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UIHI Newsletter

UIHI is a division of
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Special Interest Articles:

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Director's Report

Like many of you, I recently returned from Washington D.C. where I met with members of Congress. I also took the opportunity to meet with other health care groups to get a sense of direction and to help me decide how to position my organization to fit into the national themes that will drive health care resources. What I discovered, as I am sure did many of you, the trends are disturbing.

For those of you who provide direct health care, the Medicaid debate is of enormous importance. Here at the SIHB, 45% of our medical revenues and 30% of our dental revenues come from Medicaid. The President has asked the Congress for a \$14 billion cut to the Medicaid program. If enacted, state legislatures will be forced to cut programs, tighten eligibility standards, and/or impose cost-sharing. These solutions will decrease access for clients and reduce revenues for our agencies.

Themes that came through loud and clear were such buzz words as "accountability, efficiency and quality improvement". This latter subject I know something about as I sit on the Board of Qualis Health, a Medicare sponsored Quality Improvement Organization or QIO. The malpractice debate and a recent NIH report on medical errors are driving this initiative. It is believed that enormous resources will be directed at quality improvement initiatives if, for no

other reason, than to quell public sentiment.

There is also a strong push for electronic medical records with little consideration for privacy protections or the enormous cost of installing and maintaining these systems. As we talk about "data", the use of an ASP centralized option may be something to consider.

A bright spot is the continuing support for the Community Health Center program. The President wants to put a community health center in every poor county in the nation. I think we should help him. But are our programs ready to take on such a challenge. Is there sufficient infrastructure and professional expertise for urban Indian communities to take advantage of this opportunity? As some of your colleagues are finding, this is not an easy undertaking. But if we are to reverse the untenable health conditions faced by urban Indians, it is time we had this conversation.

Health disparities continue to spark headlines in both the public and private health care arena. While in DC, I attended a news briefing announcing a special edition of the health policy publication Health Affairs dedicated to health disparities. This publication was a collaboration of the Robert Wood

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Come Travel with Us

The Urban Indian Health Institute was able to participate in providing diabetes technical assistance meeting/training held in Fairmont, Montana February 8-9, 2005. Mr. Moke Eaglefeathers hosted the event for all urban programs. If you weren't able to join us we invite you now to travel with us to revisit the meeting/training in Montana.

The IHS Urban Indian Health Programs' Diabetes Workgroup announced on December 15, 2004 the reporting requirements for all urban diabetes programs. It is the sincere intent of urban leaders that all urban programs be included as we make the turn into the world of data gathering and reporting. The reporting requirements include:

1. The National Diabetes Program's Clinical and Non-Clinical Audit Tool be utilized as a standardized tool to document and report all urban diabetes program services.
2. Standardization of information required for patient placement on the Diabetes Registry
3. The Integrated Diabetes Education and Care Recognition Program (approved by the Centers for Medicare and Medicaid Services as a national accreditation program) be used as the "guide" to build diabetes (Developmental, Educational and Integrated) programs and would allow for seeking Medicare reimbursement of their diabetes self-management education and allows you to build program success by using a three-stage approach and to measure your program success against nationally accepted standards.

So we started our travels in the east (east of Seattle that is) toward Montana to start the journey down data row.

The meeting opened with a traditional prayer by Moke Eaglefeathers and Logan Curly followed by updates from the attending programs. Lot's of fun things are happening in Urban Indian country!! Then it was time to sit back and enjoy the festivities by providing the first of many slide shows offered by the UIHI to encourage folks to Jump on Board with data gathering. We even played the song "Jump" for My Love by the Pointer Sisters so folks knew we meant business. Next time we'll be using a better sound system. The one we had failed us, so the diabetes training specialist had to sing the song to encourage folks to Jump on Board (not Emmy worthy), but don't tell her.

You may be asking yourself by now what's so interesting about gathering data? Information and collected data about Urban Indians with diabetes can tell the story of the Urban American Indian Alaska Native population experiencing diabetes. The story will unfold the facts about the enormous need that exists for Native Americans with diabetes in an urban setting. The facts will be supported by the data and the data is what Congress asks for when considering funding. So when the reporting requirements were announced by the DM Workgroup the UIHI committed to

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Nearly 70% of American Indians and Alaska Natives Reside in Urban Areas.

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Come Travel with Us (Continued)

provide technical assistance for the urban diabetes programs wanting assistance. The UIHI is flexible in working with urban programs in that you and your diabetes staff will be in the driver's seat. The UIHI will guide the technical assistance to meet the needs of individual programs.

As we round the bend in our travels, keep in mind that we are all reaching for the same goal; Improving the health and wellbeing for all Native Americans.

Listed are some of the technical assistance services that are available upon request for all urban diabetes programs. The UIHI is flexible, so if you don't see anything that's helpful call us and we'll tailor the technical assistance according to your needs.

Guiding programs through the Diabetes Education Recognition process

- Assist with formulating policies and procedures that illustrate the services that individual programs uniquely offer to their diabetes patients
- Identify qualitative measures necessary for gathering

information you can report about your population

- Assist Non-clinical settings meet the Clinical Minimum Standards of Care for their diabetes population while maintaining their non-clinical activities
- Assist Clinical settings needing to track their Non-clinical services while maintaining their clinical activities
- Provide tools for tracking diabetes non-clinical services
- Provide tools for tracking patient outcomes
- Provide tools for tracking program outcomes
- Training workshops for data gathering

For more information please contact UIHI at info@uihi.org or call us at (206) 812-3030 and ask for Susan. She is the diabetes training specialist that will Jump on Board with you!

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Director's Report (continued)

Johnson Foundation, the W. K. Kellogg Foundation, the Henry J. Kaiser Family Foundation, and Aetna Insurance. Health policy staffs from Senators Bill Frist and Edward Kennedy's office were on the panel. Not surprisingly, their goals were the same but their methods for achieving these goals were very different.

I did not sense a great interest in Indian health with a few exceptions. I had the great pleasure of talking with Bruce Lesley who works for Senator Jeff Bingaman (D-NM). I have been talking with Bruce for some time about the financial crisis being faced by the Albuquerque Indian Health Center. This is not the First Nations, Title V program, this is the IHS service unit for the surrounding pueblos. They are experiencing a \$5 million hole in their budget, and Senator Bingaman cannot seem to find any help.

Last year, Senator Bingaman introduced, once again, a bill to make urban Indian health programs eligible for the 100% FMAP. The bill died in the last Congress, but the Senator plans to try it again. Through Bruce, the Senator also recognizes the severe disparities among urban Indians. A champion for health care for the poor and a defender of Medicaid (Smith-Bingaman Amendment), we are working on language to try and shore up improved authorizations for urban Indians. Draft language was floated, I understand, at the NCUIH conference. This was not intended as a real draft; Bruce was floating some ideas on paper. We are hoping to have a real draft by summer.

I believe that in chaos there is opportunity. The urban Indian health program in the IHS has an enormous opportunity to demonstrate our value by establishing standards and crafting data collection techniques that will address national priorities and reinforce our need for new resources. Issues such as quality improvement have not been defined at this point. Health disparities likewise lack a level of specificity that will permit us to measure changes in health status. Given the lack of standards, we have an opportunity to adopt standards

for ourselves rather than trying to meet someone else's ideals.

The UIHI can play an important role in helping us achieve these standards. We can capture data, share issues and concerns, monitor change, and set quality standards that are culturally appropriate and achievable. Our network is large enough to provide scientifically-valid results yet small enough so that it is not too unwieldy. But we will need to decide collectively, and soon, if this is the direction we choose to follow.

National Council of Urban Indian Health

At the March National Council of Urban Indian Health (NCUIH) conference in Washington, DC, UIHI hosted a roundtable discussion on maternal and child health. Four Urban Indian health organizations (UIHO) who attended the session, were updated on UIHI's plans for MCH-related activities. Roundtable participants identified maternal and child health (MCH) priorities to address, such as well child care, teenage motherhood, single parenthood, and education for women. Barriers that exist to providing MCH services were also discussed, such as long wait times, adequate transportation, and access to care. Finally, participants made suggestions for improving MCH care; these included forming partnerships with other agencies and using talking circles or support/peer groups with strong leaders. UIHI plans to follow up with a needs assessment of all 34 UIHOs to determine MCH priorities and needs. The information obtained from the assessment will be used to develop 2-3 MCH research projects. The UIHI is also recruiting members for a MCH advisory council that will serve to guide UIHI MCH research projects. If you are interested in participating on the advisory council or would like more information, please contact Alice or Mei.