

2014

Evaluation of the IHS Urban Health Business Office Concept

American Indian Health Care Association

MA. Foster

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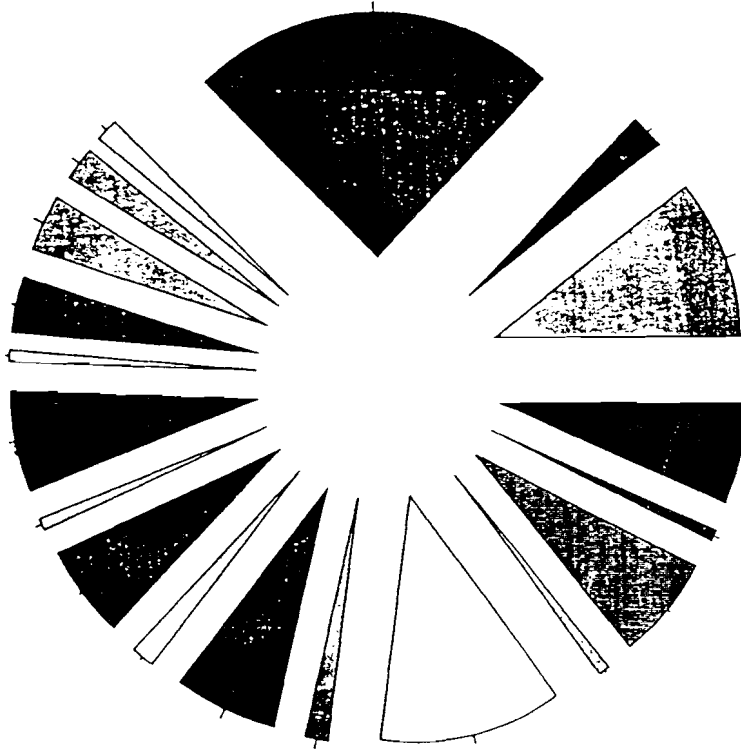
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9701582

SSI-12

EVALUATION OF THE IHS URBAN HEALTH BUSINESS OFFICE CONCEPT



A Report To:

Indian Health Service
5600 Fishers Lane
Rockville, Maryland 20857

Contract No. 282-91-0051, Delivery Order No. 2

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October, 1992

ACKNOWLEDGEMENTS

The purpose of this project was to coordinate and collaborate the urban Indian health programs, the Social Security Administration, the Disability Determination Services, and the American Indian Health Care Association in order to locate and assist potentially eligible American Indians and Alaska Natives in receiving Supplemental Security Income. Many thanks and much appreciation to the following individuals who gave as much to this important project as I did.

To the Indian Health Service, our contractor,
specifically:
Hickory Starr, jr.
Director, Division of Tribal Information Services

Leo J. Nolan
Director, Division of Program Evaluation and
Policy Analysis

Raymond Burgess
Office of Planning, Evaluation, and Legislation

To the Social Security Administration for making
this project possible, especially to:
Beulah Williamson and Beverly Crawford.

To the American Indian Health Care Association,
in particular:
Michael Arfsten, Executive Director
Peter C. Saari, Graphics Assistant
Shanda R. Martin, Research Assistant

To the Seattle Indian Health Board, the Detroit
American Indian Health Center, and to the Indian
Health Board of Minneapolis for participating.

And most importantly to:
Robert Ryan, Outreach Worker at DAIHC
Jeanne Wells, Outreach Worker at SIHB
Pam Johnson, Outreach Worker at IHB/Mpls

Michele A. Foster, Project Coordinator
October, 1992

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PRECIS

Supplemental Security Income (SSI) is a benefit program managed by the Social Security Administration (SSA). It is designed to provide basic financial support to the elderly, blind, and disabled. The states are responsible for making disability and blindness determinations. SSA manages the benefits program. The SSI Project (originally titled "Evaluation of the IHS Urban Health Business Office Concept"), administered by the American Indian Health Care Association (AIHCA), is intended to help establish linkages between urban Indian health programs, the SSA, and the Disability Determination Services (DDS) to assist potentially eligible American Indians/Alaska Natives to receive SSI. The effort is meant to increase the awareness of urban Indian health programs and their clients to the SSA program. An American Indian/Alaska Native outreach worker was hired at each site to locate and assist clients with applying for SSI benefits. The SSI Project study sites involved were: The Indian Health Board of Minneapolis; the Seattle Indian Health Board; and the Detroit American Indian Health Center.

ABSTRACT

The "Evaluation of the IHS Urban Health Business Office Concept", commonly called the Supplemental Security Income (SSI) Project, was a ten month grant demonstration project that was contracted to the American Indian Health Care Association (AIHCA) by the Indian Health Service (IHS) with the cooperation of the Social Security Administration (SSA). SSA was mandated to increase minority and target population enrollment for SSI benefits. SSA provided funding to the Indian Health Service to oversee a project designed to locate and assist urban American Indians/Alaska Natives in applying for SSI. Originally, the project was to be administered from the urban Indian clinics' business offices. Since many urban clinics do not have a 'business office', AIHCA, IHS, and SSA agreed that locating eligible candidates would be more effective conducted through established outreach programs.

Three urban Indian health programs were chosen as project sites: Minneapolis, Minnesota; Seattle, Washington; and Detroit, Michigan. An outreach worker at each site was hired with the responsibility to locate and assist potentially eligible clients from the clinic. The outreach workers reported their findings weekly to the Project Coordinator at AIHCA. Conference calls between the Project Coordinator and the outreach workers at regular intervals allowed the staff to exchange support and information on similarities and differences between sites. The Project Coordinator made three visits to each site over the course of the data collection period (March to June 1992) to ensure the progress of the project.

Intake forms (also referred to as the pre-screening forms) and consent forms provided by the Social Security Administration were completed for potentially eligible clients. This intermediary step assured the SSA and the clinics that time was not being used for a client that was not eligible to apply to SSI. This pre-screening form also served as the data collection form that was sent weekly by the outreach workers to the Project Coordinator for input into SPSS/PC+ statistical program to analyze.

EXECUTIVE SUMMARY

Project Background

More American Indians and Alaska Natives live in urban areas than all other areas combined. Figures from the 1980 census (1990 figures are not yet available) indicate that over 54% of the American Indian/Alaska Native population live reside in cities.

Supplemental Security Income (SSI) is a federal benefit program administered by the Social Security Administration that provides monthly payments to aged, blind, and disabled people who have little or no resources and income.

The SSI Project (officially titled "Evaluation of the IHS Urban Health Business Office Concept") was a 10 month contract awarded to the American Indian Health Care Association by the Indian Health Service with funding provided by a demonstration grant from the Social Security Administration (SSA). The purpose was to establish linkages between urban Indian health programs, the local SSA offices, and the Disability Determination Services (DDS) to locate and assist potentially eligible American Indians/Alaska Natives in receiving SSI benefits, and to make them aware of this program.

Results from this analysis have shown that before this project, 41% of the clients that completed the intake form had incorrect information about SSI; 17.9% had never heard of SSI before; and 11.5% did not know how to contact SSI. In addition, most staff at the urban Indian health programs had little or no information about SSI.

Before this project began, no clients at the Detroit American Indian Health Center had been receiving SSI benefits; by the end of the project data collection period, 48 had applications into the SSA office, and 7 had begun receiving benefits.

Three sites were chosen to participate in the SSI Project: the Seattle Indian Health Board; the Indian Health Board of Minneapolis; and the Detroit American Indian Health Center.

The Seattle Indian Health Board (SIHB) has provided culturally sensitive, comprehensive health care for American Indians and Alaska Natives in the greater Seattle/King County area since 1970 and is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and is state licensed with board certified physicians and dentists. Services offered include: health benefits assistance; medical clinic; pharmacy service; Women, Infants, and Children (WIC) program/nutrition services; dental care; counseling center; prevention and community education; outpatient substance abuse treatment; and Thunderbird treatment center, an inpatient substance abuse rehabilitation center.

The Indian Health Board of Minneapolis (IHB) offers complete health care services to the American Indian/Alaska Native community of the Twin Cities metropolitan area. The IHB is accredited by the Joint Commission of Accreditation on Health Care Organizations (JCAHO). Services offered include: primary health care services; dental clinic; health education including WIC;

Background of Sites

counseling and support clinic; youth programs; and transportation services.

The Detroit American Indian Health Center (DAIHC) was established by the American Indian Health Care Association in 1986. DAIHC offers health services to the American Indian/Alaska Native community in the Detroit metro area. Services offered include: medical care; dental care; community health nursing; Indian family services; substance abuse prevention and education; outpatient treatment and aftercare; WIC, nutrition and diet counseling; community health workers; health education; AIDS counseling, testing, and prevention; and health risk assessments.

Methodology

Each site hired an American Indian/Alaska Native to serve as the outreach worker for this project. The outreach worker conducted the collection and submission of the pre-screening forms to the American Indian Health Care Association and was the primary contact for clients at the urban Indian health programs.

SSA field offices in each site's city provided a general inservice for the outreach worker and other clinic staff; the AIHCA project coordinator was also present at these meetings to clarify the scope of the project and to answer any questions.

The outreach workers contacted potentially eligible clients, and set up appointments (in person or over the phone) to fill out the pre-screening form with the client to determine if he/she was to be referred to SSA to complete a full application for SSI benefits. Outreach workers made a

copy of the pre-screening form for themselves and submitted the original to the project coordinator on a weekly basis. Analysis was performed on the data by the project coordinator using Statistical Package for Social Science (SPSS/PC+). The project coordinator then copied the originals and forwarded them to SSA headquarters.

A total of 78 people participated in the SSI Project by completing the pre-screening forms and speaking to an outreach worker about the SSI program: 17 from Minneapolis, 13 from Seattle; and 48 from Detroit. The number of actual appointments at the SSA office were as follows: Minneapolis, 11; Seattle, 11; and Detroit, 48. These numbers differ from the number of pre-screening forms completed due to attrition during the interval between pre-screening and the time of the SSA appointments. Appointments were re-scheduled by the outreach workers in all cases when required.

In total, 1,891 potentially eligible people were identified and screened by outreach workers. The breakdown is as follows: Seattle, 850; Minneapolis, 891, Detroit, 150. Detroit's number of attempts is much smaller because DAIHC does not have the computer capability to generate specific reports on variables such as 100% below poverty level; disabled patients; children. Detroit's outreach worker had to resort to direct outreach instead of letter attempts, which although numbers were smaller, direct outreach has proven to be vastly more effective than letter attempts.

Out of the total number of pre-screening forms completed after screenings of patient files, following up on referrals, and interviewing walk-ins, 61.5% of the clients were from

**Data
Analysis
and
Overall
Findings**

Detroit; 21.8% were from Minneapolis; and 16.7% were from Seattle.

Although 34.6% of the total number pre-screened were aged 60 and older, 65.3% of the respondents were 59 years and younger that were potentially eligible to receive SSI benefits. In fact, percentages of potentially eligible clients were quite evenly distributed between the age cohorts.

The pre-screening form asked clients to identify the major barriers to applying for SSI benefits before this project. 41% of the respondents stated that they had incorrect information about SSI; 17.9% were unaware of SSI; and 11.5% distrusted the government.

The SSI Project has furthered the objectives of the Social Security Administration as well as the American Indian Health Care Association, and has assisted the urban Indian health programs by identifying American Indians/Alaska Natives eligible for SSI as well as other Social Security Administration benefit programs. It has improved recipients' lives and quality of life by increasing their income, access to assistance services, and health care benefits. American Indians/Alaska Natives traditionally are very distrustful of government (11.5% of those who completed the pre-screening forms stated this as a barrier to applying for SSI previously). The SSI Project has proven that with an outreach worker to help clients fill out applications, call the SSA office, explain the benefits to them, and transport them to and from interview, they understand the process more thus becoming more confident in asking for support.

Costs for the SSI Project follows. The first column of figures in the table below represents the total number of attempts, meaning the number of potentially eligible people that the outreach worker tried to contact either by phone calls, letters, or direct outreach. The second column of figures represents the total cost per person who completed the pre-screening forms. Detailed breakdowns of the formulas are found in the costs section of the report.

Costs

PROJECT SITES	TOTAL COST PER PERSON ORIGINALLY SCREENED	TOTAL COST PER PERSON WHO COMPLETED PRE-SCREENING FORMS
Seattle	\$3.08	\$237.67
Minneapolis	\$3.23	\$169.41
Detroit	\$27.20	\$85.00

One of the most significant outcomes of the SSI Project was that recipients of SSI are receiving more income and possible insurance or other public assistance in conjunction with applying for SSI. Another major benefit is that linkages have been established between the Social Security Administration, the urban Indian health program sites, the Disability Determination Services, and the American Indian Health Care Association. Also, at all three project sites, American Indians/Alaska Natives have been made aware of SSI through direct outreach, news bulletins, and SSI information distributed at other American Indian/Alaska Native organizations. The local Social Security Administration and the Disability Determination Services that worked with the urban Indian health programs have learned a great deal about American Indian/Alaska Native culture and lifestyles, thus they can be more sensitive to the needs of this group of people.

Benefits

Limitations

A major limitation of this project was the project's time constraints. Because of this time limitation, numbers for this project look relatively small. They are also small because this project is very labor intensive; it took about eight hours to complete a file on one claimant for the outreach worker. If SSI truly wishes to help under-represented groups of people benefit from SSI, then SSI must realize that there is no quick, easy or cheap way to expedite the number of claims.

Urban programs were required to become trained and mobilize services over a period of four months. The researcher is confident of continued successful referral with a longer time frame.

Recommendations

Linkages and coordination between all urban Indian health programs, SSA, and DDS should be initiated to better serve American Indians/Alaska Natives. A contact person, either an outreach or social worker, should be established to promote SSA/SSI and to educate staff and clients about SSA/SSI. A suggested format for instituting a nationwide project linking urban Indian health programs with the Social Security Administration, and the Disability Determination Services can be found later in this report.

An extended demonstration period would be expected to yield larger numbers of American Indians and Alaska Natives referred to SSI. It is understood that participants shared information about referral to SSI, thus most likely increasing awareness of the program within the Native community. Inservices or seminars should be set up by SSA and the DDS with urban Indian health programs to get cultural sensitivity training. SSA or DDS claim

representatives will have better success and a greater respect for American Indians/Alaska Natives if they are aware of cultural lifestyles and backgrounds.

BACKGROUND

Urban American Indians and Alaska Natives

More American Indians/Alaska Natives reside in urban areas of the United States than in all other areas combined. Figures from the 1980 Census: PC80-S1-13, 1984, indicate that 54 percent of the 1.4 million American Indians/Alaska Natives reside in cities. Reservations account for less than 24 percent. The remainder of the American Indian/Alaska Native population distributed among various areas, mostly rural. Eight percent live in the historic areas of Oklahoma (excluding urban areas); two percent reside on tribal trust lands, and three percent live in Alaskan Native villages (1980 Census). 1990 census data on these statistics is not yet available.

A Relocation Program influenced by Federal policy for American Indians/Alaska Natives in the early 1950s accelerated the rapid growth of the urban Indian population. In the decade between 1950 and 1960 the number of urban Indians nearly tripled, from 56,000 to 166,000. This program, administered by the Bureau of Indian Affairs (BIA), offered services such as transportation, financial assistance, job training, and counseling, to encourage Indian people to seek employment and education in the metropolitan areas. Increasing poverty and unemployment on reservations reinforced the pressure to seek jobs and other services in urban areas. However, most American Indians/Alaska Natives migrating to the cities encountered difficulties of overcoming poor education, health problems, poor living conditions and high unemployment rates. The current demographic

analyses of the Urban Indian Health Centers reveal that the major social, economic, and educational issues are severe when compared to the U.S. "All Races" population in the metropolitan areas. Also, the need to provide adequate health services to this high risk population group continue to present a major challenge especially when considering the seven fold increase in the urban Indian population since 1950.

The Urban Indian Health Program (UIHP) is an outgrowth of the small, part-time volunteer clinics organized in the late 1960s by local Indian community leaders to meet the growing health problems of urban Indians. By leaving the reservations they were confronted with limited access to federal health care and the Bureau of Indian Affairs (BIA) services. Due to low income, high unemployment, and the lack of knowledge of the health care systems, their under-utilization of the mainstream resources heightened the concerns of the federal government.

In 1972, Congress appropriated funds for a pilot urban Indian health project in Minneapolis. Congressional interest grew over the next few years, leading to the passage of the 1976 authorization which established and funded additional projects in several cities. This positive growth was noted by the House Committee on Interior and Insular Affairs with a report stating that "...the best possible evidence of the critical need for an expanded urban Indian health program and of a Federal commitment to support that program" (Committee Report accompanying H.R. 2525). As of FY 1992, there are 34 UIHPs in 41 cities located in 18 states.

The UIHP is designed to bridge reservation and urban mainstream health care. The UIHP staff are familiar with

the special needs of American Indians/Alaska Natives and in most cases are Indians themselves. They recognize endemic American Indian/Alaska Native health problems and are able to offer immediate, appropriate and cost-effective medical attention. Urban Indian clinics not only provide essential primary health care, but also contribute to the overall mental and social well-being of urban Indians (OIG, 1988).

This project furthered the philosophy and objectives of the urban clinics and of the American Indian Health Care Association by assisting American Indians/Alaska Natives in gaining access to the Supplemental Security Income (SSI) program as well as other Social Security Administration benefit programs. This in turn improved health and quality of life for those involved. American Indians/Alaska Natives traditionally are very distrustful of any government assistance. The SSI project has proven that with an outreach worker to help clients fill out applications, call the SSA office, explain the benefits to them, and transport them to and from interviews, they understand the process more, thus becoming more confident in asking for support.

**Supplemental
Security
Income
(SSI)**

Supplemental Security Income (SSI) is a federal program that provides monthly payments to aged, blind, and disabled people who have little or no resources and income.

The Social Security Administration administers the SSI program. It determines eligibility of claimants, makes the basic payments to recipients, and maintains a master record of recipients. Even though the Social Security

Administration runs the program, SSI is different than Social Security. SSI is financed from general funds of the United States Treasury - personal income taxes, corporation taxes, and other taxes. Social Security is funded primarily through the Social Security taxes paid by workers, employers, and self-employed people. The two programs also differ in other areas, such as conditions for eligibility and the method of figuring payments.

To be eligible for SSI, a person must be 65 years or older or disabled or blind, have limited resources and income, and meet certain other requirements. Disabled or blind children, as well as adults, may be eligible. The age of a disabled or blind person makes no difference.

A person who qualifies for SSI on the basis of both age and disability or blindness can receive payments under whichever category is more advantageous. For example, a person who is 65 and disabled may receive a higher payment as a disabled recipient because of the additional income exclusions allowed for the disabled. If a person qualifies under more than one eligibility category, Social Security can explain which is the most advantageous.

In 1992, the maximum federal SSI payment is \$422 a month for an eligible person and \$633 a month for an eligible couple. However, states may supplement the federal SSI payments.

To encourage the states to supplement the federal payments, the law gives states the option of having the federal government administer the state supplement and pay the administrative costs. In states that choose this option, a single application covers both the federal and state payment.

Under federal administration, the state may vary the payment amounts based on living arrangements or geographical area. The state also may disregard additional amounts of income. Some states choose to administer their own supplement. In those states, application for the supplement must be made with the state agency. States that administer their own supplement are Alabama, Alaska, Arizona, Colorado, Connecticut, Florida, Idaho, Illinois, Missouri, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Virginia, and Wyoming.

In addition to the supplemental payments, the states provide Medicaid and other services to SSI recipients.

Currently, Medicaid reimbursements to urban Indian health clinics are less than the actual costs of examinations and/or treatments. For every Medicaid patient a clinic sees, the clinic loses \$2 to \$3. Since their mission is to provide services to anyone in need, and deny no one, clinics provide treatment and services to Medicaid recipients, but there is no possible way that signing people up for Medicaid will assist clinics financially; they will always be losing money on that patient. Federal funding to the clinics offsets some of this loss.

**SSA, SSI,
and the
Disability
Determination
(DDS)**

The Social Security Administration has the responsibility to administer two disability programs, the Disability Insurance (DI) Program under Title II of the Social Security Act), and the Supplemental Security Income (SSI) program (under Title XVI).

Under Title II, monthly payments are made to people under 65 who have worked long and recently enough under Social Security. Every person who pays into Social Security contributes to the Social Security Disability Trust Fund. After a certain period of time working in employment covered under Social Security, a person gains insured status and is entitled to a disability benefit if he/she becomes severely impaired and cannot work. Medicare coverage is available to those who have received disability benefits for 24 months.

SSI disability payments are made to needy people who are under 65 and have limited income and few resources. These payments are made from General Revenue funds. Most SSI recipients qualify for Medicaid, a state run medical assistance program.

Social Security and the SSI disability program provides cash payments and health care coverage when a worker or eligible needy individual is unable to work for at least a year due to a physical or mental impairment - payments which continue as long as the person is unable to work due to his/her impairment(s).

The process of determining disability begins when a person applies for Social Security Disability Insurance (SSDI) benefits or SSI disability payments at a Social Security Administration field office, either in person, or by phone. It involves a network of federal, state and local agencies and services and input from many segments of the health community. It also involves substantial input from beneficiary support groups.

The statutory definition of disability is the same for both the SSDI and SSI programs and is as follows: the "inability to

engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." The definition for a disabled child is a child which cannot function in the same manner as any other normal child of his/her age.

Disability claims are processed through a network of some 1,300 Social Security field offices, the central office, and 54 state agencies, known as Disability Determination Services (DDS).

The DDS, which are fully funded by the federal government, are the state agencies responsible for developing medical evidence sufficient to render an equitable determination on whether a claimant is or is not disabled or blind under the law, and determine when disability began and/or ended.

The DDS obtains, if possible, medical evidence from the claimant's medical sources. If that evidence is insufficient to render a determination, the DDS will purchase a consultative examination from the treating source, or from an independent source.

The medical evidence is then reviewed by a team composed of a physician (in the case of mental impairments, a clinical psychologist may be used), and a disability examiner, and a disability determination is made. The state agency sends a determination notice to the claimant. A determination is also made as to whether the applicant is a candidate for vocational rehabilitation. If so, a referral to the state vocational rehabilitation agency is made.

After the disability determination is made, the case is forwarded to one of SSA's field offices for further action.

There were no consultative examinations given at any site clinic during this project. However, agreements are still being worked out in Minneapolis so that the Indian Health Board will be able to be one the area clinics that DDS works with when consultative examinations are needed.

Please see chart 1.1 in the appendix for organizational chart of AIHCA.

Since 1975, the American Indian Health Care Association has served as a national voice for programs that serve the health need of American Indians/Alaska Natives, especially those living in urban areas. The Association has pressed for funding to support urban Indian health clinics, and has championed the cause of improved Indian health care delivery systems. AIHCA has developed more efficient management systems for urban Indian health programs, improved communications throughout the Indian health care network, and conducted innovative research that is specific to Indian cultures and needs.

More than half of America's 1.9 million (1990 U.S. Census) American Indian/Alaska Native people now live in cities and towns, not on reservations. Prompted by the federal government's relocation programs, Indians came to cities in the 60s and 70s looking for a better life. Many found only unemployment, poverty, alienation, and overwhelming ill health. The federal Indian Health Service is responsible for Indian health care, but until the 1970s, the IHS provided no support for Indians living off the reservation.

**The
American
Indian
Health Care
Association
(AIHCA)**

American Indian/Alaska Native leaders responded to the health crisis among their people by organizing the first urban Indian health clinics. They were small, part-time, and often run by volunteers, but they filled a need for health care services that were affordable, accessible, and most of all, culturally appropriate.

Today, 34 urban American Indian/Alaska Native health care programs operate in 41 sites across the country. The range of services provided by the programs is great. Some programs concentrate on referral and outreach; others provide full ambulatory care. Full service clinics in Minneapolis, Seattle, Spokane, and Milwaukee have been accredited by the Joint Commission on Accreditation of Health Care Organizations. In recent years, all centers have added mental health and substance abuse components. Many programs bill for services and collect from patients and third party payers. Sliding fee scales are common, and no one is turned away due to inability to pay.

The costs to the taxpayer has been minimal; the federal government's 1990 appropriation for urban Indian health programs was more than \$10 million. Despite a 70% reduction in buying power over the past decade, due to inflation and increases in health care costs, the urban Indian programs have provided a major return on federal investment, more than matching IHS subsidies dollar for dollar with other sources of funding.

More importantly, the programs have provided services to people desperately in need of them. In the past year alone, nearly 100,000 American Indians were served by urban Indian health programs providing one-half million health care providers. The programs provided much more

than medical care to patients - services included alcohol and drug abuse counseling and nutrition education. Indian children came to urban clinics and centers for pediatric care, immunizations and school check-ups. Community outreach brought health care to American Indians/Alaska Natives at health fairs, and pow wows. American Indian/Alaska Native people received service from providers who are sensitive to the nuances of Indian culture, in clinics that are part of the community.

The UCRR is a semi-annual report that presents current data for all the urban Indian health programs. Caution is required in interpretations and conclusions drawn from the following analyses. Since the standardized UCRR became fully implemented only in FY 1987, previous data may be subject to reporting errors, errors in data definition, and data interpretation. These errors may affect the derived percentages, ratios, and other calculations for those programs reporting inconsistent data. In addition, five programs submitted data that could not be incorporated into the analysis due to the use of an incorrect reporting period or other unresolved errors in the data. The effect of this omission is to artificially decrease service workloads, project users, number of encounters, and funding, when compared to previous years. To improve the UCRR data reporting system and avoid unresolved errors in the future, improved training of urban Indian health program staff and IHS area urban coordinators is necessary in the future.

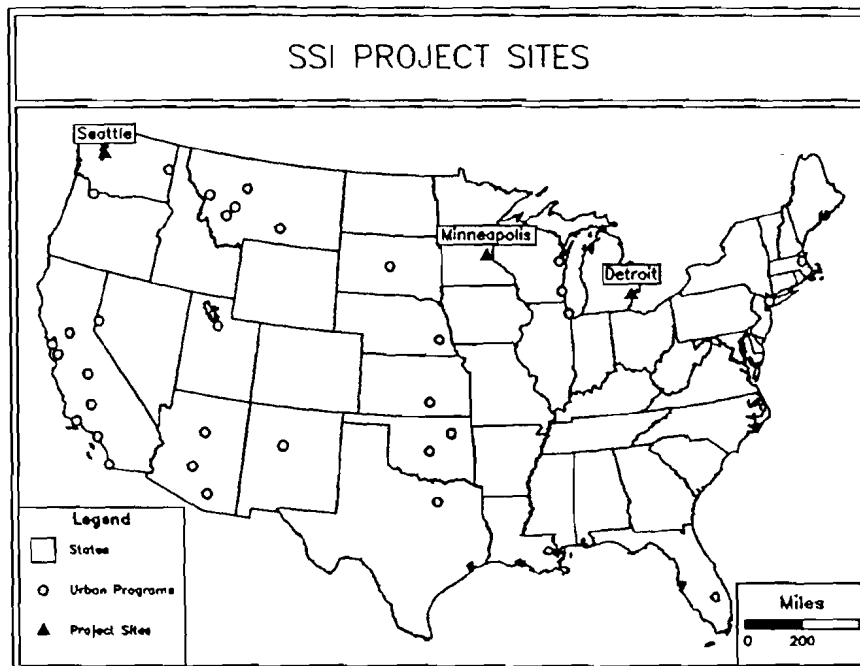
Data regarding the three project sites in comparison to all urban Indian health programs are located in tables in the appendices of this report.

**Urban
Indian
Health
Program
Common
Reporting
Require-
ments
(UCRR)**

The
Supplemental
Security
Income
(SSI)
Project

Please see map 1.1 for SSI project site locations.

Map 1.1



The SSI Project (officially titled "Evaluation of the IHS Urban Health Business Office Concept") was a 10 month contract awarded to the American Indian Health Care Association by the Indian Health Service by the Social Security Administration. The purpose was to establish linkages between urban Indian health centers and the local Social Security offices to locate and assist potentially eligible American Indians/Alaska Natives in receiving SSI benefits, and to make them aware of this program.

The project was located in three urban Indian health centers: Indian Health Board of Minneapolis; Seattle Indian Health Board; and Detroit American Indian Health Center.

At each site there was an American Indian/Alaska Native outreach worker employed to find potentially eligible American Indians/Alaska Natives, inform them about SSI, and then walk them through the entire SSI application process. The outreach worker worked closely with the local SSA office, as well as the DDS.

Results have proven that this project is viable and extremely useful not only to needy American Indians, but also to the health centers involved and SSA.

Table 1.1

1990 URBANIZED AREA POPULATIONS OF NATIVE AMERICANS

URBAN AREA	POPULATION
DETROIT	13,708
MINNEAPOLIS	12,335
SEATTLE	19,879

Source: Bureau of the United States Census

BACKGROUND OF PROJECT SITES

Data regarding the three project sites are listed in the appendices of this report, taken from the Urban Indian Health Program Common Reporting Requirements.

The Seattle Indian Health Board (SIHB)

The Seattle Indian Health Board (SIHB) has provided culturally sensitive, comprehensive health care for American Indians and Alaska Natives in the greater Seattle/King County area since 1970 and is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), State licensed with board certified physicians and dentists. Any resident of the greater Seattle area is eligible for services from the Seattle Indian Health Board. Enrollment is continuously open; however, some programs have restrictions on numbers of openings or contract restrictions.

The 1990 urbanized area population of American Indians/Alaska Natives for Seattle is 19,879 (1990 U.S. Census).

Many services are provided at the SIHB including:

Health Benefits: Assistance is available for clients needing help with applications for Medicare, Medicaid, Social Security, Veteran's Assistance, SSI, etc.

Medical Clinic: The Medical clinic provides family health care for persons of all ages. Services include:

- * Prenatal care, childbirth education and delivery

- * Well-child exams, immunizations and screening tests
- * Women's health exams and screening tests
- * School, camp, and sports physical exams
- * Adult health exams
- * Care for minor, acute illnesses
- * Sexually transmitted disease diagnosis and treatment
(including HIV confidential testing)
- * Family planning care and counseling
- * Stop smoking help-education and counseling
- * Nutrition counseling
- * Nurse consultation-health education

Pharmacy Service: The Health Board has a licensed, fully staffed, Class A Pharmacy which provides prescription medications to the Health Board patients.

WIC Program/Nutrition Services: Women, Infants, and Children Supplemental Nutrition Program provides nutrition education and vouchers for food to eligible pregnant women, nursing mothers, babies, and young children. Nutrition counseling is available for older children and adults by referral from the medical clinic or other Health Board programs.

Dental Care: Comprehensive dentistry is available to all patients of the Seattle Indian Health Board. Dental services offered are:

- * Elders Outreach Program
- * Full Dental Exams
- * Endodontic (root canals)
- * Crowns, Bridges, and Dentures
- * Dental Health Education

- * Fluoride Treatment
- * Children's Outreach Program
- * Oral Hygiene Instruction
- * Restorations (fillings)
- * Oral Surgery/Extractions
- * Limited Perio (gum work)
- * Scaling/Polishing
- * Sealants

Native American Counseling Center: The Native American Counseling Center provides the community with:

- * Mental health counseling, case management, crisis intervention, medication management, psychological assessment, long and short-term services for adults, families, and children.

- * Weekly support services or groups are held each week for parenting, depression, grief, women's issues, family violence, and post-traumatic stress for Indian Veterans.

- * A cultural enrichment program designed especially to directly involve individuals in learning about their Indian heritage, increasing self-esteem and pride.

Prevention and Community Education: The following prevention and education services on alcohol, drugs, AIDS, and health promotion are available:

- * Drug and alcohol abuse prevention classes and activities for Indian children.

- * Community education series on health promotion, alcohol, drugs, and AIDS.

- * Speakers bureau on AIDS and safer sex information.

- * Brochures, posters, and information packets.

Outpatient Alcohol/Drug Treatment: On-going recovery services, coordinating with tribal communities for effective treatment outcomes and continued recovery for patient and family. Services include:

- * Alcohol and drug counseling, intensive and follow-up case management, crisis intervention, and referral to mental health sources, if needed.

- * Family counseling, referral to support groups (ACOA, Alanon, Alateen), long and short-term services for adults, families, and adolescents.

- * Six therapy groups a week for continued sobriety support.

- * Formal or informal referrals to other support groups, as needed.

- * Referral to inpatient treatment for adults and adolescents.

- * A culturally enriching program to involve individuals in their Indian heritage, increasing self-esteem and pride.

Thunderbird Treatment Center, with 20 years of recovery experience, maintains the highest standard of excellence in the field of substance abuse rehabilitation. The program is state licensed and accredited by the Joint Commission for the Accreditation of Health Care Organizations. The

**Indian Health
Board of
Minneapolis
(IHB)**

Thunderbird Treatment Model blends the 12 Steps to recovery with cultural/spiritual refocusing, one to one and group therapy, nutritional regimen, physical exercise, family involvement and 24 hour patient supervision.

The Indian Health Board of Minneapolis offers complete health care services to the American Indian/Alaska Native Community of the Twin Cities Metropolitan Area. Care is also available to non-Indian people except where limited by provisions of the Indian Health Service funding contract. The Indian Health Board of Minneapolis is accredited by the Joint Commission of Accreditation on Health Care Organizations (JCAHO).

The 1990 urbanized area population of American Indians/Alaska Natives for Minneapolis is 12,335 (1990 U.S. Census).

Medical Clinic:

- * AIDS Education and Counseling
- * Primary Medical Care
- * Minor Emergencies
- * Health Screening and Exams
- * Outreach Services
- * Prenatal Care
- * Well-Child Care and Immunizations
- * Family Planning
- * Laboratory
- * Hospital Admission as Needed
- * Specialist Referrals
- * Nutrition Counseling

Dental Clinic:

- * Adult General Dentistry

- * Children's General Dentistry
- * Preventive Emphasis
- * Emergency Treatment
- * Specialist Referrals

Health Education:

- * WIC (Women, Infants, and Children Supplemental Nutritional Program)
- * Prenatal and Parenting

Counseling and Support Clinic:

- * Individual therapy/counseling for children, teenagers, adults, families, and elders
- * Family therapy
- * Group therapy
- * Crisis intervention
- * Walk-in counseling
- * Chemical dependency assessments
- * Outreach and referrals for chemical dependency treatment
- * Support groups
- * Psychological assessments for children and teenagers
- * Consultation and outreach with schools, community agencies and other professionals.
- * Social work and outreach
- * Consultation and visits with traditional Medicine Man

Ginew/Golden Eagle Youth Program: The Ginew/Golden Eagle Youth Program provides American Indian/Alaska Native youth with the opportunity to socialize with American Indian/Alaska Native role models while gaining self-esteem, confidence, and life skills by attending

sessions which deal with American Indian/Alaska Native culture, chemical awareness, education, and health.

- * Youth Development Programs
- * Cultural Activities
- * Earth Winds
- * The Brave Ones
- * Dance and Drum Group
- * Home Instruction Program for Preschool Youngsters (HIPPY)
- * Challenge to Achievement Grade Incentive Program
- * Indian Youth Study Time
- * Chemical Awareness Education
- * Collaboration with American Indian Magnet School at Mt. Sinai
- * Volunteer Opportunities
- * Special Events

Transportation: Rides are available for Indian Health Board appointments or referrals.

**Detroit
American
Indian Health
Center
(DAIHC)**

The Detroit American Indian Health Center (DAIHC) was established by the American Indian Health Care Association in 1986. DAIHC offers health care services to the American Indian/Alaska Native community in the Detroit metro area.

The 1990 urbanized area population of American Indians/Alaska Natives for Detroit is 13,708 (1990 U.S. Census).

Medical: A physician and a nurse practitioner are available to patients. Services available are:

- * General medical care

- * Immunizations
- * Blood Pressure Checks
- * Diabetes Screening
- * Blood Sugar Testing
- * Well Baby Exams
- * School Physicals
- * Physical Exams
- * Flu Vaccinations
- * Family Planning

A Prenatal clinic is held every other Tuesday afternoon, and is staffed by a board certified obstetrician.

Dental: Services offered:

- * Dental Education
- * Dental Cleaning
- * Fillings
- * Crowns
- * Fluoride Treatments
- * Pit and Fissure Sealants
- * Dentures
- * Partial Dentures
- * Simple Oral Surgery

Community Health Nursing: The nursing staff provides nursing visits, health education, and home health care to patients at DAIHC.

Indian Family Services: Counselors provide the following services at the Center:

- * Crisis Intervention
- * Parenting Education
- * Individual Counseling
- * Group and Family Counseling
- * Support Groups

Alcohol and Substance Abuse Prevention and Education:

The Center has a trained specialist on staff to offer prevention and education services for youth and families.

Outpatient Treatment and Aftercare: Counselors offer individual, group and family counseling for alcohol and substance abuse problems. Weekly meetings at the Center include:

- * Overeaters Anonymous
- * Narcotics Anonymous
- * Emotions Anonymous
- * Native American Adult
- * Children of Alcoholics
- * Alcoholics Anonymous
- * Adult Children of Alcoholics/Dysfunctional Families

WIC and Nutrition and Diet Counseling: A Registered Dietitian can assess nutritional status and provide nutrition counseling and information for many conditions including high blood pressure, diabetes, obesity, substance abuse, and pregnancy.

Community Health Workers: Community Health Workers at the Center provide outreach and make home visits to American Indians in surrounding Detroit metro counties. Transportation can be arranged to and from appointments for clients.

Health Education: A health educator provides information, education, presentations, and counseling to help develop healthier habits. Support groups are available for diabetes, weight reduction, and high blood pressure/hypertension, and for smoking cessation.

AIDS: Confidential counseling, testing, and information concerning AIDS and sexually transmitted diseases are available.

Health Risk Assessments: Staff can give personalized information on health profile. Clients find out about their cholesterol, blood pressure, and glucose levels, as well as health risks and what they can do to modify their behaviors.

METHODOLOGY FOR THE SSI PROJECT

Each site selected hired an American Indian/Alaska Native to serve as the outreach worker for this project. This person oversaw the collection and submission of screening forms to the American Indian Health Care Association and served as the primary contact for clients at the Urban Indian Health Centers. It was important that the outreach worker be seen as part of the American Indian/Alaska Native community because many distrust the government and this project would not have been able to make much headway if the clients did not trust the outreach worker to assist them with the SSI application and process.

Prior to the hiring of the outreach workers, each site produced a computer printout of all potentially eligible persons for SSI benefits based on age and income criteria. A list of disabled clients was also generated in Seattle. The criteria for these computer reports were as follows: clients aged 65 years or older; clients 100% below the poverty level. These lists then were given to the outreach workers to begin contacting listed persons.

Medical and allied health staff at each site were notified of this project and were advised to consult with the outreach worker if they had a patient who might be eligible for SSI. Medical staff was also asked to identify any clients with a known disability including substance abuse, mental or physical impairments, or certain medical conditions which might make them eligible for assistance.

SSA field offices in each site's city provided a general inservice for the outreach worker and other clinic staff; the AIHCA project coordinator was also present at these

meetings to clarify the scope of the project and to answer any questions.

The outreach workers then began contacting potentially eligible persons on the computer lists as well as contacting persons that were referred to the outreach worker by clinic staff or by walk-ins. The outreach worker would make an appointment (in person or by phone) to fill out a pre-screening and consent form supplied by SSA that asked questions regarding health, living, and financial status to determine if the client was to be referred to SSA for a full application for SSI benefits. A copy of each form is located in the appendices.

Outreach workers made a copy for themselves, then submitted the original pre-screening forms to the project coordinator at AIHCA on a weekly basis: the project coordinator made copies of these originals and forwarded them to SSA headquarters.

The project coordinator extracted and entered data from the pre-screening forms received from each site as the data was received. Staff re-checked for completeness and accuracy; any problems with interpretation of the data was resolved by contacting the outreach worker. Analysis of the data was completed by the project coordinator using SPSS/PC+ (Statistical Package for Social Sciences) on a CompuAdd 320s personal computer. Frequencies and crosstabulations were completed on data on each person's intake form. This data was separated by site as well as aggregated. Some of the relevant information that is used in the charts and graphs in this report is presented in tables in the appendices.

METHODOLOGY FOR THE OUTREACH WORKERS

Outreach workers reviewed the patient files from the clinic and made specific outreach attempts to those who were potentially eligible based on age, income, or disability requirements. Medical and allied health staff were asked to identify persons with known disabilities.

Outreach workers and the project coordinator at AIHCA met with the SSA field staff and visited the offices in their respective areas. They also met with DDS staff and visited their offices. This gave all parties involved a better picture of how everyone needed to work together to help the clients receive much needed aid.

Notices and news bulletins approved by SSA headquarters were posted and published in various locations and in community newsletters giving information about SSI and the name of the outreach worker to contact in each target clinic.

Potentially eligible persons were contacted and informed of the SSI program. These persons were asked questions on the pre-screening form to identify barriers, and were informed by the outreach worker of how they could be assisted in applying for SSI.

The pre-screening form was then filled out as well as the consent form. The forms were sent in weekly batches to AIHCA. If the pre-screening form results were positive, then the outreach worker would set up an appointment with the local SSA office to take the claimant in to fill out an application for SSI benefits.

If the client was claiming a disability, then the outreach worker would assist the person in filling out the Disability Determination Service (DDS) Disability Report, as well as assisting in other needed documentation to support the claim to hand to SSA at the time of the appointment.

Transportation was arranged for each claimant going to an SSA appointment; the outreach worker also went to the interview, assisting the client with difficult questions and providing general support.

Any necessary follow-up with clients such as getting additional paperwork completed for SSA was the responsibility of the outreach workers.

OVERALL FINDINGS AND ANALYSIS

A total of 78 people participated in this project by completing pre-screening forms and speaking to an outreach worker about the SSI program: 17 from Minneapolis; 48 from Detroit; and 13 from Seattle. The number of actual application appointments at the SSA field office were as follows: Minneapolis, 11; Detroit, 48; and Seattle, 11. These numbers differ from the number of pre-screening forms completed due to attrition between the time in filling out the pre-screening forms and the time of the SSA appointments. The lag time between making an appointment to go to SSA and going to the appointment was about two to three weeks in Seattle and Minneapolis. The Detroit field office was more accommodating and the outreach worker was able to get clients in usually within a

week, sometimes within a day. All but two of the clients who did not go to SSA were drug/alcohol impaired, thus could not keep their appointments. Appointments were re-scheduled by the outreach workers in all cases where possible.

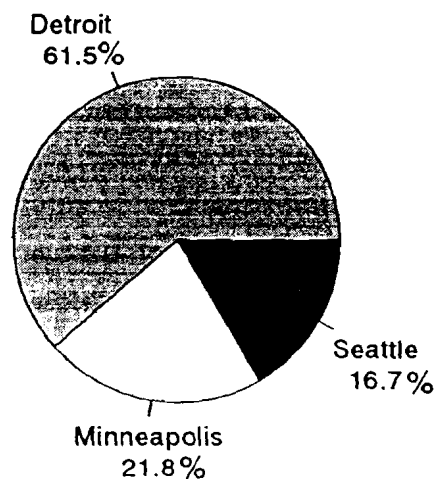
The computer statistical package SPSS/PC+ was used in analyzing the pre-screening forms. After the initial analysis, the data was exported from SPSS/PC+ into WordPerfect 5.1; from this information, the computer program Harvard Graphics was used to make charts and graphs of the SSI project data. There are tables made in Wordperfect 5.1 format of the original data in the appendices of this report. Data analysis on urban Indian health programs (UCRR data) is also available in the appendices.

Out of the total number of pre-screening forms completed after screenings of patient files, following up on referrals, and interviewing walk-ins, 61.5% of the clients were from Detroit, 21.8% were from Minneapolis, and 16.7% from Seattle.

Chart 1.2

Intake Frequencies by Site

Percent Distribution

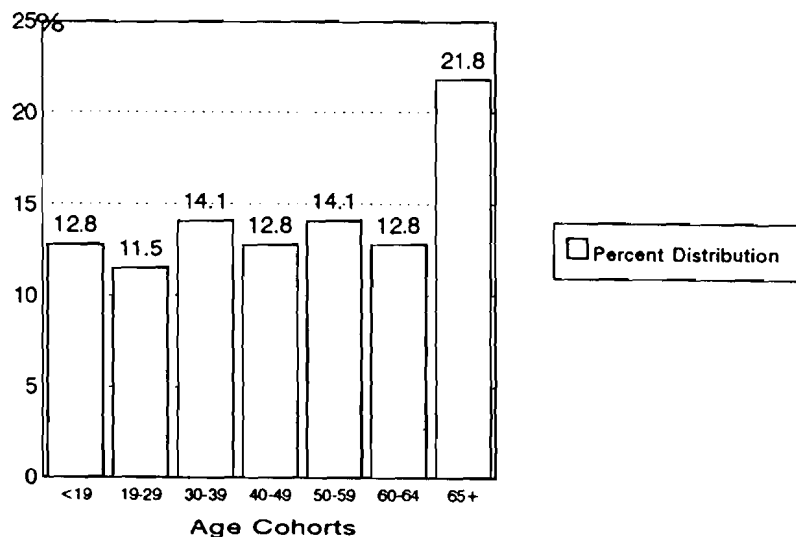


Of the clients who completed the pre-screening forms:

- 12.8% were under 19 years old
- 11.5% were between 19 and 29 years old
- 14.1% were between 30 and 39 years old
- 12.8% were between 40 and 49 years old
- 14.1% were between 50 and 59 years old
- 12.8% were between 60 and 64 years old
- 21.8% were 65 years or older

Chart 1.3

Frequency of Age Group



Although 34.6% of the total number pre-screened were aged 60 and older, 65.3% were younger people that were potentially eligible to receive SSI benefits. In fact, the percentages of potentially eligible clients were quite evenly divided between the age cohorts. The SSI project reached a great diversity of people, which was the goal. We did not want to only assist elderly clients. (See chart 1.3) Charts 1.4 and 1.5 present the frequency of age group

percent distribution by gender. Men make up about 60% of the total pre-screenings completed.

Chart 1.4

Frequency of Age Group Percent Distribution by Gender

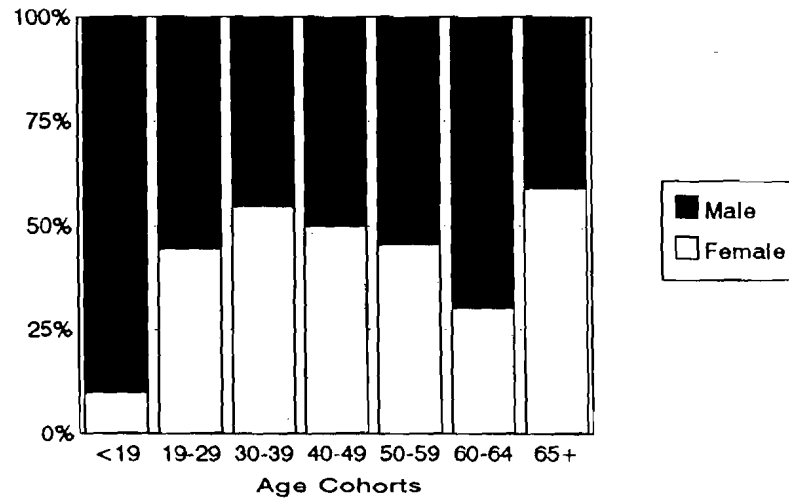


Chart 1.5

Total and Site Specific Gender Distribution by Percent

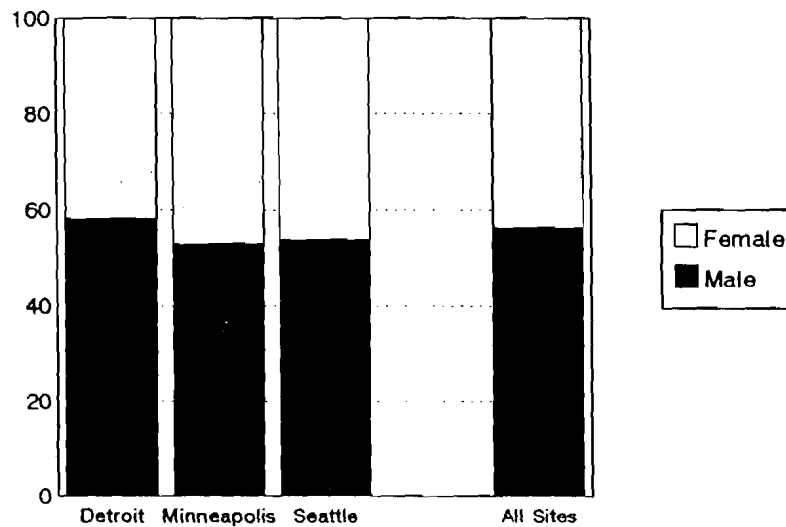
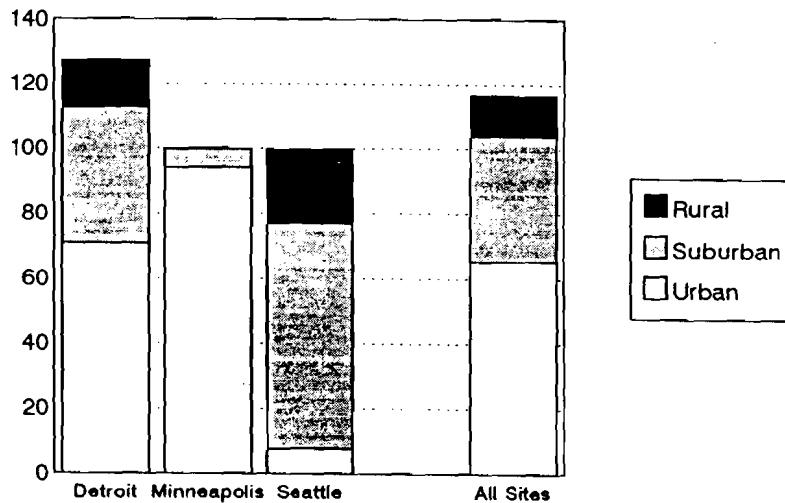


Chart 1.6 presents total and site specific urban, suburban, and rural distribution.

Chart 1.6

Total and Site Specific Urban / Rural Distribution
Percent of "Yes" Responses in Each Category



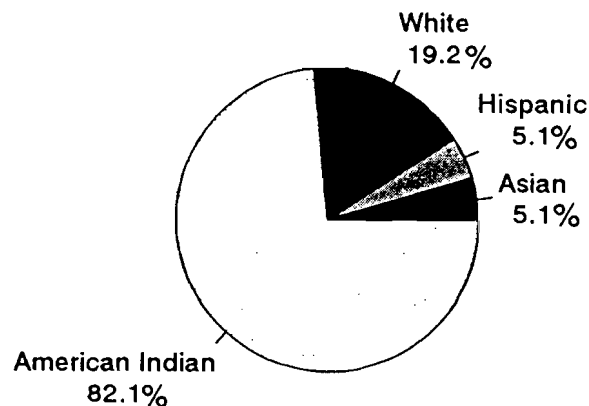
Percentages add up to more than 100% in some cases due to clients responding 'yes' to more than one area. The three project sites varied considerably in where there clients came from. Detroit had about 70% of its clients responding 'yes' to living in an urban area, 45% in suburban areas, and about 20% in rural areas. About 95% of clients in Minneapolis responded 'yes' to living in an urban area and 5% claimed suburban areas as their place of habitation. No clients at the Minneapolis clinic reported living in a rural area. The Seattle clinic clients responded as follows: 10% live in an urban area; about 67% live in a suburban area; and about 23% live in a rural area.

Chart 1.7 presents the race distribution of those who completed the pre-screening form. The chart shows the percent distribution of responses for all sites. Percents add up to more than 100% because some clients claimed more than one race for themselves or their children. 82.1% of those clients claimed their race as American Indian/Alaska Native; 19.2% of the respondents declared their race as white; 5.1% reported that they were of Hispanic origin; and 5.1% reported that they were Asian. No African-Americans were served.

Chart 1.7

Race Distribution

Percent Distribution of Responses -- All Sites



African Americans Served=0

Responses to the question of disability claims were varied: 3.8% reported blindness as disability; 6.4% reported substance abuse; 2.6% were mentally retarded; 3.8% of claimants had a mental illness; and 5.1% of claimants reported themselves as having AIDS. The AIDS percentage is important to note, because the 5.1% is much higher than the national percentage of American

Indians/Alaska Natives having AIDS. The majority of the respondents (70.5%) claimed 'other' as the reason for disability screening. This category includes all physical impairments as well as other disabilities. The percentages do not add up to 100% due to the fact that the category 'aged' was being claimed as the main reason for applying for SSI benefits. (See chart 1.8)

Chart 1.8

Reasons For Screening Disability Claim Types Percent Distribution of Responses

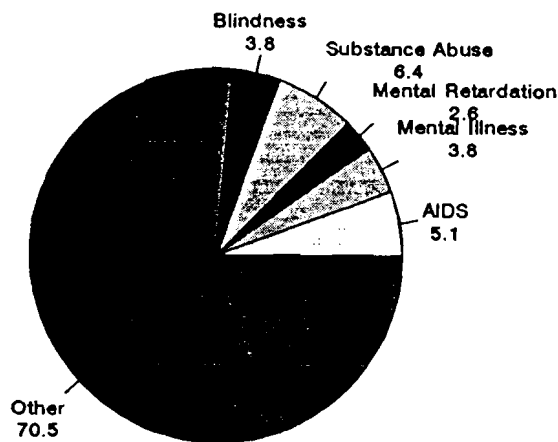
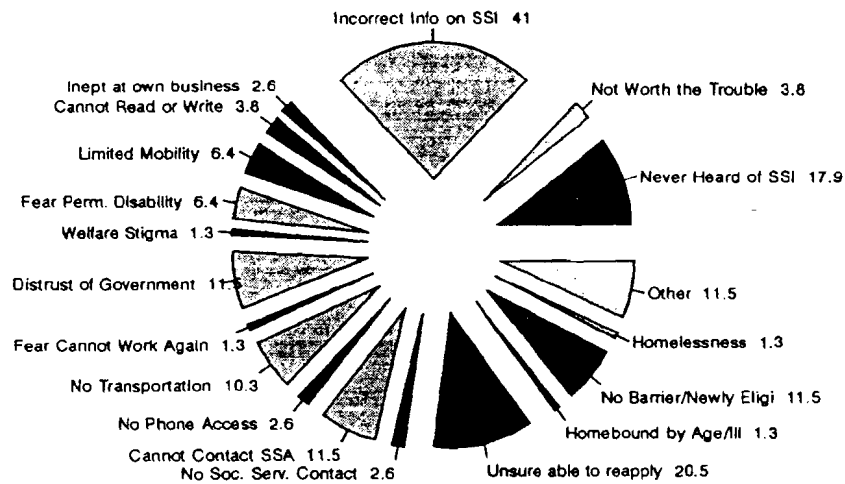


Chart 1.9 presents barriers to filing for SSI in percent distribution of responses. The percentages total more than 100% due to the fact that clients could choose up to three barriers. Also, please note that clients chose the barriers they perceived to be the most difficult. Just because only 2.6% of the applicants perceived one of their major barriers as having no phone access, that does not mean 97.4% have a phone. The distribution is as follows:

Chart 1.9

Barriers To Filing For SSI

Percent Distribution of Responses



No Media Access and Stigma of Disability=0

Table 1.2

BARRIERS TO FILING FOR SSI	PERCENTAGE
Incorrect information about SSI	41%
Never heard of SSI	17.9%
Distrust of the government	11.5%
Did not know how to contact SSA	11.5%
Were not aware that they could reapply for SSI	20.5%
Did not have transportation	10.3%
Had no barrier or were newly eligible	11.5%
Feared applying for SSI was admitting disability as permanent	6.4%
Limited mobility	6.4%
Not worth the trouble to apply for SSI	3.8%
Could not read or write	3.8%
Were unable to take care of their own business	2.6%
No phone access	2.6%
No social service contact	2.6%
Stigma of welfare	1.3%
Fear of not being able to work again	1.3%
Homebound by age or illness	1.3%
Homeless	1.3%
Other barriers	11.5%

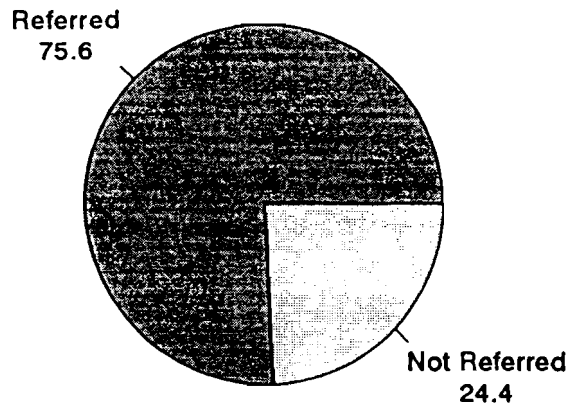
Media access or stigma of their disability was not considered a barrier for any respondent.

It is important to note that of those who completed the pre-screening form, 58.9% had never heard of SSI or had incorrect information about SSI. Other significant barriers were distrust of the government, not knowing how to contact SSA, and not being aware that former applicants could reapply for SSI benefits.

After completing the pre-screening form with the outreach worker, 75.6% were referred to SSI to apply for benefits, and 24.4% were not referred. (See chart 1.10)

Chart 1.10

Percent of Clients Referred And Not Referred To SSI
After Completing the Pre-screening Form

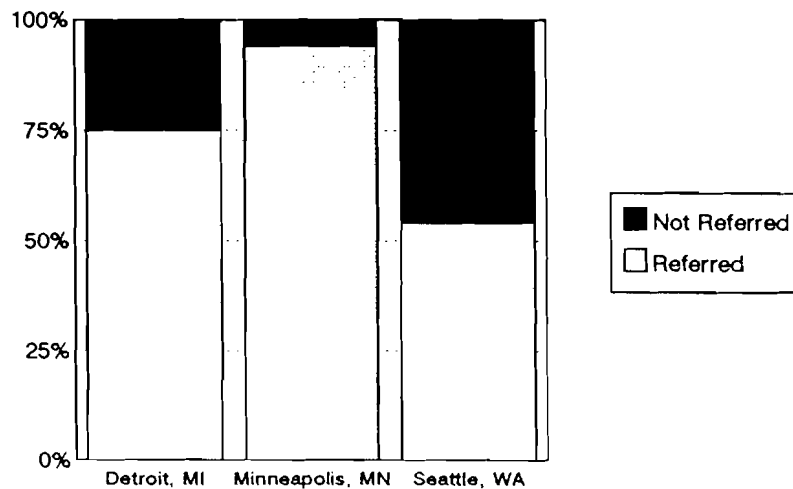


n=78

Chart 1.11 shows the percent distribution of those clients referred and those not referred to SSI after completing the pre-screening form by site. This chart indicates the level of financial counseling and services at each clinic. Seattle has a strong financial assistance program in place so they had already reached many potential eligible clients before this project came into being (about 55% were referred to SSA). Minneapolis had some service programs in place, but no links with SSA or DDS offices had ever been established before, and it is believed that the local SSA office had not done any specific outreach to the Indian community before, thus the referral rate in Minneapolis was quite high (about 90% were referred to SSA). Detroit used direct outreach (computer files to target individuals who appeared to qualify were not available here and letters were not used), thus the percent distribution is less skewed one way or another (about 75% were referred to SSA).

Chart 1.11

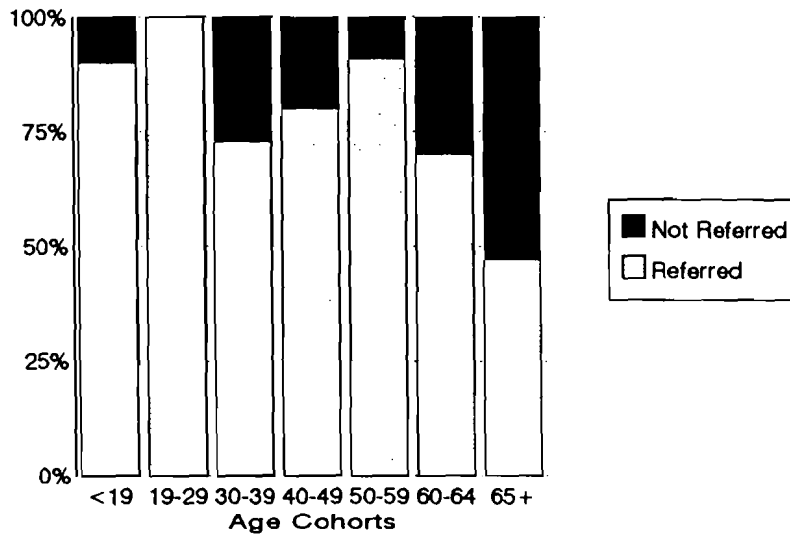
Those Referred and Not Referred by Site Percent Distribution of Clients who Completed Pre-screening Form



The percent distribution of those referred and not referred by age group is presented in chart 1.12. It is interesting that for the age cohort 65 years and older, the referral rate was the lowest and second lowest in the 60 to 65 age cohort. Every person who was between the ages of 19 and 29 was referred to SSA.

Chart 1.12

Percent Distribution of Those Referred and Not Referred by Age Group



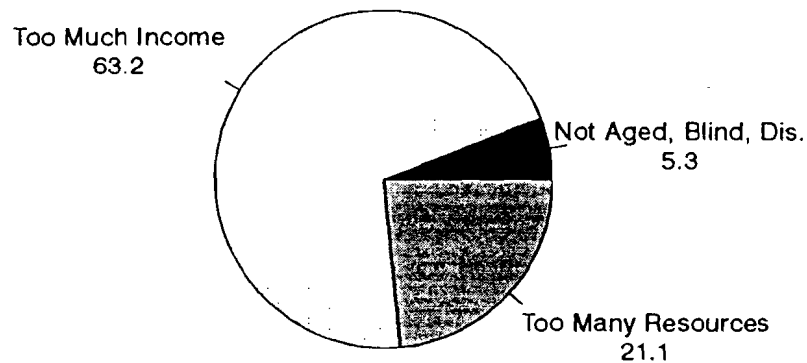
n=78

Percent distribution of the reasons why clients were not referred are presented in chart 1.13. Too much income was the primary reason (63.2%). 21.1% of those not referred to SSA was because they had too many resources. 5.3% were determined to not be aged, blind, or disabled after completing the pre-screening form, and 10.4% had other reasons why they were not referred. United States citizenship was not a reason why a client was not referred to the SSA (0%).

Chart 1.13

Reasons People Were Not Referred

Percent Distribution



Not a Citizen=0

COSTS

The total cost per person originally screened was: Seattle, \$3.08 per person; Minneapolis, \$3.23 per person; Detroit, \$27.20 per person. The formula to derive these numbers is as follows:

(Attempts is defined as the number of potentially eligible people that the outreach workers tried to contact either by phone calls, letters, or direct outreach.)

Seattle The outreach worker's hourly wage (\$8.17) multiplied by the total number of hours she worked on the project (320 hours) divided by the number of attempts to

contact potentially eligible persons (850 attempts) equals a cost of \$3.08 per person.

$$\$8.17 \times 320 / 850 = \$3.08/\text{person}$$

Minneapolis The outreach worker's hourly wage (\$9.00) multiplied by the total number of hours she worked on the project (320 hours) divided by the number of attempts to contact potentially eligible persons (891 attempts) equals a cost of \$3.23 per person.

$$\$9.00 \times 320 / 891 = \$3.23/\text{person}$$

Detroit The outreach worker's hourly wage (8.50) multiplied by the total number of hours he worked on the project (480 hours) divided by the number of attempts to contact potentially eligible persons (150 attempts) equals a cost of \$27.20 per person.

$$\$8.50 \times 480 / 150 = \$27.20/\text{person}$$

The total cost per person who completed pre-screening forms was: Seattle, \$237.67; Minneapolis, \$169.41; Detroit, \$85.00. The formula is as follows:

Seattle The outreach worker's hourly wage (\$8.17) multiplied by the total number of hours she worked on the project (320 hours) divided by the number of pre-screening forms completed after initial attempts (11 people) equals a cost of \$237.67 per person.

$$\$8.17 \times 320 / 11 = \$237.67/\text{person}$$

Minneapolis The outreach worker's hourly wage (\$9.00) multiplied by the total number of hours she worked on the project (320 hours) divided by the number of pre-screening forms completed after initial attempts (17 people) equals a cost of \$169.41 per person.

$$\$9.00 \times 320 / 17 = \$169.41/\text{person}$$

Detroit The outreach worker's hourly wage (\$8.50) multiplied by the total number of hours he worked on the project (480 hours) divided by the number of pre-screening forms completed after initial attempts (48 people) equals a cost of \$85.00 per person.

$$\$8.50 \times 480 / 48 = \$85.00/\text{person}$$

As the formulas show above, although initial attempts were the most expensive in Detroit, after pre-screening, Detroit is significantly less costly per person than Seattle and Minneapolis.

The outreach worker in Detroit actually spoke with 150 people about SSI whereas the attempt numbers in Seattle and Minneapolis account mostly for letters sent. Letters seem to have little impact reaching needy people. One-on-one conversations with an outreach worker is much more meaningful and informative than receiving a form letter in the mail from your clinic. Direct outreach is also more cost-effective over the long run with this project as Detroit has shown.

Table 1.3

PROJECT SITES	TOTAL COST PER PERSON ORIGINALLY SCREENED	TOTAL COST PER PERSON WHO COMPLETED PRE-SCREENING FORMS
Seattle	\$3.08	\$237.67
Minneapolis	\$3.23	\$169.41
Detroit	\$27.20	\$85.00

BENEFITS OF SSI PROJECT

- * Clinics receive Medicaid payments in some states when clients receive SSI.
- * If clients are receiving assistance, there is greater likelihood that clinics will get paid from these clients for services rendered.
- * Recipients of SSI improved their quality of life by receiving more income and possible insurance or other public assistance in conjunction with applying for SSI.
- * Linkages have been established between the Social Security Administration, the urban Indian health programs, the Disability Determination Services, and the American Indian Health Care Association.
- * Because of her responsibilities as Financial Counselor at the Seattle Indian Health Board, the outreach worker for this project will continue to assist American Indians/Alaska Natives in applying for SSI.
- * At all three sites, American Indians/Alaska Natives have been made aware of SSI through direct outreach, news bulletins, and SSI information distributed at other American Indian/Alaska Native organizations.
- * With an American Indian/Alaska Native outreach worker, significant headway can be made with

projects such as this to locate and assist target populations in receiving SSI or other benefits.

- * Culturally sensitive brochures giving information about SSI have been developed for participating urban Indian health programs.

LIMITATIONS

The biggest limitation of this project was time: four months is not long enough for an outreach worker to find potential eligible clients, gain the community trust, walk clients through the application process, and wait for a response from SSI. A typical disability claim can take four months before a claimant will receive word one way or another. A project such as this was given no chance for great success due to the time shortage. Many of these cases are now dead in the water because there is no outreach worker at the clinics to follow a claimant through the entire application process; and if the claimant has no one to assist him/her, he/she will not pursue it any further.

Because of the time limitation, numbers for this project look relatively small. They are also small because this project is very labor intensive; it took about eight hours to complete a file on one claimant for the outreach worker. This time does not account for getting additional medical evidence requested from DDS. If SSI truly wishes to help under-represented groups of people benefit from SSI, then SSI must realize that there is no quick, easy or cheap way to expedite the number of claims.

CONCLUSIONS

The Supplemental Security Income (SSI) Project has enabled many American Indians/Alaska Natives to receive SSI benefits they may not have received due to lack of knowledge about SSI, incorrect knowledge regarding SSI benefits, distrust of government programs, or any other number of reasons. Most importantly, this project reached a group of people that desperately need additional funds to survive without subjecting them to ambivalent claim representatives and faceless government agencies alone.

Urban Indian health centers are ideal locations from which to administer programs like the SSI Project. Urban Indian health centers are aware of the special needs of American Indians/Alaska Natives and in most cases staff are Indians themselves. The SSI Project has connected the services of the Social Security Administration, the Disability Determination Services, the American Indian Health Care Association, and the urban Indian health centers to assist American Indians/Alaska Natives in gaining access to SSI as well as other Social Security Administration benefit programs.

Many people's lives have been drastically improved thanks to this project. Unfortunately, much more needs to be done. A national SSI project should be set up in all urban Indian health centers: this project has proven that with an American Indian/Alaska Native outreach worker from the urban Indian clinics to walk clients through the application process, they understand the process more thus becoming more confident in asking for the assistance they need.

RECOMMENDATIONS

- * Linkages and coordination between all urban Indian health programs, SSA, and DDS should be established to better serve American Indians/Alaska Natives.
- * A contact person - an outreach or social worker - at each urban Indian health center should be established to promote SSA/SSI and to educate staff and clients about SSA/SSI.
- * In the future, demonstration projects like this should run longer to get a better response rate from American Indians/Alaska Natives. Much of the SSI Project's success is from word of mouth in their community; this takes time and trust. Four months does not do American Indians/Alaska Natives or the Social Security Administration justice.
- * Letters sent out informing people about SSI benefits does not work nearly as well as does person to person contact. Future projects should account for and demand personal contacts with potential clients by an outreach worker; this is where a project such as this will benefit most and see better results.
- * Social Security Administration and the Disability Determination Services need to become more culturally sensitive. This could be achieved by local SSA offices sponsoring seminars with various American Indian/Alaska Native organizations and

urban Indian health programs to learn more about American Indian/Alaska Native culture.

- * Information about SSI benefits should be published in American Indian/Alaska Native community newsletters.
- * Culturally sensitive posters and brochures should be made and disseminated to all urban Indian health programs as well as American Indian/Alaska Native organizations and cultural centers.
- * Inservices or seminars should be set up by SSA and the DDS with urban Indian health programs to get cultural sensitivity training. SSA or DDS claim representatives will have better success and a greater respect for American Indians/Alaska Natives if they are aware of cultural lifestyles and backgrounds.
- * Meetings with SSA, DDS, and local American Indian/Alaska Native organizations will enable these organizations to maintain linkages and coordination in addition to keeping each other informed of new developments in policies and procedures.

It appears as though the Indian Health Service and the Social Security Administration need to continue their relationship of providing outreach to American Indians and Alaska Natives in need of supplemental income and assistance. The SSI Project has proven that this type of project is very effective; if given more time and executed on a national scale incorporating all urban Indian health programs linking with the local Social Security offices and the Disability Determination Services, a significant dent

would be made into the current access difficulties for this underserved population.

The cost of a national project utilizing all 34 urban Indian health programs has been estimated to be \$101,680.00 annually. This includes all expenses for rental space and supplies at the urban clinics and AIHCA; 10% of the outreach workers' salaries; the project coordinator and research assistant salaries and benefits; as well as a training conference, travel expenses, and administration. Since time was a major limitation of this project, it is suggested that if a national program was implemented, the time line should be at least 12 months, preferably 18.

LITERATURE REVIEW

Shannon & Bashshur. (1982) "Accessibility to Medical Care Among Urban American Indians in a Large Metropolitan Area". Soc. Sci. Medicine, 16, pp. 571-75.

Household survey conducted among a representative American Indian/Alaska Native population living in a large metro area (Detroit, MI). Evaluated accessibility experience of this population as it pertained to primary medical care.

Examined accessibility using only the access measures that had been established quantitatively in PL 93-641; the National Health Services Planning and Development Act. These measures stipulate that, in other than exceptional cases:

- 1.) A source of primary care should be available within 30 min. travel time;
- 2.) Appointment delay time be no more than 7 days; and
- 3.) Waiting room time be no more than 30 min. beyond the scheduled time.

Estimated that 50% of approximately 1 million American Indians/Alaska Natives live off-reservation, mostly in urban areas (a trend begun in the late 1950s). In comparison to Native Americans on reservations, urban Native Americans have been generally neglected and few among them receive benefits from the I.H.S. or other federal or state programs. Serious unmet needs of the urban American Indian/Alaska Native population has been recognized by Congress through the passage of the "Indian Health Improvement Act (PL 94-437) in 1976. Title V refers specifically to development of programs making health

services more accessible to urban Native Americans. Funding of such programs has been predicated upon availability of info documenting the accessibility status and needs of the Native Americans in urban areas.

205 respondents were interviewed; 80% of the selected sample. Used 21 American Indian/Alaska Native field workers recruited and trained by the Detroit American Indian Health Center. Information was obtained from the mother/wife about recent medical care experience of each member of the family as well as other socio-demographics, attitudinal and locational characteristics of the respondent and the family unit.

Pertinent to the study were questions about use of a physician's services in the last 6 month period.

Authors acknowledge that they examined only one dimension of accessibility ("convenience factors"). They noted there appeared to be considerable variation from region to region in terms of convenience experience and expectations. They suggest development of regional standards rather than dependence upon national figures. They also suggest indices be based on the preference structures of the population under study as well as other factors.

Red Horse, Lewis Feit & Decker. (1978) "Family Behavior of Urban American Indians". Social Casework, February 1978, pp. 67-72.

American Indian/Alaska Native family networks assume a structure radically different from other extended family units in Western society (eg. accepted structural boundary of the

European model, is the household). An extended family is defined as 3 generations within a single household.

American Indian/Alaska Native family networks are structurally open (in contrast to European family constructs) and assume a village-type characteristic. Extension is inclusive of several households representing significant relatives along both vertical and horizontal lines.

Network structure influences individual behavior patterns because family transactions occur within a community milieu.

Structural characteristics of American Indian/Alaska Native family networks confront human service professionals with judgmental issues beyond that of labeling. Extended family often serves as a major instrument of accountability.

Three distinct family patterns:

- 1.) A traditional group which overtly adheres to culturally defined styles of living;
- 2.) A non-traditional, bi-cultural group which appears to have adopted many aspects of non-Indian styles of living; and
- 3.) A pantraditional group which overtly struggles to redefine and reconfirm previously lost cultural styles of living.

Many observers of American Indian/Alaska Native life tend to hold biases concerning which pattern is most legitimate or functional in contemporary American society. This is a luxury that in the authors' opinion must be avoided because "each pattern is legitimate within its own relational field and contributes to a family sense of selfhood." (p.70). Caution is advised in appraising issues of "coping ability"

and "openness to mainstream social methodologies" - there is an overwhelming preference by Native Americans for self-determination and self-governed programs, regardless of differences in family lifestyle patterns."

Re: family network dynamics...American Indian/Alaska Native relational values have remained intact through the years: extended family networks have remained as a constant regardless of family lifestyle patterns.

Network behavior patterns clearly point to emergence of a distinct, closed American Indian/Alaska Native community. Outsiders, including representation of agencies providing mandated services, do not gain entrance easily.

Conclusion: because any health care is dependent upon client utilization, an understanding of American Indian/Alaska Native network behaviors appears critical to policy development.

Murdock & Schwartz. (1978) "Family Structure and the Use of Agency Services: An Examination of Patterns Among Elderly Native Americans." *The Gerontologist*, 18:5, pp. 475-481.

Data from interviews with 160 elderly Native Americans living on a reservation setting indicate that levels of objective need are uniformly high, but especially so for elderly persons living alone. Levels of perceived service needs, awareness of service agencies and the use of agency services, however, are higher for those living in extended family settings. Family structure appears to be

an important factor in the provision of services to elderly Native Americans.

It appears that children may assist elderly persons by both creating greater awareness of the needs for and availability of services, and indirectly obtaining the required services. At the time of the article (1978) the authors concluded that "no effective mechanism for service delivery has yet reached many of the elderly Native Americans that must live alone. (p. 481)"

**Beauregard, Cunningham & Cornelius (1991, July).
"Access to Health Care: Findings from the Survey of
American Indians and Alaskan Natives." AHCPH Pub.
No. 91-0028.**

Presents results from the 1987 National Medical Expenditure Survey (NMES) II. NMES provides info about the non-institutionalized population; It also provides extensive information on populations residing in /admitted to nursing homes and facilities for the mentally retarded.

NMES II was based on a national probability sample of civilian non-institutionalized population living in the community. It was designed to provide a larger representation of population groups of special interest to the federal government than would have been obtained from a random sample.

Morgan, James and Curry O'Connell, Joanne. The Rehabilitation of Disabled Native Americans. Int. J. Rehab. Research. 1987, 10 (2), 139-149.

The Native American population remains a special ethnic group in the United States that is overrepresented at the lower end of the socio-economic scale, with a suspected greater than average rate of disabling conditions.

Utilization of rehabilitation services by adult Native Americans was studied. Three years of Rehabilitation Services Administration (RSA) data were analyzed to compare the rehabilitation success rate of Native Americans with that of all other population groups.

Native Americans were significantly less likely to be rehabilitated than clients from the general population. Factors contributing to the poor rehabilitation of Native Americans were analyzed. Three factors identified as significant were the socioeconomic characteristics of the clients, the type of disabilities presented by the clients, and the inability of the counselors to locate clients and complete the rehabilitation plan.

Recommendations for improving the rehabilitation of Native Americans are discussed.

Stifle, J.M. and Haskins, James S. ...he will lift up his head: A Report to the Developmental Disabilities Office on the Situation of Handicapped Navajos and the Implications Thereof for All Native Americans. 1978.

This report gives background information on the handicapped in America. The United States has lacked as

a nation the social, emotional, and financial commitment needed to achieve a better life for the handicapped. In the 1970s, the handicapped became more publicly active in their cause and now stand closer to their goal of achieving full citizenship.

The Handicapped Navajo: The traditional belief of the Navajo is that Nature is all-powerful and that people can do nothing but submit to its will. This is opposite and alien to white people who usually seek to conquer Nature through expanding technology.

Navajo believe that injury and disease is supernatural in origin. The problems of handicapped Native Americans demand unique solutions because they occupy a unique position in society.

The Problem: Native Americans suffer prejudices and problems such as poverty, high unemployment, substandard housing, lack of education, poor health, and exclusion from the mainstream of "American life". The Navajo reservation is in bad shape with half of it being barren desert and 15% of it totally inaccessible. These factors prevent Navajo parents from giving their handicapped children the special attention that they need. Many Native Americans are not even aware that there are any services available to the handicapped.

Smith, Ellen. "Health Care for Native Americans: Who Will Pay?"

Health Affairs. Spring, 1987. p. 123.

The Federal Indian Health Service (IHS), in the Department of Health and Human Services, provides comprehensive

inpatient and ambulatory care services at no charge to American Indians/Alaska Natives who are eligible on the basis of Indian descent, but IHS does not serve all American Indians/Alaska Natives. Of the 1.4 million American Indians/Alaska Natives and nearly 7 million persons with some degree of Indian ancestry in 1980, IHS recognized about 830,000 as eligible to use its health care system.

Historically, federal services to Indians have centered on the reservations, and IHS continues to direct its health services to Indians who live on or near federal reservations. This effectively excludes approximately half of all Indians (54% in 1980), those who live in metropolitan areas.

In April 1986, the congressional Office of Technology Assessment (OTA) published a major review of Indian health status, services delivery, and other issues related to Indian health care (Indian Health Care, OTA-H-290, April 1986). Sadly, the findings of the OTA assessment were much the same as those of earlier studies: the health status of American Indians/Alaska Natives is poorer than the general population, and the services provided to meet Indian health needs are limited.

IHS service utilization data, weak as they are, do not correlate with the health problems identified by mortality rates. Some diagnoses for which death rates were relatively high were associated with lower-than-expected hospitalization rates, suggesting limited access to needed services.

Eligibility for IHS services is a controversial subject. Underlying conflicts about who is and who is not Indian, for purposes of receiving IHS benefits, were brought to the

surface in 1986 by proposed new IHS eligibility regulations that included sensitive "blood quantum" requirements, as well as geographic limitations.

Although the federal government recognizes a legal and moral responsibility for the well-being of Native Americans, neither funding levels nor minimum benefits packages are guaranteed. The range of services IHS provides is determined within the broad authorization of the Snyder Act of 1921 and delivered with "such moneys as Congress may from time to time appropriate".

Specialized services , such as cardiac intensive care, radiation therapy, organ transplants, burn care, neonatal intensive care, and others are available to IHS beneficiaries only through contract care, which is rationed on the basis of medical urgency. As a result, contract services for conditions that are not life-threatening may be deferred or denied.

An immediate problem is the loss of NHSC physicians. The NHSC, in the Public Health Service, provides medical scholarships in exchange for one to four years of obligated service in areas with a shortage of health personnel, which include IHS sites. The number of physicians who will be available to IHS from the NHSC will be sharply reduced after 1988, and there will be none after 1991, because new scholarship awards have been practically eliminated since 1980 by the Reagan administration.

Waddell, Jack. Watson, Michael O., ed. The American Indian in Urban Society. University Press of America, Inc. Lanham, MD. 1984. (Originally published by Little, Brown, and Co., Inc. 1971.)

Courses on American Indians/Alaska Natives have been a part of the anthropological curriculum for many years. But despite the overwhelming body of literature, both ethnological and historical, the amount written for classroom use that focuses on contemporary Indians is negligible. Texts on urban studies or on ethnic minorities contain few pages devoted to American Indians/Alaska Natives. Despite their significance in United States' history and their value as a source from which theories and generalizations about man and culture may be drawn, enough information has not been available about these American Indians/Alaska Natives so their situation may be understood. As Indians strive to gain a social and economic foothold in a national political economy that historically has been devastatingly unkind to them, they encounter problems that are, in many ways, unique among minority groups.

A few questions are raised to point out some of these issues and to show how the authors address themselves to these concerns. The first question is: Are Indian problems in the urban environments related to cultural incompatibilities between Indian segments and the dominant urban ideologies, or are the problems presented here "third world" problems that encompass all the socially and economically deprived irrespective of cultural factors?

The next question is: Shall we attribute the frustration, futility, and apathy so frequently thought to be characteristic of dislocated urban migrants to failings in social organization, or do we assess these symptoms to result from failings in the cultural mechanisms available for personality integration?

There are other questions to be raised which would allow the reader to identify other important facts about Indians in cities. Is it entirely a matter of who has or does not have social, economic, and political power, or are there other cultural-ideological factors not related to power structures that explain the present dilemma of contemporary urban-oriented Indian? Does the lack of understanding of urban Indians suggest that we need more sophisticated sociological techniques including such things as better sampling, better demography, better surveys, and greater use of quantification. or do we still need more traditional ethnographic approaches and particularistic case studies? Do we achieve greater understanding by restricting our time horizon to the current scene, or are time depths essential to that understanding? Finally, are we more correct in emphasizing the maladaptive aspects of urbanization process, or are there more cases of successful adaptation than allowed by our emphasis on social problems?

Hodge, Felicia. Disabled American Indians: A Special Population Requiring Special Considerations. *American Indian Culture and Research Journal* 13:3 & 4 (1989). pp. 83-104.

The health status of American Indians/Alaska Natives is unparalleled among other ethnic and racial minorities in the United States. Identified health difficulties include a pattern of social problems, poverty, and disease. The disabled American Indian/Alaska Native, however, faces additional disadvantages in the form of major barriers to care and rehabilitation services. Problems associated with mental and emotional conditions cannot be overlooked. The recent epidemic of suicides among young people on

the Wind River Reservation in Wyoming brought nationwide attention to the critical state of mental health problems on Indian reservations.

This study provides a clear picture of disabled Indians and points out the difficulties and barriers to care faced by this population. Further, this study investigates the client's point of view and his/her feelings, and community attitudes, regarding the disability. The disabled are given the opportunity to voice their needs and to explain the difficulties they face. Policy implications arising from this study are identified and discussed. Service delivery, cultural sensitivity, and prevention should become a part of all plans developed to mitigate the problems and issues that face the disabled Native American.

Campbell, Gregory, R. The Changing Dimension of Native American Health: A Critical Understanding of Contemporary Native American Health Issues. *American Indian Culture and Research Journal* 13:3 &4 (1989). pp. 1-20.

The health problems Native Americans are confronting today did not arise out of an historical vacuum. Diseases and ill health have a history. Health levels are linked to the social, political, and economic forces present at any historical moment. Thus, in order to understand some of the present day factors determining Native American health levels, it is imperative to examine the historical context from which these health problems emerged.

The medical history of Native American since European contact can be characterized as an "unnatural history of disease" - unnatural because the epidemiology of Native

American people changed under the hegemony of European contact. Reservation life brought further alterations of Native American societies. Under full governmental control, the Bureau of Indian Affairs (BIA) launched its assimilation program. As part of this assimilation process, the BIA took charge of medical care for Native American people. The role of reservation medicine therefore was never separate from the political policy of assimilation. Hospitals, for example, were not constructed to isolate infectious Indian people or to provide a sanitary location to perform medical services, but were constructed to "civilize" sick Indian people away from tribal influences. Needless to say, ill health continued into the mid-twentieth century.

Today, new disabling diseases such as AIDS, substance abuse and diabetes are taking its toll in the Native American community. Especially at risk are the Native American elderly, disabled, and infants.

Just as health is connected to society, so too, are the origins of ill health. By examining the health levels within an historical and social context, we can begin to comprehend the situation of the Native Americans.

Longres, John F. Toward a Status Model of Ethnic Sensitive Practice. *Journal of Multicultural Social Work*, Vol. 1(1) 1991. pp. 41-56.

Ethnic sensitive models of practice emphasize the importance of culture and cultural differences. The cultural model is described and critically evaluated; it is most appropriate when working with recent refugees and immigrants but less appropriate when working with people

as part of the 1987 SAIAN which collected information from the civilian non-institutionalized population eligible for care from the Indian Health Service (IHS) and living on or near reservations. Disability is defined as the inability to perform normal roles, particularly the work role. This approach is widely accepted for the population under 65 years of age. For those over 65 who frequently have left the work role, the most commonly used measure is associated with dependency and operationalized in terms of functional ability to perform activities of daily living.

APPENDICES

The following is a listing of UCRR tables to give the reader a comparison between the UIHPs and between the three SSI project sites. The tables themselves come after the listing.

**TABLE 2.1
PRESENTS THE RECEIPTS BY SOURCE AND BY PROGRAM FOR FY 1990**

PROGRAM	Section 330	MCH	Title X	WIC	IHS Title V	IHS Other
ALL	\$2,293,193	\$130,415	\$57,664	\$1,343,074	\$8,250,231	\$1,483,840
Percent	9.7%	0.5%	0.2%	5.7%	33.4%	6.2%
Average	\$69,491	\$3,952	\$1,747	\$40,699	\$240,431	\$44,965
Minimum	\$0	\$0	\$0	\$0	\$0	\$0
Maximum	\$874,504	\$77,428	\$57,664	\$557,770	\$1,192,614	\$647,339
SEATTLE	\$468,686	\$20,000	\$0	\$27,163	\$1,192,614	\$73,000
MPLS	\$377,267	\$0	\$0	\$0	\$743,144	\$15,113
DETROIT	\$0	\$0	\$0	\$0	\$316,017	\$0

**TABLE 2.1 CONTINUED
URBAN PROGRAM RECEIPTS BY SOURCE AND BY PROGRAM FOR FY 1990**

PROGRAM	Other	Medicare	Medicaid	Title XX	3rd Party	Pt. Collect
ALL	\$1,705,672	\$109,420	\$1,814,370	\$41,466	\$931,058	\$663,021
Percent	6.9%	0.5%	7.6%	0.2%	3.9%	2.7%
Average	\$49,559	\$3,303	\$54,899	\$1,257	\$27,836	\$19,559
Minimum	\$0	\$0	\$0	\$0	\$0	\$0
Maximum	\$769,348	\$25,049	\$410,304	\$29,210	\$368,302	\$92,852
SEATTLE	\$175,559	\$25,049	\$410,304	\$0	\$67,971	\$52,106
MPLS	\$239,314	\$8,199	\$315,528	\$0	\$118,301	\$26,027
DETROIT	\$70,230	\$423	\$2,691	\$0	\$12,462	\$17,574

TABLE 2.1 CONTINUED

URBAN PROGRAM RECEIPTS BY SOURCE AND BY PROGRAM FOR FY 1990

PROGRAM	State	County	City	Other	TOTAL
ALL	\$2,259,405	\$1,523,687	\$427,228	\$6,053,279	\$24,280,122
Percent	9.1%	6.4%	1.8%	25.5%	100.0%
Average	\$65,437	\$46,172	\$12,719	\$183,319	\$719,681
Minimum	\$0	\$0	\$0	\$0	\$0
Maximum	\$519,084	\$577,707	\$171,340	\$4,562,717	\$3,345,189
SEATTLE	\$110,664	\$328,688	\$171,340	\$212,045	\$3,345,189
MPLS	\$170,503	\$202,786	\$48,342	\$543,551	\$2,808,075
DETROIT	\$100,000	\$0	\$7,500	\$3,742	\$530,638

TABLE 2.2

URBAN PROGRAM SERVICES FOR 1990

PROJECT SITE	MEDICAL SERVICES	DENTAL SERVICES	COMMUNITY SERVICES	OTHER SERVICES	TOTAL SERVICES
SEATTLE	19,009	5,628	13,389	11,629	49,655
MPLS	13,887	9,704	6,381	44,300	37,477
DETROIT	3,199	1,423	2,567	6,927	14,116
TOTAL	181,974	72,470	137,200	175,379	620,224
ALL PROGRAMS					

TABLE 2.3

INDIAN HEALTH SERVICE COST PER INDIAN ENCOUNTER BY YEAR 1984-1990

PROGRAM	1984	1985	1986	1987	1988	1989	1990
ALL PROG.	\$20.00	\$29.02	\$28.73	\$28.59	\$31.70	\$29.78	\$20.48
Average	\$28.91	\$40.38	\$36.97	\$44.18	\$55.91	\$47.37	\$41.09
Minimum	\$9.00	\$7.65	\$4.30	\$2.86	\$3.09	\$3.97	\$5.39
Maximum	\$91.00	\$175.63	\$111.39	\$158.44	\$193.96	\$162.10	\$170.60
SEATTLE	\$30.00	\$29.50	\$29.47	\$29.47	\$41.44	\$29.39	\$72.39
MPLS	\$19.00	\$15.81	\$18.76	\$12.46	\$17.78	\$23.48	\$35.48
DETROIT	\$91.00	\$175.63	---	\$69.08	\$122.57	\$122.57	\$15.16

TABLE 2.4
TOTAL PROJECT USERS BY SERVICE AREA, FY 1990

PROGRAM	Medical	Dental	Hth Ed	Nutrit.	Ment. Hth	Optom.	Comm.Srv	Proj.
ALL PROG.	80,310	30,720	18,499	17,563	4,959	3,469	46,738	134,160
Percent	59%	22%	13%	13%	3%	3%	34%	100%
Average	2,195	817	490	469	127	94	1,263	3,699
Minimum	0	0	0	0	0	0	0	0
Maximum	11,532	6,294	7,609	7,614	2,236	1,975	6,327	21,780
SEATTLE	5,534	2,032	1,247	1,166	382	456	1,168	6,580
MPLS	11,532	6,294	1,306	0	2,236	1,975	6,327	21,780
DETROIT	758	516	363	195	271	0	1,100	1,998

TABLE 2.5
INDIAN SERVICE USERS BY PROGRAM, FY 1990

PROGRAM	Medical	Dental	Hlth Ed.	Nutrition	Ment. Hth	Optometry	Comm. Srv	Total
ALL PROG.	53,834	19,588	8,416	4,978	4,349	3,213	38,516	91,408
Percent	59.3%	21.6%	9.0%	5.3%	4.5%	3.5%	41.4%	100.0%
Average	1,452	528	220	130	111	87	1,013	2,448
Minimum	0	0	0	0	0	0	0	0
Maximum	10,125	4,819	1,182	991	1,950	1,893	5,378	18,567
SEATTLE	4,148	1,397	1,019	841	269	333	986	4,817
MPLS	10,125	4,819	1,182	0	1,950	1,893	5,378	18,567
DETROIT	676	502	287	161	241	0	1,036	1,822

TABLE 2.6
NON-INDIAN SERVICE USERS BY PROGRAM, FY 1990

PROGRAM	Medical	Dental	Hlth Ed.	Nutrition	Ment. Hlth	Optometry	Comm. Srv	Project Users
ALL PROG.	26,476	4,759	10,083	12,585	610	256	9,322	44,750
Percent	59.4%	23.2%	21.6%	27.1%	1.3%	0.6%	20.0%	100.0%
Average	743	290	270	339	16	7	250	1,251
Minimum	0	0	0	0	0	0	0	0
Maximum	5,519	1,960	7,308	6,623	286	123	2,888	9,970
SEATTLE	1,386	635	228	325	113	123	182	1,763
MPLS	1,407	1,475	124	0	286	82	949	3,213
DETROIT	82	14	76	34	30	0	64	176

TABLE 2.7
AGE DISTRIBUTION OF TOTAL USERS BY PROGRAM, FY 1990

AGE	0-4	5-9	10-14	15-19	20-34	35-44	45-64	65+	Total
ALL	2,765	10,008	7,607	8,793	2,834	14,492	12,497	4,465	119,781
Average	716	245	184	212	795	347	293	104	2,896
Minimum	0	0	0	0	0	0	0	0	0
Maximum	6,491	2,697	2,049	1,723	5,996	2,601	2,314	920	21,780
SEATTLE	931	503	334	457	2,133	1,031	938	253	6,580
MPLS	3,909	2,697	2,049	1,723	5,996	2,601	2,314	491	21,780
DETROIT	152	79	74	82	261	114	119	48	929

TABLE 2.8

AGE DISTRIBUTION OF FEMALE PROJECT USERS BY PROGRAM, FY 1990

AGE	0-4	5-9	10-14	15-19	20-34	35-44	45-64	65+	Total
ALL PROG.	14,748	5,220	4,048	5,582	22,343	8,856	7,547	2,770	71,124
Percent	20.6%	7.4%	5.7%	7.9%	31.4%	12.5%	10.6%	3.9%	100.0%
Average	353	127	98	135	539	214	182	67	1,715
Minimum	0	0	0	0	0	0	0	0	0
Maximum	3,211	1,356	1,020	1,140	4,165	1,552	1,454	633	13,032
SEATTLE	485	253	178	271	1,207	473	482	144	3,493
MPLS	2,017	1,356	1,020	1,140	4,165	1,552	1,454	328	13,032
DETROIT	79	36	46	44	161	74	70	32	542

TABLE 2.9

AGE DISTRIBUTION OF MALE PROJECT USERS BY PROGRAM, FY 1990

AGE	0-4	5-9	10-14	15-19	20-34	35-44	45-64	65+	Total
ALL PROG.	14,647	4,788	3,409	3,080	10,471	5,636	4,950	1,637	48,659
Percent	29.9%	9.9%	7.1%	6.3%	21.6%	11.6%	10.2%	3.4%	100.0%
Average	351	116	83	75	254	136	120	39	1,175
Minimum	0	0	0	0	0	0	0	0	0
Maximum	3,280	1,341	1,029	583	1,831	1,049	860	287	8,748
SEATTLE	446	250	156	186	926	558	456	109	3,087
MPLS	1,892	1,341	1,029	583	1,831	1,049	860	163	8,748
DETROIT	73	43	28	38	100	40	49	16	387

TABLE 2.10

PRIMARY CARE SERVICES FOR PROJECT SITES

PRIMARY CARE SERVICES	SEATTLE	MPLS	DETROIT
PRIMARY PREVENTION			
Family Planning	*	*	*
Prenatal Care/OB	*	*	*
Well Child Care	*	*	*
Well Adult Care	*	*	*
Preventive Dental	*	*	*
Nutrition Education	*	*	*
SECONDARY PREVENTION			
Screening - Child		*	*
Screening - Adult		*	*
Acute Medical Care	*	*	*
Mgmt Chronic Disease	*	*	*
SUPPORT SERVICES			
Laboratory	*	*	*
Diagnostic X-ray	*	X	X
Pharmacy	*	X	*
Medical Consultation	*	X	X
SPECIAL PROGRAMS			
Adolescent Care	*	*	
Health Education	*	*	*
Chemical Dependency Counseling	*	*	*
Mental Health	*	*	*
SUPPLEMENTAL SERVICES			
Dental Treatment	*	*	*
Audiology	X	X	*
Social Services	*	*	*
Transportation	*	*	*
Home Health Services		X	X
Nursing Home Services		X	X
Environmental Health		X	X
Health Education Services	*	*	*
Outreach/Referral	*	*	*
Optometry	X	X	X
Podiatry	X	X	X
Public Health Nursing		X	X
WIC Program	*	*	*

KEY: * = onsite X = referral blank = not provided

TABLE 2.11

AVERAGE NUMBER OF ENCOUNTERS PER USER BY SERVICE AND PROGRAM, FY 1990

SERVICES	DETROIT	MINNEAPOLIS	SEATTLE	ALL PROGRAMS
Medical	4.2	1.2	3.4	2.2
Dental	2.8	1.5	2.8	2.4
Health Education	1.8	1.9	1.7	2.4
Nutrition	1.8	---	1.6	1.9
Mental Health	1.8	2.3	7.7	2.8
Optometry	---	18.6	---	11.2
Community Services	2.3	1.0	11.5	2.9

TABLE 2.12

PERCENT AMERICAN INDIAN/ALASKA NATIVES USERS UTILIZING SERVICES BY PROGRAM, FY 1990

SERVICES	DETROIT	MINNEAPOLIS	SEATTLE	ALL PROGRAMS
Medical	37.1%	54.5%	86.1%	59.3%
Dental	27.5%	26.0%	29.0%	21.6%
Health Education	15.8%	6.4%	21.2%	9.0%
Nutrition	8.8%	---	17.5%	5.3%
Mental Health	13.2%	10.5%	5.6%	4.5%
Optometry	---	10.2%	6.9%	3.6%
Community Services	56.9%	29.0%	20.5%	41.4%

SSI DATA TABLES

The following data is the SPSS/PC+ analysis completed from the pre-screening forms.

FREQUENCY: AGE GROUPS

AGE	FREQUENCY	PERCENT	CUM PERCENT
Less than 19	10	12.8%	12.8%
19 - 29	9	11.5%	24.4%
30 - 39	11	14.1%	38.5%
40 - 49	10	12.8%	51.3%
50 - 59	11	14.1%	65.4%
60 - 64	10	12.8%	78.2%
65 +	17	21.8%	100.0%
TOTAL	78	100.0%	100.0%

CROSTABULATION: AGE GROUP BY SEX

AGE GROUP	FEMALE	MALE	ROW TOTAL
Less than 19	1	9	10
19 - 29	4	5	9
30 - 39	6	5	11
40 - 49	5	5	10
50 - 59	5	6	11
60 - 64	3	7	10
65 +	10	7	17
Column Total	34	44	78
Percent Total	43.6%	56.4%	100.0%

CROSSTABULATION: AGE GROUP BY AIDS

AGE GROUP	NO	YES	ROW TOTAL
Less than 19	10	0	10
20 - 29	7	2	9
30 - 39	10	1	11
40 - 49	9	1	10
50 - 59	11	0	11
60 - 64	10	0	10
65 +	17	0	17
Column Total	74	4	78
Percent Total	94.9%	5.1%	100.0%

FREQUENCY: SITE

PROJECT SITE	FREQUENCY	PERCENT	CUM PERCENT
DETROIT	48	61.5%	61.5%
MINNEAPOLIS	17	21.8%	83.3%
SEATTLE	13	16.7%	100.0%
TOTAL	78	100.0%	100.0%

FREQUENCY: SEX

SEX	FREQUENCY	PERCENT
FEMALE	34	43.6%
MALE	44	56.4%
TOTAL	78	100.0%

RESIDENCE OF RESPONDENTS

RESIDENCE	PERCENT
URBAN AREA	65.4%
SUBURBAN AREA	38.5%
RURAL AREA	12.8%

* Percents add up to more than 100% because some respondents claimed more than one area of residence.

REASONS FOR SCREENING

REASON CLAIMED	PERCENT
AGED	14.1%
BLIND	3.8%
AIDS	5.1%
MENTAL ILLNESS	3.8%
MENTALLY DISABLED	2.6%
SUBSTANCE ABUSE	6.4%
OTHER	70.5%

* Percents add up to more than 100% because a few respondents listed more than one reason for screening.

RACE DISTRIBUTION OF RESPONDENTS

RACE	PERCENT
ASIAN	5.1%
HISPANIC	5.1%
WHITE	19.2%
AMERICAN INDIAN/ALASKA NATIVE	82.1%
AFRICAN AMERICAN	0%

* Percents add up to more than 100% because some respondents claimed more than one race affiliation.

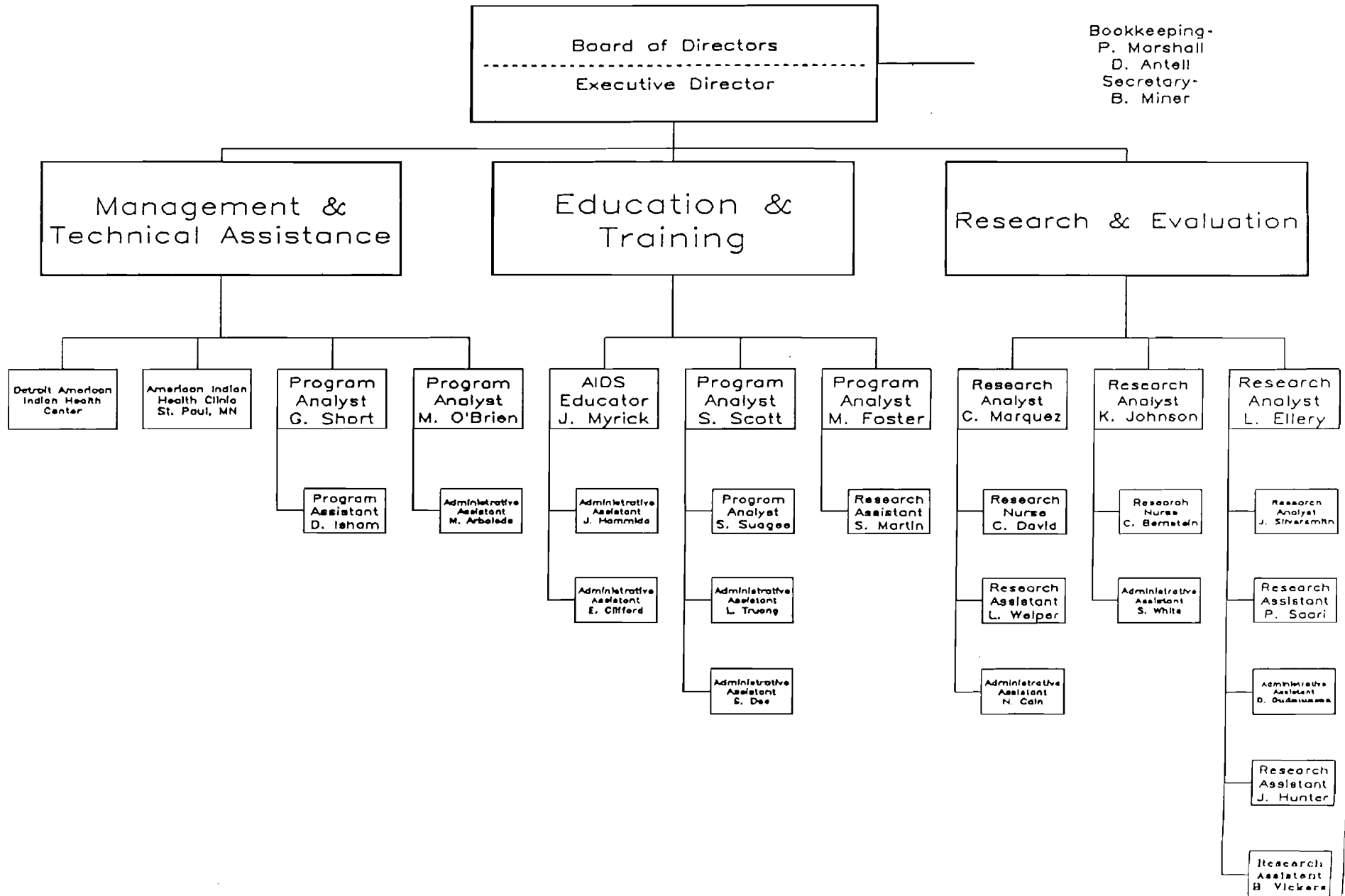
REFERRED TO SSI

REFERRED TO SSI	PERCENT
REFERRED	75.6%

REASONS FOR NOT REFERRING RESPONDENTS TO SSI

REASONS FOR NOT REFERRING	PERCENT
NOT AGED, BLIND, OR DISABLED	5.3%
NOT A U.S. CITIZEN	0%
TOO MUCH INCOME	63.2%
TOO MANY RESOURCES	21.1%
OTHER	10.4%

American Indian Health Care Association



Social Security Administration

Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number
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I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
American Indian Health Care Association	245 East 6th St, Ste. 499 St. Paul, MN 55101

I want this information released because:

I am a client of this organization's SSI Outreach Demonstration Project under a cooperative agreement with the Social Security Administration.
I understand that this organization needs this information to assist me in the SSI application process and to evaluate this project.

Please release the following information:

- Social Security Number
- Identifying information (includes date and place of birth, parents' names)
- Monthly Social Security benefit amount
- Monthly Supplemental Security Income payment amount
- Information about benefits/payments I received from _____ to _____
- Information about my Medicare claim/coverage from _____ to _____ (specify) _____
- Medical records
- Record(s) from my file (specify) _____
- Other (specify) Information about my SSI (and Social Security) application(s) and about the initial decision on the application(s).

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____
(Show signatures, names, and addresses of two people if signed by mark.)

Date: _____ Relationship: _____

4/20/92

A Native American SSI Project Success Story

The following briefing will highlight a personal experience with special needs and issues, as well as bring us closer in tune with the unique needs of Native Americans.

A Native American outreach project worker at the Detroit American Indian Health Center recalled a client who the outreach worker had the pleasure of meeting on several occasions for various resources which the Health Center provides. The worker remembered that this particular client was living on a day to day basis with the help of a significant other in the client's apartment, and the client seemed to always have a deep concern about how he would be able to make all of his monthly bills, let alone the medical bills. Enlightened by these facts and a concern for the client, the worker decided to pursue this client as a potential SSI recipient.

The outreach worker screened this client's file and spoke with several other resource staff at the Health Center to determine an over-all picture of the client's situation. The client appeared to meet the standard criteria for SSI.

The outreach worker called the client and was able to set up an initial appointment in the client's home in order to make a further evaluation, as well as get a better picture of the client's living situation.

While interviewing the client, the outreach worker noticed many of the basic necessities absent and it seemed that the client and his significant other were living below standard means to the degree that something was wrong. The outreach worker asked the client if he would mind the outreach worker evaluating his significant other while he was there. The response was positive, and the following discoveries were made:

It was discovered that the significant other had previously lost her widow's pension when she became of age to receive her own benefits from Social Security. She was unaware that she could apply for SSI. A Teleclaim was made and the outreach worker did the footwork to get the application signed and to copy records for the local SSI office.

At the same time it was discovered that the initial client with the medical problems was eligible for early Social Security benefits as he would turn 62 in the next month. Application was made for both SSI and SSA at the same time.

The client is presently awaiting his first payment from SSA of 296.00, and he has a very good chance of receiving SSI.

The significant other's income has increased from 227.00 to approx. 400.00 with the benefits of Medicaid added to her Medicare A&B.

Due to the reception that the outreach worker received at the Social Security Administration, Detroit Southwest, as well as the good working relationship that has developed between them and Detroit American Indian Health Center and coordination through

American Indian Health Care Assoc., these two people's lives have been changed to the degree that they are happily considering moving out of the semi-condemned apartment complex where they live and into a more suitable and appropriate place that they may call home.



INDIAN HEALTH BOARD OF MINNEAPOLIS, INC.

1315 East 24th Street Minneapolis, MN 55404-3959

Dear _____:

The Minneapolis Indian Health Board is coordinating an SSI Project between Social Security Administration and American Indian Health Care Association.

As the Financial Counselor I will be assisting clients for SSI eligibility through this project for Disable/Blind/Children Disable/Elders-65 and over. I will assist the client in filling out the application process.

If you have any clients who you think might be eligible for this project, please have them contact me at the Outreach Office.

You may contact me at 721-9835.

Sincerely,

Pam Johnson
Financial Counselor

An Equal Opportunity Employer

SAMPLE
LETTER
< This would go on
SIHB letterhead >

DATE:

CLIENT NAME
CLIENT ADDRESS

Dear Client:

This letter is to inform you that the Seattle Indian Health Board is coordinating with the American Indian Health Care Association and the Social Security Administration to assist clients apply for Supplemental Security Income (SSI). Our records show that you may be eligible for assistnace from this program. As the Finanacial counselor for the Seattle Indian Health Board, I can help you through the application process.

Please contact me at 324-9360, ext. 595, or stop by Patient Services reception desk and ask to see me. I am available Monday through Friday from 8:30 AM - 4:30 PM.

I look forward in assisting you in this program.

SINCERELY,

JEANNE WELLS,
Financial Counselor

JW/jmw