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9701613

# FINAL REPORT

## EVALUATION OF THE URBAN INDIAN HEALTH PROGRAM'S MANAGEMENT AND ADMINISTRATIVE CAPABILITIES AND TRAINING CONFERENCE TO REINFORCE DESIRABLE MANAGEMENT AND ADMINISTRATIVE TECHNIQUES

Prepared by

THE AMERICAN INDIAN HEALTH CARE ASSOCIATION

August 31, 1992

9701613

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# EXECUTIVE SUMMARY

## Purpose

A study was conducted to evaluate the management and administration of urban Indian health programs by the Urban Program Branch at the Indian Health Service (IHS). In order to do this, an assessment was made of the ability of the Urban Program Office and the IHS Area Offices to successfully carry out their duties and responsibilities to the urban Indian health programs; and the ability of the individual urban Indian health programs to meet their IHS contract and grant obligations. Findings are categorized into four areas: reporting standards and procedures; roles and responsibilities of management; provision of technical assistance and training; and planning for the future. Based on these findings, recommendations are presented for improvements to be made in urban Indian health program management.

## Reporting Standards and Procedures for the UIHPs

Requirements for reporting are specified in the Indian Health Care Improvement Act, the Indian Alcohol and Substance Abuse Treatment Act, and in Federal Regulations. Individual urban Indian health programs, though possessing a good understanding of contractual and legislative reporting requirements, varied in their ability to meet their reporting obligations. One reason for lack of compliance lay in the fact that there is no standardized reporting format. Another problem is that reported information is not aggregated, analyzed and used for setting priorities and for program planning for the urban Indian health programs. Coupled with a lack of feedback from management in the IHS Area Office and at Headquarters on reported information, many urban program directors were given the impression that reports written in compliance with their contracts are mere "busy work," rather than relevant information that would be used and shared in a meaningful manner.

## Roles and Responsibilities Of Management

The Urban Program Health Activities Chapter (Draft) of the *Indian Health Manual* defines roles and responsibilities at each level of organization within the Urban Health Program. These were well understood be the Urban Program Office at IHS headquarters. Within

the IHS Area Offices, however, the self-described duties of the Urban Coordinator and the Project Officer did not consistently match the position as described in the *Indian Health Manual.* Directors of individual urban Indian health programs tended to see the roles of Area Office staff more in terms of their own needs rather than in accordance with the written position descriptions. This is an indication that urban Indian health programs have needs from IHS management that are not being met within the current management structure.

## Provision of Technical Assistance and Training

Directors of individual urban Indian health programs rated the availability, quality, appropriateness and timeliness of technical assistance and training provided by the IHS Area Office. Most urban Indian health program directors rated the quality of technical assistance and training that they receive as adequate. However, Area Office technical support is tailored to the health care environment in which reservation programs. Therefore, though technical assistance and training might be of sufficient quantity, many urban Indian health program directors reported that little training in their Area Office is appropriate for the needs of their program. Urban Indian health program directors also reported regional variations in the type of training that is available, and in the availability of Area Office manpower to provide the quantity of assistance needed. Understaffing was a common problem within the management structure of the urban Indian health programs. According to IHS Area Office reports, the number of full time equivalent employees varied from 0.55 to 1.0, with an average of 0.22 FTE. This translates to 457 manhours per urban Indian health program per year. Most of this time was spent in carrying out administrative duties. Little time was available for providing guidance, technical assistance or training. Another problem lay in responding to requests for technical assistance in a timely fashion. Fifty-four percent of urban Indian health program directors rated stated that the timeliness of their requests for technical assistance was barely adequate or slow.

## Planning for the Future of the Urban Indian Health Programs

Urban Indian health program directors commented on planning processes within their individual programs for planning and preparation for future development; and made suggestions for how the IHS Urban Program Office can best address issues concerning the future of health care services for the urban Indian population.

Nearly all urban Indian health program directors described provisions for program planning, such as yearly strategic planning meetings to set goals and objectives, with quarterly reviews to monitor progress. In planning strategies to meet current and future challenges in health services delivery, they cited involvement with local health agencies

and universities to develop partnerships to ensure operational stability; diversification of funding sources; and plans to enter the managed care arena.

## Recommendations

1. Establish a central agency to collect necessary data to profile the urban Indian community for health planning purposes, such as health status, population, and HRA data; to provide leadership and to facilitate consultative Urban Program decision-making among the UIHP directors;

2. Facilitate consultation among UIHP directors, in order to develop goals for the Urban Indian Health Program; using, for example, the Year 2000 Objectives or Objectives stated in the Indian Health Care Improvement Act. In order to ensure that goals are realistic and responsive to the health care needs of urban Indians, urban Indian health programs should consult with IHS in developing Urban Program Objectives, rather than IHS consulting with the urban Indian heath programs in a top-down fashion;

3. Assist each urban Indian health program in formulating an action plan with specific outcomes within the collective Urban Program objectives, based on the health care priorities within each urban community and the budgetary limitations of each urban Indian health program. It is expected that, because of the tremendous variation that exists among urban Indian communities, each UIHP will need to tailor the the Urban Program priorities and objectives to meet their own community's needs.

4. Monitor outcomes periodically, with annual review to measure progress, and also determine whether objectives are still relevant.

# PURPOSE

This document reports the findings of a study conducted by the American Indian Health Care Association (AIHCA) on the activities of the Urban Programs Branch within the Office of Health Programs at the Indian Health Service (IHS). The Urban Programs Branch is responsible for overseeing the management and administration of contracts to federally funded urban Indian health programs (UIHPs) located in areas with significant American Indian/Alaska Native (AI/AN) populations.

The need for this study arose from a request from the Urban Programs Branch to the IHS Office of Planning, Evaluation and Legislation (OPEL) to provide additional manpower to carry out its increasing level of responsibilities. One suggested response to this request was to reorganize some of the urban Indian health program organizations to absorb some of the Urban Program Branch's workload. The purpose of this study was to assess the feasibility of such a solution.

In order to do this, information was gathered regarding:

- the demands placed on the Urban Programs Branch, and that office's ability to meet those demands.
- the ability of the individual urban Indian health programs (UIHPs) to meet their IHS contract and grant obligations.

# BACKGROUND

## ORIGINS OF THE URBAN INDIAN HEALTH PROGRAM

Between 1950 and 1960, the urban Indian population nearly tripled, from 56,900 to 166,000. This rapid growth was in part due to the Federal relocation policy in the 1950s, which relocated American Indians from reservations to metropolitan areas. Voluntary migration of Indian people seeking jobs in urban areas also contributed to the accelerated growth of the urban Indian population, fueled by high unemployment and poverty on reservations.

Once in the urban setting, however, many Indians found that migration did not necessarily alleviate unemployment and poverty, but rather compounded them with the social stresses of an unfamiliar urban milieu; a dispersed, heterogeneous Indian community; and lack of access to affordable, culturally competent health care.

In response to the needs of the growing urban Indian population, urban Indian community leaders initiated a grassroots effort in the late 1960s to provide health services to urban Indians in the form of volunteer-run clinics. In 1972, Congress appropriated funds for a pilot urban Indian health program in Minneapolis. The success of this program, as well as documented evidence of cultural and economic barriers to health care, led to the passage of Title V of *The Indian Health Care Improvement Act of 1976* (P.L. 94-437), which established additional urban Indian health programs in various cities nationwide.

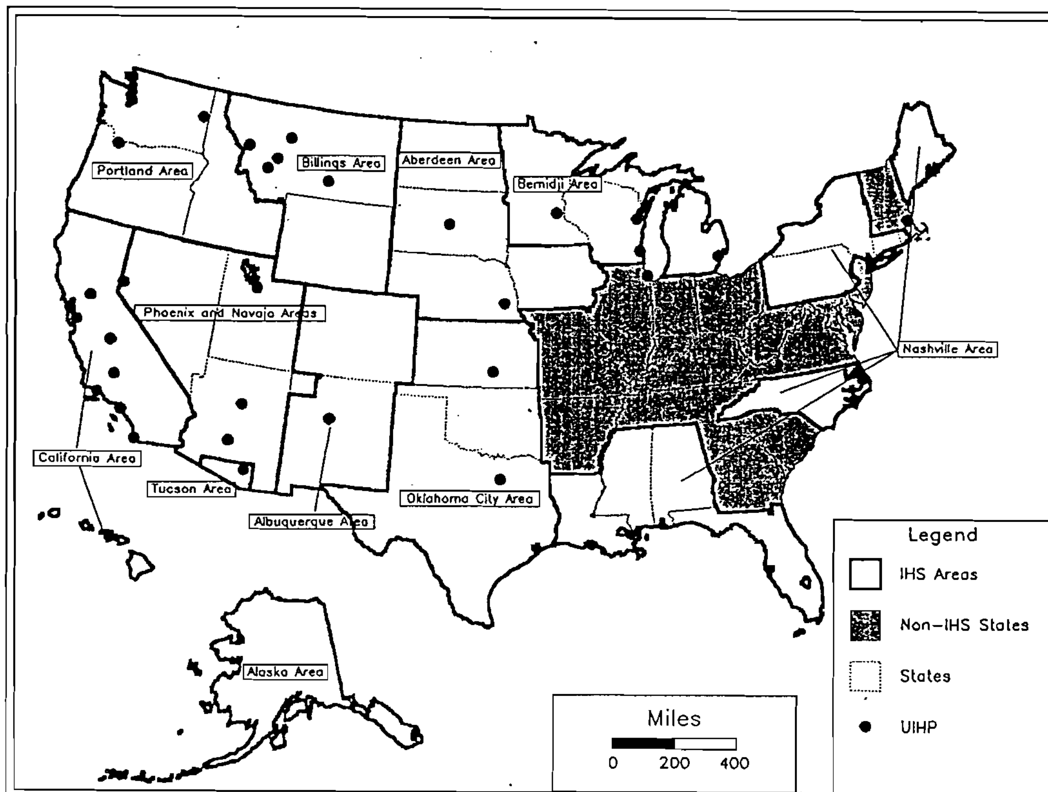
Along with the Snyder Act of 1921 (25 U.S.C 13), the Indian Health Care Improvement Act of 1976 (P.L. 94-437) provides the principal statutory foundation for urban Indian health programs. The Snyder Act broadly commits the Federal Government to be responsible "for the benefit, care and assistance of Indians throughout the United States...for the relief of distress and conservation of health." The Indian Health Care Improvement Act, passed in 1976, includes an additional goal, "to raise Indian health status to the highest level possible," and "provide for the unmet health needs of both reservation and urban Indians."

Since the enactment of P.L. 94-437, the number of urban Indian health programs has grown. As of July 1992, there were 33 federally funded health programs serving urban Indians, of which 28 were health clinics and 5 were community service programs. The Urban Indian Health Programs are listed below, by IHS Service Area:

| Table 1. Federally Funded Urban Indian Health Programs | | | |
|---|---|---|---|
| **BEMIDJI AREA** | **CALIFORNIA AREA** | **BILLINGS AREA** | **PHOENIX AREA** |
| Chicago, Illinois | Bakersfield, California | Billings, Montana | Phoenix, Arizona |
| Detroit, Michigan | Fresno, California | Butte, Montana | |
| Minneapolis, Minnesota | Los Angeles, California | Great Falls, Montana | **PORTLAND AREA** |
| Milwaukee, Wisconsin | Sacramento, California | Helena, Montana | Portland, Oregon |
| Green Bay, Wisconsin | San Diego, California | Mausolea, Montana | Seattle, Washington |
| | San Francisco, California | | Spokane, Washington |
| **ABERDEEN AREA** | San Jose, California | **NASHVILLE AREA** | |
| Pierre, South Dakota | | Boston, Massachusetts | **OKLAHOMA AREA** |
| Lincoln, Nebraska | **ALBUQUERQUE** | New York, New York | Dallas, Texas |
| | Albuquerque, New Mexico | | Wichita, Kansas |
| **TUCSON AREA** | Reno, Nevada | **NAVAJO AREA** | |
| Tucson, Arizona | Salt Lake City, Utah | Flagstaff, Arizona | |

Figure 1 displays the location of each of the 33 urban Indian health programs by IHS Service Area.

## Figure 1. LOCATION OF URBAN INDIAN HEALTH PROGRAMS



## MANAGEMENT PHILOSOPHY OF THE INDIAN HEALTH SERVICE

In its mission statement, the Indian Health Service states that its goal is to "elevate the health status of American Indians and Alaska Natives to the highest level possible...to ensure equity, availability and accessibility of a comprehensive high quality health care delivery system ... The IHS also acts as the principle federal health advocate for Indian people by assuring they have knowledge of and access to all Federal, State, and local health programs they are entitled to as American citizens."

The operation of the IHS health services delivery system on reservations is managed through local administrative units called service units. A service unit is the basic health organization for a geographic area served by the IHS program, just as a county or city health department is the basic organization in a State health department. Service units are defined areas, usually centered around a single federal reservation in the continental United States, or a population concentration in Alaska. Service units are grouped into larger cultural, demographic, and geographic management jurisdictions administered by one of 12 regional Area Offices.

Though the majority of efforts to elevate American Indian/Alaska Native health status is directed towards those who are members of federally recognized tribes living on reservations in 33 states, IHS has a responsibility to develop health programs for urban Indians under the Indian Health Care Improvement Act. The Urban Program Health Activities Chapter (Draft) of the *Indian Health Manual* establishes the general policy, staff responsibilities, operating relationships, standards and guidelines for the development of urban Indian health programs supported by IHS under contracts administered by the Area Office. The stated policy of IHS is to (1) assure that resources for a comprehensive program of health services are developed to reach the urban Indian community, and (2) to evaluate and monitor program performance of IHS supported urban Indian health programs.

Both the Urban Program Branch Office, established under the Amendments to the Indian Health Care Improvement Act, and the regional Area Offices operate with complementary authority in administering contracts to the Urban Indian Health Programs. The *Indian Health Manual* states that the IHS Headquarters' responsibility towards the urban Indian health programs is to:

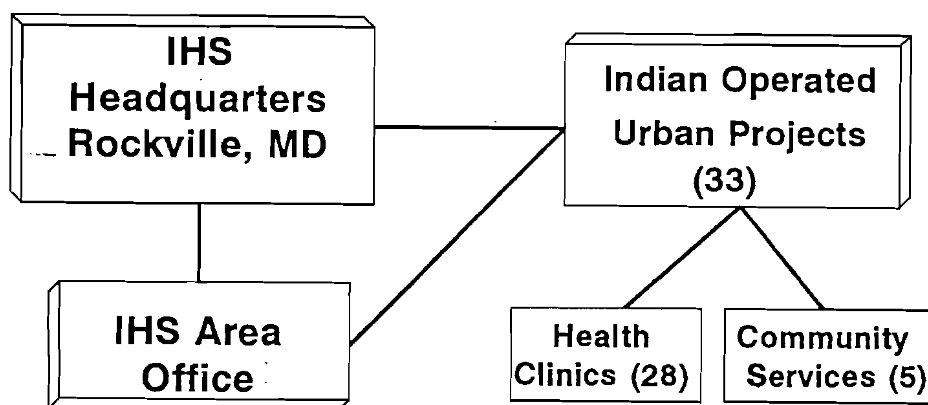
> "ensure implementation and monitoring of all the legislative and regulation requirements, policies, and funding of Urban Health Programs. To provide advocacy, consultation, technical assistance and capacity building to IHS funded Urban Indian Programs. To provide reports and responses to Congress, Administration, Department of Health and Human Services, Public Health Service, IHS Tribal Organizations and other interested organizations and individuals."

Similarly, the Area Offices' responsibility towards the urban Indian health programs is:

> "direct administration, management, evaluation, monitoring and funding responsibilities...consistent with legislation, regulation, policies, and standard for IHS funded Urban Indian Programs. IHS Area Offices will give the same support and assistance as they do with tribal and other program activities."

Figure 2 displays the organizational structure of the urban Indian health programs funded by the Indian Health Service.

**Figure 2. ORGANIZATION OF URBAN INDIAN HEALTH PROGRAMS**




THE AMERICAN INDIAN HEALTH CARE ASSOCIATION

Since 1978, the Indian Health Service has held contracts with the American Indian Health Care Association to provide training and technical assistance to urban Indian health programs. Training conducted by the AIHCA has taken the form of national and regional urban Indian health conferences on administrative and management issues that enhance the capability of urban programs to deliver accessible health services to Indian people. Conferences have included workshops on resource development, Urban Common Reporting Requirements (UCRR), policy issues, medical and dental outreach and referral, health promotion and disease prevention, health care for special groups (such as adolescents and the elderly), mental health and substance abuse. Information is further disseminated through publication of an urban Indian health newsletter that provides those working in urban Indian health with the latest updates on health issues.

During the past 14 years, the AIHCA has provided onsite technical assistance and training to individual urban Indian health programs in the areas of administration, management, governance, UCRR, data collection and analysis, report writing, resource development,

computerized patient records/patient billing systems, JCAHO Accreditation, and board training.

The AIHCA has also contributed to the development of the urban Indian health programs through documents such as the *Guidelines and Sample Plan*, to be used in developing health plans specific to the needs of Indian people in locations with federally funded urban programs; *The Urban Common Reporting Requirements Manual*, developed to provide a standard reporting format for performance indicators; and the *Program Evaluation Criteria*, a which sets forth standards for evaluating urban Indian health programs.

Deliverables on the yearly AIHCA contract have typically included special reports to Congress or the IHS on health issues that affect urban Indians, such as *The Resource Allocation Methodology Report*, *National Urban AIDS Education and Prevention Report*, *Epidemiology Needs Assessment*, *Evaluation of Potential Locations for New Urban Indian Health Programs*, and the *Urban Indian Comparative Health Analysis*. In addition, the IHS has awarded a separate contract to the AIHCA to research *The Health Status of Urban Indians Living in Arizona*. A synopsis of these reports may be found in Appendix A.

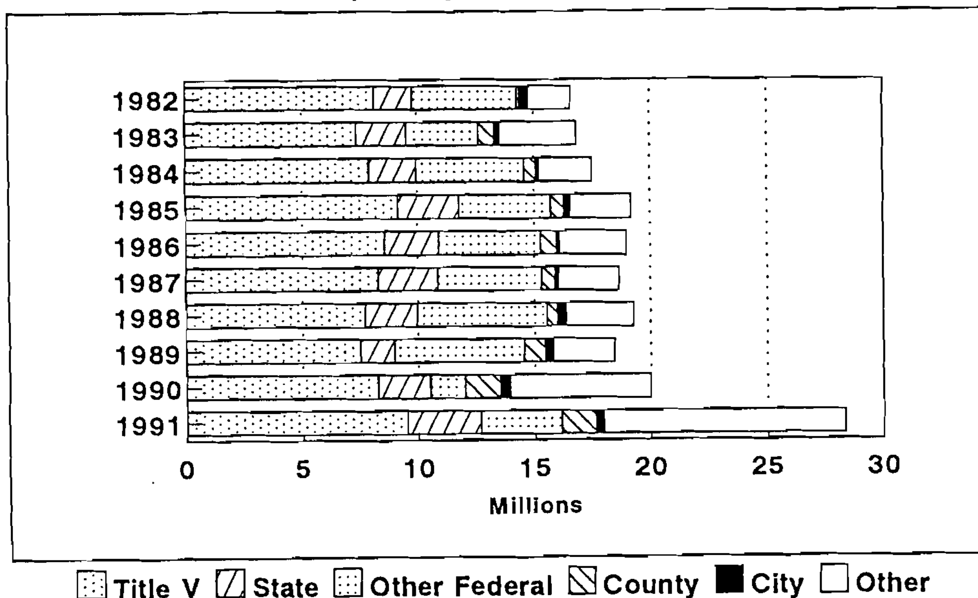
One shortcoming of the projects undertaken by AIHCA is that they lacked a dissemination phase to transfer findings to urban Indian communities to use in health planning and program evaluation. For example, though the *Urban Indian Health Program Charts and Graphs*, which reports the analysis of compiled Urban Common Reporting Requirements data from all programs, is published biannually, there is no formal dissemination of results to urban Indian health programs. Even if a mechanism to forward reports to the urban Indian health programs were be established, there would remain the need to provide training to the urban Indian health programs on how to use information for health planning purposes. Data from the Health Risk Appraisals, which have been conducted on convenience samples in nearly every city with a federally funded urban Indian health programs, would be an excellent information source on which to base a health planning workshop for the urban programs to address the specific health problems in each urban Indian community.

## FUNDING FOR URBAN INDIAN HEALTH PROGRAMS

Unlike IHS health centers, IHS hospitals or Tribal facilities, urban Indian health programs have diverse sources of funding. Figure 3 graphically illustrates the urban program funding history by source. Though the amount contributed by the federal funds through the Indian Health Service has remained relatively constant over the past ten years, funding from additional sources (State, County, City, Other Federal, and Other Sources) has grown to equal, and then exceed, IHS funding. Though the contribution by the IHS has constituted an increasingly smaller proportion of urban program funding over time, IHS has maintained a management position towards the urban programs that is similar that

of reservation-based programs, treating the urban Indian health programs as if IHS were the sole financial contributor, and therefore the sole master, of the urban programs.

Figure 3. Urban Program Receipts By Source by Year




Administration of contracts to the urban Indian health programs is modelled after management of IHS facilities and Tribal Programs. The environment in which urban Indian health programs must operate, however, is very different than reservation-based health programs. Unlike other IHS programs, urban Indian health programs do not define the health care system in urban centers. Rather, urban Indian communities are dependant upon a healthcare system defined by state and local health agencies, hospitals, Health Maintenance Organizations and Managed Care that are designed for the general population. The amount of funding and type of services that are available from public health agencies will vary from community to community; however, it is unlikely that any community will have sufficient resources to provide for all those who need health care services. Those few resources available to urban Indian health programs are already extended to the maximum limits.

IHS provides funding for ambulatory care, but without provision of contract funds for referrals. Urban Indian health programs are therefore dependant upon the goodwill of these healthcare agencies to negotiate and to fund comprehensive referral services, and must compete with other community health centers for limited resources. Unlike reservation-based programs, urban Indian health programs are highly dependant on revenues from Medicare and patient fees. Again, urban Indian health programs must compete with other community health centers for Medicare eligibles and for patients with the ability to pay.

# METHODS

## Defining Program Issues

Preliminary discussions were held at the start of the project with officials at the Indian Health Service in order to define program issues and data sources to be explored. In addition, other federal officials, urban Indian organization officials, and subject matter experts were consulted to help refine the issues to be examined, identify additional data sources (reports, models, etc.) to be examined, and to make suggestions regarding related training and technical assistance that could be provided as part of this project.

Based on these discussions, a set of study questions was developed. A plan was developed for evaluating existing sources of information, identifying knowledge gaps, collecting primary data, and analyzing results.

## Examination Of Sources And Existing Databases

In order to summarize findings from relevant research and secondary data from IHS concerning the management and administration of the urban Indian health programs, list of existing literature was compiled and reviewed. Data sources included measures of 1) urban Indian health program performance and 2) Urban Program Office/Area Offices' effectiveness in providing oversight, technical assistance and training to the urban programs. Data from these sources were compiled for further analysis. Subsequent to the review of existing data and literature, gaps in current knowledge were identified. The completed literature review is included as Appendix A.

## Collection Of New Data

Based on the defined program issues and identified knowledge gaps, a set of study questions and discussion topics were developed for collection of primary data. Data collection took the form of discussions with a representative sample chosen from the list of IHS urban Indian organization officials from the Urban Program Office, IHS Area Office, and individual urban Indian health programs. Prior to the interview, the selected individuals received a letter explaining the purpose and nature of the project, as well as a list of interview discussion topics. Those who agreed to participate in the project were contacted by telephone for an interview that lasted about thirty minutes. The compiled results of primary data collection are incorporated in the body of this report; a complete report of findings appears as Appendix B.

## National Meeting

As part of this project, a National Meeting of Urban Program Directors was conducted. Invited guests included directors of urban Indian health programs, Urban Coordinators and Project Officers from the Area Office, and officials from IHS headquarters.

The purpose of the meeting was to clarify reporting requirements mandated by legislation and necessary for contract compliance; to discuss the roles and responsibilities of staff within the Urban Health Program at IHS headquarters and the Area Office; and discuss problems and concerns of urban program directors, and propose solutions, especially with regard to staffing needs within the Urban Program Office. The results of this meeting are incorporated in the body of this report; for a complete description of the National Meeting of Urban Program Directors, please see Appendix C.

The results of the evaluation of the IHS Urban Program's management and administration of contracts with the urban Indian health programs (UIHPs) are organized under the following categories:

A. **Reporting Standards and Procedures for the urban Indian health programs**, including types of data that the urban Indian health programs are required to report to IHS, and the legislative requirements for collecting and reporting urban Indian health programs data. This section includes a review of the type of information needed by the Chief of Urban Programs for effective monitoring of the urban programs, as well as how data is used, and what feedback is provided to the urban Indian health programs.

B. **Roles and Responsibilities Of Management**, including the specific tasks required of the Chief of Urban Programs and the Area Office Urban staff.

C. **Provision of Technical Assistance and Training**, including the availability, quality, appropriateness and timely provision of technical assistance and training for the urban Indian health programs.

D. **Planning for the Future of the Urban Indian Health Programs**, including comments from the urban Indian health programs directors regarding provisions they have made within their individual programs for planning and future development of health care services for the Indian population in their urban center.

E. **Summary and Recommendations**

## RESULTS

In general, perceptions differ both within and between each organizational level (IHS Headquarters, Area Offices, and urban Indian health programs) regarding each discussion topic category: reporting requirements, roles and responsibilities, and need for technical assistance.

Differences exist both within each level of organization and between organization levels. For example, between the Area Offices there were some variations as to the number of reports required, and opinions differed as to the specific roles of staff at each organizational level. Among individual urban Indian health programs directors there was a wide range of understanding of, and compliance with, reporting requirements. According to the urban Indian health programs directors, the understanding of the respective responsibilities to the urban programs varies by Area Office, as does the capacity to provide appropriate technical assistance.

When compared with one another, the collective experience of urban programs under the oversight of an IHS Area Office differs from Area to Area. For example, within certain Areas, urban programs describe good working relationships with their Area Urban Coordinator, while others report that their Area Office is unable to provide adequate information and technical assistance, either due to lack of understanding of urban program issues, or due to lack of sufficient resources or expertise.

## A. REPORTING STANDARDS AND PROCEDURES FOR THE UIHPs

### OVERVIEW

This section reviews regulations that establish reporting standards and procedures for the urban Indian health programs. It then draws comparisons between the Urban Program Office, the Area Offices, and the individual urban Indian health programs regarding their understanding of reporting requirements mandated by legislation, by grant, and by contract. Finally, this section evaluates the reporting system with regard to its completeness and usefulness in enabling urban program organizations to plan, manage and administer urban Indian health services.

Requirements for reporting are specified in the Indian Health Care Improvement Act, Indian Alcohol and Substance Abuse Treatment Act, and receive further treatment in federal regulations. However, individual urban program compliance with reporting requirements is not yet universal. Part of the difficulty lies in the lack of a standardized reporting format that is equally well-understood by urban program staff at all levels.

Though reporting requirements are defined by the Indian Health Care Improvement Act, the mechanisms for routine gathering and reporting of information by each urban Indian health program is left to the discretion of each Area Office. Other than the Urban Common Reporting Requirements, there are no standards or formats for the uniform collection of data or reporting of information.

Further, there is no central agency to supply aggregate analysis of reported information. This omission underutilizes compiled data that is a valuable resource for setting goals and objectives for the Urban Program, for individual urban Indian health programs program planning and evaluation of processes within the Urban Indian Health Program.

Finally, lack of relevant feedback to the urban Indian health programs after reports are submitted denies them access to useful measures of program performance. Most Urban Program directors (95%) say that they do not receive feedback from the Urban Program Office on reports that they submit, nor do they ever hear of how data are used. Likewise, little feedback is received from the Area Office, except when reports are late or missing. A few programs report that their Area Office explains why data is needed, how to locate and use needs assessment data for program planning, and to identify the training needs of the urban Indian health programs.

## REGULATIONS THAT ESTABLISH REPORTING STANDARDS AND PROCEDURES

The Indian Health Care Improvement Act and its Amendments (P.L. 100-713), together with the Alcohol and Substance Abuse Treatment Act, specify the criteria for award and/or renewal of contracts to urban Indian health programs, require the Indian Health Service to develop procedures for the evaluation of contract compliance and performance of urban Indian health programs; require that the Indian Health Service submit reports to Congress on urban Indian health status, services, and unmet needs; and establish the Branch of the Urban Indian Health Programs as the agency responsible for carrying out provisions of P.L. 100-713. According to the Indian Health Care Improvement Act, the Urban Program Office is required to submit the following reports to Congress:

1. **Section 503 (a)** of the Indian Health Care Improvement Act requires that each urban Indian health programs:

> 1. estimate the population of American Indians who reside in the urban center in which such organization is situated, and are or could be recipients of health care or referral services;
> 2. estimate the current health status of urban Indians residing in such urban center;
> 3. estimate the current health care needs of urban Indians residing in such urban center;

4. identify all public and private health service resources within such urban center which are or may be available to American Indians;
5. determine the use of public and health services resources by the urban Indians residing in such urban center;
6. assist such health services resources in providing services to urban Indians;
7. assist urban Indians in becoming familiar with and utilizing such health services resources;
8. provide basic health education, including health promotion and disease prevention education, to urban Indians;
9. establish and implement training programs to accomplish referral and education tasks;
10. identify gaps between unmet health needs of urban Indians and the resources available to meet such needs;
11. make recommendations to the Secretary and Federal, State, local and other resource agencies on methods of improving health service programs to meet the needs of urban Indians; and
12. where necessary, provide, or enter into contracts for the provision of, health care services for urban Indians.

2. Funding for mental health and Indian child welfare grants is based on urban Indian communities needs assessments. Section 503(e)(3) requires that in making any grant to provide mental health services to urban Indians, the following information is used as a basis for funding services:

a. the size of the urban Indian population to be served;
b. the utilization by the urban Indians of alternative resources from State and local governments for no-cost or low-cost services to the general population; and
c. the capability of the urban Indian organization to carry out appropriate services.

3. **Section 507 (2) and (3)** of the Indian Health Care Improvement Act, Amended, require that all urban Indian health programs submit an account of activities performed under its contract and an account of the amount and purposes for which Federal funds were expended. Section 507 also specifies the content of quarterly reports that urban Indian health programs are required to submit:

- determination of the gaps between unmet urban Indian health needs and the resources that exist to meet such needs;

- recommendations on methods of improving health service programs to meet the needs of urban Indians;

- information on activities conducted by the organization pursuant to the contract;

- an account of the amounts and purposes for which Federal funds were expended; and other information as requested by the Secretary of the Department of Health and Human Services.

4. An annual onsite evaluation is required of each of the federally funded urban Indian health programs, as per Section 505 (b) of P.L. 100-713 to determine the contract compliance of the program and evaluate its performance, according to criteria set forth in the *Program Evaluation Criteria*, developed by the American Indian Health Care Association in 1987.

5. **Section 511 (b)** of the Indian Health Care Improvement Act, Amended, requires the Urban Program Office in IHS headquarters to prepare a report to Congress analyzing the need to provide an urban health program analyst for each Area Office to be submitted with the FY 1993 budget request.

6. An Urban Health Status Report is also required (by March, 1992) from the Urban Program Office to the Congress under **Section 507 (d)(1)** of the Indian Health Care Improvement Act, Amended. The purpose of the report is to evaluate:

- the health status of urban Indians;

- the services provided to Indians through the IHS programs;

- areas of unmet needs in urban areas served by IHS urban Indian health programs;

- areas of unmet needs in urban areas **not** served by IHS urban Indian health programs;

In addition, contracts to the urban Indian health programs require that the Urban Common Reporting Requirements (UCRR) report be submitted to the Area Office on a biannual basis. The UCRR reporting period covers a six month period from October 1 - March 31, and a twelve month period from October 1 - September 30 for each fiscal year. Each urban Indian health programs sends a copy of the UCRR report to the American Indian Health Care Association, who compiles and analyzes the aggregate information to produce a report of performance indicators, financial data, and utilization patterns for all of the IHS funded urban Indian Health Programs.

Federal Regulations governing reports and records required from federally funded urban

Indian organizations reiterate Section 507 (2) and (3) of the Indian Health Care Improvement Act:

> "For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract under this title, such an organization shall submit to the Secretary a report including information gathered pursuant to 36.350(a) (7) and (8) of this subdivision, information on the activities conducted by the organization pursuant to the contract, an accounting of the amounts and purposes for which Federal funds were expended and such information as the Secretary may request."

Further, 36.350(a) (7) and (8) state refer to the requirement for each urban Indian health programs to:

> "(7) Identify gaps between unmet health needs of urban Indians and the resources available to meet such needs;
> "(8) Make recommendations to the Secretary and Federal State local and other resource agencies on methods of improving health service programs to meet the needs of urban Indians."

## COMPARATIVE UNDERSTANDING OF REPORTING REQUIREMENTS

**Urban Program Office**: The Urban Program Office at IHS Headquarters has a thorough understanding of reporting requirements and regulations. According the Chief of Urban Programs at IHS headquarters, the following reports are currently required from all urban Indian health programs:

Contract/Grant Information: Needs assessment reports, required for Indian child welfare and mental health grants.

Evaluation: An annual program activities report is required that includes examination of the gaps between unmet urban Indian health care needs and existing resources, as required by the PL 100-713 (Indian Health Care Improvement Act) Amendments. The Area Office produces a report of the annual onsite evaluation of each urban Indian health programs under its jurisdiction.

Management/Administration: A biannual UCRR report is required from all urban Indian health programs.

**IHS Area Offices**: The requirements for the type and number of reports that the urban Indian health programs are required to send varies by Area Office. According to Urban

Coordinators/Project Officers at the Area Office level, the reports currently required from all urban Indian health programs are as displayed in Table 1:

| TABLE 1. REQUIRED REPORTS ACCORDING TO THE IHS SERVICE AREA OFFICE | |
|---|---|
| **IHS AREA** | **REPORTS REQUIRED BY THE AREA OFFICE** |
| **ABERDEEN** | UCRR, Annual Onsite Evaluation, Quarterly Report (Gap and Unmet Needs Report, Activity Narrative), Annual Property Report, 3rd Party Income Report, Monthly Financial Report. |
| **ALBUQUERQUE** | UCRR, Quarterly Report, Financial Statements, Program Narratives. |
| **BEMIDJI** | UCRR, Annual Onsite Evaluation, Quarterly Report, Financial Report, Progress Report, AIDS Reports Section 503 Report. |
| **BILLINGS** | UCRR, Quarterly Report, AIDS Report, Correction Action Plan (Status Reports), Monthly Invoice and Workload Report, Fiscal Year Final Report, Government Property Report, Annual CPA Audit, Indian Preference Report. |
| **CALIFORNIA** | UCRR, Annual Onsite Evaluation, Quarterly Report, Financial Report. |
| **NASHVILLE** | UCRR, Annual Onsite Evaluation, Quarterly Report (Gaps Report, Unmet Needs Report), Monthly Report, Program Operating Plan, Population Demographics, Goal Statements and Objectives, Workload, Needs Assessments. |
| **NAVAJO** | UCRR, Annual Onsite Evaluation, Quarterly Report. |
| **OKLAHOMA** | UCRR, Annual Onsite Evaluation, Quarterly Report, Monthly Invoices, 3rd Party Collections, Annual Property Reports. |
| **PORTLAND** | UCRR, Annual Onsite Evaluation, Invoices, Program Progress Reports. |
| **PHOENIX** | UCRR, Annual Program Evaluation, Quarterly Report, Monthly Financial Report. |
| **TUCSON** | UCRR, Quarterly Report, Activities Report, Annual Needs Report, Monthly Reports and Vouchers |

Urban Coordinators and Project Officers from all of the Area Offices included the UCRR and Quarterly Reports Among those required of the urban Indian health programs. Several Area Office staff mentioned that the Quarterly Report, required by legislative mandate, includes (1) an identification of unmet health needs of urban Indians and the resources available to meet such needs; (2) recommendations to the Secretary and Federal State, local and other resource agencies on methods to improve health service programs for urban Indians; (3) information on activities conducted by the organization pursuant to the contract; and (4) an account of the amounts and purposes for which

federal funds were expended. Other Area Office staff specified the components of this requirement as separate reports. The majority (73%) also mentioned the Annual Onsite Evaluation.

**Urban Program Directors**: Urban program directors have a clear understanding of the reporting expectations of the Area Office. The following list identifies types of information directors say they report to the Area Office on a routine basis. Directors did not distinguish between requirements specified in the Indian Health Care Improvement Act, and those specified by contracts through their Area Office.

Contract/Grants Information: Project Officer Report; Contract Compliance Report; Monthly Progress Report; Program Narratives; Travel Report; Quarterly Reports (including Activity Report, Unmet Needs, Gap Report, Title V Improvements Reports); Utilization Report and Annual Summary Report.

Financial Information: Audit; Vouchers; Financial Projections; Reimbursements; Third Party Income; Purchases; Monthly Expenditures; Budget Modification.

Health Services Information: Alcohol Treatment Guidance System Treatment Plan; Mental Health Report; Immunization; Report; Pap-Smear Tracking Report; Patient Care Report; Dental Report; Nursing Report; Pharmacy Report; Primary Care Report; Patient Tracking Report.

Management/Administration: Goal and Objectives; Equal Employment Opportunity Report; Quality Assurance; Report; Indian Preference; Board Minutes;Fire Drills; Workload; Monthly Statistics; ; UCRR; Maintenance Report; Property Inventory; Insurance Coverage.

According to the self report of urban Indian health program directors, most have a good understanding of what documentation and reports required of them by contract and legislation. With regard to *legislative* reporting requirements, most (92.9%) of the urban Indian health program directors stated that the IHS Area Office provided them with sufficient explanation of legislative requirements to know what is expected of them. Fifty-seven percent of all directors rated their personal knowledge and understanding of legislative requirements as "complete and thorough", and 43% rated their knowledge as "good, but not complete."

With regard to reporting to comply with their *contract*, 85.7% of the urban Indian health program directors reported that the Project Officer in the IHS Area Office provided sufficient information to comply with contract reporting requirements. Fifty-seven percent rated their personal knowledge and understanding of contract requirements as "complete and thorough", and 43% rated their knowledge as "good, but not complete".

## COMPLIANCE WITH REPORTING REQUIREMENTS

In the opinion of some Area Urban Coordinators, urban programs in their Area had trouble submitting reports in a timely fashion, despite sufficient knowledge of reporting requirements. Potential barriers to completing reports for timely submission were explored further through discussion with the directors of individual urban programs.

Difficulties in obtaining data to write reports was one reason for late submission of reports for some urban Indian health program directors. About half (55%) of the urban program directors indicated that there were problems in locating and retrieving information. The problems were identified as follows:

- lack of cooperation from state and local agencies to access data
- misclassification of non-Indians who identify themselves as AI/AN, or AI/AN who are misclassified as non-Indian (on the census, for example)
- lack of local data on AI/AN for needs assessment
- cumbersome manual records system; need for computers, software, training and assistance to set up computer system and create computer databases
- lack of proficiency with the UCRR
- duplication of effort; (the same data are required for various reports, often to the same agency)
- resistance on the part of clients and staff who are suspicious of how data will be used

Difficulties in obtaining necessary data was not the only barrier to timely submission of reports. Two thirds of the urban programs (67%) indicated that they experienced problems such as:

- length of time required to abstract data from paper record-keeping system
- fragmentation of the reporting and record keeping system; many different people are involved
- problems with computers: lack of software, trained personnel, accidental loss of data files
- lack of sufficient staff to complete the number of reports required

- gap between the time that the contract requires submission of voucher statements (10th of the month) and the time that internal reports are completed (15-20th of the month). This gap necessitates use of estimates, which creates difficulties for auditors who must reconcile estimates at the end of the year.

## USEFULNESS OF COLLECTED DATA

To determine whether data presently collected from the urban Indian health programs is sufficient and appropriate to meet the requirements of the Indian Health Care Improvement Act (P.L.100-713), officials in the Urban Program Office and Area Office staff described:

- how data generated by the urban programs are used;

- whether feedback on the data sent to the Area Offices is available and, if available, whether it is helpful in the management of the urban Indian health programs;

- data that are not currently collected but are needed in order to carry out job responsibilities.

**Urban Program Office**: According to the Chief of Urban Programs, data are used when 1) the IHS Program Office requests information; 2) for reports that are requested by the Office of the Inspector General; and 3) to respond to any inquires outside of the IHS for data. Available data may be found in quarterly reports, onsite evaluation reports, patient records and financial databases. Other than the Urban Common Reporting Requirements (UCRR) Report, there are no provisions for compiling and analyzing aggregate urban program data of this type except when specially requested. There are no standardized reporting formats for quarterly reports, annual reports or needs assessments. Therefore, even if provisions were made for the compilation and analysis of aggregate data, this would be difficult due to the different definitions, methods of data collection, and reporting formats between programs.

Many of the reports mandated by Congress have been developed through contracts with the American Indian Health Care Association (AIHCA). For example, the AIHCA recently provided reports to the Urban Program Office on AIDS education activities within the urban Indian health programs, monitoring the Year 2000 Objectives in urban Indian communities, and the Urban Comparative Analysis report, based in part on compilations of health status indicator data reported by the various urban Indian health program. These reports are used to justify funding for the urban programs; demonstrate need for new programs such as AIDS education and prevention, Health Promotion/Disease Prevention activities, Mental Health services, Immunization services, and Substance Abuse prevention; and to document contract compliance.

The Chief of Urban Programs identified three types of data that the Area Office currently does not provide, but would be useful in performing job responsibilities:

1. Monthly urban Indian health program monitoring report, in order to determine whether urban Indian health programs are in compliance with their contract and meeting legislative requirements.

2. A report from each Area Office that documents urban Indian health program monitoring and the percentage of requests for technical assistance that are accommodated.

3. Quarterly funding report (amount and activities) to verify that funds go to the urban Indian health programs in the amounts intended. Also, documentation that urban Indian health programs are included in IHS activities such as training, conferences, seminars, etc.

**Urban Program Coordinators**: Urban Coordinators and Project Officers within the Area Office state that reported data from urban Indian health programs is used to ensure compliance with contracts, for contract renewal, and to meet other legal and funding requirements. There are no formal mechanisms, however, to provide feedback to the individual urban programs; this is left to the discretion of the Area Office staff. Though some urban program directors report good communication with their Urban Coordinator and Project Officer, others report that they do not receive feedback, guidance or technical assistance in response to information they have reported to the Area Office.

Based on the reports of officials at IHS headquarters and Area Office staff, it appears that reports from individual urban programs are used primarily to satisfy administrative and contractual requirements, rather than serve the needs of the urban Indian health programs. No attempt is made to compile aggregate data from the urban programs for comprehensive analysis of performance, or assessment of needs.

Furthermore, Area Office staff report that they provide urban program directors with little useful feedback or technical assistance on how to use reported data for planning purposes. Thus, the opportunities for using data for program planning or further development of urban program potential are lost.

Area Office staff involved with management of the urban Indian health programs state that they need better direction and leadership from the Urban Program Office, especially to clarify the roles and responsibilities of all urban program officials (Chief of Urban Programs, Urban Coordinator, Project Officer, individual urban program director). Timely information on funding is also desired, including notification of new grants, changes in the funding cycle, and allocation formulas. Area Office staff would like regular updates on legislative activity that affects urban Indian health programs. A number of Urban

Coordinators and Project Officers stated that insufficient staffing within the Urban Program Office makes the transfer of information difficult. This is especially true when information is required on short notice.

## INFORMATION GAPS IN THE CURRENT REPORTING SYSTEM

Current reporting requirements, as specified by legislative mandate, focus on ensuring that urban programs fulfill contract obligations; no provision is made for collecting data to identify the health care needs of the aggregate urban Indian population. This lack belies an element that is missing from IHS management of the urban Indian health programs: providing leadership in program planning.

As specified in Section 503 of the Indian Health Care Improvement Act, individual urban Indian health programs are required to assess the health needs of Indians in their urban area as part of the application for federal contract; including the size of the urban Indian population, the population health status, and existing available resources. Urban program directors know their communities well, and use these types of information routinely in planning and evaluating health programs within their organization. However, there is no standard type or format for information included on contract applications; therefore, data cannot be aggregated to provide a national picture of urban Indian health needs for use in formulating objectives and directing the future of the Urban Program. Standardization of application format would provide the Urban Program Office with relatively current information on which to define program needs and evaluate accomplishments, which is necessary in formulating a vision for the future of the Urban Program.

Another gap lies in the lack of certain information that would be useful in monitoring progress towards defined objectives for urban Indian health. For example, the current UCRR form includes the percentage of completed patient followup on selected clinical services: childhood immunizations, screening for childhood anemia, diabetes screening, abnormal pap test results. However, these figures are drawn from a small, non-random sample of records, and data is not specific as to demographic characteristics of patients using these services or stage of diagnosis, specific followup, etc.

Another type of information that could be included in contract applications is a detailed listing of onsite staff by profession and specialty, including qualifications and credentials. The UCRR does include the number of full time equivalent staff by type of provider, but these categories are general, such as physicians, mid-level practitioners, mental health providers, etc. Detailed staffing data compiled from applications would include useful, fairly current information on the number of physicians employed by the urban Indian health programs who have hospital privileges, are liscenced and board-certified.

Many types of information required of the urban Indian health programs by IHS contract

rely on systems that have been developed within the IHS, which are not necessarily compatible with accepted standard reporting systems, such as JCAHO quality assurance, diagnostic codes (ICD-9-CM), and procedural codes (CPT and ADA). Since programs are heavily funded by non-IHS agencies, the requirement to report essentially the same information, but using non-standard formats, is an undue burden on the urban program director's workload.

## B. ROLES AND RESPONSIBILITIES OF MANAGEMENT

### OVERVIEW

This section discusses the roles and responsibilities of the Indian Health Service staff in providing for the development, monitoring, and evaluation of the individual urban Indian health programs. First, documentation is reviewed which defines the respective roles of the IHS Urban Program Office and the Area Offices. Secondly, the perceptions of the Urban Program Office, Area Offices, and the individual urban Indian health programs regarding their respective roles are compared, in order to evaluate how well each understands urban program administration.

The Urban Program Health Activities Chapter (Draft) of the *Indian Health Manual* defines roles and responsibilities at each level of organization. These are well understood by the Urban Program Office at IHS headquarters. Within the Area Offices, however, the self-described duties of the Urban Coordinator and the Project Officer do not consistently match the position as described in the Manual. Directors of the individual urban Indian health programs tend to see the roles of Area Office staff more in terms of their own needs rather than according to written position descriptions.

### ROLES AND RESPONSIBILITIES OF THE CHIEF OF URBAN PROGRAMS AT IHS

According to the Urban Program Health Activities Chapter (Draft) of the *Indian Health Manual*, the Chief of Urban Program's responsibilities include:

a. Assuring that health services, outreach and referral of urban health programs are of the highest quality consistent with recognized patient care standards, and provided in an ethical fashion with respect for the rights and dignity of the patient.

b. Assuring the coordination of urban health programs with the IHS Area Office Staff and other federal and non-federal agencies;

c. Disseminating information to Congress and the American people based on reports and evaluations;

d. Distribution and monitoring of all resources appropriated by Congress for urban health programs;

e. Systematically monitoring services and performance through the use of an approved data system;

f. Administration, implementation, analysis and monitoring of Congressionally mandated Urban Common Reporting Requirements (UCRR);

g. Developing evaluation criteria, performance standards and a corrective action plan processes;

h. Coordinating program activities with the Director, Division of Clinical and Preventive Services, Office of Health Programs;

i. Providing technical assistance and capacity building to IHS Area Offices and urban Indian health programs;

j. Implementing, monitoring, and submitting required reports as necessitated by Congress, Administration, Department of Health and Human Services, Public Health Service, IHS, tribal organizations, and other organizations and individuals;

k. Recommending program or policy changes as a result of data reports, recommendations and research results;

l. Maintaining the continuity of networking with federal, regional, state, county, local governments, urban Indian health programs, tribal organizations, other organizations, and individuals;

m. Planning directly and evaluating the implementation of urban Indian health programs;

n. Participating on committees, task forces, etc., which may have an impact on urban Indian health programs.

**Urban Program Office**: According to the Chief of Urban Programs at IHS Headquarters, the role and responsibility of the Urban Program Office is "to establish and assist in the administration and management of IHS funded urban Indian health program contracts, to ensure that these programs maintain legislative, contract and grant compliance in order to provide culturally sensitive outreach, referral and direct health care services to American Indian/Alaskan Natives residing in urban centers." This definition of the Chief of Urban Program's role emphasizes the oversight function of the position as defined in the *Indian Health Manual*. In practice, however, the Chief of Urban Programs devotes the majority of his time responding to requests for information regarding urban program

issues from IHS or Congress; justifying urban program needs to IHS officials and outside agencies; and dealing with immediate crises that arise in the Area Offices and within individual programs.

**IHS Area Office**: From the viewpoint of staff in the Area Offices, the Urban Program Office at Headquarters has the final responsibility for management of the urban Indian health program contracts, including the review of urban Indian health programs to investigate duplication of services and recommend closure of facilities that have IHS clinics nearby. The Urban Program Office is responsible for developing standard policies for nationwide compliance, and serving as the liaison between Congress, IHS, and Urban Programs. According to Area Office staff, they would like the Urban Program Office to keep them informed as to any legislative, policy, procedure or financial changes that affect the urban programs, although this is not specified in the Urban Program Activities Chapter (Draft) of the *Indian Health Manual*.

**Urban Program Directors**: Urban program directors define the role of the Chief of Urban Programs by his responsibilities in several categories. The understanding of the urban program directors differs from that described in the *Indian Health Manual*, in that it describes what the urban Indian health programs want from the Urban Program Office in terms of leadership. For example, it is not within the purview of the Chief of Urban Programs to investigate the needs, provide leadership, or formulate goals and objectives for the urban Indian health programs, although the strong opinion of the urban Indian health program directors is that it should be. On the other hand, urban program directors state that it is important that the Chief of Urban Programs have firsthand knowledge of the environment in which urban programs must operate, and therefore appreciate onsite visits that have been made by the Chief of Urban Programs, though once again, this is not within the purview of his position. According to the urban program directors, the responsibilities of the Chief of Urban Programs include:

Program Oversight: to formulate plans and objectives for the Urban Program; provide program monitoring, evaluation, and future development; to oversee the operations of the urban Indian health programs; ensure compliance with contracts; administer IHS grants and contracts; facilitate cooperation between urban and tribal programs;

Advocacy: to promote the needs of urban Indian health programs as equal to those of tribal programs; serve as a liaison between IHS Headquarters and Area Offices; facilitate better cooperation between the urban Indian health programs and the Area Offices; reinforce the common mission to serve AI/AN people; serve as a public relations representative for the urban Indian health programs to IHS and national communities, increasing the visibility of the health needs of urban Indian communities; advocate for necessary funds for urban program needs, and the just allocation of those funds among the various programs

Legislative Issues: to update the urban Indian health programs on legislative activity in a timely fashion;
help create a national public policy on urban Indian issues; to set goals for changes in local policy by regions; serve as a liaison to Congress on legislative issues

Program Development: to provide technical assistance to increase effectiveness of programs and services; facilitate networking and sharing of information through annual conferences conducted by the AIHCA; ensure a smooth and predictable flow of funds to urban Indian health programs; provide technical training and assistance for computer technology

## ROLES AND RESPONSIBILITIES OF THE AREA OFFICE STAFF

The Urban Program Health Activities Chapter (Draft) of the *Indian Health Manual* defines the roles, responsibilities, relationships and specific tasks required of the Area Office Urban Coordinators and Project Officers in monitoring the operation of urban Indian health programs, and in responding to requests for technical assistance and training. According to the Urban Program Health Activities Chapter (Draft) of the *Indian Health Manual*, the Area Urban Coordinator's responsibilities include:

a. Serving as primary liaison between IHS Area Offices and IHS Headquarters on urban affairs;

b. Coordinating management and administrative activities, such as evaluations, data collection and analysis, within the IHS Area Office;

c. Coordinating corrective action plan processes in the Area Offices;

d. Coordinating technical assistance and program support to urban programs;

e. Coordinating urban Indian health programs with federal/non-federal agencies and institutions;

f. Coordinating, developing, and implementing Area activities for improving urban Indian health;

g. Insuring that urban Indian health programs are evaluated per IHS guidelines;

h. Consulting with Area Director and staff on urban Indian health program services;

i. Maintaining the institutional file for each urban Indian health program.

According to the Urban Program Health Activities Chapter (Draft) of the *Indian Health*

*Manual*, the Area Project Officer's responsibilities include:

a. Reviewing general and specific terms of the IHS urban grant/contract;

b. Writing and implementing corrective action plans;

c. Completing and forwarding corrective action plan updates to IHS Area Urban Coordinator and Contract Officer;

d. Reporting work progress to the Contract Officer;

e. Visiting urban program sites to review contractor performance;

f. Assisting urban Indian health programs to resolve problems in the course of contract/grant performance;

g. Initiating technical training assistance at the request of urban Indian health programs;

h. Monitoring program performance;

i. Reviewing and approving, under the contract or grant, invoices for payment for progress reports, modification requests, waivers, subcontracts and property acquisition requests.

The perceived roles and responsibilities of Area Office staff devoted to serving the needs of the urban Indian health programs differs between the individual urban programs, Area Offices and IHS Headquarters.

**Urban Program Office**: According to Chief of Urban Programs at IHS Headquarters, the role and responsibility of the Urban Coordinators should be to ensure effective administration and management of the urban Indian health programs; to monitor and evaluate their performance and provide oversight; to provide crisis management; to give technical assistance and training in a systematic fashion; to make sure programs comply with contract/grant regulations and legislative requirements, and that they insure that appropriate services are provided by IHS funded programs.

**IHS Area Office**: Urban Coordinators see themselves as the liaison between IHS Headquarters and local programs, responsible for providing legislative information, coordination of program reviews and technical assistance, and facilitators of cooperation between urban and tribal programs as well as other Area Office staff. However, in the opinion of Area Office staff, they should not be required to monitor programs on a daily basis. Many expressed frustration in their role as transmitters of information from

Headquarters to the urban Indian health programs, reporting that information is not supplied by the Urban Program Office in a timely fashion, if at all. Another comment from Area Office staff was that the tasks of Project Officer and Urban Coordinator should be performed by separate individuals. Others would like Area Office staff to have greater input in funding decisions.

**Urban Program Directors**: Urban program directors have an understanding of the roles and responsibilities of the Urban Coordinator and Project Officer that is consonant with those outlined in the IHS Manual; however, their descriptions of the Urban Coordinator and Project Officer once again reflect the roles they would like Area Office staff to play. Some of the duties that urban Indian health program directors would like to see Area Office staff assume include:

Training and Technical Assistance: provide orientation for new urban Indian health program directors; facilitate sharing of information between urban Indian health programs regarding successful programs, perhaps by establishing quarterly meetings; identification of common problems among the urban Indian health programs, taking initiative to resolve them; provision of public relations coordination, i.e. AIDS awareness

Advocacy: advocate within IHS for funding, policy changes, and technical assistance to meet the urban Indian health programs' unmet needs; advocate at the Area Office that urban Indian health programs do not compete with the tribal programs; intervene with Indian Child Welfare policy; advocate for increased funding, explain funding criteria; increase visibility of urban Indian health programs; facilitate cooperation between urban and tribal program; reinforce the common mission to serve AI/AN people

Information Dissemination: legislative monitoring with an executive summary on state and local legislative activity to keep urban Indian health programs informed; identification of funding sources, including key people to contact; provide strategies for how to involve the local community in Indian health; act as an clearinghouse for information on urban AI/AN health issues; identify noteworthy programs for urban Indian health programs to model; create instructional videos on UCRR, contract compliance and reporting requirements; provide a link to legislative decisions made in Washington

## C. PROVISION OF TECHNICAL ASSISTANCE AND TRAINING

The following section addresses technical assistance and training issues for the urban Indian health programs. Regarding the urban Indian health program training in general, 14 percent of the urban Indian health program directors said their training needs were not met at all. Twenty one percent described training efforts as "barely adequate" to meet their needs.

In order to further assess the degree to which urban Indian health programs get their needs met from the Area Offices and from the Urban Program Office at IHS Headquarters, directors evaluated technical assistance from the Area Office in terms of four characteristics: quality, appropriateness, availability, and timeliness.

## QUALITY

Quality refers to the adequacy of technical assistance and training supplied by each Area Office to meet a range of needs of the urban Indian health programs.

Urban program directors' rating of the quality of technical assistance provided by the Area Office is listed in Table 3. Most directors (71.5%) rated technical assistance as adequate or better: 21.4% rated technical assistance received from the Area Office as "excellent", 7.2% rated it "satisfactory" and 42.9% rated it "adequate". Twenty-one percent rated technical assistance from the Area Office as "barely adequate" and 7.1 percent rated it "poor". Figure 4 displays urban program directors' rating of the quality of technical assistance Provided by the Area Office.

**Figure 4. QUALITY OF UIHP TECHNICAL ASSISTANCE**

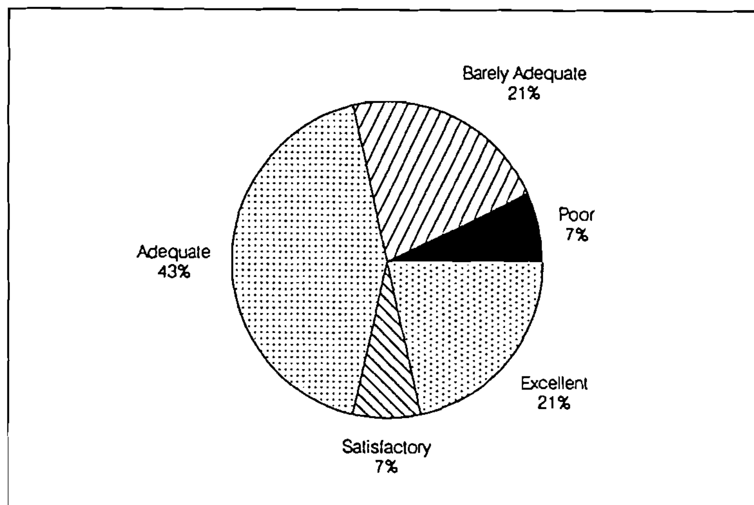



**Table 3. Quality of Technical Assistance**

| Rating | Number Responding | Percent of Total |
|---|---|---|
| Excellent | 3 | 21 |
| Satisfactory | 1 | 7 |
| Adequate | 6 | 43 |
| Barely Adequate | 3 | 21 |
| Poor | 1 | 7 |

## APPROPRIATENESS

Appropriateness refers to the extent to which technical assistance and training to address the issues and challenges that face urban Indian health programs. Appropriateness may include both the range of assistance offered and its level of sophistication.

When asked what type of assistance was available from the IHS Area Office, urban Indian health program directors included the following:

Technical Training: assistance with computer purchase and training; computerized billing systems, medical recordkeeping

Grants/Contracts: information concerning contract modifications; contract interpretation and contract compliance program issues; update on alternative funding sources; grants management training

Program Management: billing system, bookkeeping; criteria and preparation for program review; limited board training; assistance with property inventory; personnel planning, policies, recruitment; development and implementation of policy/procedures; fundamentals of program evaluation; peer review; pre-survey for Joint Commission on Accreditation for Health Organizations

Information Dissemination: resource for timely and current research information in the areas of: substance abuse, mental health, environmental health, diabetes, maternal and child health, 1990 census information; assists in crisis management, runs interference and provides advocacy for their urban Indian health program.

Though technical assistance is available on many subjects in the Area Offices as a whole, an urban program may not have access to the type of assistance they need from their specific Area Office. Sixty-four percent of the urban Indian health program directors reported that the type of technical assistance offered by the Area Office was not appropriate to meet the program's technical assistance and training needs. Staff in the Area Office, though well versed in the administrative issues that concern IHS Tribal programs, are unfamiliar with urban program issues and needs. A comment frequently heard from urban program directors is that Urban Coordinators and Project Officers are uninformed and unaware of the unique environment in which urban programs must operate. And, though the urban situation is quite different from that of reservations, Area Office staff often attempt to "apply reservation solutions to urban problems".

Urban Indian health program directors were also dissatisfied with the poor communication, slow response to requests for assistance, and information that is inappropriate for their program needs. These programs reported that they either contact

the Urban Program Office at IHS Headquarters directly, or rely upon the American Indian Health Care Association to provide timely, appropriate training and technical assistance. As one program director commented, "Technical assistance is available only in a limited fashion for IHS contract issues only--we tend not to use IHS for technical assistance due to their narrow focus."
Directors noted that due to high turnover, periodic standardized training is needed to provide orientation for new staff. Several directors also mentioned a need for board training: "The board needs training to understand the complexity of (legislative and contractual) requirements for accountability." These types of training have been unavailable during the 15 month period between June 1991 and September, 1992, since AIHCA had no contract to from IHS to provide regional workshops, National training conference, or onsite technical assistance.

Another complaint concerns the lack of training to prepare urban Indian health program directors for challenges they might face in the changing urban healthcare environment. Due to limited manpower at the Area Office, much of the assistance available falls into the category of crisis management, with few resources left over for training for prospective planning or capacity building. Two programs noted "we were told by the Area Office that there were no funds for this kind of training."

## AVAILABILITY

Availability refers to whether services are equally available to all programs, and whether there are regional variations in the quality or type of technical assistance and training that is available. To evaluate availability of assistance for the urban Indian health programs, the level of dedicated staff was first examined.

The amount of manpower devoted to urban Indian health program issues varies considerably from Area to Area. Table 4 displays the number of urban Indian health programs in each IHS Area, the size of the urban programs (by aggregate workload), and the number of Full Time Equivalents (Project Officer/Urban Coordinator) available in each Area Office.

| Table 4. STAFFING IN THE AREA OFFICE BY WORKLOAD | | | | |
|---|---|---|---|---|
| IHS Service Area | # UIHPs in Area | Total Workload[1] | Total UIHP FTEs[2] | FTEs per UIHP |
| Aberdeen | 2 | 39,949 | 0.50 | 0.25 |
| Albuquerque | 2 | 6,152 | 0.05 | 0.025 |
| Bemidji | 5 | 207,108 | 1.0 | 0.20 |
| Billings | 5 | 47,719 | 0.75 | 0.15 |
| California | 7 | 132,711 | 0.40 | 0.057 |
| Nashville | 2 | 5,672 | 0.37 | 0.185 |
| Navajo | 1 | 1,353 | 0.12 | 0.12 |
| Oklahoma | 2 | 57,982 | 0.60 | 0.30 |
| Phoenix | 3 | 76,269 | 0.32 | 0.10 |
| Portland | 3 | 82,624 | 0.45 | 0.15 |
| Tucson | 1 | 9,239 | 0.50 | 0.50 |
| TOTAL | 33 | 666,778 | 5.06 | 0.22 |

The Area Office staffing devoted to urban Indian health program ranges from 0.05 FTE to 1.0 FTE, with an average of 0.22 FTE. Thus, Area Offices have an average of 457 hours per year (about 11 weeks) to devote to the administration of each urban Indian health program. Of that, only a fraction is available to provide programs with the technical assistance and training they need.

For example, when Area Office staff were asked how much time they spent in carrying out each responsibility outlined in the Urban Indian Health Section (Draft) of the IHS Manual, Urban Coordinators said they spent the greatest proportion of their time coordinating administrative and management activities (20%), and only 16% of their time was spent providing technical assistance and training (16%). Because the Urban Coordinator may contribute only a small amount of the total FTEs devoted to urban program administration within the Area Office, 16% of the Urban Coordinator's time may not be sufficient to address the needs of the urban programs.

The number of requests for technical assistance from urban Indian health programs within each Area Office ranged from 6 to 100 per year, with an average of 25 requests per Area Office. The Billings Area Office, with 5 urban Indian health programs, reported the greatest number of requests (100 requests, or 40% of the aggregate number of requests),

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[1] Workload Data Taken from the *Urban Indian Health Charts and Graphs, FY 1990*

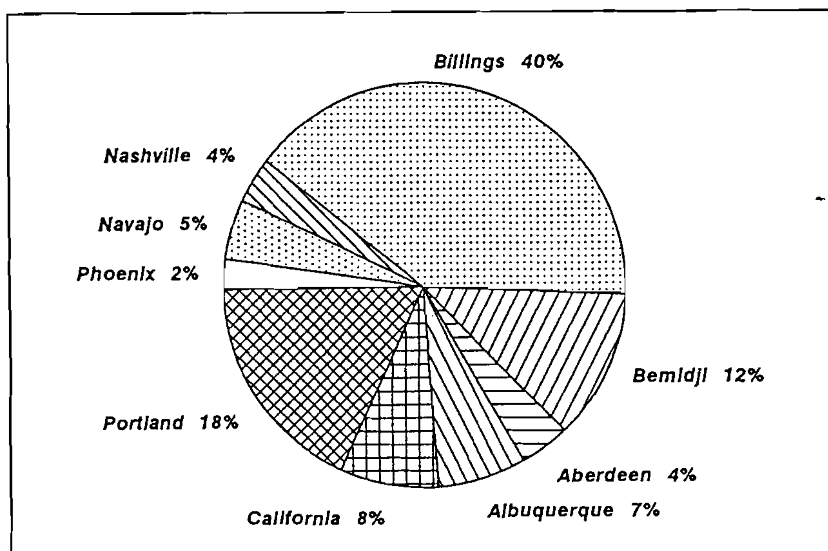
[2] Based on self-report by Area Staff

followed by Portland Area (45 requests, or 18% of total) and Bemidji Area (30 requests, or 12% of the total). The Billings, Portland, and Navajo Areas had the greatest number of average requests per urban Indian health program; 20, 15, and 12 requests respectively.

Table 5 lists the reported number of requests for technical assistance received in 1991, according to each Area Office. Figure 5 graphically displays the information in Table 5.

| Table 5. Number of Requests for Technical Assistance | | | |
|---|---|---|---|
| IHS Area | # Requests for T.A.[3] | Percent of Total | Ave. Requests for T.A. |
| Aberdeen | 10 | 4% | 5 |
| Albuquerque | 18 | 7% | 6 |
| Bemidji | 30 | 12% | 6 |
| Billings | 100 | 40% | 20 |
| California | 20 | 8% | 2.5 |
| Nashville | 9 | 4% | 4.5 |
| Navajo | 12 | 5% | 12 |
| Phoenix | 6 | 2% | 2 |
| Portland | 5 | 18% | 15 |
| Tucson | 0 | -- | 0 |

Figure 5. Requests for Technical Assistance From UIHPs

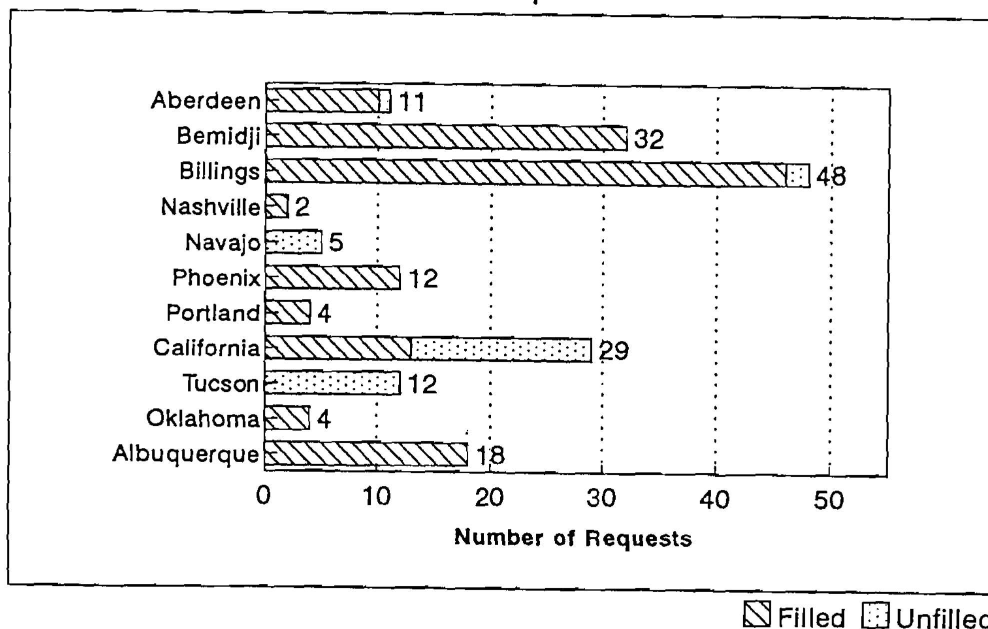



[3] As reported by Area Offices

On the average, 96% of all requests for technical assistance made to the Area Office were accommodated. About a third (35%) of all technical assistance responses involved onsite visits. Within each Area Office, the proportion of onsite visits for technical assistance varied from 13% to 50%. Onsite technical assistance may be provided by staff other than the Urban Coordinator or Project Officer within the Area Office, such as physicians and dentists, or health education specialists.

Urban Indian health programs differ by Area in the self-reported number of requests for technical assistance and training that were accommodated in FY 1991. Figure 6 illustrates the number of requests for technical assistance by IHS Area, and the proportion of requests that were accommodated. Most UIHPs report satisfactory responses from the Area Office in filling requests, however, UIHPs in the Tucson, California, and Navajo Area received little or no technical assistance in FY 1991.

Figure 6. Proportion of Assistance Requests Filled

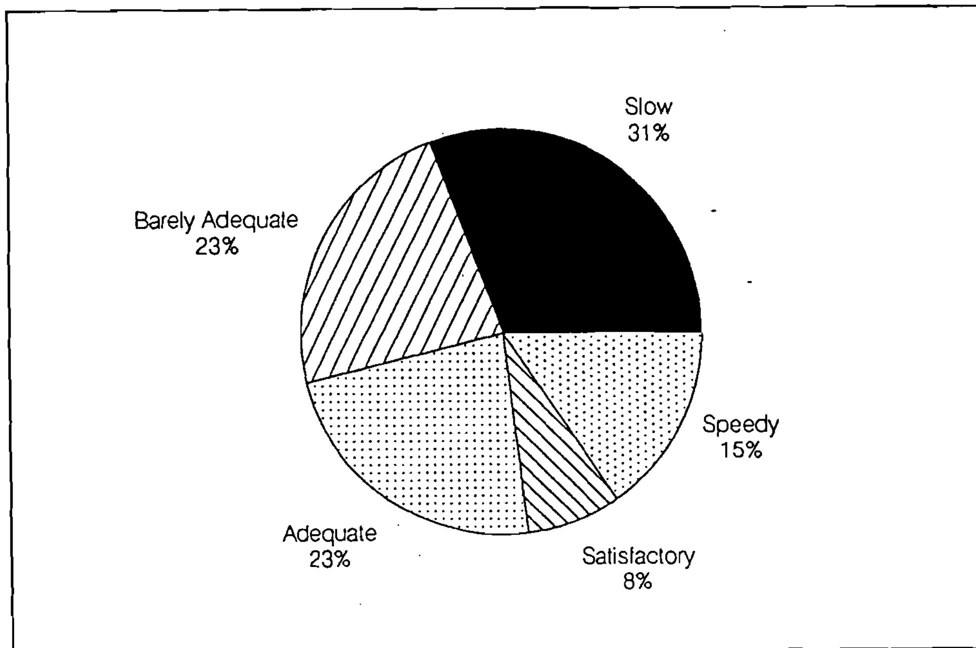



According to UIHP Directors

## TIMELINESS OF RESPONSE TO TECHNICAL ASSISTANCE REQUESTS

As displayed in Figure 7, 54% of the directors stated that requests for technical assistance received a response in a less than adequate timeframe: 31% rated response time "slow" and 23% rated it "barely adequate". Of the 46% who rated the timeliness of technical assistance as adequate or above, 15% rated the timeliness of the Area Office's response as "speedy", 8% rated it as "satisfactory", and 23% rated it "adequate" to meet program needs.

Figure 7. Timeliness of UIHP Technical Assistance



## D. PLANNING FOR THE FUTURE OF THE UIHPs

The following section of this report summarizes Urban Indian health program directors comments on:

1) planning processes within their individual urban Indian health program to prepare for challenges they face in a rapidly changing health care environment; and

2) suggestions for how the IHS Urban Program Office can best address issues concerning the future of the urban Indian health programs.

### IN-HOUSE PLANNING

#### Current Provisions for Program Planning

Nearly all of the urban program directors report that provisions for program planning are a regular part of their administrative tasks. Most take the form of regularly scheduled meetings with staff, department heads, and the Board of Directors for operational and strategic planning. Strategic planning includes defining the organizational mission, short-term and long-term goals and planning for the future. Some directors meet as often as monthly to identify problems and evaluate progress; others rely on yearly meetings with quarterly reviews. Several programs conducted yearly offsite planning retreats, as funds allowed, for setting yearly short-term and long term goals.

#### Impact of Trends in Health Service Delivery

A high percentage (88%) of the urban Indian health program directors stated that their program had a system for monitoring the trends that affect health service delivery, such as legislative and regulatory changes, changes in the IHS budget, political influences, and social trends such as urban/reservation migration, unemployment, homelessness.

Many urban program directors keep abreast of local, state and national trends through periodic literature review and networking with state and local health agencies. Networking may be passive, such as relying on health boards and agencies to relay information, or may be highly interactive, such as involvement on local health consortiums and boards. Others conduct periodic analysis of existing data, or conduct surveys and needs assessments of the local urban Indian population.

## Plans to Meet Long-term and Short Term Challenges

In discussing the provisions they had made in their programs for confronting the factors that influence health service delivery, those urban program directors who said their program did long-term planning emphasized four key areas.

First, many directors were in the process of, or anticipated, working closely with local hospitals, county and local health departments, and universities to develop partnerships to ensure long term economic and operational stability. "Creating networks and collaborations is the only means to long term viability as an ambulatory service providers," said one director. "Affiliations with major academic institutions assists with prospective planning, by affording direct contact with state-of-the art innovations for confronting social, economic and policy changes."

Another priority area for ensuring the viability of urban programs is the diversification of funding sources. Urban program directors had plans to continue their efforts to broaden resources and expand activities in areas that would generate more revenues.

Nearly all program directors had plans for expanding the range and level of services offered. Some directors mentioned specific plans and programs for the immediate future, such as: expanding to accommodate a larger patient volume, providing more traditional types of ambulatory care services, and developing a Health Promotion/Disease Prevention program based on Healthy People 2000 recommendations for the Nation.

Finally, several directors planned to become a federally qualified health center. One director had plans to enter the managed care arena, for delivery of services to state medical insurance recipients.

## Long Range Plans for Management Improvement

Discussion of long-term plans focussed less on specific management development and more on the needs of strengthening programs within the clinic. General areas for planning, rather than examples of specific plans, were outlined in discussions with the urban program directors.

Several programs mentioned that their biggest need was increased funding for hiring new staff, new programs, and expansion of existing services. Therefore, long-term plans include strategies to increase program income through exploration of alternative funding sources.

Revision of policies and procedures, especially relating to attracting and retaining

quality staff, was frequently mentioned as a priority planning area. Installation of computerized systems for billing, patient registration and medical recordkeeping was another priority for several directors, who recognize that technical upgrades will require technical training and assistance for existing staff.

## SUGGESTIONS TO THE URBAN PROGRAM OFFICE

### Plans for Meeting the Needs of Urban Indians

The data from the 1990 United States Census demonstrated that the urban Indian population is growing; more than 65% of American Indians live off reservations. Urban program directors voiced a number of opinions concerning possible actions the IHS could take to systematically define and meet the unmet needs for the urban Indian population, both in the urban centers that currently have urban Indian health programs and those which do not.

Urban program directors mentioned a need to centralize leadership of urban Indian health program administration within the Urban Program Office. Currently, each Area Office has authority and latitude regarding administration of contracts to urban Indian health programs. In addition there is no standardization of contract administration practices, disbursement of funding, provision of technical assistance and format for required reporting from Area to Area. The Urban Program Office has been established as a separate branch within the IHS, yet has neither the authority to standardize practices within the Area Office with regard to urban Indian health programs. Nor does the Urban Program Office have the staffing to compile and analyze urban Indian health program reports on an aggregate level. Finalizing the IHS Urban Program Manual would provide clear and consistent standards, and ensure that the roles of staff at the HQ level and the Area Level would be clear.

Technical assistance and training should be equally available to all urban Indian health programs, consistent with their needs and of sufficient quantity and quality to address program issues specific to the urban Indian health programs. Many urban program directors stated that they rely on the American Indian Health Care Association for technical assistance, training, and legislative updates, yet the role of the AIHCA with respect Urban Program administration is not clear. Urban program directors suggest that a more formal relationship with the AIHCA would provide them with technical assistance and training of high quality that is responsive to their needs.

The Indian Health Care Improvement Act requires that all urban Indian health programs undertake assessments of the size, characteristics, and needs of the urban Indian population they serve. Urban program directors are very interested in training that will help them identify appropriate data sources, compile Indian-specific

information and interpret data for health planning purposes. In addition, directors say they would like to see plans for further research initiatives to better define health issues for urban Indians.

All of the urban program directors mentioned the need for increased funding for the urban programs. Some cited the need to provide funding for the Urban Program Office for adequate human resources needed to provide service and assistance to local programs. Others mentioned the need to improve technical skills within the urban Indian health programs to meet the challenges of a rapidly changing healthcare environment. The need to expand existing programs and establish new programs in unserved urban centers was another justification for increased funding. Many directors thought that the there should be a more equitable distribution of resources between Tribal and urban programs. One director commented that the proportion of IHS funds for urban programs should reflect the fact that urban Indians constitute more than 50% of the American Indian population.

Despite provisions for establishing and maintaining urban Indian health programs under the Indian Health Care Improvement Act, urban program directors lack confidence in the IHS' commitment to services for urban Indians. There is a perceived lack of support by the IHS for existing programs, especially with regard to program expansion. Urban program directors expressed the need for a more equal partnership with the IHS, requesting more input into funding decision-making and program planning for the urban Indian health programs. Others suggested self-governance for urban Indian health programs, similar to Tribal initiatives under the Self-determination Act. One director commented:

> "Under the current political attitude towards Indian affairs, it is unlikely that the Indian Health Service will be able to change its focus to address Urban Indian health concerns. Perhaps their best avenue would be to ...(allow) urban programs to establish accountability standards at the community level for monitoring purposes. Trying to apply national norms in a highly diverse market leads to misleading and often conflicting results."

## Coordination of Service Delivery

Urban program directors had several suggestions as to how service delivery might be coordinated between the individual urban Indian health programs, Tribal program facilities, IHS hospitals, and local hospitals, private physicians, and local community health centers to better fill the gaps in unmet health care needs for urban Indians.

Urban program directors were confident that networking with representatives of Tribal programs would increase cooperation in sharing resources for service delivery.

Formal cooperative agreements for sharing services and establishing referrals were cited as an outgrowth of the type of relationship built through periodic meetings with Tribal program representatives. It is important that the urban Indian health programs and Tribal entities are involved in all phases of problem solving and decision-making, rather than imposing decisions made at IHS headquarters. IHS upper management has a key role in facilitating cooperation, as one director stated:

> "The IHS could be of great assistance in improving relations with Tribal programs. There remains a gap between the urban and Tribal programs which is frequently fueled by IHS' lack of timely and straight-forward responses to tribal attitudes. The IHS is the only vehicle that can squelch this type of misrepresentation --but for this to happen, it will require leadership."

Involvement of the urban Indian health programs in decision making is essential because urban program directors have specific knowledge of the population they serve and the financial climate in which they must operate. As one director summarized: "Most urban Indian health programs understand service delivery issues for urban Indians better than officials in IHS facilities or Tribal programs because we serve a broad-based population in a competitive health care environment. We understand metro community issues better than IHS, who tend to be ...more concerned with their own budgets and Tribal responsibilities."

### The Effect of Changes in Medicare and Medicaid Reimbursement

Urban program directors state that changes in Medicare/Medicaid reimbursement have already had a severe financial impact in their program. Decreased revenues from third party billing have impaired the urban programs' ability to cover costs and deliver services. At the same time, patient workload continues to increase due to the growing number of urban Indians on Medicaid compared to the number of physicians who are willing to accept them as patients.

A few urban Indian health program directors did not feel that changes in Medicare/Medicaid were their most challenging issue, as "most of our clients have no medicare or medicaid." Others were more concerned with impending national/state health insurance plans.

### Assistance from the Urban Program Office

Urban program directors rely on the Urban Program Office for information on changes in public policy and the financial impact implied by such changes. However, they recognize that this Office is severely understaffed, and cannot always provide information in a timely fashion. There is a need for central leadership and direction to

the Area Offices to help urban Indian health programs deal with legislative and policy issues that will affect them.

Many programs feel that becoming a federally qualified health center (FQHC) would help to deal with Medicaid/Medicare reimbursements. IHS could assist in this endeavor by providing timely information, direction and technical assistance for programs to successfully qualify as FQHCs. However, they do not wish IHS to decrease the Urban Program budget or assume programs will generate large incomes as FQHCs. Another way that IHS could help urban Indian health programs would be to give them the same reimbursement benefits as 330 funded programs.

Increased technical assistance and training from the Urban Program Office would be useful on such subjects as 1) how to maximize revenues from 3rd party billing; 2) computerized billing operations for greater efficiency; and 3) providing cost-effective services in a managed care environment, including risk factors and service delivery models.

Although certain changes will affect all the urban programs to a certain degree, there are local variations that will require individual solutions tailored to the specific circumstances of each urban Indian health program. In the words of one urban Indian health program director:

> "The current trend in health care reform is to allow the states to control change. As such, the best recommendation is for the central Urban Program Office to assure urban Indian health programs that IHS rules and regulations do not interfere with local adjustments in operations and management. In this current health care environment, flexibility must be the watchword. Understanding that reform will affect urban Indian health delivery and being willing to help accommodate local changes will be IHS' best assistance."

## Impact of Licensing and Regulatory Changes

Many urban Indian health program directors did not address the potential impact of changes in licensing and regulations in their comments, saying it was difficult to predict the effect of changes that had not yet occurred. However, those who did respond focussed on two areas.

First, the Urban Program Office should ensure that urban Indian health programs are fully and adequately informed of changes in regulations, IHS policy, or funding that occur on a national level. Also, the Urban Program Office should ensure that appropriate technical assistance and training are provided, either through the Area

Office or the AIHCA, to adequately prepare the urban Indian health programs to adapt to changes that occur.

Second, though legislative and regulatory changes cannot always be anticipated in advance, such changes usually have an accompanying financial impact. One program director summarized the sentiments of all in saying, "State licensing under new regulations have cost us plenty, at the cost of other programs and services....In order to comply with regulatory changes, dollars must be allocated to fund and support necessary adjustments in the urban Indian health programs."

## E. SUMMARY AND RECOMMENDATIONS

Leadership Within the Current Management Structure

Current IHS management of the Urban Indian health program contracts is reactive rather than proactive. The Urban Program Office has not taken leadership in setting specific health objectives for the urban Indian health programs; consequently, there is no sense of direction, no comprehensive plan, no vision for the future. Without leadership, urban Indian health programs are left to plan for the future of their programs as best they can, and struggle to find the guidence and assistence that is unavailable from the Urban Program Office or the IHS Area Office.

The role of the Chief of Urban Programs includes provision of oversight to the urban Indian health programs. However, most of his time is spent manipulating government paperwork, justifying the need for and explaining urban Indian health programs to his superiors and to outside agencies. Little time is spent investigating the needs, providing leadership, or forging goals and objectives for the urban Indian health programs. Nevertheless, the Chief of Urban programs has demonstrated a commitment to stay in touch with the conditions, concerns and needs of each individual urban Indian health program through onsite visits and frequent telephone contact.

Neither IHS Headquarters nor the Area Offices have a mechanism to prospectively develop action plans to address the specific needs of Indian people within each urban community. Staff within the Area Office are unfamiliar with the needs of urban communities and lack knowledge of the unique health care environment in which community health centers must operate. Therefore, most Area Office staff are unable to provide the urban Indian health programs with what they need in terms of technical assistance and training. In addition, sufficient technical assistance and training for urban Indian health programs are not always available, due limited manpower and funds.

The AIHCA is funded to investigate health problems that affect urban Indians, but not to work with urban Indian health programs at a national or individual level to develop plans to remedy health problems. Some attempt is made to address current health services issues through workshops at regional and national conferences organized by the AIHCA. Without leadership and longterm planning, however, such workshops can only meet short term training needs, rather than serve as systematic approaches to resolve long term solutions. Another problem is that there is no mechanism to disseminate information resulting from AIHCA's indepth analysis of health problems to the urban Indian health programs, or to use findings as the basis for individual program planning. Part of the AIHCA contract from IHS to conduct studies should

include an information dissemination phase, to assist the urban Indian health programs with planning, monitoring, and evaluation. For example, aggregate results from Health Risk Appraisals could be compiled and analyzed by the AIHCA, reported on at a national meeting of urban program directors, with workshop sessions to assist each urban Indian health programs address health problems within its respective community. Finally, there is little indication that reports and recommendations made by AIHCA are used to by IHS Urban Health Program management to set goals and objectives.

The basis of public health management lies in needs assessment, program planning, implementation, process evaluation and program evaluation. Monitoring the progress of the program throughout the implementation of the project is necessary to ensure that stated goals and objectives are being met; program evaluation is likewise necessary to measure the project's accomplishments against the original aims. Evaluation also provides a "reality test" to see how well the plan translates to real life implementation. These standard public health practices are currently absent in Urban Health Program management structure. For example, the Urban Program Office has no national plan for the vis-a-vis the Year 2000 objectives for urban Indian communities.

Setting program plans and objectives must be done in consultation with urban Indian health program directors, who are close to their communities. It must be done from the grassroots level, not through top-down management. Typically, urban Indian health programs caucus at the behest of IHS on unimportant issues. Important decisions are made by IHS headquarters, without soliciting input urban Indian health care administrators who have a much better grasp of what their communities need. Consultation is not sought with urban Indian health program directors, who are not given a hearing as to what their programs need.

Health Care Needs and Environment of the Urban Health Programs

IHS headquarters is out of touch with the health care problems and needs of the Indian people living in urban centers. The Chief of Urban Programs is the only IHS headquarters staff who makes regular onsite visits.

Unlike the Tribal programs, in most cases, the urban American Indian community does not control the health care system. Urban Indian communities are at the mercy of the state and health departments, managed care facilities, and hospitals. The availability of services within state and local health departments vary. Some have limited primary care, others only do public health immunizations. In any case, there is more need than resources. Thus, alternative resources that urban Indian health programs might use to supplement their own programs are similarly stretched to the maximum limits.

There are no contract care monies available through IHS, to negotiate referrals in order to set up a comprehensive referral system. IHS pays for ambulatory care only, and if patients need more than that they must depend on the goodwill of the healthcare system that will vary from community to community.

The conditions under which each urban Indian health programs must operate varies, and each defines the local environment and community needs differently. The Area Offices and the IHS headquarters do not understand the healthcare environment in which the urban Indian health programs must operate: a highly competitive environment where programs must compete for paying clients, medicare patients, shared services, and other resources with other Community Health Centers.

Programs are more dependant on patient billing for funds than tribal programs, therefore they are more like local non-profit community health clinics than they are like any IHS facility. Medicaid provides contracts to HMOs or managed care facilities to retain patients. There are multiple networks of healthcare providers for referrals and managed care system. Individual urban Indian health programs must join the managed care system or they will be excluded from obtaining a portion of medicare and medicaid dollars. They also must compete for other agencies for state, city, county, and local funding.

Contracts

Contracts are too global in the scope of activities that urban Indian health programs are required to provide. Urban Indian health programs are expected to provide a total system of healthcare for limited funds. At the same time, IHS contracts are specific in ways that are not relevant to the provision of healthcare to urban communities. For example, the contract may specify a certain number of full time equivalent employees with corresponding position descriptions; may specify that a X number of persons will be trained at Y number of workshops. This is not relevant to ensuring that specific outcomes will be achieved towards defined goals and objectives. The IHS contracts for processes and activities, rather than outcomes. In other words, IHS contracts for health professionals performing healthcare activities, rather than a number of specific services performed. IHS should contract for the delivery of the desired number of services in order to achieve specified, defined outcomes.

Historically, because IHS provided 100% of urban Indian health program funding, they expected full control over how urban Indian health programs were managed and operated. At the same time, programs were always been encouraged to apply for funding from alternative resources. As a result, the majority of funds now come from outside agencies; yet the IHS continues to behave as if it were the only master of the Urban Indian health programs.

Reporting

Since the urban Indian health programs are so heavily funded by non-IHS agencies, it is not reasonable to expect them to collect and report items other than those which are standard among the various health care disciplines. Doing otherwise places an onus on the urban Indian health programs by requiring and unnecessary amount of time to be devoted to administrative duties.

There are no standard reporting periods or reporting formats for the reports that are required by law or by contract, except for the UCRR. There is no mechanism for compilation and analysis of aggregate data, to provide a basis for planning and policy making. Results are not formally disseminated to urban Indian health to be used in planning programs and for program evaluation. In order to obtain useful data on community health status for program planning purposes, it would be fairly simple to get DSM III codes, ICD-9, CPT and ADA electronically from computerized patient billing records, and then send data to a central agency for compilation and analysis. The report generated from a yearly report could then be used to set priorities and monitor progress towards the defined Urban Program objectives.

For the sake of efficiency, quarterly reports should be used instead of monthly reports. If contracts are based on outcomes, then those specified outcomes must be reported in the quarterly reports. There is also a need to implement a method to ensure quality, such as JCAHO; this method should be a recognized quality assurance method that is tailored to meet the quality assurance needs of each individual program.

Recommendations for Relevant Leadership within the Urban Indian Health Programs:

1. Establish a central agency to collect necessary data to profile the urban Indian community for health planning purposes, such as health status, population, and HRA data; to provide leadership and to facilitate consultative Urban Program decision-making among the UIHP directors;

2. Facilitate consultation among UIHP directors, in order to develop goals for the Urban Indian Health Program; using, for example, the Year 2000 Objectives or Objectives stated in the Indian Health Care Improvement Act. In order to ensure that goals are realistic and responsive to the health care needs of urban Indians, urban Indian health programs should consult with IHS in developing Urban Program Objectives, rather than IHS consulting with the urban Indian heath programs in a top-down fashion;

3. Assist each urban Indian health program in formulating an action plan with specific outcomes within the collective Urban Program objectives, based on the health care priorities within each urban community and the budgetary limitations of each urban Indian health program. It is expected that, because of the tremendous variation that exists among urban Indian communities, each UIHP will need to tailor the the Urban Program priorities and objectives to meet their own community's needs.

4. Monitor outcomes periodically, with annual review to measure progress, and also determine whether objectives are still relevant.

## APPENDIX A
# LITERATURE REVIEW

This Literature Review has been prepared as part of the *Assessment of the Urban Indian Health Program's Management and Administrative Capabilities*, to be delivered to the Indian Health Service (IHS) under contract #281-91-0055.

Literature reviewed is relevant to the development of management and administrative techniques of the Urban Indian Health Program, developed under Title V of the Indian Health Care Improvement Act of 1976. The report:

- Begins by tracing the legislative foundations of the urban Indian health programs (UIHP);

- Reviews early manuals written prior to 1987 that develop the administrative structure and provide for evaluation criteria of the urban Indian health programs;

- Reviews reports written prior to 1987 that provide data as required by the Indian Health Care Improvement Act with regards to the health status and unmet health care needs of urban Indians, identification of public and private health service resources available within each urban center, and provision of basic health education services to urban Indians with regard to health promotion and disease prevention in the cities that have urban Indian health programs;

- Outlines the major review and audit of the urban Indian health programs that was conducted by the Office of the Inspector General (OIG) in 1988 with its recommendations for improvements in the operation of the programs; and

- Discusses, point by point, the action steps proposed by the Indian health service in response to each of the five recommendations made by the OIG, and the extent to which each of the actions steps has been carried out.

Based on information reviewed in the literature, the final section of this report identifies areas for further exploration, defining questions that may be answered either through the analysis of existing databases or in discussion with program officials. Specific questions to be asked of program officials are identified at the IHS Urban Program Office, Area Office, Tribal Program and local urban Indian health program levels. These questions will form a part of the of the plan to collect new data to assess the current status of urban program administrative development.

## Origins Of The Urban Indian Health Program

Between 1950 and 1960, the urban Indian population nearly tripled, from 56,900 to 166,000. This rapid growth was in part due to the Federal relocation policy in the 1950s, which relocated Indian families and individuals from reservations to metropolitan areas. Voluntary migration of Indian people seeking jobs in urban areas also contributed to the accelerated growth of the urban Indian population, fueled by high unemployment and poverty on reservations.

Once in the urban setting, however, many Indians found that migration did not necessarily alleviate unemployment and poverty, but rather compounded them with (1) the social stresses of an unfamiliar urban milieu; (2) a disperse, heterogeneous Indian community; and (3) a lack of access to and information on affordable, culturally sensitive health care.

In response to the needs of the growing urban Indian population, urban Indian community leaders initiated a grassroots effort in the late 1960s to provide health services to urban Indians in the form of volunteer-run clinics. In 1972, Congress appropriated funds for a pilot urban Indian health program in Minneapolis. The success of this program, as well as documented evidence of cultural and economic barriers to health care, led to the passage of Title V of *The Indian Health Care Improvement Act of 1976* (P.L. 94-437), which established and funded additional projects in various cities nationwide.

## Indian Health Care Improvement Act of 1976

The Snyder Act of 1921 (25 U.S.C 13) and the Indian Health Care Improvement Act of 1976 (P.L. 94-437) provide the principal statutory foundation for urban Indian health programs. The Snyder Act broadly commits the Federal Government to be responsible "for the benefit, care and assistance of Indians throughout the United States...for the relief of distress and conservation of health". The Indian Health Care Improvement Act, passed in 1976, included an additional goal, "to raise Indian health status to the highest level possible", and "provide for the unmet health needs of both reservation and urban Indians".

*1. The Indian Health Care Improvement Act* defines urban Indian health programs primarily as a source of information and referral services for urban Indians, and secondarily as providers of direct services. Under Title V, urban Indian health programs are required to:

1) Document Needs:

- estimate the local urban Indian population who would need the services of the urban Indian health program;
- estimate the current health status and health care needs of Indians within the urban center;

- determine the existing public and private health service resources;

- determine the use of existing resources by the local urban Indian population;

- determine the gaps between unmet urban Indian health needs and the resources that exist to meet such needs.

2) Information and Referral:

- identify all public and private health service resources within the urban center that are available for urban Indians;

- assist urban Indians to become familiar with and utilize such services;

- assist health services in providing services to urban Indians.

- establish and implement manpower and training programs to accomplish information and referral tasks listed above.

3) Provide services:

- provide basic health education, including health promotion and disease prevention to urban Indians;

- provide direct health care services or enter into contract for health care services where necessary.

4) Make recommendations to the Secretary of the Department of Health and Human Services, and other Federal, State and local resource agencies on methods of improving health service programs to meet the needs of urban Indians.

Title V of the Indian Health Care Improvement Act specifies the content of quarterly reports that urban Indian health programs are required to submit to the IHS Area Offices:

- determination of the gaps between unmet urban Indian health needs and the resources that exist to meet such needs;

- recommendations on methods of improving health service programs to meet the needs of urban Indians;

- information on activities conducted by the organization pursuant to the contract;

- an account of the amounts and purposes for which Federal funds were

expended; and other information as requested by the Secretary of the Department of Health and Human Services.

Finally, the Indian Health Care Improvement Act specifies the criteria for award and/or renewal of contracts to urban Indian health programs, requires the Indian Health service to develop procedures to evaluate contract compliance and performance of urban Indian health programs, requires that the Indian Health Service submit reports to Congress on urban Indian health status, services, and unmet needs, and establishes the Branch of the Urban Indian Health Programs as the agency responsible for carrying out Title V provisions.

Since 1976, various amendments to the Indian Health Care Improvement Act have expanded the scope of the Urban Indian Health Program to include immunization services, outpatient mental health services, alcohol and substance abuse programs, programs for the protection of children and treatment for victims of child neglect and abuse. Provisions are also made for contracts to determine unmet health care needs for urban Indians living in areas that do not have an urban Indian health program, and for minor facilities renovations.

2. *Federal regulations* (36.350-36.353, revised as of October 1, 1988) provide further detail on such Urban Program elements established by Title V as:

- Contracts with urban Indian organizations (including definition of the scope of activities for UIHPs; Federal contracting laws and regulations; payments under contract; utilization of Federally owned facilities for UIHPs)
- Application and selection (Including statistical requirements for establishing extent of unmet health care needs of urban Indians; prioritization by urban population ; factors to consider in defining "accessible" health care)
- Fair and uniform provision of services;
- Reports and records (including requirements for financial accounting and reporting).

## Administrative/Management Structure Prior To 1987

The reports reviewed below represent attempts made prior to 1987 to develop management and administrative standards in accordance with mandates of the Indian Health Care Improvement Act for the urban Indian health programs.

**Manuals Developed Prior To 1987:**

3. The American Indian Health Care Association, *Guidelines and Sample Plan: To be Used in Developing Urban Specific Health Plans* This 1978 manual was developed to assist the Urban Indian health programs in developing health plans specific to the needs of the Indian population in their urban area. The resulting Urban Specific Health plan would, in turn, provide the Indian Health service with information needed to prepare its report to Congress on "expenditures and progress made under the Act and make recommendations...concerning any additional authorizations for fiscal years 1981 through 1984" as required by the Indian Health Care Improvement Act. The document is divided into three parts: Guidelines, a Resource Allocation Formula, and Sample Urban Health Plan.

The Guidelines section includes instructions on how to gather urban Indian specific data on population distribution, socio-economic status (education, housing, economic level, marital status) health status (births, mortality and morbidity), availability of public transportation, and existing health resources available in order justify the establishment of urban Indian health program to fill the gaps in unmet health needs. Instructions for completing the following application forms for Title V programs required by the IHS are described in detail:

I. Demand Workload to Justify Resources for Ambulatory Patient Care (Direct)

II. Determination of Ambulatory Patient Care Unmet Health Needs

IIa. Distribution of 'Other' than IHS Funded Positions (Ambulatory Care)

III. Determination of Unmet Preventative Health Care Needs

IIIa. Distribution of 'Other' than IHS Funded Positions (Preventive Health Care)

IV. Grand Total Unmet Health Manpower Needs from FY 1981 - 1984

The Resource Allocation Criteria provides the criteria for staff resources needed to provide ambulatory care and dental care in health centers. This information is required to fill out application forms for Determining Health Manpower Needs.

Finally, the Sample Urban Health Plan, using existing data, begins with a background historical statement, timeframe for the provision of services, description of the catchment area and population to be served (including tribal affiliation, language, and blood quantum), health status data and existing available resources. Examples of completed forms I - IV use existing data from 1981-1984

4. The American Indian Health Care Association, *The National Urban Specific Health Plan: Urban Indian Statistical Reporting System, 1979. Updated in 1985 as the Instruction Manual: the Urban Indian Statistical Reporting System.* Copy of report not available for review.

5. The American Indian Health Care Association, *Board Member-Individual Responsibilities Urban Indian Health Program Service and Administrative Standards,* 1987. Copy of report not available for review.

6. The American Indian Health Care Association, *Simulate Funding Distributions for Urban Indian Health Programs,* August 18, 1987
Various methods of funding allocation criteria were applied to the urban programs to distribute the $9 million appropriation in FY 1986 for that fiscal year. The report was developed to address the issue of funding allocation, and implemented all hypothetical models.

## Review Of Reports Written Prior To 1987

Reports Concerning Management Issues

7.The American Indian Health Care Association, *An Assessment of the Need for Standardized Definitions and Performance Indicators,* 1982. Copy of report not available for review.

8. The American Indian Health Care Association, *Topology of Urban Programs: Studies Involving Data Processing and Analysis on Issues Identified by the Operations Analysis Task Force on Urban Programming*, August 18, 1987. All programs funded under the urban Indian health program are examined in this report, which develops a topology based on distinctive elements such as services provided, funding sources, etc. The existing urban Indian health programs are categorized into five levels of service delivery.

9. The American Indian Health Care Association, *Minimum Service Package: Studies Involving Data Processing and Analysis on Issues Identified by the Operations Analysis Task Force on Urban Programming*, August 18, 1987. This report examines the range of services offered by the urban Indian health programs, assessing the feasibility of setting up a minimum benefits package that urban Indian patients would be eligible to receive. Preliminary data suggest that the minimum package would cost approximately $133 million per year.

10. The American Indian Health Care Association, *Service and Administrative Standards: Studies Involving Data Processing and Analysis on Issues Identified by the Operations Analysis Task Force on Urban Programming,* August 18, 1987. Service and Administrative

standards for urban Indian health programs are developed in this report. Productivity and performance data from the existing Urban Common Reporting Requirements system are used in allocating resources to urban Indian health programs using defined methods (see reference 34.)

11. The American Indian Health Care Association, *Recommendations for Changes: Studies Involving Data Processing and Analysis on Issues Identified by the Operations Analysis Task Force on Urban Programming, August, 1987*

12. The American Indian Health Care Association, *Data Needs of Urban Indian Health Programs*, 1981. This report is the result of investigations and analysis by the Data Needs Assessment Task Force on the development of a minimum data set for the urban Indian health programs. The report identifies four basic data component that should be collected on a regular basis with standardized format from the UIHPs. They include:

- Patient Data Items (including address, phone, social security number, patient identification number)
- Demographic Information (including date of birth, residence zip code and census tract, sex, race, employment status)
- Eligibility (including blood quantum, income source and amount, third party coverage, expected principal source of payment)
- Provider Data Items (including date and location of encounter, patient reason for encounter, number and type of services provided, follow-up and continuity of care, quality assurance, diagnosis, procedures, patient records)

In addition to the elements of a minimum data set, the following performance indicators are suggested as additional elements which should be standardized and developed within the urban Indian health programs:

A. Program Utilization and Growth (including users/target population, user growth rate, encounters/user)

B. Provider Productivity (including users/provider, encounters/provider, support staff/provider)

C. Cost Analysis (including average cost/user, cost/encounter, administrative/clinical costs)

D. Fiscal Management (including costs/charges, collections/charges, adjustments/charges, self-sufficiency ratio, break even ratio, average collection

period and rate)

E. Clinical Management (including no-show rate, heath care plan compliance for immunization, pap smear, prenatal, hypertension, diabetes, etc.)

13. The American Indian Health Care Association, *Urban Common Reporting Requirement Manual*. The activities of the urban Indian health programs are monitored through the use of information collected by Common Reporting Requirement for Urban Indian Health Program forms. These forms, approved by the Office of Management and Budget (OMB), provide comprehensive performance information from all urban Indian Health Programs in a standard manner, using standardized definitions and reporting formats. Data is used to accomplish the following objectives:

- Ensure compliance with legislative mandates;
- Report on urban Indian health status to Congress at oversight or appropriations hearings;
- Provide annual information to Congress and DHHS for appropriations and budgets;
- Provide a data base for the objective allocation of resources to the IHS Area/Program Offices; and
- Conduct program evaluation, including comparisons among urban Indian health programs.

Information is collected from urban Indian program directors from patient records, administrative, and financial records. Data are reported for a Mid-year (6 month) and an Annual (12 month) period. The *Urban Common Reporting Requirement Manual* defines terms and provides step-by-step instructions for completing each on the 8 tables in the report. The data in collected reports are reviewed and edited for completeness and consistency, then results are tabulated and analyzed.

From 1982 to the present, UCRR reports have been compiled for both the mid-year and fiscal year reporting period, to summarize aggregate data from the urban Indian health programs. The reports include complete aggregate and program specific statistics on user demographics, clinic penetration, workloads, funding, staff productivity, costs by program component, costs per user, costs per encounter, range of services provided, etc.

14. The American Indian Health Care Association, *Program Evaluation Criteria,* 1987. This evaluation manual sets forth standards for evaluating urban Indian health programs,

consisting of checklists of key elements associated with the following areas:

a. Governance
b. Administration
c. Financial Management
d. Facilities and Environment
e. Medical Program Management
f. Dental Program Management
g. Outreach/Community Service
h. Transportation
i. Allied Health
j. Quality Assurance
k. Medical Records
l. Patient Rights/Responsibilities
m. Contract Services
n. Substance Abuse Services

15. The American Indian Health Care Association, *Technical Assistance Needs to Correct Deficiencies in Urban Indian Health Programs as Indicated in "A Comparative Assessment of Urban Indian Health Projects" and Related Site Visit Reports by Regional Evaluation Teams,* 1982. Copy of report not available for review.

**Reports Profiling Indian Health Status**

16. The American Indian Health Care Association, *Report on Urban Indian Health,* February 28, 1986. This report constitutes a historical overview of the urban Indian health programs through a twelve year period, from 1972 to 1986. The report also covers current policy and programmatic issues within the Urban Indian Health Program. The report is divided into the following sections:

- The background of the urban Indian health effort prior to passage of the Indian Health Care Improvement Act (P.L. 94-437) in 1976;
- Growth of urban Indian health programming activities since the passage of the Act (P.L. 94-437);
- Funding history of the urban Indian health programs, in terms of IHS funding, other federal funding, state, county, local and private insurance;
- The current status of urban Indian health compared to that of urban Indians prior to the passage of the Act;
- The leading health problems of urban Indians and health trends since the inception of Title V funding;

- Services most frequently provided by urban Indian health programs and a discussion of changes in types of services provided since the inception of Title V funding; and

- Recommendations to improve urban Indian health programming; for example, legislative changes, changes in administration by the Indian Health Service, and changes at the local level.

17. The American Indian Health Care Association, *Special Study on Mental Health Problems for the Indian Health Board Clinic of Minneapolis, Incorporated,* September, 1978. This report, based on 1977 data submitted to the Urban Indian Statistical Reporting System (UISRS) by the Indian Health Board Clinic of Minneapolis, describes the occurrence of mental health problems among the Minneapolis urban Indian population. The report includes tables of the total clinic patient population by age and sex versus those with diagnosed mental health problems, plus those patients presenting various types of injuries that may be indicative of mental health problems.

18. The American Indian Health Care Association, *Otitis- Special Study for Indian Health Board of Minneapolis, Inc.* 1978. Copy of report not available for review.

## 19. OFFICE OF THE INSPECTOR GENERAL REPORT AND AUDIT -- 1988

In 1987, the Office of the Inspector General initiated a statistical evaluation whose purpose was to determine whether direct health care provided by the UIHP was justified, based on urban program statistical data for 1984-1986 provided by the Indian Health Service. The audit also included a limited review of the extent to which other services were available.

The OIG audit found a disturbingly low overall clinic penetration of the urban Indian community: only 7.8% of the Indians living in the targeted urban areas used any medical service, only 2.6% used any dental service, and little more than 17% used the urban Indian health program for any purpose, including outreach and referral. In addition, over 36% of all visits were made by non-Indians. Though legislated to provide annual studies to identify gaps between the health needs of urban Indians and the resources available to meet those needs, none of the 7 California programs nor those in three other Service Areas produced such studies.

The OIG audit concluded by recommending that:

1) procedures be implemented to enforce compliance with annual evaluations of the urban Indian health programs, as mandated by Title V legislation;