources to populations in need, including Indian populations. Urban Indian health programs receive approximately 6.3% of their funding from state governments; yet there are some states unwilling to reach out to Indian populations, and Indian populations do not always aggressively seek state resources. A number of states have Indian Commissions which could help access state resources. It was the consensus of the urban round table that:*

- a. IHS should conduct a study of all states to determine the amount and types of state health resources serving Indians, both urban and tribes.*
- b. IHS needs to be an advocate with states. IHS Area Directors need to initiate meetings with State Health Departments regarding Indian health and to provide an "entree" for Indian urban communities to state resources.*
- c. IHS should fund or provide needed technical assistance directly to Indian communities on accessing state resources, including skills on coalitions building and understanding the state funding categories.*
- d. IHS should be an advocate for urban Indian health programs with alternate state and other resources. This can be in the form of writing letters of support for the program, attending meetings with the program staff, and providing documentation and data on health needs.*

BACKGROUND INFORMATION:

The panel of experts added this topic to the agenda because of the common experiences of participants who had difficulty dealing with state government resources in coordination with IHS funding. The panel voiced concern that many Indian communities have not been successful, despite good faith efforts to leverage state resources for health and social service needs of Indian residents of the state. Still, others reported that many Indian communities are reluctant to access state resources because of real or perceived strain in relationships between states, tribes, and the federal agencies charged with assisting Indian populations.

For other urban programs the experience has been quite different. Many urban programs rely heavily on state resources. These are primarily the urban programs in the State of California where the state has developed an Indian health funding program in coordination with the Indian Health Service. Other states with urban Indian health programs provide relatively little support, excluding federal pass-through resources, such as the Women, Infants, and Children (WIC) programs.

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CONSENSUS STATEMENT: *States have a responsibility to help provide health care resources to populations in need, including Indian populations. Urban Indian health programs receive approximately 6.3% of their funding from state governments; yet there are some states unwilling to reach out to Indian populations, and Indian populations do not always aggressively seek state resources. A number of states have Indian Commissions which could help access state resources. It was the consensus of the urban round table that:*

- a. Increased urban Indian health programs*
- b. IHS needs to be an advocate with states. IHS Area Directors need to initiate meetings with State Health Departments regarding Indian health and to provide an "entree" for Indian urban communities to state resources.*
- c. Feasibility study of urban Indian health programs*
- d. The round table study on Association study on*

BACKGROUND

The American Indian Health Service (AIHS) areas in the United States under the Urban Indian Health Program (UIHP) are the 8 cities with Indian populations between the Indian population poverty level. The cities experienced high of 62.9% in

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7. UNSERVED URBAN INDIAN COMMUNITIES

CONSENSUS STATEMENT: *Many urban Indian populations in need of health care remain unfunded by the IHS urban program. There is a need for centers to be started in these areas. The number of urban centers funded by IHS has been reduced from 41 to 34. Although legislative authority exists for "New Starts", none have been funded under this mechanism. It was the consensus of the urban round table, that:*

- a. *Increased urban funding should be provided for new starts to avoid a negative impact on existing programs.*
- b. *IHS needs to request an enhancement to urban health funding in its FY 93 Budget Process and efforts by IHS and urban programs should be targeted at developing the justification for this need. This should include efforts at the tribal consultation meetings.*
- c. *Feasibility studies (which include Needs Assessments) should be funded and conducted in urban communities demonstrating need and interest.*
- d. *The round table supports the recommendations of the American Indian Health Care Association study on unserved cities.*

BACKGROUND INFORMATION:

The American Indian Health Care Association (AIHCA) conducted a study on urban areas in the United States with significant Indian populations not currently receiving support under the Urban Health Program. The study identified 2 unserved cities with Indian populations greater than a 12,500; 6 cities with Indian populations between 4,600 and 9,000; 8 cities with Indian populations between 3,000 and 4,499; and 14 cities with unserved Indian populations between 2,000 to 2,999. The AIHCA Study also examined the percentage of the Indian populations in these identified cities which live below 200% of the Federal poverty level. The percentage of Indian people living in these areas was significant. The cities experienced an Indian poverty range from a low in Anaheim, California of 26.8% to a high of 62.9% in Bellingham, Washington.

The Indian Health Care Amendments of 1988 provides legislative authority for the Indian Health Service to enter into contracts with cities not currently served by the Urban Health Program for the purpose of conducting an assessment of health status and health needs of the urban Indian population in that urban center. If IHS determines that the assessment justifies the need for the provision of health services to Indians in that urban center, then the IHS can contract with the urban Indian organization to provide services. To date, this provision has not been utilized by IHS or the unserved urban areas to develop services.

"An Assessment of the Health Needs of the Urban Indian Population in the State of Arizona" was completed after the Committee on Appropriations directed in its Conference Report (No. 100-498) for fiscal year 1988 appropriations that such an assessment should be done. The assessment provided an in-depth analysis of the health needs of urban Indian populations and made recommendations on developing new services and improving coordination of services with existing IHS providers in the state of Arizona.

The AIHCA Study recommended that Congress appropriate funds specifically for Needs Assessments for New Starts, and that 5-10 locations be funded over the next two years. (The AIHCA "Evaluation of Potential Site Locations for New Urban Indian Health Care Programs" of September 1989, is Attached to the Briefing Book).

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SELECTED AND ANNOTATED
BIBLIOGRAPHY
RELATED TO
URBAN INDIAN HEALTH CARE

1. American Indian Health Care Association, Inc., "Barriers to Mainstream Health Care Experienced By Urban American Indians", Ruth Hograbe, R.D., M.P.H., Program Analyst and Donna Isham, Program Analyst, Unpublished September 30, 1989

This report was prepared in consultation with urban health programs and the IHS headquarters staff, in response to questions raised by two reports from the Office of Inspector General related to "Barriers to mainstream care" experienced by urban Indians and the practice and need for "direct service delivery" by urban contractors. The study concluded that cultural and economic access barriers exist and recommends efforts to increase Indian health professionals and outreach workers among Indian and mainstream providers. A national study on urban Indian health care utilization and access barriers is also called for.

2. American Indian Health Care Association, Inc., "Epidemiology Needs Assessment Report", Sheri Scott, M.P.H., Unpublished, May 15, 1990.

This report outlines techniques to conducting needs assessments in urban communities and suggests a national model be implemented. It provides preliminary data on urban Indian health based on a Health Risk Appraisal instrument used on a sample of urban Indians in selected cities. The HRA was first used in the Phoenix Needs Assessment.

3. American Indian Health Care Association, Inc., "Evaluation of Potential Site Locations for New Urban Indian Health Care Programs", Unpublished, September 30, 1989.

This report examines cities in the U.S.A. with a large Indian population and no Indian Health Service urban health funded program. It examines the poverty and mortality rates for these cities as well as their Indian population size. It identifies cities in rank order by size of unserved population. It makes recommendations that congress provide adequate funds to serve these area and that standards be developed to implement a means for IHS to fund "new starts".

4. American Indian Health Care Association, Inc., "Feasibility of Linking Urban Indian Health Programs and Community Health Centers", Karen M. Johnson, M.P.H., Research Analyst, Unpublished, September 30, 1989.

This reports was prepared in response to a report by the Region IX Office of Inspector General which called for the IHS to develop explicit linkages between urban programs and local community health centers (CHC). The conclusion of the report sited the cultural access barriers experienced by Indians attempting to utilize mainstream providers and the cultural expertise of urban programs. The report also discusses the positive working relationship in existence among local clinics and CHC's and the need for these relationships to continue.

5. American Indian Health Care Association, Inc., "Healthy Traditions: The Health Risk Appraisal Project for Urban Native Americans", Donna Isham, Project Coordinator, Sheri Scott, Research Analyst, Michael Arfsten, Executive Director, Unpublished, 1990.

This report provides an update of the ongoing project of AIHCA to conduct the Health Risk Appraisal on selected urban Indian populations.

6. American Indian Health Care Association, Inc., "Minimum Service Package: Studies Involving Data Processing and Analysis on Issues Identified by the Operations Analysis Task Force on Urban Programming" Prepared for the Indian Health Service, Unpublished, August 18, 1987.

This report examines the range of services provided by the urban health programs and attempts to assess the feasibility of setting a minimum benefits package which urban Indian patients would be eligible to receive. Preliminary data suggest that even a minimum package would cost approximately \$133 million per year.

7. American Indian Health Care Association, Inc., "National Uniform Aggregate Epidemiological Statistical Data and Analysis Report", Karen M. Johnson, M.P.H., Research Analyst, Unpublished, September 30, 1989.

The purpose of this study was to identify the morbidity data being collected by urban health programs and assess the feasibility of establishing a uniform morbidity collection method which could be compared to data for other races and to IHS morbidity data. The problems encountered could be resolved with adequate program training and support by IHS. It was recommended that IHS initiate the data collection of ICD-9-Cm, CPT, and ADA/IHS for all programs beginning in 1990.

8. American Indian Health Care Association, Inc., "Recommendations for Changes: Studies Involving Data Processing and Analysis on Issues Identified by the Operations Analysis Task Force on Urban Programming", Prepared for the Indian Health Service, Unpub., August 18, 1987

The report made recommendations for changes in the authorizing legislation for urban health programs, based on a survey of program directors. Twenty-six (26) recommendations were made to the authorizing legislation.

9. American Indian Health Care Association, Inc., "Service and Administrative Standards: Studies Involving Data Processing and Analysis on Issues Identified by the Operations Analysis Task Force on Urban Programming", Prepared for the Indian Health Service, Unpublished, August 18, 1987.

The report developed Service and Administrative Standards for urban programs. The method of data collection focused on existing performance and productivity measures available in the UCRR system. While the urban programs represent a broad range of service delivery systems, the report did arrive at recommended standards.

10. American Indian Health Care Association, Inc., "Simulate Funding Distributions: Studies Involving Data Processing and Analysis on Issues Identified by the Operations Analysis Task Force on Urban Programming" Prepared for the Indian Health Service, Unpublished, August 18, 1987.

Various methods of funding allocation criteria were applied to the urban programs in to distribute the \$9 million appropriation for that fiscal year. The report was developed to address the issue of funding allocation, and implemented all hypothetical models.

11. American Indian Health Care Association, Inc., "Minimum Service Package: Studies Involving Data Processing and Analysis on Issues Identified by the Operations Analysis Task Force on Urban Programming" Prepared for the Indian Health Service, Unpublished, August 18, 1987.

The report examines the range of services provided by the urban health programs and attempts to assess the feasibility of setting a minimum benefits package which urban Indian patients would be eligible to receive. Preliminary data suggest that even a minimum package would cost approximately \$133 million per year.

12. American Indian Health Care Association, Inc., "National Uniform Aggregate Epidemiological Statistical Data and Analysis Report", Karen M. Johnson, M.P.H., Research Analyst, Unpublished, September 30, 1989.

A complete agreement was reached between the Urban Indian Health Care Association and the Indian Health Service regarding the collection of morbidity data.

13. Children's Developmental Center, "Access to Obstetric and Gynecological Services: A Study of Small Business and Community Health Centers", Sara Rosenbaum, IHS, Unpublished, October 1987.

This testimony was given by the Children's Developmental Center, a small business and community health center, to the Indian Health Service regarding the need for obstetric and gynecological services in urban Indian communities.

14. Indian Health Service, "Legislation, Division of Health and Human Resources", Unpublished, August 18, 1987.

This report of the Indian Health Service regarding the need for obstetric and gynecological services in urban Indian communities.

15. Indian Health Service, "Recommendations for Changes: Studies Involving Data Processing and Analysis on Issues Identified by the Operations Analysis Task Force on Urban Programming", Prepared for the Indian Health Service, Unpublished, August 18, 1987.

This is a complete draft stage and the urban Indian Health Care Association is in the process of increasing the number of urban Indian health centers. The report does not contain any recommendations for changes in the authorizing legislation for urban health programs.

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11. American Indian Health Care Association, Inc., "Typology of Urban Programs: Studies Involving Data Processing and Analysis on Issues Identified by the Operations Analysis Task Force on Urban Programming" Prepared for the Indian Health Service, Unpublished, August 18, 1987.

The report examines all the programs funded under the urban health program and develops a typology based on distinctive elements, such as services provided, funding sources, etc. The programs are categorized into five levels of service delivery.

12. American Indian Health Care Association, Inc., "Urban Indian Health Program Charts and Graphs, FY 1988", Prepared for the Indian Health Service, Unpublished, March 28, 1990.

A complete aggregate and program specific summary of FY 1988 data taken from the Urban Common Reporting Requirements (UCRR) data is provided.

13. Children's Defense Fund, "The Effect of Medical Malpractice Insurance Costs & Practices on Access to Obstetrical Care", Testimony before the House of Representatives Committee on Small Business Subcommittee on Regulation, Business Opportunities and Energy, Presented By Sara Rosenbaum, Director of Programs and Policy and Molly McNulty, Senior Health Specialist, Unpublished, October 11, 1989.

This testimony describes the amount of public moneys lost to the private insurance industry and the limited amount of funds returned to community clinics for malpractice claims settlements. The testimony also cites the loss of obstetrical services to poor, minority and rural women as a result of the malpractice crisis. The testimony calls for congress to extend Federal Tort Claims Act Coverage to community health centers and other providers of care to the medically indigent.

14. Indian Health Service, "Trends in Indian Health: 1989", Office of Planning, Evaluation and Legislation, Division of Program Statistics, Anthony J. D'Angelo, Director, Department of Health and Human Services, Public Health Service, Indian Health Service, 1989.

This report of the IHS provides tables and charts reflecting the morbidity, mortality, and workload data for all IHS programs. Limited workload and appropriations data is provided on urban health programs on page 61.

15. Indian Health Service, "Urban Indian Health Program: Background, Assessment, Recommendations and Action Plan", C. Vanderwagen, M.D., W. LaRoque, M.P.H., Tom Owan, A.C.S.W., Unpublished, Undated, DRAFT.

This is a comprehensive report on the urban health program. It appears to be in a draft stage and is undated. Most data appears to be from FY 1987. The report note that the urban Indian population is "significant and growing". It concludes that the urban Indian population has increased seven (7) fold since 1950 and will continue to increase. The text of the report by the Office of Inspector General on urban programs is inserted in its entirety along with the IHS response to OIG recommendations. The report does not include independent recommendations.

16. Institute of Medicine, "Medical Professional Liability and the Delivery of Obstetrical Care", Volume I, SUMMARY, Committee to Study Medical Professional Liability and the Delivery of Obstetrical Care, Division of Health Promotion and Disease Prevention, National Academy Press, Washington, D.C. 1989.

This document summarizes a major study by IOM which examined the effect of the malpractice crisis on prenatal and obstetrical care for women. It concluded that there has been a drastic reduction in the availability of services to poor, minority, and rural women due to the growing cost of medical malpractice for obstetrical care. The report urges congressional action.

17. The National Association of Community Health Centers, "The Medical Malpractice Claims Experience of Community and Migrant Health Centers: A Comparative Study", Unpublished, February, 1986.

The NACHC conducted a survey of community health centers to measure their malpractice claims experience and their risk management practices. They found that the claims experienced by health centers physicians were lower than the national average.

18. The National Association of Community Health Centers, "Testimony of Daniel R. Hawkins, Jr., Director of Policy Analysis, NACHC" before the U.S. House of Representatives Small Business Subcommittee on Regulation Hearing on Medical Liability Coverage Issues, Unpublished, October 12, 1989.

Testimony by Dan Hawkins addresses the need for congressional intervention in the growing cost of medical malpractice and its effect to eliminate basic prenatal and obstetrical care for poor, minority and rural women. NACHC called for Federal Tort Claims Act Coverage to be extended to community health centers and like providers of care.

19. The Washington Post, Article: "Serious Threat to Obstetrical Care Seen: Insurance Costs, Fear of Lawsuits are Scaring Off Doctors, Report Says", Thursday, October 12, 1989.

This article in the Washington Post examines the research by the Institute of Medicine regarding the negative impact medical malpractice insurance rates is having on prenatal and obstetrical care to poor, minority and rural women. A map of the U.S. shows the trend in most states to move away from normal vaginal deliveries to caesarean sections. It also correlates the increase in black infant mortality rates during the first 28 days of life with the lack of adequate health care. The report describes how doctors are "backing away" from care to the poor.