

Response to Questions from the Senate Committee on Indian Affairs on the Urban Indian Health Program

Kinds of Services and Non-Duplication

Drafted 9/18/05 by Liz Hunt, Executive Director of the Indian Health Center of Santa Clara Valley, the urban Indian health program located in San Jose, California.

Questions from the Senate committee seemed to indicate that what they wanted was:

- A description of the urban Indian program
 - # of comprehensive & other
 - types of services provided
 - new/additional services will provide
 - where referral programs refer clients
 - description of patients served (age, gender, disease classification, length and type of treatment)
 - how eligibility is checked
 - # urban programs that are CHCs & advantages & barriers
- To know how urban Indian services are different from CHCs & are non-duplicative

Information in this document is from the PART Workgroup response, urban Indian agency profiles, and other data sources.

A. Description of the Urban Indian Health Program

There are 34 urban Indian health programs in the United States. 90% are in the mid-West, southwest, or on the West coast.

- 62% (22) provide comprehensive primary medical care, behavioral services, and community health. 14 of these provide onsite dental service, which include general preventive, restorative, and reconstructive dentistry for both adults and children.
- 20% provide outreach, referral to medical services, behavioral services, and community health. These agencies provide onsite health education and information services and play a very important role in connecting urban AI/AN to medical assistance.
- 17% provide limited medical care, behavioral services, and community health.

All but 2 of the 21 comprehensive primary medical care programs are federally qualified health centers (FQHCs); some limited medical care programs are as well. Five programs that provide comprehensive medical services are also community health centers under the Bureau of Primary Health Care's 330 program. The 330 program remains highly competitive and requires rigorous preparation and maintenance of national standards of medical care. Advantages of being in the 330 program include having access to technical assistance, a nationwide network of CHCs, and increased funding.

Primary medical care includes comprehensive general medical care, health and well baby check-ups, vision and hearing screenings, simple procedures, immunizations, lab work, chronic disease care, women's health care such as PAP smears and breast exams, flu shots, urgent care, prenatal care, perinatal care, HIV/AIDS testing and counseling, and podiatry.

Response to Questions from the Senate Committee on Indian Affairs on the Urban Indian Health Program

Kinds of Services and Non-Duplication

Behavioral health services include mental health counseling for individuals, couples and families; psychiatric services; substance abuse counseling and education; emergency on-call coverage; talking circles; workshops; anger management classes; and play therapy.

Community health services include diabetes support groups, youth groups, accident prevention, chronic disease education, case management, exercise and fitness, tobacco abuse education and prevention, nutrition, and elder programs.

All urban programs provide referrals to other needed services that they cannot provide such as dermatology, optical care, specialty medical care, etc. Clients are referred to outside agencies based on cooperative agreements that have been established with the urban Indian program. Many urban programs have traditional or cultural activities involving spiritual healers and ceremonies. Many urban programs are located in rural areas away from other IHS facilities, making their role even more critical in the care and preventing of medical conditions.

All programs report diabetes as being a significant health problem for the AI/AN population that they serve. The incidence of alcohol and other drug abuse remains high; and other health issues include cancer, obesity and health neglect, lack of preventative care, lack of culturally competent care, lack of transportation, low-cost prescriptions, asthma and respiratory problems.

B. Uniqueness and Necessity of the Urban Indian Health Program

The Federal Government's Trust Obligation to the AI People to Provide Care and Education
Urban Indian programs were created and operate under legislative authority of Title V of the AIHCIA which was passed by Congress in 1975. Urban programs were created because of the federal recognition of responsibility for the care and education of the Indian people. The US government has had a long-standing policy of termination of Indian tribes. The most recent of this was the Bureau of Indian Affairs' Relocation/Employment Assistance Program which enticed AI/AN families to relocate from reservations to urban areas. The program was in operation through the 1950s and 60s and those who participated ended up in urban areas with little support, often exchanging poverty on the reservation for poverty in the city. In late 1960s AI/AN community leaders brought attention to the enormous health disparities that existed for the AI/AN population and advocated for appropriate health programs. In 1972 Congress appropriated funds to study these unmet health needs, which documented considered health needs as well as barriers to access of existing health care services. These health disparities continue today and include some of the following statistics:

1. AI/AN are 53% more likely to get diabetes.
2. AI/AN are twice as likely as white adults to not receive needed medical care due to the cost of care.ⁱ
3. AI/AN were about three times as likely as white adults to have felt hopeless and worthless most or all of the time within the past 30 days.ⁱⁱ

Response to Questions from the Senate Committee on Indian Affairs on the Urban Indian Health Program

Kinds of Services and Non-Duplication

The urban Indian programs were authorized in 1975 by the American Indian Health Improvement Act (AIHCIA) to address these health disparities by providing culturally competent care. Previous policy recommendations that came from the report of the American Indian Policy Review Commission of the Congress of the United States in 1977 noted that the trust relationship of the United States to the Indian people is one of the two most important concepts underlying Federal-Indian law. Broad concepts that were agreed upon to guide future policy in relationship to the trust doctrine included:

1. The trust responsibility to American Indians extends from the protection and enhancement of Indian trust resources and tribal self-government to the provision of economic and social programs necessary to raise the standards of living and social well being of the Indian people to a level comparable to the non-Indian society.
2. The trust responsibility extends through the tribe to the Indian member, whether on or off the reservation.

In the *Declaration of Health Objectives*, Section 3, Part A of the 1992 amendment to the American Indian Health Care Improvement Act of 1975 states that:

“The Congress hereby declares that it is a policy of this Nation, in fulfillment of its special responsibilities and legal obligations to the American Indian people to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to affect that policy.”

In addition, Section 501 of the AIHCIA states that “the purpose of this title is to establish programs in urban centers to make health services more accessible to urban Indians.”

It is Critically Importance for AI People to be Involved in Their Care

In a recent groundbreaking study, the Institute of Medicine reported that the use of community-based initiatives that include community involvement and empowerment strategies are recommended as means to reduce the health disparities that exist among racial and ethnic minorities.ⁱⁱⁱ Urban Indian health programs are led by a Board of Directors, the majority of who are members from the AI/AN community. This ensures that services are developed with the community’s needs at the forefront and reduces real cultural barriers to health care for AI/ANs in urban areas.

The urban Indian health program is not redundant of other US government efforts to improve the health care for medically underserved citizens. Services that are provided to urban Indians by these programs are very much needed and because they are culturally competent, have a better success rate at engaging American Indians in their long-term care. The provision of culturally competent services includes using traditional AI/AN healing methods including talking circles, sweat lodges, ceremonies such as the Wiping of the Tears, and traditional healers. Additional outreach and ongoing participation in community events is necessary to engage clients and convince them to get medical care. Because a relationship and much trust must be established before clients will come in

Response to Questions from the Senate Committee on Indian Affairs on the Urban Indian Health Program

Kinds of Services and Non-Duplication

for care, all urban programs have a strong outreach component and are an integral part of the local AI/AN community which they serve.

Other Governmental Planning Efforts are Focusing on the Importance of Providing Culturally Competent Care

One of core planning principles of the distribution of new mental health Prop 63 funding in California is to design and provide services that are culturally competent and that transform the mental health system. Counties from Los Angeles to the Bay Area and beyond have started planning processes that have engaged community leaders from the AI/AN, Hispanic, Vietnamese, Cambodian, Chinese, and other communities to plan services. In Santa Clara County the County Department of Mental Health has fostered the development of a community AI/AN Advisory Group which is giving input on proposed services to ensure they are appropriate for AI/AN clients.

C. Health Status of Urban American Indians & Alaska Natives (AI/AN); Findings from the Urban Indian Health Status Report, published by the Urban Indian Health Institute.^{iv}

Approximately 4.1 million Americans indicated they were of AI/AN heritage on the 2000 census. Of these, 60% (approximately 2.5 million) identified themselves as AI/AN alone. Of the latter, 61% (approximately 1.5 million) lived in urban areas and of these, 34% (approximately 500,000) lived in counties served by Urban Indian Health Organizations (UIHOs). The AI/AN population living in UIHO service areas varied substantially ranging from approximately 700 persons in the Butte, Montana area to 77,000 in the Los Angeles, California area. Of AI/AN populations living in the UIHO service areas, 88% were living in areas designated by the census as urban.

Based on 1999 income, approximately a quarter of AI/AN individuals residing in UIHO service areas and nationwide lived in households with incomes below poverty; this was close to twice the rate of the general population living in these same areas. Poverty status by age groupings is the highest in AI/AN children (30% to 32%). This compared to adults in the general population (5% to 6%), the AI/AN children's rate was as much as six times higher. In all UIHO service areas, the poverty level of AI/AN populations consistently exceeded the general population in these same areas.

Significant disparities between the UIHO AI/AN populations and the general population living in the same area were found in: birth to teenage mothers, unmarried mothers, mothers receiving late or no prenatal care, and mothers who smoked during their pregnancy. For example, the rate of births to teenage mothers in the UIHO AI/AN population was 80% higher than births to teenage mothers in the general population in the same areas. Over time, decreasing trends in the birth rate of teenage mothers from the late 1990's was significant for all populations except the UIHO AI/AN population. The rate of UIHO AI/AN mothers receiving late or no prenatal care was more than twice the rate of the general population in these areas (7.4% and 3.4%, respectively); this disparity was consistent for all of the UIHO service areas. Smoking rates during pregnancy were substantially higher in UIHO AI/AN populations than the general population in these areas (17.2%

Response to Questions from the Senate Committee on Indian Affairs on the Urban Indian Health Program

Kinds of Services and Non-Duplication

and 10.7% respectively). Smoking rates during pregnancy varied greatly between the different UIHO service areas with one area reporting rates of up to 45%.

From 1995 to 2000, the average infant mortality rates among infants born to UIHO AI/AN mothers were higher than the general population in these areas (8.8 and 6.6 per 1,000 live births respectively). Over time, significant decreases in the rate of infant mortality in the general population were seen (both UIHO service area and nationwide), however, no such trend was observed in either AI/AN population. For all UIHO service areas, the AI/AN infant mortality rate consistently exceeded that of the general population living in these areas.

From 1995 to 2000, Sudden Infant Death Syndrome (SIDS) was the leading cause of death among infants born to UIHO AI/AN mothers. The UIHO AI/AN rate was at least twice that of the general population in these same areas (1.8 and 0.7 per 1,000 live births, respectively) but comparable to the nationwide AI/AN population (1.6 per 1,000 live births). Over time, a significant decrease in the infant mortality rate due to SIDS was seen in all populations except the UIHO AI/AN population.

With respect to overall mortality for all age groups, nearly 100,000 deaths nationwide were reported in the AI/AN population from 1990 to 1999. Of these, nearly 20% (approximately 18,000) were in the UIHO AI/AN population. Over time, a significant decreasing trend in population was seen for all populations except the nationwide AI/AN population; this had a significant upward trend. Heart disease was the leading cause for deaths in all four populations. Substantial differences were found between the UIHO AI/AN populations and the general population living in these areas (145.0 and 290.0 per 100,000). Over time, from 1990 to 1999, heart disease mortality decreased significantly among all four populations.

Cancer was the 2nd leading cause of death among all populations with lung cancer mortality as the most common type among AI/AN living in UIHO service areas and nationwide. The 10-year average cancer rates for both AI/AN populations were lower than the general population in these areas. Despite decreasing cancer and lung cancer mortality rates in the general population over time from 1990 to 1999, the rates in the AI/AN population has either remained level or increased. Mortality rates attributed to accidents, chronic liver disease, diabetes, and alcohol in the UIHO AI/AN population, all surpassed the mortality rates of the general population living in these areas.

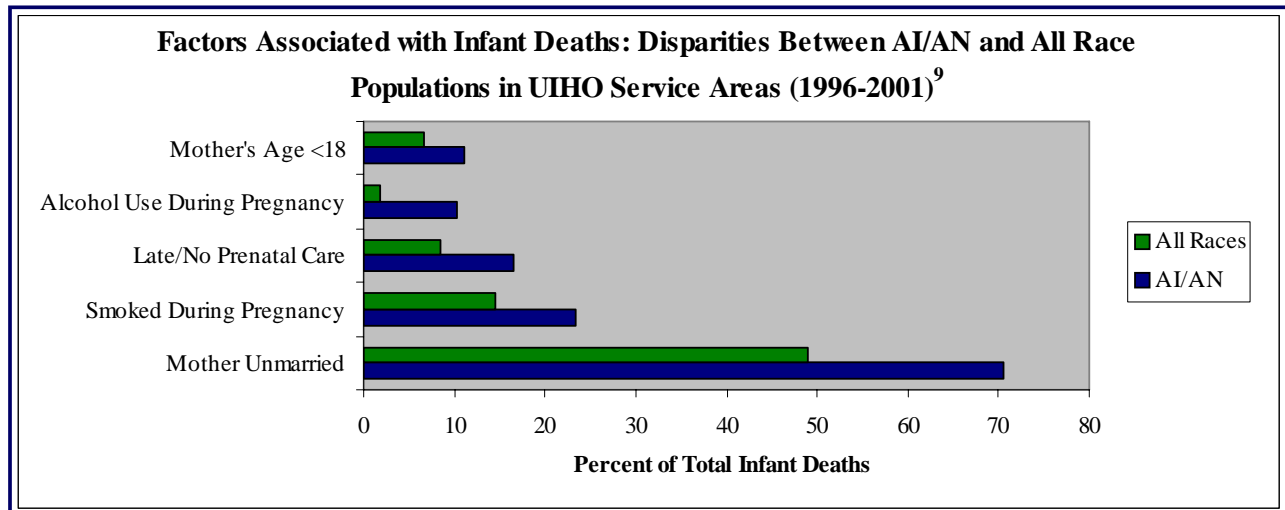
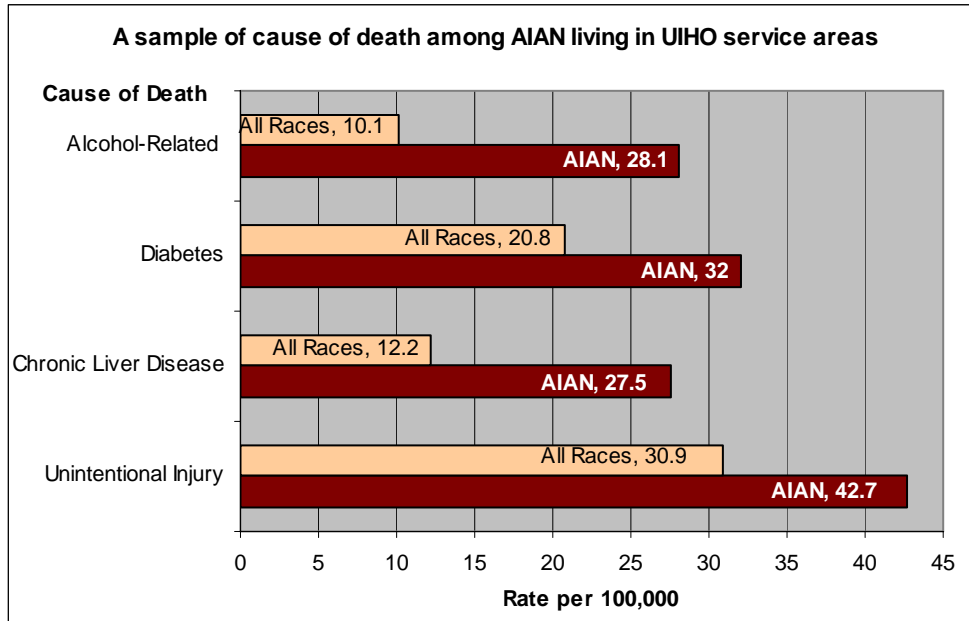
Over time from 1990 to 1999, accident mortality rates significantly decreased in all populations except the UIHO AI/AN population. Likewise for the same period, chronic liver disease mortality rates significantly decreased in all populations except the UIHO and nationwide AI/AN populations. While a significant increase in diabetes mortality is evident in all four populations, diabetes mortality over time in the AIAN population appears to be increasing at a faster rate than the general population. Alcohol-related mortality was observed to significantly decrease in all four populations.

These findings show that AI/AN populations living in UIHO service areas suffer a greater degree of socioeconomic burdens and poor health when compared to the general population living in the same

Response to Questions from the Senate Committee on Indian Affairs on the Urban Indian Health Program

Kinds of Services and Non-Duplication

areas. The striking disparities seen in rates of poverty, disability, and other socioeconomic indicators, put AI/AN populations at a disadvantage with respect to access to healthcare and a better health status.



ⁱ US Department of Health and Human Services, Centers for Disease Control and Prevention, Advance Data from Vital and Health Statistics, Number 356, April 27, 2005.

ⁱⁱ Ditto

ⁱⁱⁱ Smedley, B., & Stith, A. eds. 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, p. 198. National Academies Press; Washington, D.C

^{iv} For more information, please visit the Urban Indian Health Institute; www.uihi.org