NATIONAL COUNCIL *of*
URBAN INDIAN HEALTH

2023

Annual

POLICY ASSESSMENT

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2023 ANNUAL POLICY ASSESSMENT

Overview

The National Council of Urban Indian Health (NCUIH) hosted five focus groups to identify Urban Indian Organization (UIO) policy priorities for 2024 as they relate to Indian Health Service (IHS)-designated facility types (Full Ambulatory, Limited Ambulatory, Outreach and Referral, and Outpatient and Residential Alcohol and Substance Abuse Treatment). NCUIH hosted five focus groups on October 3, 4, and 5, 2023. NCUIH also collected information on policy priorities from UIOs through a written questionnaire sent out via email to all 41 UIO leaders. The 41 UIOs NCUIH represents have different priorities depending on their facility type, services offered, and the needs of the community they serve. During the focus groups, as well as in the written questionnaire, UIO leaders had the opportunity to share their opinions on the successes and challenges they experienced in 2023 and provide input on the policy areas where they would like to see the greatest policy support from NCUIH. The goal of the assessment was to provide NCUIH with necessary first-hand information from UIOs to support the identification of policy priorities for UIOs in 2024. The top 2024 priorities for UIOs are stable funding for the Indian Health Service (IHS), addressing workforce shortages, and support for traditional healing services.

NCUIH has conducted focus groups for four consecutive years to collect the information required to accurately reflect the needs of UIOs in NCUIH policy and advocacy efforts. Since launching the annual focus groups and assessment, there have been tremendous strides for urban Indian health policy. For data from last year, please view the 2022 Policy Assessment and the 2023 Policy Priorities.

Objective

This assessment aims to identify and analyze the policy needs and priorities of UIOs for the upcoming year and develop a comprehensive advocacy strategy for engaging, educating, and informing UIOs, their invested partners, and the necessary government entities.

FOCUS GROUP AND QUESTIONNAIRE PARTICIPANTS (UIOS)

Total Participants: 18/41 UIOs

Full Ambulatory (11/23 UIOs)

- American Indian Health & Services (Santa Barbara, CA)
- Hunter Health (Wichita, KS)
- Indian Health Care Resource Center of Tulsa (Tulsa, OK)
- Indian Health Center of Santa Clara Valley (San Jose, CA)
- NARA NW (Portland, OR)
- Native Americans for Community Action (Flagstaff, AZ)
- NATIVE Health (Phoenix, AZ)
- The NATIVE Project (Spokane, WA)
- Oklahoma City Indian Clinic (Oklahoma, OK)
- San Diego American Indian Health Center (San Diego, CA)
- Seattle Indian Health Board (Seattle, WA)

Limited Ambulatory (2/6 UIOs)

- United American Indian Involvement, Inc. (Los Angeles, CA)
- Urban Indian Center of Salt Lake City (Salt Lake City, UT)

Outreach and Referral (4/6 UIOs)

- Bakersfield American Indian Health Project (Bakersfield, CA)
- Fresno American Indian Health Project (Fresno, CA)
- Native American LifeLines of Baltimore (Baltimore, MD)
- Native American LifeLines of Boston (Boston, MA)

Outpatient and Residential (1/ 6 UIOs)

- Kansas City Indian Center (Kansas City, MO)

PART 1. KEY FINDINGS FROM FOCUS GROUP DISCUSSIONS AND QUESTIONNAIRE

This section identifies key findings from the focus group discussions and questionnaire. NCUIH intends to use these findings in tandem with information gathered throughout the past year from discussions with UIO leaders to identify policy priorities and policy strategies to support these priorities in 2024.

Monetary Cuts to the Indian Health Service Would Have Catastrophic Impacts on Urban Indian Organizations

Similar to the 2021 and 2022 Policy Assessment,[1] increasing funding for IHS and the Urban Indian line item remains a top priority for UIOs.[2] IHS is historically both under-resourced and underfunded. For example, the National Tribal Budget Formulation Workgroup (NTBFW), a national workgroup of Tribal leaders that identifies annual Tribal funding priorities for IHS, stated it would require $50.1 billion to fully fund IHS, and $973.59 million for urban Indian health in FY24.[2] However, in FY23, Congress funded the IHS at $6.96 billion, and urban Indian health at $90.41 million.[3] As medical inflation rates continue to rise, IHS and urban Indian health must continue to receive stable funding levels and work to increase funding to the rates requested by the NTBFW. [4] Ensuring that funding consistently adjusts to account for medical inflation and working closer to the funding level of need identified by the NTBFW is essential to ensuring that UIOs can adequately address and adapt to the needs of their communities.

[1] National Council of Urban Indian Health, *2022 Annual Policy Assessment: Setting Policy Priorities for 2023, (*March 6, 2022), Policy-Assessment-22_NCUIH_D284_V6.pdf
[2] *National Indian Health Board. FY 2024 Tribal Budget Formulation Workgroup Recommendations.* (May, 2022) FY 2024 Tribal Budget Formulation Workgroup Recommendations.pdf (nihb.org)
[3] Consolidated Appropriations Act of 2023, Pub. L. No. 117-328 (2022) https://www.congress.gov/bill/117th-congress/house-bill/2617/text.
[4] United States Bureau of Labor Statistics. Consumer Price Index. How BLS Measures Price Change for Medical Care Services in the Consumer Price Index: U.S. Bureau of Labor Statistics

The end of the COVID-19 Public Health Emergency (PHE) has further highlighted the need for stable and consistent funding. During the height of the COVID-19 PHE, Congress passed a series of bipartisan relief bills that provided UIOs with additional monetary support.[5] These funds allowed them to advance existing programs, invest in infrastructure needs, establish mobile clinics, expand dental healthcare, and engage in additional outreach efforts. One UIO shared that increased funding from COVID-19 relief allowed them to onboard "higher quality staff" and double the size of their workforce. With the end of the PHE, many of these funding sources have expired, and UIOs must find other funding sources to sustain program advancements made with COVID-19 funding assistance.

As unused COVID-19 supplemental funding was being rescinded, UIOs were asked about what impacts there would be to services if Congress were to cut funding. One UIO shared that any funding below the level provided with the COVID supplemental funding would mean "rationing care. And delayed care is denied care." Funding reductions have already negatively affected their ability to afford vaccines, delayed care, and reduced capacity to address the growing need of behavioral health. Regarding the COVID-19 funding, a full ambulatory UIO stated, "The COVID funding is not sustainable, yet the issues are still here. If you look at behavioral health the need has tripled because people are going through depression, anxiety." One outreach and referral UIO stated that cuts from Congress "would be detrimental because we are already underfunded. Personnel is always the most expensive, and any cut would reduce our ability to serve." Another full ambulatory UIO highlighted that cuts would "mean lost staff because of the increase in salaries around us, it is hard enough to recruit and retain in this market. We would also have to cut ancillary services." Specifically, since the end of the PHE one full ambulatory UIO stated, "We have to pay for the vaccines, it is not cheap and for our patients and our community in particular because we were able to give it to them first without cost and they are expecting the same. That increased cost is significant. Those new additional costs as well in addition to labor and operation." One full ambulatory UIO cited that "post-COVID" referrals can take 6 to 8 months, so they are compensating by trying to do more at their clinics to avoid having to do referrals out for long wait times. If that funding is reduced, then "everything's going to become a referral and that is delayed care." Essentially, "to be given less funding is an insult to our clients." Stable funding is necessary for UIOs to be able to maintain and expand services to meet the needs of their patients.

[5] Government Accountability Office, Indian Health Service: Relief Funding and Agency Response to COVID-19 Pandemic, Mar. 31, 2023, available at: https://www.gao.gov/assets/gao-22-104360.pdf

UIOs Face Workforce Recruitment and Retention Concerns in the Competitive Job Market

UIOs continue to face challenges maintaining a culturally competent and skilled workforce as they experience many barriers to remaining competitive in the current job market. Without future investments in workforce development, UIOs will struggle to increase salaries to compete with other employers amidst inflation and rising cost-of-living. One UIO shared that due to high cost-of-living and lack of affordable housing some staff must travel up to two hours to get to work and others live in their cars. Additionally, many full ambulatory UIOs expressed difficulty in recruiting and retaining behavioral health staff, despite the growing need for these services. They shared that following the end of the PHE, many behavioral health workers want to continue to work remotely, while many UIO patients prefer in-person services, adding an additional barrier to recruitment. One outreach and referral UIO noted the issue with non-culturally competent providers and differences in maintaining competitive benefits by state: "We have applicants who are qualified, but they view Natives as mystical beings. They have all these ideas about how they will fix the community. So having non-Natives and people who are unwilling to listen to the needs of the community, makes it very difficult. [U.S. city] also has so many hybrid jobs, but that doesn't really fit our needs. We can't have people remote. We also have a cost-of-living issue. In [U.S. state] it is required to provide a fertility plan, but our home base in [different U.S. state] doesn't require that. So we are having to adjust to meet these requirements."

To help fill workforce gaps, UIOs can utilize federally supported workforce programs like the IHS and Health Resources and Services Administration (HRSA)'s loan repayment and scholarship programs. Unfortunately, several UIOs report difficulty leveraging HRSA scholarship and loan repayment programs due to lower than appropriate Health Professional Shortage Area (HPSA) scores. HRSA scholarship and loan repayment programs require eligible practitioners to serve at approved sites in a Health Professional Shortage Area (HPSA) above a certain minimum score.[6] Unfortunately, UIOs generally receive lower HPSA scores than appropriate because HRSA calculates the score based off general data, rather than data specific to the Indian healthcare system. One UIO shared that it has been difficult to work with their state primary care office and HRSA to get their HPSA scores updated, and to obtain staff through the program due to delayed response times. While several UIOs have reported challenges with HPSA scoring, one UIO reported that they have seen success with their HPSA scoring, allowing them to receive funding through HRSA to hire Native pediatricians and a general practitioner.

[6] HRSA, *Review Site HPSA Score and Job Search Requirements for the NHSC Students to Service Loan Repayment Program*, available at: https://nhsc.hrsa.gov/loan-repayment/s2s/service-requirements/jobs-and-site-search (last accessed Nov. 11, 2023).

Increased Funding for Traditional Healing is Crucial to Advance Comprehensive Healthcare for UIO Patients

UIOs emphasized that traditional healing is necessary to provide comprehensive healthcare to their patients, and consistent funding to support these services is essential. UIOs fill a gap in care for many Native living in urban areas by providing culturally sensitive and community-focused care options. UIOs "are an important support to Native families and individuals seeking to maintain their values and ties with each other and with their culture," which exist to provide "a wide range of culturally sensitive programs to a diverse clientele."[7] For many UIOs, traditional healing services are not stand-alone programs, but integrated into all aspects of care by a staff member trained in traditional healing. Common activities for traditional healing discussed in our focus groups were talking circles, smudging, sweat lodge ceremonies, drum making, indigenized substance use recovery programs, and traditional food and diet programs.

Unfortunately, UIOs are often limited in their ability to use federal dollars to support traditional healing especially because Medicaid, the Children's Health Insurance Program and Medicare do not adequately cover traditional healing services.[8] As a result, to support these services, UIOs must rely on other limited and inconsistent sources of funding, such as funding from private foundations, state and local government grants, donations, as well as non-monetary resources from community partners. Beyond funding, UIOs face other barriers to traditional healing, for example, one UIO described that their local city was requiring their sweat lodge to go through some "red tape" due to the city government denying permits to practice the full extent of the ceremony.

[7] Nat'l Urban Indian Family Coalition, Urban Indian America: The Status of American Indian & Alaska Native Children & Families Today 12 (2008). https://assets.aecf.org/m/resourcedoc/AECF-UrbanIndianAmerica-2008-Full.pdf.

[8] *See* Medicaid and CHIP Payment and Access Commission, Issue Brief: Medicaid's Role in Health Care for American Indians and Alaska Natives, (Feb. 2021), https://www.macpac.gov/wp-content/uploads/2021/02/Medicaids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf (stating that "Researchers, advocates, and state and federal officials have also called for Medicaid to improve its ability to provide culturally competent services to AIAN beneficiaries . . . Even so, traditional healing services are not a Medicaid covered service.").

Clear Need to Increase Resources to Address Food Insecurity

UIOs have expressed the need for additional support and funding to address food insecurity in the urban American Indian and Alaska Native populations they serve. Many UIOs operate programs to address food security and nutrition, such as food banks and meal services, community gardens, and cultural cooking and nutrition classes. UIOs incorporate cultural knowledge into their offerings to support efforts to reinvigorate traditional practices in healthy eating and physical activity. UIOs shared that in response to needs that arose during the COVID-19 pandemic, they developed and expanded food distribution services and food pantries. One UIO shared that during the height of the pandemic, a survey reflected that their clients "…were more afraid of going hungry than getting COVID." Despite these programs and services, UIOs do not have enough funding to improve or expand these services to promote equitable access to food security programs to address the disproportionately high rates of food insecurity and associated diseases in urban American Indian and Alaska Native populations. Additionally, UIOs described the need for federal funding and programs to be less restrictive to allow for UIOs to receive and distribute food.

Housing Insecurity Impacts Staff and Patients at UIOs

At least three UIOs felt that housing should be top priority when advocating to Congress. Since 2015, there has been a 30 percent increase in homelessness and a 61 percent increase in unsheltered homelessness for American Indian and Alaska Native people, and urban American Indian and Alaska Native people are not exempt.[9] Based on UIO feedback, housing challenges are particularly worse in California, Oregon, and Washington where 32% of UIOs (13 UIOs) are located. UIO leaders shared that patients are struggling to find stable housing, and that housing insecurity is the worst with their patients facing behavioral health issues. One UIO noted that housing support is being increasingly requested of them by their patients, even though it is outside their scope of practice. UIOs are struggling to help address this issue with limited resources and funding. While they have been able to provide temporary housing support, such as renting hotel rooms to avoid homelessness, their ability to support access to safe, sustainable housing is limited.

These issues are not only affecting UIO patients, but also UIO staff. Given the inherent higher cost-of-living in cities and the barriers for UIOs to provide competitive salaries, UIO staff are also facing issues of lack of affordable housing. One full ambulatory UIO noted that staff are moving farther from the UIO itself, with staff taking-on hours-long commutes to access affordable housing elsewhere.

[9] State of Homelessness: 2023 Edition, NATIONAL ALLIANCE TO END HOMELESSNESS, https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness/ (last visited Dec 11, 2023).

Health Information Technology and Electronic Health Record Modernization Implementation Must Include Technical Assistance for UIOs

While UIOs are encouraged by the IHS' Health Information Technology (HIT) Modernization process, UIOs emphasized that IHS must continue to be transparent in this long-term, financially significant project and ensure communication and collaboration between the entire IHS/Tribal/Urban ("I/T/U") system.

The I/T/U system's primary HIT system, the Resource and Patient Management System (RPMS), has been in use for nearly 40 years and has developed significant issues and deficiencies during this time, which has severely limited the ability of UIO providers to exchange information in an efficient and seamless manner. Because of these issues, and because HIT is so critical to the modern provision of healthcare services, many UIOs have spent significant amounts of money to better serve their patient populations by purchasing commercial-off-the-shelf (COTS) electronic health record (EHR) systems. Unfortunately, this means that UIOs have had to divert significant funding that could have been spent on other aspects of care to replace a system which it is the federal government's responsibility to provide and maintain.

Many UIOs expressed concerns relating to the availability of technical assistance during the new IHS' EHR system rollout, costs related to the transition away from RPMS and staffing, and the rollout schedule. According to several UIO leaders, their facilities are often the last to receive assistance from IHS with IT issues. UIOs have expressed that because they are not viewed as federal facilities, despite being an equal partner in the I/T/U system, their IT needs are often last to be addressed. This is especially true with respect to RPMS; many UIOs feel that they do not receive the training or support required to properly understand, implement, and operate the system. For example, a UIO recently informed NCUIH that, due to its RPMS not functioning and lack of support from its area office, it was forced to hand count its data to meet the Government Performance and Results Act (GPRA) and Health Center Program Uniform Data System (UDS) reporting requirements. The UIO was also forced to hire an IT consultant, a costly and avoidable expense. Without timely HIT modernization and maintenance of I/T/U HIT systems at the highest level, American Indian and Alaska Native healthcare will be greatly affected.

More Federal Resources for UIOs are Necessary to Address Murdered and Missing Indigenous Persons

Addressing issues relating to Missing and Murdered Indigenous People (MMIP) remains a top priority for UIOs. MMIP, also referred to as "Missing & Murdered Indigenous Women (MMIW)," "Missing & Murdered Indigenous Women & Girls (MMIWG)," and "Missing & Murdered Indigenous Women, Girls, & Two Spirits (MMIWG2S)," is a crisis that refers to the disproportionate amount of violence and abuse that occurs to Indigenous people in the United States. Unfortunately, urban American Indians and Alaska Natives generally do not have access to many federal programs and resources specifically designed to prevent violent crime against American Indians and Alaska Natives, as well as those programs and resources intended to assist victims of crime. This is deeply concerning as the Congressional Research Service has found that "the majority of missing and unidentified cases involving AI/AN persons occur off tribal land. In addition, the majority of NCMEC [National Center for Missing & Exploited Children] cases involving AI/AN children occurred outside of tribal lands."[10] The Congressional Research Service further found that "[g]iven that most Native Americans reside outside of tribal lands, it is likely that a considerable percentage of violent victimizations of people were also occurring off tribal lands."[11]

Several UIOs are already important partners in combatting crime and addressing violence prevention in urban Native communities. For example, one UIO works with the Department of Justice to be a liaison with law enforcement for any local missing Native person, as well as provides behavioral health services. Another full ambulatory UIO has supported trafficked individuals who are living at fraudulent substance abuse treatment centers by building a coalition to address and raise awareness of the issue. However, UIOs need more support and resources from the federal government to be able to expand their services to fully serve those American Indian and Alaska Native people living in urban areas who are impacted by the MMIP crisis.

[10] Congressional Research Service, *Missing and Murdered Indigenous People (MMIP): Overview of Recent Research, Legislation, and Selected Issues for Congress* 17 (Jan. 10, 2022).
[11] *Id.*

Critical HIV Prevention Funding and Treatment Resources Remain a Priority

UIOs are an important connection in testing and referral to appropriate HIV/AIDS care, and a lack of funding towards UIO services threatens the health of urban Natives. In terms of funding, UIOs report that the grants available have diminished over the past few years, despite the need for expanded treatment and testing. While UIOs have made significant strides in tackling HIV /AIDS, they require more funding to procure the additional resources necessary to fully address this issue within their American Indian and Alaska Native communities. HIV funding is being threatened due to political disputes. FY24 Congressional proposals could cut nearly $500 million across multiple programs, such as $238.5 million from the Ryan White HIV/AIDS Program, $226 million from the National Center for HIV, Viral Hepatitis, STD and TB Prevention at the Centers for Disease Control and Prevention, and $32 million from the Minority HIV/AIDS Fund.[12] Many UIOs receive funding through these programs and would be greatly impacted by any loss in funding, and thus affecting health equity for urban Natives.

Additionally, American Indian and Alaska Native people have the highest rate of undiagnosed HIV cases compared to other racial/ethnic groups in the U.S[13], and according to IHS, as many as 34% of the American Indian and Alaska Native people living with HIV infection do not know it.[14,15] UIOs work to fill in this awareness gap as they recognize that testing for HIV is not a priority for most patients, as many do not understand their risk. Despite a lack of consistent funding, UIOs are working hard to provide access to testing at their organizations or through health department partnerships. Other barriers to HIV prevention described by UIOs were concerns over data collection of American Indian and Alaska Native incidence and prevalence of HIV, access to counseling, and culturally competent messaging. One UIO is working to develop culturally appropriate materials through their Tribal epidemiology center to emphasize to their patients the importance of testing. UIOs are also working to address the stigma surrounding HIV through events like an HIV vigil or 5ks in order raise awareness.

PART 2. NEXT STEPS

NCUIH is using the information and context obtained from the assessment process to create an advocacy strategy to include federal and congressional policy priorities for 2024, design handouts and other informational resources for the identified issues and inform relevant agencies and Congress about the major issues impacting UIOs.

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[12] Warren, G., *Proposed Cuts to HIV Programs Would Make Ending HIV Epidemic More Difficult*, AIDS UNITED (2023), https://aidsunited.org/proposed-cuts-to-hiv-programs-would-make-ending-hiv-epidemic-more-difficult/ (last visited Dec 11, 2023).
[13] *IHS Awards New Cooperative Agreements for Ending the HIV and HCV Epidemics in Indian Country*. (2022, September 27). Retrieved January 5, 2023, from https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/HIV-Funding-PressRelease09272022.pdf
[14] Indian Health Service, HIV/AIDS in American Indian and Alaska Native Communities. Retrieved August 8, 2023, from: https://www.ihs.gov/hivaids/hivaian/#:~:text=The%20IHS%20National%20HIV%2FAIDS,Get%20tested%20for%20HIV.
[15] Centers for Disease Control and Prevention. (2019, March 21). *Vital signs: HIV transmission along the continuum of care - United States, 2016*. Morbidity and Mortality Weekly Report (MMWR). Retrieved January 5, 2023, from https://www.cdc.gov/mmwr/volumes/68/wr/mm6811e1.htm?s_cid=mm6811e1_w

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