The mission of the Urban Indian Health Institute is to support the health and well-being of Urban Indian communities through information, scientific inquiry and technology.

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Please contact the Urban Indian Health Institute with your comments: info@uihi.org or 206-812-3030. You can also fill out the form on page 21 with comments or questions.

# ACKNOWLEDGEMENTS

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The UIHI would like to thank the staff at the urban Indian health organizations for their input and acknowledge the excellent work they do daily on behalf of their communities.
Accurate and timely information is essential for understanding and improving the health of all Americans. This is especially important for the American Indians and Alaska Natives (AI/AN) residing in urban areas who receive their health services through a network of urban Indian health organizations (UIHOs). This community driven health care network is successful at addressing many of the health needs because it tailors health care delivery to the unique needs of the urban Indian population.

As the nation engages in fervent debate about the future of health care, the need for data to inform the process for organizations that serve urban AI/AN is needed. But unlike the rest of the American health care system, the diversity across the urban Indian health landscape demands a thorough assessment and defined strategy to move toward Health Information Technology (HIT) that will meet the requirements outlined by health care reform.

HIT is integral in quality improvement. Quality can be defined as delivering the right care, at the right time to meet the patient’s needs. Effective and timely utilization of a patient’s information combined with knowledge of the best treatment information available will be critical in improving quality of care to patients. In addition, HIT promises to provide significant improvements in: preventive care, chronic disease management, care coordination, non-visit-based care, or “e-care”, knowledge-based medication management, to name a few. Improvement in these areas could make serious inroads in eliminating the health disparities for urban AI/AN.

A major barrier to widespread implementation of these HIT models is the provider payment system. The current U.S. health care payment system pays predominantly for the volume of services rendered, such as office visits and procedures, and not for the quality of health care outcomes. And it’s a payment system that effectively punishes providers for achieving efficiencies such as the elimination of avoidable readmissions and unnecessary in-person office visits. If the average medical practice today were to reduce its volume of reimbursed office visits in order to spend more time on unreimbursed care coordination, chronic care management, non-visit-based care, and medication management in order to improve patient health, care quality, and care efficiency, then the practice would not survive.

HIT can provide valuable inroads to quality improvement related to patient care, but it also lends itself to a critical role in payment reform. HIT implemented specifically as an accelerator of health care delivery innovation and payment reform could transform U.S. health care as we know it.
MANY UIHOS WILL BE AFFECTED BY PAYMENT REFORMS

Health Information Technology could serve to assist those organizations faced with handling the challenges of bundled payment reforms. Without HIT many UIHOs will not be able to meet those challenges and may not survive; thus leaving a gap in much needed care for urban Indian communities. UIHOs must be able to meet the needs of the community and respond to the challenging changes of the business of health care delivery. Simultaneously fulfilling both of these roles will be essential for survival. HIT may play an important role in that survival.

PLANNING SESSION

On August 13, 2009, urban Indian health organizations from 21 cities from across the nation participated in a planning session to consider strategies for a National Urban Indian Health Data System. This Robert Wood Johnson Foundation sponsored effort built off the findings of the 2007 Urban Indian Health Commission report, and focused on the process of defining HIT goals across urban Indian health organizations. The considerations and requirements identified in this report will help ensure thoughtful implementation of HIT tailored to the needs of organizations individually and across the urban Indian health organizations as a whole. There remains much to be done in implementing HIT for improving health services, capturing accurate data for population analysis, and meeting the requirements for securing and retaining resources to better serve the urban AI/AN health community. This report aims to provide guidance in this important work and the next steps required to bring the strategic plan to action.

FOCUS AREAS

The following focus areas were identified in the strategic planning process as priority action items.

- Assess Technology Readiness
- Coordinate Advisory Workgroups
- Build Technology Infrastructure
- Arrange Ongoing Strategic Planning
- Analyze Data Capacity Gaps
- Provide Technical Assistance
- Establish Centralized HIT Guidance
- Develop Staff Training and Education
EXECUTIVE SUMMARY

FOCUSING ON UIHO STRENGTHS

UIHOS DEMONSTRATE NATIONAL-REGIONAL INTERPLAY

Urban Indian health organizations (UIHOs) are independent, private, non-profit organizations located in 19 states and with service areas encompassing 102 U.S. counties. The 34 UIHOs offer a range of services from referral and case management to direct health care, including medical, dental, and chemical dependency programs. UIHOs work toward improved access to health care services and building local capacity to support health improvement for urban Indians.

Data at the local level is needed for program planning and service delivery. This includes connecting patients to resources and services beyond what is available on site, including advanced and specialty care. Participating in a broader health network in the local community can be essential for the UIHOs. Many UIHOs have made the most of their local resources, ensuring broader, more comprehensive access to services for their clients.

While the UIHOs are focused on their local community, they all share a common national link. The Indian Health Care Improvement Act directs the Indian Health Service (IHS) to provide grants and contracts with Indian health organizations in 34 cities across the nation. Partial funding for the UIHOs is congressionally appropriated. When educating policy makers, the UIHOs collectively voice the needs of all urban Indian communities across the nation. Data is gathered across the nation to describe the needs of Indians residing in cities.

Urban Indian health organizations are in unique position to demonstrate national-regional interplay and therefore serve as a model for organizations designed to serve a local community while connected to a broad national vision.

A MECHANISM FOR NATIONAL COORDINATION

One way the UIHOs might be able to successfully engage in the national efforts of HIT implementation is through Regional Health IT Extension Centers. Regional Extension Centers will be established by Health Information Technology for Economic and Clinical Health Act (HITECH Act) to offer technical assistance, guidance, and information on best practices to assist health providers in implementing HIT.
EXECUTIVE SUMMARY

REGIONAL EXTENSION CENTERS

A POPULATION TARGETED REGIONAL HEALTH IT EXTENSION CENTER
• Could Assist with Collaborative Vendor Selection and Group Purchasing
• Enable Coordinated Implementation and Project Management
• Support Practice and Workflow Redesign
• Ensure Functional interoperability and Health Information Exchange
• Support Privacy and Security Best Practices

LIAISON WITH REGIONAL HEALTH EXTENSION CENTERS
• The Urban Indian Health Institute could serve as a Coordinating / Facilitating / Liaison Center to facilitate the relationship between urban Indian health organizations (UIHOs) and Regional Health IT Extension Centers (REC).

ASSESSMENT
• Evaluating the current technology capacity and progress towards adopting HIT across the 34 UIHOs.
• Documenting UIHOs’ efforts to rapidly, effectively and efficiently achieve meaningful use of certified HIT systems.
• Assisting in evaluation of the complex workflows and processes, such as billing and reporting, that must be addressed by HIT.

SUPPORT
• Promoting UIHOs’ access to services provided by REC.
• Establishing effective relationships and developing outreach programs for building joint efforts among UIHOs and REC.

GUIDANCE
• Acting in coordination with REC as a resource for best practices in standards, methodologies, tools, and processes for HIT implementation customized to UIHOs.

CULTURAL COMPETENCY
• Enabling culturally respectful partnerships between UIHOs and REC.
• Providing support to REC for tailoring their services to the unique needs of UIHOs and the communities they serve.

SHARED LEARNING
• Developing a collaborative learning network among UIHOs to compile and share lessons learned about effective practices in implementation and use of HIT.

SUSTAINABILITY
• Developing and sustaining relationships between UIHOs and REC.
As national initiatives to bring HIT into every health care organization gain energy, the 34 urban Indian health organizations (UIHOs) have sought guidance on strategies and resources to carry forth this important work in their organizations as well. The diversity within the collection of data at UIHOs makes creating a uniform health information system that can be both practical and effective for the organizations extremely challenging. Although individual UIHO have distinct HIT needs, they share a common desire to collect accurate data on urban AI/AN health issues. And like all health care providers, UIHOs are seeking an optimal technological system that addresses their specific needs - from complex billing, to unique demographics, to cultural/traditional services, to clinic outcomes. For that solution to be successful, it must be affordable, industry standard, and meet the unique needs of the UIHOs.

The first step in developing a strategic plan was an assessment of current HIT capacity at each UIHO. A brief survey about current HIT capacity was developed and sent to UIHOs’ Executive Directors prior to engaging in the strategic planning process as a group. Survey results were shared with the strategic planning participants and provided a basis from which to think about future HIT strategic goals.

Of the 34 UIHOs given the HIT capacity survey, data was collected from 30 organizations. A total of 32 responses were collected, since 3 surveys were received from one large UIHO operating 3 separate clinics, each with differing HIT capacity. The survey found that 91% of respondents (29 of 32) are using an electronic system to collect, store, manage or analyze information. Half the respondents (16 of 32) use commercially available Practice management systems to support functions such as billing and scheduling. Many are looking to upgrade their systems or incorporate them into the adoption of an Electronic Health Record (EHR). Only 12.5% of respondents (4 of 32) indicated that they currently use an EHR system. Some have chosen commercially available systems while others have implemented the Resource and Patient Management System (RPMS) developed by the IHS.

Interestingly, 72% of respondents (23 of 32) stated that they have the RPMS system. Based on follow up discussions with UIHOs, many sites that report having RPMS may only use the system for reporting to IHS, and not as a fully functional EHR system. Tailoring RPMS to meet the needs of urban AI/AN health services has been a challenge, met with varied levels of success.
The majority of respondents, 62.5% (20 of 32), are interested in implementing an EHR within the next few years. Of those looking to adopt an EHR system:

- 45% (9 of 20) are looking to implement within the next year
- 45% (9 of 20) planned to implement in 2-4 years
- 10% (2 of 20) wish to implement in 5+ years

Although many UIHOs expressed interest in implementing EHR in the next few years, follow up discussions often centered on significant funding and other challenges that must be addressed before these sites can move forward with implementation.

While many sites are looking to implement EHR systems to support their clinical applications, several UIHOs may not have the need for an EHR. Some of the UIHOs are referral and case-management agencies, rather than full service clinics providing direct medical services. Because there is a broad spectrum of services across the UIHOs, the requirements for HIT are quite heterogeneous. Therefore, it was important to ensure that the strategic planning session addressed the differences in information technology capacity and needs across the entire 34 organizations.

Although individual UIHOs have distinct HIT needs, they share a common desire to collect accurate data on urban AI/AN health issues. Prior to the strategic planning session activities described in this document, there existed no current operational process for identifying and communicating HIT capacity at UIHOs as a collective. This report seeks to document the collaborative strategic planning process as well as to communicate the participants’ recommendations.
In a round-table format, the strategic planning session participants were invited to provide input about what they envisioned as an ideal information technology system, its functionalities, and how it would be implemented.

Attendees identified considerations and requirements for HIT, outlined in areas such as affordability, organizational capacity and workflow, quality improvement, surveillance, reporting and accountability, technology and security, and strategy. Although the recommendations have been grouped, it should be noted that the categories are interrelated.

**AFFORDABILITY**
- Utilization of affordable/existing infrastructure
- Inexpensive/Cost Effective Software Solutions
- Resources are needed for technical assistance, (eg. access to help desk and additional IT staff)
- Funding for ongoing IT support and improvement is needed

**ORGANIZATIONAL CAPACITY AND WORKFLOW**
- Training for staff and support for facilitate buy-in is needed
- Strategies to reduce double/triple data entry need to be developed
- Assistance is needed with migration from paper records to electronic system
- Strategies to collect traditional/cultural, non-medical, and community data are needed
- A strong implementation processes and workflow analysis is essential

“[Our organization] would like to use RPMS for billing but can’t afford the staff. [We] received funds for hardware but we need funding for staff positions too.”

**QUALITY IMPROVEMENT**
- Enable quality assurance and improvement
- Allow for internal audit and risk management
- Integrate services and ensure continuity of care
- Provide benefit to the communities UIHOs serve
- Incorporate national indicators (e.g. Healthy People 2010)
- Maintain system accreditation/certification and support industry standards
SURVEILLANCE, REPORTING AND ACCOUNTABILITY

• Support documentation of AIAN Tribal Demographics
• Ability to retrieve management data and reports
• Support the streamlining reporting to federal and private funders

TECHNOLOGY AND SECURITY

• Technology must be accessible, i.e. user friendly
• Ensure scalable platform for growth
• Integrate or be interoperable with other systems (administrative, lab, pharmacy, etc.)
• Accessible via secure Web-based portal
• Allow customized alerts and reminders
• Automate updates/upgrades
• Support practice management (billing, scheduling, etc.)
• Enable accurate and reliable data entry, storage and retrieval

STRATEGY

• Develop UIHO best practices and knowledge transfer
• Collaborate to enable demonstration of need for resources
• Develop unified strategy that also addresses individual UIHO needs
• Preserve control over intellectual property
• Solicit Indian Health Service support and improvement of RPMS

A significant portion of the strategic planning session was spent discussing the RPMS system, as many UIHOs’ suggestions for an ideal HIT system have been influenced by their experiences with RPMS. The RPMS system has built in functionality for IHS reporting and many sites use the system only as a reporting tool. One main barrier was lack of funding for the staff needed to fully utilize RPMS.

The organizations with resources to implement RPMS have experienced varied levels of success. Working toward improvements to RPMS so that the system can meet the HIT requirements identified by the UIHOs is a major priority. What role RPMS or other systems play in the urban Indian HIT landscape remains to be seen, as the policies are set and the conversation continues among UIHOs about their ideal HIT system. After discussion about the considerations and requirements for their ideal HIT system, participants began identifying strategies and next steps to work toward realizing the best systems for UIHOs individually and as a collective.

“Even though we have RPMS, we operate another PMS [Practice Management] system fully and then enter the data into RPMS only for IHS purposes.”
SECTION II : STRATEGIC PLAN

Through a facilitated discussion, attendees provided many recommendations about the resources, data, technology, collaboration, and policy considerations required to achieve an accurate picture of urban Indian health. The following recommendations outline the goals identified during the strategic planning session:

RESOURCES
1. Access additional sources of funding to build IT infrastructure and implement HIT (e.g. foundation grants, industry sponsorship, private business grants)
2. Find resources to help develop UIHOs’ driven agenda and follow up with next steps to the strategic planning session

DATA
3. Capture data on services and outcomes of non-medical support and referral programs (e.g. diabetes prevention, outreach, and traditional healing services)
4. Explore IT systems for behavioral health and chemical dependency programs
5. Develop data standards for aggregate analyses that allow for reporting and collective demonstration of need
6. Encourage IHS to allow the UIHO access to data reported by the UIHO

TECHNOLOGY
7. Define the components of HIT needed at UIHOs (e.g. administrative, billing, clinical services, and non-clinical services)
8. Perform a UIHO-wide technology gap analysis to create a priority funding list
9. Conduct technology assessments to gauge what individual UIHO need to achieve readiness for HIT and/or EHR adoption

COLLABORATION
10. Analyze and improve current system of determining UIHO-wide priorities
11. Improve and expand the UIHI process for tracking UIHO assistance requests (e.g. data requests, etc.)
12. Identify UIHOs that have HIT in place who are willing to share lessons learned and host site tours and system demonstrations
13. Formulate workgroups to develop recommendations and continue dialogue about HIT

**COMMUNICATION**
14. Develop materials about value and impact of HIT to assist UIHO directors in conversations with Board members

15. Create adaptable tools and strategies to provide information about the importance of data and to gain buy-in for data collection

16. Collect anecdotal stories to couple with data so that both quantitative and qualitative information about the community is available

**DEMONSTRATION OF NEED**
17. Adopt formal resolution to address lack of IHS stimulus funding allotted to UIHOs

18. Address the need to develop RPMS in accordance with UIHOs’ needs

19. Engage in Census activities and Healthy People 2020 priorities so that funding is directed toward UIHO

20. Promote UIHOs’ contact with local and federal representatives to advocate for funding

21. Leverage UIHI endorsement of data for UIHO to demonstrate the need for support from local, state and national agencies

22. Exercise collective power and voice of alliances and consortia (e.g. Urban Indian Health Institute, National Council of Urban Indian Health, California Consortium on Urban Indian Health)

23. Maintain relationship with the Office of the National Coordinator to follow-up on offer of resources and assistance (e.g. via regional Health IT Extension Centers)

24. Create a list of potential partners and alliances to help promote UIHO agenda (e.g. Out of Many One, NAACP)

The comments offered by meeting participants highlighted the importance of addressing HIT needs at UIHOs from a strategic and collective perspective. Having the ability to collect and report accurate data on urban Indian health will help demonstrate the need for resources to enable delivery of quality health care services to urban AI/AN communities.

“Resources follow good outcomes. Outcomes are measured by good data.”

**Envisioning a National Health Information System for Urban Indian Health Organizations**
LIAISON WITH REGIONAL HEALTH EXTENSION CENTERS:
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SHARED LEARNING:
• Developing a collaborative learning network among UIHOs to compile and share lessons learned about effective practices in implementation and use of HIT.

SUSTAINABILITY:
• Developing and sustaining relationships between UIHOs and REC. Assisting in strategic planning for future HIT at UIHOs.
SECTION III: RECOMMENDATIONS

REGIONAL HEALTH IT EXTENSION CENTERS COULD ENABLE:

COLLABORATIVE VENDOR SELECTION AND GROUP PURCHASING
Provide assistance in assessing the Health IT needs of UIHOs and selecting and negotiating contracts with vendors or resellers of HIT systems, hardware and network infrastructure, and IT services. The Regional Center could also assist UIHOs by holding vendors accountable for adhering to service level agreements.

COORDINATED IMPLEMENTATION AND PROJECT MANAGEMENT
Provide guidance in end-to-end project management support throughout the HIT implementation process, including: individualized and on-site coaching, consultation, troubleshooting, and other activities required to assure that the supported provider is able to assess and enhance organizational readiness for Health IT; assess and remediate gaps in IT infrastructure, configure software to meet practice needs, and enable meaningful use; ensure adequate software training for all staff, and track and adhere to implementation timelines.

PRACTICE AND WORKFLOW REDESIGN
Provide support for UIHOs to complete practice and workflow redesign to implement and troubleshoot the use of HIT systems. The Regional Center should assist in consistent documentation of essential clinical information in a structured format; instituting electronic administrative transactions, electronic prescribing, electronic laboratory ordering and results, sharing key clinical data across practice settings; providing patient access to their health information, public health reporting, and policies and practices that protect the privacy and security of personal health information.

FUNCTIONAL INTEROPERABILITY AND HEALTH INFORMATION EXCHANGE
Assist the UIHOs in connecting to available health information exchange infrastructure(s), including an urban Indian data exchange, local health information exchanges, state-based shared utilities, and State/Federal plans for health information exchange. Assist UIHOs in focusing on meeting the functional interoperability needs of practices, including, but not limited to the electronic exchange of administrative transactions, laboratory orders and results, medication prescriptions, quality and public health reports, patient summaries, and the information required to ensure continuity across the spectrum of care.
SECTION III : RECOMMENDATIONS

PRIVACY AND SECURITY BEST PRACTICES
Support the UIHOs in implementing best practices with respect to the privacy and security of personal health information, including: implementation and maintenance of physical and network security, user-based access controls, disaster recovery, encryption and storage of backup media, human resources training and policies. Identification of and guidance around laws and regulatory requirements that impact privacy and security policies for electronic interoperable health information exchange.
Based on the recommendations from participants, the following section describes some of the areas that have been identified as next steps to building HIT capacity and data collection at UIHOs. These next steps aim to carry on the momentum of the work accomplished during the strategic planning session, to help better understand and address urban Indian health issues.

**CONTINUED DIALOGUE**

The strategic planning meeting participants voiced the desire to continue the dialogue around HIT in follow-up to the planning session. Coordination of the next steps will require dedicated efforts by individuals representing the UIHI, the individual UIHOs, and other organizations working for urban Indian health. Participants expressed interest in forming Advisory Workgroups to develop guidelines for the following areas:

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<th>Metrics</th>
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A preliminary survey indicated willingness by at least 5 participants to participate on each of the identified workgroups. Nominations to the workgroups were also given for individuals who did not attend the strategic planning meeting. In order to facilitate an ongoing dialogue and Advisory Workgroups, resources will be required for administrative coordination, meeting logistics, expert consultation, communications procedures and project oversight.

**FUNDING AND RESOURCES**

Not only is funding necessary for continued work on strategic HIT planning for urban Indian health, it is a primary concern for general UIHO operations. The strategic planning participants identified lack of funding as a significant barrier in the implementation of information technology systems and in providing the best health care to urban AI/AN populations.

In addition to funding needed for building HIT infrastructure, resources are also needed for supporting the staffing, training and technical assistance needed to ensure successful system implementation.

“In order to get to HIT ability, you need some baseline technology.”
Many organizations currently may not apply for non-federal resources available, especially in the private and business sectors. Alliances with corporate partners and other influential entities could increase the opportunities for funding. Additionally, leveraging the collaborative power of the 34 UIHOs can also enable collective application for larger pools of funding. Demonstration of need for funding using the joint efforts of the 34 UIHOs can also open doors to future allocation of resources for HIT. A unified approach to seek out and apply for funding such as this would require consolidated efforts, strategies and communication between the UIHOs.

**HIT GAP AND READINESS ANALYSIS**

Gap analyses at individual UIHOs and across the 34 organizations (as a network) are necessary to identify the areas of need that can be addressed with HIT. This work must take into consideration the unique nature of UIHO programs and data relevant to urban Indian health. One area to concentrate on in particular is the collection and utilization of data within each organization and how processes at individual agencies can be applied in a network of UIHOs. These gap analyses will help inform the decisions about which HIT systems would best address the needs of the UIHO.

Once decisions are made on the HIT system to be developed, organizational readiness assessments will help inform the next steps toward system implementation. Adopting enterprise-scale HIT systems such as EHR will impact an organization in significant ways. Implementing HIT requires preparation beyond technical considerations, such as developing staff training and education, and providing ongoing technical assistance to users. It is imperative that an organization is prepared for the inevitable changes to its processes.

A crucial step for an organization to take in determining whether they are ready for HIT implementation and to explore the technology options available, is to visit other UIHO sites that have pioneered the implementation process. For example, the UIHOs that are using RPMS have experienced varying degrees of success and have indicated the desire for collaboration to address these issues. Seeing first-hand how a system functions at an UIHO is an invaluable opportunity to learn from each others’ experiences, obstacles and accomplishments.

Coordinating these on-site visits and consultations will require resources, time and coordination to maximize information gathered and to achieve the most benefit.

“EHR is the one thing that will change the entire aspect of the organization. It changes 30 plus years of a way of doing something.”

“Go see other clinics before you decide to implement a system. Make a deep assessment of your organization and the technology, including the fact that different systems might not work the same way at different sites.”
ADDITIONAL FOLLOW UP

Many of the recommendations for next steps suggested by the strategic planning participants require additional discussion by the group to reach consensus. For example, several participants stressed the need to address the area of data usage and relevant legal issues.

Adopting collaborative resolutions, policies, and standards can only be done via engagement from UIHOs as a collective network. Bringing together the UIHOs’ leaders for yearly strategic planning activities will provide the opportunity to reach consensus and build upon recommendations from previous years’ strategic planning sessions.

In the long term, designating an entity to provide centralized technical assistance and data management may help support HIT implementation at individual UIHOs and enable standardization of technologies as a collective. Having designated project staff will ensure that the work already accomplished is carried forward in a timely and efficient manner.

The UIHI looks forward to being a part of efforts across UIHOs in follow up on recommendations from the strategic planning session. Supporting effective HIT implementation to enable improved health care services and data collection for urban Indian health is a priority.

CONCLUSION

The UIHI hosted representatives from the UIHOs as well as other organizations working in urban Indian health to come together to discuss a strategic plan around HIT. Participants identified many challenges as well as opportunities. Going forward, the group recommended several next steps so that the conversation and work around addressing HIT can continue.

Dedicated coordination of next steps is needed so that the work outlined by the strategic plan will lead to processes and resources that enable successful implementation of HIT. The opportunities for using current and new information technologies to improve health care delivery and collect accurate data on urban AI/AN health are promising. Finding sufficient resources for implementing HIT can be a significant challenge, but is also a priority. The investment in information technology and data collection will pave the way toward a better understanding of urban AI/AN issues. Accessible data on urban Indian health issues will help demonstrate the need for more resources and increase visibility for the need to ensure that urban AI/AN get the health care they deserve.

“We need to establish proper protocol and strategies, define intellectual property, and how data will be used to make sure it is not misused.”

“Technology that is a part of our future – we need to use it in a way that will be beneficial to our individual institutions as well as all as a whole.”
UIHI Publication Feedback Form

We are very interested in your feedback regarding this and other UIHI publications. Please take a moment to detach and fill out the following form with your comments, questions and suggestions. Mail to the Urban Indian Health Institute, Seattle Indian Health Board, PO Box 3364, Seattle WA 98114 or fax to 206-812-3044. You can also fill this form out on-line at www.uihi.org. Thank you very much for your time.

I am commenting on the following UIHI publication:

☐ Envisioning a National Health Information System for Urban Indian Health Organizations (2010)
☐ Visibility Through Data (2009)
☐ Health and Health-Influencing Behaviors among Urban AI/AN (2008)
☐ Urban AI/AN Youth - An Analysis of Select National Data Sources (2007)
☐ Communications Broadcast (monthly)
☐ Other: ________________________________

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Overall, did you consider this publication helpful? ☐ Yes ☐ No

What would have made it more helpful? ________________________________________

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Overall, did you consider this publication easy to understand and use? ☐ Yes ☐ No

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<td>American Indian and Alaska Native</td>
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<td>CCUIH</td>
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<td>Resource and Patient Management System</td>
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<td>Urban Indian Health Organization</td>
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URBAN AMERICAN INDIAN AND ALASKA NATIVES

The majority of American Indian and Alaska Native (AI/AN) - nearly 67% of the 4.1 million who self-identified in the 2000 Census - live in urban areas. There are many reasons for the growing migration of AI/AN from reservations to cities, including personal choice and the aftermath of forced relocation by government programs in the 1950s. Consequently, most urban AI/AN deal with significant lifestyle changes and cultural challenges that have resulted in poor access to education, employment and health care. These circumstances have contributed to poor health for many urban Indians.

The AI/AN population is extremely diverse, including over 562 federally recognized tribes, as well as many non-federally recognized tribes. Currently, the majority of federal AI/AN health services are offered by the Indian Health Service only on or near reservations, and for individuals who are both tribally enrolled and living on the reservation. As the number of AI/AN living in urban areas grows, urban Indian health organizations are needed to ensure that adequate health services are available to the urban AI/AN population.

The Indian Health Service (IHS) contracts with 34 independent, private, non-profit urban Indian health organizations (UIHOs) located in 19 states and with service areas encompassing 102 U. S. counties. According to the 2000 U.S. Census, these 102 counties are home to more than 1 million American Indians and Alaska Natives. The 34 UIHOs offer a range of services from referral and case management to direct health care, including medical, dental, and chemical dependency programs. UIHOs work toward improved access to health care services and building local capacity to support health improvement for urban Indians.

Increasingly, the UIHOs are working to adopt HIT as a tool in delivering health services for urban AI/AN and collecting data on urban Indian health. Several organizations have implemented administrative and clinical systems and more aim to do so in the near future. With the current health care landscape engaging in debate around HIT and mandating implementation in the next few years, the need is more crucial than ever that community health programs like the UIHOs are supported in their efforts toward adopting HIT.

URBAN INDIAN HEALTH INSTITUTE

This report was produced by the Urban Indian Health Institute (UIHI), a division of the Seattle Indian Health Board, located in Seattle, Washington. Established in 2000, the UIHI is one of 12 IHS-appointed AI/AN epidemiology centers with the mission to support the health and well-being of urban Indian communities.
To help increase visibility of urban American Indian & Alaska Native health issues, the Commission report recommended efforts to:

“Expand the information technology capacity of Urban Indian Health Organizations and others who provide care for urban American Indians to help improve clinical performance and serve as a platform for data collection.”

“Data gives visibility to the importance of urban AI/AN health issues. It's a systematic way of looking at the needs of our community.”

**ROBERT WOOD JOHNSON FOUNDATION**

Through a grant from the Robert Wood Johnson Foundation (RWJF) in 2007, the Urban Indian Health Commission examined available data on urban Indian health. The Commission report, Invisible Tribes: Urban Indians and Their Health in a Changing World, noted the lack of primary source data as a key challenge in improving urban Indian health. Existing sources of secondary data often lacked standardization, contained inaccuracies due to issues such as racial misclassification, and had inadequate numbers to allow for scientifically sound analyses and reporting. Since many policy decisions are based on data analyses, urban Indian populations can easily be overlooked if the lack of data is not addressed.

To enable this work, the RWJF provided further support to the UIHI to facilitate the development of a strategic plan that addresses the HIT and data collection needs of the UIHOs. Findings from this one-year project are the basis for this strategic plan report.

**HEALTH INFORMATION TECHNOLOGY**

For the purposes of this report, the term “Health Information Technology” (HIT) includes all information technology systems used in the delivery of health care related services. Systems include, but are not limited to, Practice Management systems and Electronic Health Record (EHR) systems. Also included in this definition are information technologies that collect information on factors that influence individual health, on non-clinical services such as referral and case management, as well as traditional healing.
To facilitate a dialogue around the information technology needs of the UIHOs, the UIHI planned a one-day in-person meeting format that would enable the discussion to embark on developing a strategic plan. The UIHI invited the Executive Director or their representative from each UIHO to attend the strategic planning meeting and provide input on HIT and EHR needs at the 34 UIHOs across the country. Additional invited guests included representatives from advisory organizations working for urban AI/AN health, such as the National Council of Urban Indian Health and the California Consortium for Urban Indian Health. UIHI’s Consultant Scientific Director, Maile Taualii, PhD, MPH, was invited to facilitate the strategic planning session. Dr. Taualii has expertise in public health informatics as well as substantial experience working with the UIHOs.

The strategic planning session also included an expert panel of UIHO Executive Directors or their representatives, Pat Rock, MD, Donna Keeler, Calvin Huang, and Crystal Tetrick, MPH. The panelists discussed the benefits and challenges of implementing HIT and/or EHR systems at their organization. They shared lessons learned from the EHR implementation process, highlighting the aspects crucial to their success and answered questions about what they would have liked to do differently with the benefit of hindsight.

To ensure that the UIHOs’ strategic planning session efforts were harmonized with national efforts, the UIHI contacted the Office of the National Coordinator for Health Information Technology (ONC). The ONC is the principal Federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. David Hunt, MD, Chief Medical Officer and Acting Director in the Office of Health IT Adoption at ONC, was invited as a keynote speaker to inform the participants about national initiatives around HIT.

The UIHI also engaged the participation of the Indian Health Service (IHS), the federal agency that contracts with each UIHO to provide health services to urban American Indians and Alaska Natives. The IHS also deploys the Resource and Patient Management System (RPMS), a HIT tool for use at IHS funded facilities, including several UIHOs. Phyllis Wolfe, Director of the Office of Urban Indian Health Programs for the IHS, was invited as a keynote speaker to address RPMS and the role of IHS in strategic planning for HIT.
STRATEGIC PLANNING SESSION
The strategic planning session was held on August 13, 2009 in Seattle, WA. Attendees represented 26 organizations, including 21 of the 34 UIHOs. Several individuals participated via teleconference, reaching a total of 35 contributors to the meeting. Participants held various management, clinical, and technical roles within their organizations and provided diverse perspectives and expertise.

Prior to the strategic planning session, participants were offered the opportunity to tour the Seattle Indian Health Board and view a demonstration of the EHR system currently in use in the clinic. The session then opened with UIHI Director, Ralph Forquera, MPH, who provided an introduction to the project. The Robert Wood Johnson Foundation Project Officer, Michael Painter, JD, MD, offered opening remarks in support of the UIHOs and the strategic planning process.

The strategic planning meeting agenda prioritized discussions of both the overall lack of urban Indian health data as well as specific concerns related to information technology capacity at UIHOs. The participants had 8 short hours to engage in discussion about their needs as individual organizations and as a collective. The meeting covered a wide range of relevant concerns centered on improving data collection and addressing HIT needs at UIHOs.
Several UIHOs provide comprehensive clinical outpatient services as well as non-clinical community-based programs. The UIHOs often bill both individual patients and third-party payor organizations for healthcare services provided. Some patients may qualify for reimbursement under more than one third-party payor. In such cases, the UIHOs must bill for and document reimbursement through coordination of multiple processes. The description below outlines the billing processes at one particular UIHO.

Patients are billed on a monthly basis using a paper-based process. Uninsured patients are billed on a sliding scale, from 0%, 25%, 50%, up to 100% of reasonable fees based on family size and income. Insured Patients are billed for fees, such as copayments, not covered by third-party payors.

Third Party Payors include Medicaid, Medicare, State Children’s Health Insurance Program (SCHIP), as well as private insurance. The UIHO submits for reimbursement on a patient-by-patient basis.

Medicaid and Medicare programs are billed weekly. The UIHO submits claims using an electronic process through the UIHO’s health information technology systems.

For Medicaid billing, the UIHO submits for a fee for service reimbursement, to be adjusted at the end of each month for an increased rate available to Federally Qualified Health Centers (FQHC). Billing for SCHIP is also submitted with the Medicaid batch.

For Medicare billing, the UIHO submits for a fee for service reimbursement, at the standard 80% allowable rate. The patient is then billed for the remaining balance on a sliding scale.

Private insurance companies are billed every two weeks, currently using a paper-based process. The UIHO is working on the transition to an electronic process, which requires creating customized processes and reports since insurance procedures differ.

The billing department staff also tracks data on patient encounters for services provided free of charge to the community. The UIHO does not submit for reimbursement of these services, which includes programs such as outreach and support to enable the health and well-being of community members. The staff also conducts regular internal audits to ensure that procedures are followed according to policy and to resolve unique billing scenarios and problematic cases that may arise. The UIHO also coordinates with collection agencies to contact patients and obtain payment for outstanding balances.
The high level diagram of the UIHO’s billing processes provides an overview of the complex activities that the staff must carry out to meet various deadlines and interface with a range of systems and individuals. The above representation is only an example of the processes at one particular organization, providing a unique set of clinical and community services. In order for HIT to meet the requirements of the UIHO, the technology must demonstrate flexibility and be customizable to each organization.

- Paper-based billing – monthly
- Sliding scale based on family size and income - 0%, 25%, 50%, or 100% rate

- Paper-based billing – monthly
- For charges not covered by insurance (e.g. copayments)

- Electronic billing – weekly
- Fee for service
- Adjustment for FQHC rate each month

- Electronic billing – weekly
- Fee for service - 80% standard allowable
- Patient billed other 20% with sliding scale

- Paper-based billing – bi-weekly
- Transitioning to electronic billing

Other Activities
- Tracks patient encounters for community programs and non-clinical services that are not billed for
- Conducts regular internal audits
- Coordinates collections for overdue balances
Reporting processes at UIHOS must meet the requirements of federal agencies, regional and local health agencies, organization management, and other groups that are stakeholders in the programs provided by the UIHO. Data reported to these agencies are used for purposes such as clinical outcomes measurement, performance improvement, financial auditing, or to satisfy the requirements of specific programs and funding mechanisms.

A large UIHO that provides comprehensive clinical services may employ full time report development staff to enable data collected by HIT systems to meet the agencies various reporting requirements. The majority of efforts, up to 90% FTE, can be spent on three large reports:

1. Uniform Data System (UDS) report to the Bureau of Primary Health Care
2. Uniform Data System (UDS) report to the IHS – Urban Indian Health Program
3. Government Performance and Results Act (GPRA) report to the IHS – Urban Indian Health Program

These reports provide information for reviewing the operation and performance of health centers. Many clinical and organizational indicators on these reports are nearly identical except for slight, but crucial, differences in measurement criteria. For example, the UDS report required by BPHC and IHS are identical except for additional analyses that specify data on AI/AN patients. Staff efforts may be duplicative in order to satisfy the precise requirements for each report. Detailed descriptions of the UDS and GPRA reporting requirements are outlined in following sections of this document.

Other reports are produced on demand for agencies that oversee, fund, or otherwise support the UIHO's many clinical and community-based programs. For example, UIHO may work with federal, state, regional and local public health authorities to provide healthcare services and programs, such as chemical dependency treatment, maternal and child health services, and diabetes management support.
A snapshot of reporting requirements includes:

**INDIAN HEALTH SERVICE (IHS - URBAN INDIAN HEALTH PROGRAM; IHS REGIONAL CONTRACT)**
- Semi-annual and annual progress report
- IHS Special Diabetes Program - Annual report
- Chemical Dependency Treatment - Monthly Target report

**STATE HEALTH AUTHORITY**
- Women, Infants and Children (WIC) - Program report
- Tobacco Prevention Program - Monthly report

**COUNTY AND CITY PUBLIC HEALTH DEPARTMENT**
- Infant Mortality - Monthly report
- Medical and Dental Visits - Quarterly report; Semi-annual demographics report
- Breast and Cervical Health Program - Monthly report
- Healthcare for the Homeless - Monthly report
- Veteran’s Mental Health Program - Monthly report; Quarterly narrative
- Domestic Violence Prevention and Women’s Program - Monthly report; Annual demographics and outcomes report
- Chemical Dependency Outpatient Program - Monthly Target report; Annual report
- Health Insurance ACCESS program - Quarterly report

**OTHER ORGANIZATIONS**
- United Way- Progress reports; Annual demographics report

Reports are also generated on demand for use within the agency, such as clinical performance scorecards used by department managers, fiscal and organization performance reports for executive level directors, and advisory or governing boards to guide organizational strategy and planning. Reporting requirements will vary greatly across the UIHOS, depending on the range of programs and services they offer.
The above diagram provides a general overview of the agencies that may require clinical and organizational reports from UIHO. The complexities of reporting processes at the UIHO are compounded by variations in:

- Report timelines, baseline periods and deadlines
- Criteria for performance and clinical indicators, outcomes, and other data elements
- Definitions and identification of urban Indian patients

For HIT systems to meet these reporting requirements, they must provide flexible and customizable collection of data, as well as retrieval for recurring and on demand reporting.
UNIFORM DATA SYSTEM (UDS) REPORT(S)

AGENCIES
1. Bureau of Primary Health Care
2. Indian Health Service – Urban Indian Health Program

GRANTEES REQUIRED TO REPORT
The UDS is a reporting requirement for grantees of the following HRSA primary care programs: Community Health Center; Migrant Health Center; Health Care for the Homeless; Public Housing; Primary Care.

DATA COLLECTED
UDS tracks a variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. UDS data are collected at the grantee, state, and national levels. UDS reports to the Indian Health Service also include additional information specific to American Indian and Alaska Native patients.
DATA ELEMENTS
The UDS is composed of 11 tables intended to yield consistent clinical, operational and financial data that can be compared with other national and State data and trended over time:

1. Patient Origin form: Provides zip codes of patients served.
2. Table 3A: Provides a profile of patients by age and gender.
3. Table 3B: Provides a profile of patients by race, ethnicity and language.
4. Table 4: Provides a profile of patients by income (% of poverty level) and third party medical insurance source. It also reports the number of targeted population patients receiving services.
5. Table 5: Reports staffing full-time equivalents by position, and visits and patients by provider type and service type.
6. Table 6A: Reports on primary diagnoses for medical visits and selected services provided.
7. Table 6B: Reports findings on quality of care indicators.
8. Table 7: Reports findings on health outcomes/disparities.
9. Table 8: Details direct and indirect expenses by cost center.
10. Table 9D: Reports full charges, collections and allowances by payor as well as sliding discounts and patient bad debt.
11. Table 9E: Reports non patient-service income.

SCHEDULE
The UDS report is always a calendar year report.

USE OF DATA
The data are reviewed to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments. The data help to identify trends over time, enabling HRSA to establish or expand targeted programs, services and interventions to improve the health of underserved communities and vulnerable populations. UDS data are compared with national data to look at differences between the U.S. population at large and those individuals and families who rely on the health care safety net for primary care. UDS data also inform Health Center Program grantees, partners, and communities about Health Centers and their patients.
GOVERNMENT PERFORMANCE AND RESULTS ACT (GPRA) REPORT

AGENCY
Indian Health Service – Urban Indian Health Program

GRANTEES REQUIRED TO REPORT
Health care facilities operated and run by the Urban Indian Health Program are now required to report their Government Performance and Results Act (GPRA) clinical performance measures to IHS and Congress. This is required of both Urban facilities using the Resource and Patient Management System (RPMS) and facilities not using RPMS. RPMS users must use the Clinical Reporting System (CRS) for reporting, and non-RPMS users must decide whether to use electronic and/or manual reporting methods for reporting and must ensure they use performance measure logic that corresponds with the CRS logic. With either method, information that is reported must include a data supported audit trail that can be verified and validated by the Office of Management and Budget (OMB).
DATA COLLECTED
GPRA measures include clinical, such as various diabetes measures, cancer screening and others; Office of Information Technology (OIT)-related, such as increasing sites using certain software; quality of care, such as percent (%) of accredited hospitals; prevention, such as immunizations and injury prevention; and infrastructure, such as access to or improved sanitation facilities.

DATA ELEMENTS
GPRA clinical measures are reported in the Prevention and Treatment categories, and some of these measures are listed below:

- Quality of care for patients with diabetes
- Cancer Screening
- Immunizations
- Domestic Violence Screening
- FAS Prevention
- Tobacco Cessation
- Depression Screening

SCHEDULE
The GPRA report year runs July 1 through June 30 of each year and GPRA reports are due every quarter. The GPRA quarterly report is compared to the previous baseline that contains one year’s worth of data.

USE OF DATA
The Government Performance and Results Act (GPRA) requires Federal agencies to demonstrate that they are using their funds effectively toward meeting their missions. The law requires agencies to have both a 5-year Strategic Plan in place and to submit Annual Performance Plans describing specifically what the agency intends to accomplish toward those goals with their annual budget request. Every year, the agency reports on how the agency measured up against the performance targets set in the Plan.
APPENDIX E
HEALTH INFORMATION TECHNOLOGY SURVEY

We are requesting this information in order to understand current and future information system needs at each Urban Indian Health Organization. Any member of your organization who is knowledgeable about your information and reporting needs can complete this survey. We are looking for the most accurate and up-to-date information possible.

Name: ______ Title: ______

Organization: ______ Email: ______ Phone: ______

1. Does your organization use an electronic system to collect, store, manage or analyze information? (e.g. for registration, billing, clinical services, non-clinical services, etc.)
   - Yes
   - No

2. Does your organization have an electronic Practice Management system?
   - Yes
   - No

   a. If YES, what functions does your system provide?
      - [ ] Registration
      - [ ] Billing
      - [ ] Other: ______

3. Does your organization have RPMS (Resource and Patient Management System, IHS)?
   - Yes
   - No

4. Does your organization have another Electronic Health Record (EHR) System?
   - Yes
   - No

   a. If YES, which system(s) does your organization use? ______

5. Is your organization satisfied with your Practice Management and/or EHR system?
   - Yes
   - No
   - We do not have a Practice Management or EHR system

   a. If NO, why not? ______

6. If you do not currently have an EHR system, are you looking to implement one?
   - Yes
   - No

   a. If YES, what is the timeframe?
      - [ ] 0-1 year
      - [ ] 2-4 years
      - [ ] 5+ years

   b. If NO, why not? ______

7. Do you have any additional comments? ______
# APPENDIX F

## STRATEGIC PLANNING SESSION AUGUST 12, 2009 AGENDA

**RWJ Strategic Planning Session**  
August 13th 2009  
Silver Cloud Hotel – Broadway/Madison Rooms

## Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tr>
<td>7:45am</td>
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| 8:00am| Welcome  
Blessing  
Urban Indian Health Institute  
Robert Wood Johnson Foundation | Moke Eaglefeathers  
Ralph Forquera  
Michael Painter* |
| 8:30am| Introductions                                                                              | All Attendees                     |
| 10:00am| Mid-morning Break                                                                          |
| 10:15am| Local and National Data Needs and Challenges                                               | Maile Taualii                     |
| 10:45am| Findings from EHR Survey                                                                   | Ye Song                           |
| 11:00am| EHR Panel Presentations                                                                     | UIHO Panelists                    |
|       | Seattle Indian Health Board                                                              | Crystal Tetrick                   |
|       | Indian Health Center of Santa Clara Valley                                               | Calvin Huang                      |
|       | Indian Health Board of Minneapolis                                                      | Pat Rock                          |
|       | South Dakota Urban Indian Health                                                          | Donna Keeler*                     |
| 12:00pm| Lunch (provided)                                                                           | Keynote Speakers                  |
|       | Office of the National Coordinator for Health Information Technology                    | David Hunt*                       |
|       | Indian Health Service                                                                     | Phyllis Wolfe*                    |
| 1:30pm| Information Technology Needs Discussion                                                    | Ralph Forquera & Maile Taualii   |
| 3:00pm| Mid-afternoon Break                                                                        |
| 3:15pm| Information Technology Needs Discussion (cont’d)                                           | Ralph Forquera & Maile Taualii   |
| 4:00pm| Summary and Next Steps                                                                     | Maile Taualii                     |
| 4:45pm| Wrap-Up                                                                                    | Ye Song                           |
| 5:00pm| Closing and Safe Travels!                                                                  |                                   |

*Via teleconference
# APPENDIX G

## PARTICIPANTS AND CONTRIBUTORS

<table>
<thead>
<tr>
<th>Urban Indian Health Organization</th>
<th>Representative(s)</th>
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</table>
| » First Nations Community HealthSource  
   *Albuquerque, NM* | Marjorie Bear Don’t Walk  
   Kathleen Harris |
| » American Indian Health Project Bakersfield  
   *Bakersfield, CA* |  |
| » Indian Health Board of Billings  
   *Billings, MT* |  |
| » North American Indian Alliance  
   *Butte, MT* | Delbert Nutter |
| American Indian Health Services of Chicago, Inc  
   *Chicago, IL* |  |
| » Urban Inter-Tribal Center of Texas  
   *Dallas, TX* | Angela Young |
| » Denver Indian Health and Family Services  
   *Denver, CO* | John Lemire, JD |
| » American Indian Health and Family Services of SE Michigan  
   *Dearborn/Detroit, MI* | Rube Chaney, BSN, BSA, MHA |
| » Native Americans for Community Action  
   *Flagstaff, AZ* |  |
| » Fresno American Indian Health Project  
   *Fresno, CA* |  |
| » Indian Family Health Clinic  
   *Great Falls, MT* |  |
| United Amerindian Health Center, Inc  
   *Green Bay, WI* |  |
| » Helena Indian Alliance  
   *Helena, MT* |  |
| » North American Indian Center of Boston, Inc  
   *Jamaica Plains/Boston, MA* | Lisa Sockabasin |
| » Nebraska Unban Indian Health Coalition  
   *Lincoln, NE* | Donna Polk-Primm, PhD |
| » United American Indian Involvement, Inc  
   *Los Angeles, CA* |  |
| » Gerald L. Ignace Indian Health Center, Inc  
   *Milwaukee, WI* | Hope Johnson |
| » Indian Health Board of Minneapolis  
   *Minneapolis, MN* | Pat Rock, MD |
| Missoula Indian Center  
   *Missoula, MT* | Anthony Hunter, RN |
| » American Indian Community House, Inc  
   *New York, NY* |  |

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<tbody>
<tr>
<td>§ Keynote Speaker</td>
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<tr>
<td>» HIT Implementation Survey Respondent</td>
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<tr>
<td>‡ EHR Implementation Panelist</td>
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<tr>
<td>✔ Strategic Planning Session Facilitator</td>
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<td>* By Teleconference</td>
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### APPENDIX G - CONTINUED

#### PARTICIPANTS AND CONTRIBUTORS

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<tbody>
<tr>
<td>Native American Health Center</td>
<td>D’Shane Barnett</td>
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<tr>
<td><a href="#">Oakland, CA</a></td>
<td>Gregory Harmon</td>
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<tr>
<td></td>
<td>Susan Jamerson, MPH</td>
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<tr>
<td></td>
<td>Dawn Lulua-Claxton</td>
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<tr>
<td>Native American Community Health Center</td>
<td>Richard Zephier, PhD</td>
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<tr>
<td><a href="#">Phoenix, AZ</a></td>
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<tr>
<td>South Dakota Urban Indian Health, Inc</td>
<td>†‡ Donna Keeler</td>
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<tr>
<td><a href="#">Pierre, SD</a></td>
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<td>NARA Indian Health Clinic</td>
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<td>Sacramento Native American Health Center</td>
<td>Britta Guerrero</td>
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<td>Indian Walk-In Center</td>
<td>Ella Dayzie</td>
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<tr>
<td><a href="#">Salt Lake City, UT</a></td>
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<tr>
<td>San Diego American Indian Health Center</td>
<td>Joe Bulfer</td>
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<tr>
<td><a href="#">San Diego, CA</a></td>
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<tr>
<td>Indian Health Center of Santa Clara Valley, Inc</td>
<td>Aldon Wayne Scott, ABD, MAED</td>
</tr>
<tr>
<td><a href="#">San Jose, CA</a></td>
<td>† Calvin Huang</td>
</tr>
<tr>
<td>American Indian Health &amp; Services Corporation</td>
<td>Merin McCabe</td>
</tr>
<tr>
<td><a href="#">Santa Barbara, CA</a></td>
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<tr>
<td>Seattle Indian Health Board</td>
<td>† Crystal Tetrick, MPH</td>
</tr>
<tr>
<td><a href="#">Seattle, WA</a></td>
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<tr>
<td>N.A.T.I.V.E. Project</td>
<td>Candy Jackson, RD, JD</td>
</tr>
<tr>
<td><a href="#">Spokane, WA</a></td>
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<tr>
<td>Tucson Indian Center</td>
<td>Jacob Bernal</td>
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<td><a href="#">Tucson, AZ</a></td>
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<td>The Hunter Health Clinic</td>
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<thead>
<tr>
<th>Other Organizations</th>
<th>Representative(s)</th>
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<tbody>
<tr>
<td>California Consortium for Urban Indian Health</td>
<td>Jyl Hardenbergh, MNA</td>
</tr>
<tr>
<td><a href="#">San Francisco, CA</a></td>
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<tr>
<td>National Council of Urban Indian Health</td>
<td>Alejandro Bermudez-Del-Villar, MA</td>
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<tr>
<td><a href="#">Washington, DC</a></td>
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<tr>
<td>Robert Wood Johnson Foundation</td>
<td>Michael Painter, JD, MD</td>
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<tr>
<td><a href="#">Princeton, NJ</a></td>
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<tr>
<td>Office of the National Coordinator for HIT</td>
<td>§‡ David Hunt, MD</td>
</tr>
<tr>
<td><a href="#">Washington, DC</a></td>
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**Note:**

- Representative(s) indicates the specific individual(s) from the organization.
- † Indicates a representative from the organization.
- †‡ Indicates a secondary representative.
- § Indicates the office of a national coordinator.
- §‡ Indicates a co-author or contributor.
ACKNOWLEDGEMENTS

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