THE URBAN INDIAN HEALTH PROGRAM

A Bridge to Mainstream Health Care Delivery

OFFICE OF INSPECTOR GENERAL

OFFICE OF ANALYSIS AND INSPECTIONS

JULY 1988

OFFICE OF INSPECTOR GENERAL

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THIS REPORT

Entitled "The Urban Indian Health Program--A Bridge to Mainstream Health Care Delivery," this inspection recommends changes in the title V Urban Indian Health Program and suggests improvements in program planning and evaluation as well as in Federal contract monitoring and management. The report was prepared under the direction of Kaye D. Kidwell, the Regional Inspector General, Office of Analysis and Inspections, Region IX.

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INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

The objectives of this inspection were to determine, in select communities, (1) the extent to which community health services, other than the Urban Indian Health Program (UIHP), are available and accessible to low-income and indigent urban Indians, (2) the extent of Indian and non-Indian utilization and (3) the factors influencing utilization. An additional objective, which developed during the inspection, was to identify program planning and management problems.

BACKGROUND

Over the past four decades, increasing numbers of American Indians have left reservations to live in cities. More than half of the 1.4 million Indians in the United States are currently estimated to live in cities or metropolitan areas. National and community studies in the late 1960s and early 1970s documented barriers faced by urban Indians in obtaining necessary health care services, in part because of their low income levels and complex social problems. In recognition of these needs, Congress enacted the UIHP through Title V of the Indian Health Improvement Act of 1976. The intent of title V was to provide improved access to health care for urban Indians through outreach and referral efforts and, where necessary, direct health care services.

The Indian Health Care Improvement Act, including title V, expired in 1984. From fiscal years (FY) 1984 through 1987, the Administration did not request funding for the program, which is administered by the Public Health Service (PHS). Appropriations have continued through joint resolutions of Congress. Currently, the UIHP accounts for $9 million of the FY 1987 PHS Indian Health Service (IHS) budget authority of $848 million. For FY 1988, the Administration requested $8 million and recommended a phase-out of the program by 1991.

This inspection was designed to complement a statistical evaluation of the UIHP which was completed by the Office of Inspector General (OIG), Office of Audit (OA). The objective of the OA review was to determine whether direct health care provided by the UIHP was justified based on an analysis of nationwide UIHP reporting data for fiscal years 1984 through 1986. This Office of Analysis and Inspections (OAI) study expanded on the OA data review by undertaking supplemental fieldwork to gain further information on the need of Indians for UIHP services.

MAJOR FINDINGS

INADEQUATE MONITORING AND TECHNICAL ASSISTANCE

Uniform national criteria for monitoring projects are lacking, and there is inconsistent management oversight of the UIHP. Budgetary decisions are not necessarily based on documented need or organizational effectiveness. This has resulted in inequitable and fluctuating funding of some projects, which hampers their ability to plan or provide consistent levels of service. Finally, IHS provides only limited technical assistance to the projects.

ESSENTIAL PLANNING DATA ARE LACKING

The title V legislation called for detailed needs assessment and program planning processes. In recent years, most UIHP projects have not implemented this requirement. Only two local needs assessments have been carried out in the past 3 years. Standardized national statistics on urban Indian health needs do not exist.

UTILIZATION RATES LACK ACCURATE POPULATION BASE

Accurate population statistics do not exist in many areas and are skewed in others. If the indigent and low-income Indian population were used as the base and defined consistently, utilization rates in many areas would be considerably higher than shown in the IHS statistics for the UIHP program.

INDIANS FACE BARRIERS TO HEALTH CARE

Urban Indians who are indigent or who lack health insurance face barriers in attempting to gain access to health care. Barriers to mainstream care include complex and restrictive eligibility requirements for State and local assistance programs, lack of outreach or targeted services from other community providers and, on occasion, direct prejudice. These are similar to barriers faced by other indigents, but include some cultural factors unique to Indians.

MANY NON-INDIANS USE THE URBAN INDIAN HEALTH PROGRAMS

For all centers, 37 percent of users are non-Indian. The utilization rate for non-Indian users ranged from 1 percent to 55 percent for the UIHP sites visited. Multiple funding sources require nonrestrictive services. Reasons given for use of the UIHP by non-Indian clients are convenience, low cost and accessibility.

RECOMMENDATIONS

- The Public Health Service should strengthen management of the UIHP by (1) implementing a monitoring and evaluation system with uniform national criteria for all area offices, (2) completing an updated standardized national needs assessment (based on a standardized updated needs assessments in each local area) and (3) continuing the effort to improve the collection and dissemination of uniform national aggregate and comparative statistics.
- The PHS should use needs assessment and evaluation data to decide future funding allocations and individual project-level funding.
- The PHS should provide more explicit guidelines concerning adequate information and referral programs, including assistance in gaining access to Medicaid, other medical assistance programs and mainstream health providers.
- The PHS should complete a detailed analysis of the barriers which inhibit Indian access to mainstream health care and develop an action plan to overcome the barriers.

- The Public Health Service should:

  1. move the UIHP from IHS to the Bureau of Health Care Delivery and Assistance (BHCDA) where it could be integrated with the community health services program and other programs providing health care to urban residents or

  2. develop explicit linkages locally between UIHP clinics and community health centers (CHCs) and nationally between IHS and BHCDA so that the clinics and IHS staff can take full advantage of the urban community health care expertise of the CHCs and the BHCDA.

AGENCY COMMENTS

The PHS concurred with all of the OIG recommendations and has taken steps to implement the recommended changes. Of the alternatives presented in our fifth recommendation, PHS has chosen to adopt the second option.

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INTRODUCTION

BACKGROUND

Legislative Perspective

The Snyder Act of 1921 and the Indian Health Care Improvement Act of 1976 form the principle statutory bases for the provision of health care programs by the Indian Health Service (IHS). The Snyder Act broadly describes the Federal role in Indian health care matters "for the benefit, care, and assistance of Indians throughout the United States...for relief of distress and conservation of health." The Indian Health Care Improvement Act further defines the scope of Federal responsibility to raise Indian health status to the highest level possible. Congress passed the act to address the unmet health needs of both reservation and urban Indians. Title V of the act established the Urban Indian Health Program (UIHP) to provide outreach and referral services and, where necessary, direct health care services. The funding for the program is a separate budget line item under the IHS appropriation.

The legislative authority for the Indian Health Care Improvement Act expired in 1984. Congress has extended appropriations through continuing resolutions. A bill for the reauthorization of the act has been introduced in Congress. A portion of this bill would continue the UIHP under the general authority of the Snyder Act thereby ensuring its permanent inclusion in the Indian health care delivery network.

Factors Contributing to Urban Indian Growth

Approximately 50 percent of the total 1.4 million American Indians are concentrated in urban areas, compared with 24 percent remaining on reservations and 26 percent in nonmetropolitan areas. Between 1950 and 1960, the size of the urban Indian population nearly tripled from 56,900 to 166,000. This rapid growth was influenced by Federal policy in the 1950s which relocated many tribes and individual Indian families from rural areas to cities. Escalating unemployment and poverty on reservations contributed to voluntary urban migration by Indians seeking jobs and other services. Since 1950, the Indian population in urban areas has grown more than sevenfold.

Title V Urban Indian Health Program

National policy has long emphasized Federal responsibility for providing health care to Indians living on or near reservations where they are part of a total care service system. The assumption has been that urban Indians can obtain services at the local level the same as non-Indians. In cities, however, experience has shown that Indians are ill-prepared to use local health and social services. The difficulties encountered by many Indians in gaining access to and using mainstream resources prompted the establishment of the UIHP.

The origins of the UIHP predate the title V program. The UIHP began in the late 1960s as a grassroots effort by Indian community leaders in response to growing health problems of urban Indians. The origins of some urban Indian projects were part of community efforts sponsored by the Office of Economic Opportunity. Initially, small clinics were operated on a part-time basis and staffed by volunteers.

In 1972, Congress appropriated funds for a pilot urban Indian project in Minneapolis. Congressional interest grew over the next few years, leading to the passage of the 1976 authorization which established and funded additional projects in several cities. As of Fiscal Year (FY) 1986, there were 37 title V sites located in 18 States. A listing of these sites is shown in appendix A.

Justification for separate Indian health centers in urban areas has been given by several sources, including UIHP staff, board members and patients as well as community providers. The following points were presented by these sources:

- For urban Indians, cultural barriers are not easily surmountable. Indians may be reluctant or unable to describe their health needs to strangers outside their own culture. Frequently, mainstream providers misunderstand or misinterpret the reticence and stoicism of Indians.
- Some health care providers are reluctant to serve Indians because they believe Indians cannot or will not pay. In some cases, outright prejudice is a factor.
- The UIHP is designed to bridge reservation and urban mainstream health care. The UIHP staff are familiar with the special needs of Indians and in most cases are Indians themselves. They recognize endemic Indian health problems and are able to offer immediate, appropriate and cost-effective medical attention. Urban Indian clinics not only provide essential primary health care, but also contribute to the overall mental and social well-being of urban Indians.

Title V requires UIHP projects to implement the following planning activities:

1. determine the size of the local urban Indian population,
2. identify public and private health care resources,
3. identify gaps between unmet health needs and the resources available to meet such needs,
4. help Indians to become familiar with health resources and
5. recommend ways to improve urban Indian health projects.

In FY 1986, the title V funding for 37 sites in existence at that time was $8.6 million. Since most sites have additional funding from other sources, their aggregate funding was $19 million. The following table shows funding sources and amounts since 1984.

URBAN INDIAN HEALTH PROGRAM RECEIPTS BY SOURCE
1984-1986
(Millions of dollars)

	1984	1985	1986
Title V	7.9	9.1	8.6
Other Federal	4.6	3.9	4.3
State	2.0	2.7	2.3
County	.5	.5	.7
City	.1	.3	.1
Other	2.3	2.6	2.9
TOTAL	17.4	19.1	18.9

SOURCE: Urban Indian Health Care Program, FY 1986 Charts and Graphs, American Indian Health Care Association, Minneapolis, 1986, p. 3

Since 1982, title V has contributed between 45 and 49 percent of the projects' budgets. Other funding comes from other Federal, State, city and county sources. For FY 1986, title V funds constituted 45.1 percent of the total funding. Appendix A contains a complete breakdown of funding by source and by UIHP project.

The following table shows services provided, as measured in encounters, which IHS defines as a discrete service given. An individual user may have multiple encounters during a year. According to IHS, the decrease in total services shown since 1982 may be a result of improved accuracy in reporting to eliminate duplicate counting, rather than an actual reduction in numbers served.

SERVICES PROVIDED BY UIHP CENTERS

YEAR	TOTAL NUMBER OF ENCOUNTERS
1982	582,567
1983	534,157
1984	487,153
1985	504,133
1986	472,009

SOURCE: Urban Indian Health Program, FY 1986 Charts and Graphs, p. 16

Direct Health Services Provided by UIHPs

The UIHP program defines direct health services as "delivery of outpatient medical, dental and mental health services administered by licensed health care professionals." The following table shows 1986 total funding amounts for direct health services by major functional areas including optometry and inpatient care.

FUNDING FOR DIRECT HEALTH SERVICES

FUNCTIONAL AREA	1986 AMOUNT (Millions of Dollars)
Medical	7.8
Dental	3.7
Inpatient	0.1
Mental Health	1.0
Optometry	0.2
Allied Health	0.6
TOTAL	13.4

SOURCE: Urban Indian Health Program, FY 1986 Charts and Graphs, pp. 7-8

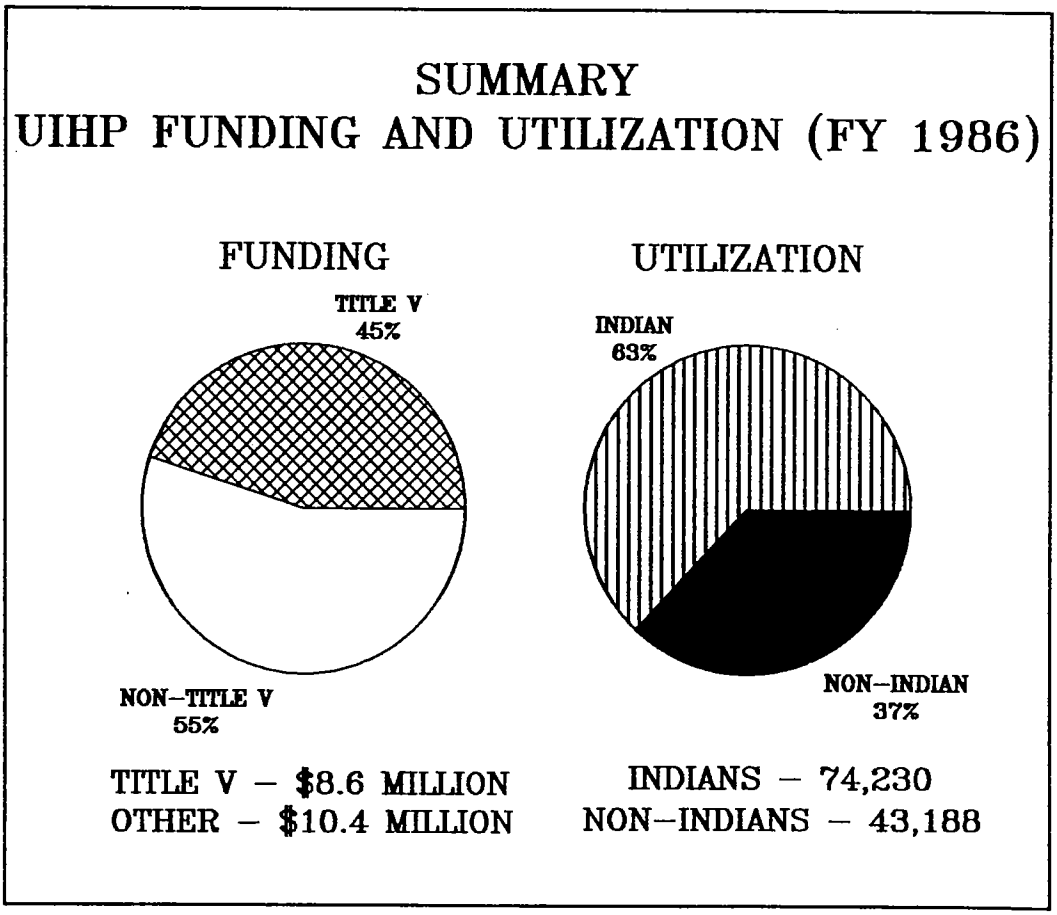
OBJECTIVES

The principal objectives of this inspection were to determine (1) whether the Urban Indian Health Program duplicates other sources of health care by analyzing the extent to which community health services are available and accessible in select communities, (2) the extent of Indian and non-Indian utilization and (3) the factors which influence utilization. Another objective, which developed during the course of the inspection, was to identify program planning and management problems.

METHODOLOGY AND SCOPE

The 37 title V sites funded in FY 1986 were stratified into 7 tiers based on the level of program funding and utilization. Selection of sites was based on an analysis of historical data, current funding and health service delivery patterns and practices. Nine sites were selected to include at least one site from each stratum. In order to determine if direct health services are justified, the OIG staff identified available health care providers and reimbursement mechanisms in each site and the extent to which these are accessible to Indians. Interviews were conducted with urban Indian health program staff, community health centers, representatives of hospitals and other health care providers, advocacy and public interest groups and Indian clients. In seven out of the nine sites, a random sample of medical records was drawn and data were analyzed to assess utilization patterns and client characteristics (see appendix B).

This inspection was not intended to be a comprehensive assessment of urban Indian health needs or a definitive program evaluation. Some observations on project accessibility and health care barriers for urban Indians have been made. While this inspection examines some of the factors contributing to high/low utilization, it does not provide new or comprehensive data on urban Indian health needs, population characteristics or health resources available.



FINDINGS

SERVICE DUPLICATION

Access to Community Health Programs Is Limited for Indigent and Working Poor Indians

A variety of health care financing mechanisms and health providers are potentially available to urban Indians in most sites. All communities visited have physicians, hospital emergency rooms and public health clinics, and most have community health centers. All States have Medicaid and most States or counties have medically-needy or medically-indigent adult eligibility categories. The availability of such services does not mean, however, that they are accessible to urban Indians. As is true of many other low-income or indigent groups, urban Indians face a variety of problems in gaining access to health services.

Few Urban Indians Receive Medicaid

Although the Indian unemployment rate is 50 percent or more in some urban areas, fewer than 15 percent of urban Indians are enrolled in Medicaid. In 1986, according to statistics from the Health Care Financing Administration, 174,000 out of 1.4 million Indians, or 12 percent nationally, were Medicaid recipients. Many low-income Indians do not enroll in Medicaid. Some do not make the effort to determine if they are eligible. Others do make the effort but find they do not qualify.

There are several reasons why Indians do not apply for Medicaid. Eligibility requirements are complex and growing increasingly restrictive. For example, in Arizona, the Medicaid eligibility forms are 25 pages long. An Indian affairs director in one State explained, "You have to be an attorney to wade through the Medicaid application form. Many Indians won't bother." Enrollment assistance is sought in crowded and unpleasant waiting rooms. To some, especially pregnant women, returning to the reservation may seem like a more attractive alternative. Others forgo primary care, seeking health services only when their illness becomes severe or when true medical emergencies develop.

Some States have eligibility standards more stringent than the Federal poverty standards. Reports from several UIHP sites indicate that some Indians either resign from jobs or move back to the reservation in order to become eligible for Medicaid or IHS health services. An Indian multi-service center director explained that "taking a low-income job with no health benefits is more costly than staying on welfare. Many Native Americans go back on welfare to keep their benefits."

A few jurisdictions provide help in overcoming enrollment barriers. In Salt Lake City, the Maternal and Child Health program brought social services and health department personnel together with patient advocates to deal with barriers to the application process. As a result, Medicaid participation by Indians and other indigents increased by more than 40 percent. In Phoenix, a full-time UIHP community representative offers direct and intensive help to overcome individual eligibility barriers.

Other Medical Assistance Programs Offer Highly Restrictive Coverage and Benefits to Urban Indians

Many States offer medically-needy or medically-indigent adult (MIA) programs to those not eligible for Medicaid. Even with assistance in completing the eligibility process, many Indians do not qualify for these services because employment, even though marginal, puts them over the income criteria. Urban Indians are largely the working poor. Many have only part-time jobs. Although their jobs are low-paying, they pay salaries sufficiently high to place them just above the income scale for Medicaid or medically- indigent adult programs. In addition, these jobs do not usually offer health insurance. The lack of financial assistance severely restricts accessibility to these programs.

In several California locations, MIA funding once received by the UIHP projects has been redirected to county facilities. Some UIHP center directors stated that Indians covered by the MIA program must now use a source of care that is often less accessible or forgo needed health care altogether.

Indians Face Problems in Access to Private Physicians

Problems for Medicaid beneficiaries in obtaining primary health care were documented in a service delivery assessment on "Access to Physicians for Medicaid Beneficiaries," conducted by the OIG Dallas Regional office in 1980. Physicians and staff in many UIHP sites report that access to private providers continues to be a problem for Indian and other Medicaid recipients. Physicians increasingly refuse to accept new Medicaid patients. This is especially true of key specialist fields, such as obstetrics and gynecology. Reasons for physician refusal to accept Medicaid patients continue to be (1) perceived low reimbursement rates, (2) complex claims forms and (3) payment processing delays.

Physician access is equally difficult, or more so, for non-Medicaid assistance programs. San Francisco UIHP staff report that it can take up to 4 months to see a physician under the county-operated MIA program. For an Indian to see a private practice physician, having insurance or the ability to pay fees is paramount. Most physicians are not willing to see indigent patients as charity cases except in very special circumstances. One of the UIHP staff physicians in Montana reported that private practice physicians had exercised peer pressure to stop a few who had been providing charity care to Indian patients, evidently because of fears that this could affect their fees. Medical staff at UIHP sites also reported that most private physicians are not aware that Indians are specially prone to certain disorders such as diabetes and otitis media and, therefore, do not always provide the necessary testing for these diseases.

Non-urgent Care through Hospital Emergency Rooms is Costly and Lacks Continuity

Many urban Indians use hospital emergency rooms (ERs) for non-urgent care. Hospital ERs, particularly public ones, have traditionally served as a source of care to indigents. As a 1983 OIG Service Delivery Assessment on "Use of Hospital Emergency Rooms for Non-Urgent Care" showed, non-urgent care offered through emergency rooms is very costly and tends to be episodic in nature. Follow-through services may be sporadic, and preventive care is not given. Long delays in waiting rooms and additional referrals are common.

In many areas, the UIHP projects are alternatives to the more costly hospital ERs. The hospital or the county has to absorb the costs for non-urgent ER use by indigents. Many jurisdictions have set up a system of satellite outpatient clinics at the hospital or other locations to provide alternatives to ER services. In a few areas, such as San Francisco and Alameda Counties, the UIHP and the hospital satellites are part of a consortium of neighborhood clinics. In some sites, if the UIHP clinics did not exist, most of their clients would turn to much more expensive care through the emergency rooms, unless they were served by community health centers.

Even public hospitals expect payment for services. If there is no third party coverage for an individual patient, a sliding scale fee is applied. Letters are frequently sent demanding payments.

Federal Hill-Burton construction funding obligates hospitals to provide indigent care. Nearly all hospitals built or modernized through 1975 are under this obligation. In several sites, the OIG team was told that hospitals seek to provide only minimal services to fulfill their Hill-Burton obligations. In one of the sites, the single community hospital budgets a limited amount for Hill-Burton obligations which is usually expended by mid-year.

Community Health Centers Have Few Indian Patients

Community health centers (CHCs) do not constitute a significant source of primary care for urban Indians. Of the 10 CHCs visited by the OAI team, none had more than an estimated 3 percent Indian patient population. Most CHCs noted that they did not serve any Indians, while others indicated that they had very few. Statistical data on Indian utilization of CHCs are not available since these facilities do not keep records of patients by ethnic identity. The chart in appendix C shows the location and funding of federally-funded CHCs in those cities where there are also UIHP projects.

Community health center directors, staff and others highlighted several reasons why Indians do not use CHC services:

- Indians represent a small percentage of the total population of the communities included in this inspection. In Los Angeles, Indians represented less than 1 percent of metropolitan area residents. In none of the other sites do Indians represent more than 3 percent of the total metropolitan population.
- The CHCs generally tend to serve clearly defined neighborhoods and those individuals living near the facilities. Indians, unlike most other ethnic groups, tend to be scattered throughout metropolitan areas. This limits the potential of CHCs to provide outreach to Indians. In addition, targeting the Indian population would require a formal and structured outreach program--a costly service that most CHCs indicate they cannot afford.
- The CHCs are not free clinics. Most bill for services as aggressively as hospitals and private physicians. The OIG staff was told that while no CHC will refuse service to an indigent client because of inability to pay, Indians, as well as other indigent individuals, are often intimidated or discouraged from seeking CHC services.

A CHC in San Francisco, located near the UIHP clinic, voiced concerns similar to other CHCs. Staff stated that given limited resources and pressing demands, they do not have the capacity to serve an additional population group, whether it be Indians

or others. With additional resources, the center director indicated that this would be possible. The director stressed, however, that even if the staff and budget were increased, the center does not have staff currently trained to appropriately address the health and social needs of Indians.

Public Health Clinics Lack Capacity to Provide Adequate Primary Care to Urban Indians

Public health clinics face problems similar to CHCs in serving Indians. Clinic staff and others report that they have little outreach capacity and find Indians, who do not congregate in easily identified community groups, a difficult population to target. County budgets, like Federal funds, are also shrinking, thereby increasing the budgetary constraints placed on public health centers.

PROGRAM UTILIZATION

Utilization Rates Are Not Fully Accurate

Utilization rates for the UIHP need to be carefully interpreted before they can be fully understood. The IHS utilization rates are based on the 1980 census data. Indian population beyond the census year is projected through linear regression techniques using Indian birth and death data provided by the National Center for Health Statistics.

Census data are the only comprehensive data available. They are subject to data-gathering imperfections, however, as Indians are highly mobile and difficult to track. In addition, using the total number of Indians to calculate utilization disguises the fact that the actual target population is, or should be, indigent, unemployed or marginally-employed Indians who are not covered by health insurance and who have difficulty in gaining access to mainstream health care. The Census Bureau publishes data on Indian population by metropolitan and urbanized areas. These data are broken down to show Indian population in 1979 for all income levels as well as those below the poverty level. The IHS uses the figures for all income levels as its base; however, data for Indians living below the poverty level might be a more accurate base. A table showing these data for several California cities is contained in appendix D.

There are also anomalies in calculating the base rates since some UIHP catchment areas are not synonomous with the census areas. Population figures utilizing Standard Metropolitan Statistical Areas (SMSAs), for example, include multi-county areas which may extend well beyond the UIHP catchment areas. Population figures shown for some areas include Indians living on reservations. Finally, only a fraction of Indians or any other population group will be sick and in need of health services in a given year.

The IHS has been working for several years with the American Indian Health Care Association to improve data gathering and utilization statistics for the program. Much progress has been made, but further improvements would ensure greater accuracy in utilization and other needed data.

What Current Indian Patients Say About Utilization

The OIG inspection team talked to approximately 50 Indians. Interviews were conducted randomly with patients waiting for services at the UIHP projects visited.

Nearly all (46 of the 50) were current users of the Indian health centers. The other four were former patients who accompanied friends to the project. The Seattle Indian Health Board also conducted a survey early in 1987 of 613 patients, 18 years or older, who lived in King County and who had used the Health Board's services within the past 3 years. Finally, analyses of medical records in seven of the nine sites visited provides further indicators of utilization.

Urban Indians Use the UIHP Centers Because They Are Affordable and Accessible

Affordability, presence of qualified "caring" staff and perception of the UIHP as a special place for Indians were the primary reasons given by current patients who utilize the projects.

WHY PATIENTS COME TO UIHP FOR CARE

	Percent OAI Client Sample (N=46)*	Percent Seattle UIHP Sample (N=613)*
Affordability/SlidingFee	30	55
Qualified and "Caring" Staff	24	17
Special Place for Indians	56	28
Friend or Relative Goes There	10	31
Don't Know of Other Programs	2	-
Convenient/Accessible Location	2	9

*The percentages total more than 100 because patients could give more than one response.

Indian UIHP patients interviewed by OIG staff were mostly satisfied with the services. Only seven respondents expressed dissatisfaction. Those who were dissatisfied gave reasons such as "had to travel too far" and "disliked director."

Word-of-Mouth Referrals Are a Key Utilization Factor

Most Indians heard about the UIHP from a friend or relative (39 percent), from "other Indians" or individuals (26 percent) or from a referral from another health center (13 percent). Six percent said they "always knew of the center" and only 2 percent said they became aware of the program from the phone book, newsletters or from former staff members.

Other Sources of Care and Barriers

Respondents were asked what sources of care would be used if the UIHP centers were not available. While many answered they would use private physicians, hospital emergency rooms or other community or public health clinics, the most common answer (36 percent) was that they did not know. When asked what barriers existed at other sources of care, long waits (34 percent) was mentioned most often. Other barriers mentioned included overworked, uncaring staff (15 percent) and "no understanding of Indians."

Many Factors Limit Utilization

Several factors prevent greater utilization of the UIHP centers. The highly mobile and migratory nature of the population makes outreach more difficult and thus decreases utilization. Budgetary and staffing limitations constrain the maximum capacity of many UIHP centers to provide services. In Boston, for example, there are funds to maintain a primary care physician for only 4 hours per week, during

which time no more than 10 to 15 patients are seen. The Boston project does not advertise or employ active outreach for fear that its limited capacity would be overwhelmed. Other UIHP projects curtailed outreach because of similar concerns. Even when the centers operate at full capacity, they reach only a small percentage of the Indian population.

Finally, many Indians return to their reservations for health care. This is particularly true of pregnant women who want to deliver their babies on the reservation or who encountered difficulty in accessing the UIHP or mainstream services.

Utilization Could Be Improved

Many respondents felt that more could be done to improve outreach and utilization rates. The Maternal and Child Health (MCH) and Women and Infant Care (WIC) programs are among the most popular and successful UIHP-operated programs. These are magnet programs which bring in families who then use general medical services. Several projects reported that outreach for these two programs had been cut sharply with adverse effects on general utilization rates. Greater outreach efforts for MCH and WIC would immediately increase utilization. Several UIHP staff reported that word-of-mouth was the most effective means of informing urban Indians about health services. More effective use of Indian organizations, newspapers and powwows would result in increased utilization.

Many of the UIHP projects are housed in run-down facilities in less desirable neighborhoods. Clinic location in the most run-down areas deters many Indians, especially the working poor, from seeking services. In recognition of this factor, several centers have plans to move or to upgrade their present facilities.

Many Non-Indians Use UIHP Centers

The following table shows non-Indian utilization for the 9 sites visited and for the 37 sites funded in 1986. Over one-third of the users of the UIHP program are non-Indian. Nearly one-half of the total UIHP budget comes from sources other than title V. In most sites, those projects where title V is a smaller proportion of the total budget have a higher percentage of non-Indian users. For some, such as Seattle, San Francisco, Phoenix and Los Angeles, title V represents less than one-half of the total project budget. Although some of the non-title V funding is earmarked for Indians, most funding sources do not permit restriction of client populations to a particular ethnic group.

UIHP CLIENT POPULATION

	Indian Users	Non-Indian Users	Percent Non-Indian	Title V Percent of Budget
All 37 UIHP Sites	74,230	43,188	36.8	45.2
Selected sites				
Boston	721	6	.8	100.0
Seattle	5,895	1,431	19.5	48.0
Salt Lake City	2,054	160	7.2	72.8
San Francisco	4,596	5,618	55.0	33.9
Los Angeles	3,968	3,723	48.4	50.1
Phoenix	8,064	88	1.1	38.4
Tucson	893	255	22.2	92.2
Helena	710	220	23.7	75.3
Missoula	586	148	20.2	100.0

Source: Urban Indian Health Program, FY 1986 Charts and Graphs, pages 47-51

Non-Indian patients did not express any concern about using a clinic that was designated Indian. They were attracted by the same considerations as Indian patients, but with slightly different priorities: the low fees that were charged if the patient had no source of third party payment and the accessibility of the UIHP center. Two of the most popular programs, MCH and WIC, were particularly attractive to non-Indian as well as Indian patients.

PROGRAM MANAGEMENT

The Indian Health Service Has Not Managed the Program Adequately

The IHS has not provided resources to properly manage the UIHP. Until recently, there were no full-time staff in IHS headquarters or in the area offices with responsibility for the urban projects. Each area office has its own system for monitoring projects. Some area office staff conduct on-site visits two or three times a year, while others may conduct only one or none. The IHS uses standard procedures for review and approval of contracts, but has no national procedures prepared for specific use in managing the UIHP. Clinical reviews of urban projects have been done on an individual basis, but there is no required schedule or protocol.

Basic Program Planning and Evaluation Is Lacking

The original models for the programs were supposed to be based on locally determined needs. It is not clear to what extent such needs assessments were done during the initial stages of the program. Once the initial allocations were made, however, they frequently became the basis for all subsequent allocations. Variations in funding have not been based on changing needs or on evaluations of effectiveness.

The last national compilation of Indian health needs was conducted in 1976 with the submission of the Indian Health Care Improvement Act. Updated needs assessments have not been required by IHS as a condition of continued funding. Until 1985 there was no uniform statistical reporting for the urban programs to show comparative data on utilization, services provided, sources of funding or expenditures. Although the annual national census data have been useful in aiding the health planning process for urban Indians, these data are inadequate.

One of the few urban Indian needs assessments to be carried out in recent years was conducted in 1986 by the San Francisco UIHP with assistance from the Robert Wood Johnson Foundation. This survey encompassed a 5 percent sample of Indians living in the San Francisco Bay area and represented both users and non-users of the San Francisco UIHP. Findings from this assessment show a disparity between Indian socio-economic status and that of the general population, even for Indians who had lived in the city for many years. The methodology for this Bay Area assessment is available for replication by other UIHP centers.

Inadequate Criteria Exist for Evaluating Information and Referral Services

Information and referral (I & R) was a primary purpose of the UIHP program set forth in the 1976 Indian Health Care Improvement Act. The table in appendix E shows the amount expended for I & R services for each of the nine sites in this inspection and for all sites funded in 1986.

Neither the Act nor IHS guidelines delineate what I & R services should encompass. In some locations, they consist of little more than compiling a directory of health

services that are available in a community and handing this to clients. Other centers provide much more comprehensive services. These include counseling, identification of individual needs and available community resources, help with the preparation of eligibility documents and follow-through.

For this reason, many of the projects have negotiated written agreements with public or private hospitals. These agreements make admission to the hospital (or transfer back to the UIHP center) much easier. Transfer and referral forms sent with the patient include information about current medical findings, diagnosis, rehabilitation potential and pertinent administrative and social information. While the transfer agreements state that the patient is responsible for the payment of hospital bills, written documents simplify the hospital admission process for indigent patients.

Lack of Permanent Legislation Impedes Effectiveness

Lack of permanent legislative authorization since 1984 has impeded effective operation of the UIHP projects. Funding is available only on a year-to-year basis, and funding levels have been uncertain. This impedes program planning, especially for those who have depended on title V monies for most or all of their funding. This has compounded the problems which stem from lack of consistent monitoring by IHS.

Variation Exists in Licensing and Accreditation

There is considerable variation concerning the licensure and accreditation status of the UIHP projects. Those that provide only information and referral are usually located in an Indian multipurpose center and do not need licensing as a health facility. At the other extreme are four centers which meet the exacting standards of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). The remaining centers meet minimal State and local requirements for the licensure of an outpatient health facility.

RECOMMENDATIONS

RECOMMENDATION #1--PROGRAM PLANNING AND MANAGEMENT

FINDING: Uniform national criteria for monitoring projects are lacking, and there is inconsistent management oversight of the UIHP. Budgetary decisions are not necessarily based on documented need or organizational effectiveness. This has resulted in inequitable and fluctuating funding of some projects which hampers their ability to plan or provide consistent levels of service. Furthermore, IHS provides only limited technical assistance to the projects.

RECOMMENDATION: The PHS should strengthen management of the UIHP by (1) implementing a monitoring and evaluation system with uniform national criteria for all area offices, (2) completing an updated standardized national needs assessment (based on a standardized updated needs assessments in each local area) and (3) continuing the effort to improve the collection and dissemination of uniform national aggregate and comparative statistics.

PHS COMMENTS: We concur. The IHS has already taken action to strengthen management by refining the UIHP evaluation criteria which will be included in the IHS manual. These criteria will define the responsibilities of IHS headquarters and area offices regarding monitoring and review of the administrative and clinical components of the health care delivery system.

The IHS has also established a monitoring and evaluation system and has initiated on-site quality assurance program reviews of UIHP clinics. These reviews are using a structured review protocol patterned after that used by the JCAHO.

The IHS expects to complete the development of a standardized national needs assessment in FY 1989. The IHS expects that the standardized needs assessment will be in use for all UIHP clinics by the end of FY 1989.

The IHS has implemented the Urban Common Reporting Requirements (UCRR) and is currently improving the national data by collecting diagnostic and epidemiological data for the UIHP. These efforts will continue.

RECOMMENDATION #2--FUNDING DECISIONS

FINDING: Funding and budgetary decisions are not based on documented need or organizational effectiveness. The UIHP reporting and data system, which is now partially implemented, is not being fully utilized as an accurate base for the equitable distribution of funding among urban Indian projects.

RECOMMENDATION: The PHS should use the needs assessment and evaluation data to decide future funding allocations and individual project level funding. Projects that do not provide essential or cost-effective services should have funds redirected or reprogrammed to areas of greater need.

PHS COMMENTS: We concur. The IHS will initiate shortly a process to document the need for direct services at each current or proposed UIHP clinic. This

assessment of need will include documentation of the availability of health care services from providers not specifically funded to service American Indians and Alaska Natives. Any cost savings will be redirected or reprogrammed to areas of greater need.

RECOMMENDATION #3--INFORMATION AND REFERRAL

FINDING: Criteria concerning adequate information and referral services are lacking.

RECOMMENDATION: The PHS should provide more explicit guidelines concerning what constitutes an adequate information and referral program, including assistance in gaining access to Medicaid and other medical assistance programs and mainstream health providers.

PHS COMMENTS: We concur. The IHS will develop a program guidance reference which details the individual components of adequate information and referral programs. The guidance will include suggested methods for improving access to Medicaid, Medicare, medical assistance and mainstream health providers.

RECOMMENDATION #4--BARRIERS

FINDING: Access to available community health services is limited for Indians who are indigent or who lack health insurance, despite information and referral efforts made by the UIHP. Barriers to care include restricted eligibility and lack of outreach or targeted services.

RECOMMENDATION: The PHS should complete a detailed analysis of the barriers which inhibit Indian access to mainstream health care and develop an action plan to overcome the barriers.

PHS COMMENTS: We concur. The IHS has taken the first step towards the achievement of this objective by commissioning the Arizona access study. This study will determine the size of the urban Indian population in Arizona, barriers to health care and alternate health resource availability. The methodology used in that study will be modified as necessary and implemented nationally in urban areas with a significant Indian population. Based upon those results, further efforts will be undertaken to determine what steps can be taken to reduce the barriers to health care for urban Indians. The IHS expects to complete the analysis in late calendar year 1989.

RECOMMENDATION #5--UIHP AND COMMUNITY HEALTH CONSOLIDATION

FINDING: The UIHP has many similarities to the CHC program. Many UIHP centers, in fact, serve a majority of non-Indian patients. While a few UIHP centers are members of local community health provider consortia, most UIHP centers have few formal or informal ties to other community health or public health programs. Federal technical assistance to UIHP centers on urban health issues has been very limited. The priorities of the Indian Health Service are with Indians living on or near reservations.

RECOMMENDATION: The PHS should:

- move the UIHP from IHS to the Bureau of Health Care Delivery and Assistance (BHCDA) where it could be integrated with the community health services program and other programs providing health care to urban residents or
- develop explicit linkages locally between UIHP clinics and community health centers (CHCs) and nationally between IHS and BHCDA so that the clinics and IHS staff can take full advantage of the urban community health care expertise of the CHCs and the BHCDA.

PHS COMMENTS: We concur with the second option. The IHS will direct the UIHP clinics to develop written memoranda of agreements and referral linkages with the local CHCs to share information, expertise and facilitate patient referral. The IHS will develop a general guideline for a memorandum of agreement for use at the local level between CHCs and UIHPs. The IHS and BHCDA will develop linkages to enable the IHS to benefit from BHCDA's experience in marketing and program development.

Receipts by Source and by Program, FY 1986

APPENDIX A

Program	Section 330	MCH	WIC	IHS Title V	IHS Other	Other Federal	Medicare	Medicaid
ALL PROGRAMS	$1,514,152	$179,181	$839,253	$8,575,619	$1,515,918	$373,784	$127,458	$880,570
Percent	8.0%	.9%	4.4%	45.2%	8.0%	2.0%	.7%	4.6%
Average	$378,538	$89,591	$83,925	$245,018	$216,560	$93,446	$7,966	$48,921
Minimum	$186,459	$62,241	$24,557	$32,946	$3,990	$8,150	$107	$634
Maximum	$807,614	$116,940	$212,807	$1,186,354	$854,000	$261,967	$24,257	$227,193
ABERDEEN AREA								
Omaha				$86,000				
Pierre				$185,600	$12,551			$1,353
ALBUQUERQUE AREA								
Albuquerque			$24,557	$132,000				
Denver				$217,406				
BEMIDJI AREA								
Chicago				$151,125				$6,693
Detroit								
Green Bay				$135,000				
Milwaukee	$807,614	$62,241	$212,807	$465,865	$28,951		$16,611	$110,056
Minneapolis	$269,010			$751,395				
BILLINGS AREA								
Anaconda				$32,946				
Billings				$127,923				
Butte				$41,521				
Great Falls				$112,558				
Helena				$68,446				$5,147
Miles City				$37,791				
Missoula				$64,501				
CALIFORNIA AREA								
Bakersfield				$53,073				
Fresno				$173,510	$854,000		$17,916	$44,814
Los Angeles			$55,228	$565,157			$12,550	$32,889
Sacramento				$258,066			$14,866	$141,557
San Diego				$281,807			$6,406	$12,107
San Francisco		$116,940	$126,518	$414,319			$7,698	$97,589
San Jose			$56,279	$239,800			$1,627	$61,818
Santa Barbara				$236,075				$73,207
OKLAHOMA AREA								
Dallas			$169,940	$475,400		$94,043	$228	$1,872
Oklahoma City				$499,000			$1,772	$634
Tulsa	$186,459		$42,687	$365,468	$3,990	$261,967	$5,368	$13,316
Wichita				$247,610			$523	$25,620
PHOENIX AREA								
Phoenix			$75,648	$136,000	$130,849	$9,624	$941	
Reno				$149,631				
Salt Lake City			$39,810	$185,500				$3,566
PORTLAND AREA								
Portland								
Seattle	$251,069		$35,779	$1,186,354	$281,777		$14,578	$227,193
Spokane				$55,084	$203,800		$2,010	$21,139
TUCSON AREA								
Tucson				$141,020			$107	
USET AREA								
Boston				$138,531				
New York City				$164,138		$8,150	$24,257	

Program	Other 3rd Party Pt. Collections	State	County	City	Other	TOTAL
ALL PROGRAMS	$1,071,184	$1,155,483	$1,269,125	$679,289	$132,594	$682,510	$18,991,445
Percent	5.6%	6.1%	6.7%	3.6%	.7%	3.6%	100.0%
Average	$59,510	$57,774	$84,608	$84,911	$44,198	$31,023	$542,613
Minimum	$115	$300	$6,583	$5,514	$12,607	$296	$34,580
Maximum	$751,585	$373,211	$270,576	$184,823	$95,599	$184,826	$2,631,924
ABERDEEN AREA							
Omaha							$86,000
Pierre		$4,722					$199,551
ALBUQUERQUE AREA							
Albuquerque	$192		$16,420			$29,699	$202,868
Denver				$43,738		$38,012	$299,156
BEMIDJI AREA							
Chicago	$9,904	$13,365				$9,731	$190,817
Detroit							
Green Bay			$73,525	$32,632		$26,886	$268,043
Milwaukee	$751,585	$61,277				$114,917	$2,631,924
Minneapolis		$373,211	$9,179	$184,823	$24,388	$184,826	$1,796,832
BILLINGS AREA							
Anaconda						$1,634	$34,580
Billings							$127,923
Butte						$5,073	$46,594
Great Falls				$5,514		$3,240	$121,312
Helena	$2,761	$1,384				$13,155	$90,893
Miles City						$5,500	$43,291
Missoula							$64,501
CALIFORNIA AREA							
Bakersfield						$812	$53,885
Fresno	$41,264		$199,203	$40,000			$1,370,707
Los Angeles		$93,314	$270,576	$72,676		$25,952	$1,128,342
Sacramento	$46,375	$103,224	$130,732				$694,820
San Diego	$13,744	$19,370	$92,850				$426,284
San Francisco	$86,421	$92,953	$117,084	$120,157		$41,542	$1,221,221
San Jose	$11,320	$32,224	$131,221			$9,827	$544,116
Santa Barbara	$34,399	$148,581	$54,870				$547,132
OKLAHOMA AREA							
Dallas	$5,288	$31,322	$47,000			$49,198	$874,291
Oklahoma City	$3,406	$33,991	$24,925				$563,728
Tulsa	$5,188	$33,435				$23,172	$941,050
Wichita	$2,887	$21,451	$27,000			$53,387	$378,478
PHOENIX AREA							
Phoenix		$300				$296	$353,658
Reno							$149,631
Salt Lake City	$4,311	$21,559					$254,746
PORTLAND AREA							
Portland							
Seattle	$40,227	$56,437	$67,957	$179,749	$95,599	$32,892	$2,469,611
Spokane	$11,796	$6,503	$6,583		$12,607	$7,513	$327,035
TUCSON AREA							
Tucson	$115	$6,860				$5,246	$153,348
USET AREA							
Boston							$138,531
New York City							$196,545

MEDICAL RECORD REVIEW

A total of 186 medical records were reviewed in 7 of the 9 sites visited for this study. Records were selected in such a way as to represent a random sample of both active and inactive cases. There is no uniformity, however, in the kind of information maintained in the records. Some UIHP sites keep records according to the JCAHO standards while other sites keep records in an informal manner more suitable for drop-in clinics. All of the sites maintained intake data showing age, status as Indian or non-Indian and employment and insurance coverage. All records showed each visit made, symptoms presented, treatment given and follow-up or referral recommended.

The following summaries highlight the results of this review.

Race

Ethnicity	Number of Individuals	Percent
Indian	135	72.6
Non-Indian	51	27.4
Asian	5	2.7
Black	6	3.2
Greek	1	0.5
Hispanic	14	7.5
White	7	3.8
Information not available	18	9.7
Total	186	100.0

Residence

Of the 140 individuals in the sample who had information regarding their residence, 127 or 90.7 percent lived in urban areas. Thirteen, or 9.3 percent, were from rural or reservation areas. The remaining 46 individuals did not provide this information.

Employment

Only 32 of the 186 records clearly showed that the patient was employed. For most, the information was not included.

Age

The following table shows a breakdown of the ages of the population sampled.

Age	Number of Individuals	Percent
0-2	20	11.5
3-5	13	7.5
6-18	22	12.6
19-55	105	60.3
56+	14	8.1
Total	174	100.0

The date of birth for 12 individuals was missing.

Total Visits and Utilization

The following tables describe the number of visits each person made to the UIHP and the number of years they had used the facility.

The total number of visits per individual ranged from 1 to 75 visits.

Number of Visits	Number of Individuals	Percent
1	66	36.9
2-3	44	24.6
5-20	58	32.4
21+	11	6.1
Total	179	100.0

The information for seven individuals was not available.

Number of Years	Number of Individuals	Percent
1	135	78.0
2-3	18	10.4
4-10	9	5.2
11+	11	6.4
Total	173	100.0

The information for 13 individuals was not available.

Insurance

The following is the breakdown of the insurance, or lack thereof, that these individuals possess.

Insurance	Number of Individuals	Percent
Welfare	1	0.5
SSI	1	0.5
IHS/reservation	6	3.2
Medicaid	26	14.0
Medicare	14	7.5
Other/private	10	5.4
None	53	28.5
No information available	75	40.3
Total	186	99.9

COMMUNITY HEALTH CENTERS

APPENDIX C

	UIHP Projects	UIHP Direct Services	UIHP Title V	CHCs # Clinics	CHCs Section 330
AZ	Phoenix	Limited	$ 136,000	2	$ 1,576,421
	Tucson	I & R	$ 141,020	1	$ 3,154,052
CA	Bakersfield	I & R	$ 53,073	1	$ 1,651,328
	Fresno	Full	$ 173,510	1	$ 508,000
	Los Angeles	Limited	$ 565,157	5	$ 8,294,024
	Sacramento	Full	$ 258,066	0	-0-
	San Diego	Full	$ 281,807	2	$ 2,491,683
	San Francisco	Full	$ 414,319	3	$ 6,687,838
	San Jose	Full	$ 239,800	1	$ 1,415,904
	Santa Barbara	I & R; Dental	$ 236,075	0	-0-
CO	Denver	Limited	$ 217,406	1	$ 7,455,742
IL	Chicago	Limited	$ 151,125	4	$ 7,131,337
KS	Wichita	Full	$ 247,610	1	$ 221,977
MA	Boston	Limited	$ 138,531	6	$ 3,308,340
MI	Detroit	*	*	2	$ 1,557,012
MN	Minneapolis	Full	$ 751,395	1	$ 255,694
MT	Anaconda		$ 32,946		-0-
	Billings	Limited	$ 127,923	1	$ 256,200
	Butte	I & R	$ 41,521	1	$ 175,450
	Great Falls	I & R	$ 112,558	0	-0-
	Helena	Limited	$ 68,446	0	-0-
	Miles City		$ 37,791		-0-
	Missoula	I & R	$ 64,501	0	-0-
NB	Omaha	Full	$ 86,000	1	$ 328,719
NM	Albuquerque	Limited	$ 132,000	1	$ 2,293,194
NV	Reno	I & R	$ 149,631	0	-0-
NY	New York City	I & R	$ 164,138	18	$16,750,000
OK	Oklahoma City	Full	$ 499,000	1	$ 1,038,898
	Tulsa	Full	$ 365,468	1	$ 1,768,838
OR	Portland	Limited	*	1	$ 2,697,000
SD	Pierre	Full	$ 185,000	1	$ 100,000
TX	Dallas	Full	$ 475,400	2	$ 2,031,879
UT	Salt Lake City	Limited	$ 185,500	1	$ 1,030,000
WA	Seattle	Full	$1,186,354	3	$ 3,100,000
	Spokane	Full	$ 55,084	1	$ 65,000
WI	Green Bay	I & R	$ 135,000	0	-0-
	Milwaukee	Full	$ 465,865	3	$ 1,468,143

* Data unavailable.

Indian Population Below Poverty Level

The Census Bureau publishes data on Indian population by metropolitan and "urbanized" areas. These data are broken down to show Indian population in 1979 for all income levels as well as for Indians below the poverty level. The IHS uses the figures for all income levels as the base for its projections of current year Indian population in UIHP cities. These data, in turn, are used to calculate utilization rates.

The following table shows the Indian population for 1979 for all income levels and for those below the poverty level for several California cities:

City	1979 Indian Population	
	All Income Levels	Income Below Poverty Level
San Francisco	35,946	5,225
San Jose	9,728	1,080
Los Angeles	53,581	9,101
Sacramento	12,407	2,797
Santa Barbara	3,065	359

SOURCE: Bureau of the Census, 1980 General Social and Economic Characteristics, California, p. 543. The 1980 Census asked about 1979 income.

Indian population below the poverty line might provide a more realistic basis for projecting current Indian target population.

Community Penetration

Community penetration examines to what extent the Indian community, based on IHS population projections, is utilizing the project. The IHS population projections are based upon county Indian population census data, except in the case of Anaconda, Butte, Pierre, Missoula, Miles City, Fresno and Helena, where they are based upon a smaller subdivision. The IHS population projections for the urban areas may, in some cases, include reservation populations.

The following table presents the Indian census compared to Indian users by program for FY 1986.

The Indian census data was provided by the Indian Health Service.

Indian Census Compared to Indian Users by Program, FY 1986

Program	Indian Users/Census
ALL PROGRAMS	17.4%
Average	61.7%
Minimum	1.8%
Maximum	717.3%
ABERDEEN AREA	
Omaha	83.8%
Pierre	717.3%
ALBUQUERQUE AREA	
Albuquerque	7.4%
Denver	10.3%
BEMIDJI AREA	
Chicago	11.6%
Detroit	-
Green Bay	37.1%
Milwaukee	38.2%
Minneapolis	21.8%
BILLINGS AREA	
Anaconda	136.5%
Billings	46.0%
Butte	62.8%
Great Falls	34.8%
Helena	165.5%
Miles City	271.6%
Missoula	95.4%
CALIFORNIA AREA	
Bakersfield	7.1%
Fresno	25.5%
Los Angeles	7.6%
Sacramento	5.9%
San Diego	2.9%
San Francisco	23.1%
San Jose	7.1%
Santa Barbara	54.8%
OKLAHOMA AREA	
Dallas	22.0%
Oklahoma City	18.7%
Tulsa	8.2%
Wichita	30.6%
PHOENIX AREA	
Phoenix	29.8%
Reno	42.1%
Salt Lake City	27.4%
PORTLAND AREA	
Portland	-
Seattle	32.0%
Spokane	48.0%
TUCSON AREA	
Tucson	5.1%
USET AREA	
Boston	19.7%
New York City	1.8%

APPENDIX E

I & R VERSUS DIRECT HEALTH COSTS

	Dollars Expended		
	Direct Care[1]	I & R[2]	% I & R
Boston	43,111	68,373	61.0
Seattle	2,560,437	168,348	6.0
Salt Lake City	165,965	26,975	14.0
Helena	72,112	20,140	22.0
Tucson	111,562	56,881	34.0
Phoenix[3]	122,234	230,148	65.0
Los Angeles	935,480	232,460	20.0
San Francisco	1,356,505	103,511	7.0
Missoula	12,332	56,526	82.0
Total--Nine Sites	5,379,738	963,362	15.2
Total--All Sites	13,356,987	4,570,759	25.0

[1] Includes all expenditures other than I & R
[2] Includes all community and health education costs
[3] Excludes direct care from Phoenix IHS Hospital

SOURCE: Urban Indian Health Program, FY 1986 Charts and Graphs, American Indian Health Care Association, Minneapolis, 1987