

**URBAN INDIAN HEALTH CARE FOR THE WASATCH FRONT:
NEEDS ASSESSMENT AND PROPOSED RECOMMENDATIONS
2003 - 2006**

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**URBAN INDIAN HEALTH CARE FOR THE WASATCH FRONT
NEEDS ASSESSMENT & PROPOSED RECOMMENDATIONS
October 2002 – October 2003**

I. Introduction and Purpose of this Report

The descendants of those who first lived on this beautiful land deserve and need a culturally sensitive, capable, and responsive system of health care services.

The purpose of this report is to summarize data collected in a community-led survey of the health care needs of American Indian/Alaska Natives in and around Salt Lake City, Utah. The information indicates that there still exists an extensive array of unmet health care needs among urban dwelling American Indian/Alaska Natives who live along the 50 mile radius that extends north and south of Salt Lake City, as far north as Ogden and as far south as Provo, an area known as the Wasatch Front.

Salt Lake City is the only major metropolitan area along the Wasatch Front and is the only major metropolitan area between Denver and Reno. As such, it serves as the **hub of access to a continuum of resources** not only for the AI/AN population who dwell within the state, but for many AI/AN people from neighboring mountain west and southwest states who migrate to this urban center in search of jobs and resources for their families.

The Indian Walk-In Center (IWIC) of Salt Lake City, Utah, is the recognized center of that urban hub for the growing population of American Indian/Alaska Native people from a variety of tribes. New and long-time urban AI/AN dwellers can come to the IWIC in Salt Lake and know they will be greeted by friendly faces who understand the challenges of moving a family from reservation life to an urban setting. Here they can expect support for finding ways to meet basic health, housing, and other human services needs, as well as culturally appropriate and nurturing social networks for their families while living in the city.

For the past decade, the IWIC has functioned as an important cultural gathering place. Frequent Pow-Wows draw enthusiastic participants of all ages and tribes from across the Wasatch Front. These social and cultural gatherings are key to the well-being of the American Indian/Alaska Native community. Active youth programs, resource advocacy services, mental health services, substance abuse programs, and health care linkages in concert with a wide group of health care providers, deliver critical services to many people.

New Leadership/A New Era

With the **recent appointment of Dena Ned, MSW, as Executive Director**, the time is ripe for the Indian Walk-In Center (IWIC) to define practical strategies to meet the health care needs of this AI/AN population during the first decade of the 21st century and to set

a foundation for expanding ways to meet these needs well into the future. Dena returns to her home in Salt Lake after having spent almost ten years in California, first as a graduate student and then as the program coordinator for American Indian/Alaskan Native support services at Humboldt State University in Arcata, California.

Current Challenges

In her work in California, Ms. Ned became familiar with the structure of successful comprehensive programs for American Indian/Alaska Natives throughout the United States. She is aware of the enormous possibilities for the Indian Walk-In Center of Salt Lake to provide excellent services and support for those Native Americans and Alaska Native people who live along the Wasatch Front. **She is also aware of the financial constraints that are forcing thoughtful planners across the country to make difficult decisions about which services to provide to whom.**

While the IWIC is the only major urban link to a broad array of services, resources, and cultural events that is staffed by American Indian/Alaska Natives, it cannot itself provide all the necessary services that are needed by this population. **Decisions must be made as to which events and services to provide on site, what services to provide collaboratively with other agencies, and how these collaborations and linkages might be developed and sustained to provide culturally sensitive services in the most economical and productive way.** This is particularly relevant in the provision of **health care services**, which are expensive and complex in regard to developing inter-related systems for primary, secondary, and tertiary levels of care.

II. Background Information

This report seeks not to duplicate, but rather to draw on the excellent work that has preceded this particular effort at assessing the unmet health care needs of the AI/AN population along the Wasatch Front. The demographics reflect the outcome of the latest census figures. In addition, it is also useful to consider tribal data that suggests there are significant additional clusters of people to be served by the IWIC, but remain “uncounted” in the official census.

The data here reflects the results of five key documents. This evaluator strongly supports a particularly careful read of the first document, whose purpose it was to develop a long term health care service plan. It is insightful and describes the key inter-relationships among health care needs, socioeconomic levels, education, employment, transportation, all the elements of a comprehensive strategic planning process. Further, the health care needs that were described, as well as the barriers to meeting those needs, have not changed considerably since 1998 – except that the needs have expanded with the declining situation of the economy.

These documents include the following:

1. In 1998, Melissa Zito, RN, MS, submitted a comprehensive needs assessment conducted at the beginning of the federal health care grant that is also financing this end of project needs assessment.
2. In 1999, Melissa Zito, RN, MS, published a thesis entitled *Health Care Among Urban American Indians*.
3. In 2001, a team of graduate nursing students updated this information and added to the knowledge base.
4. From 1998 to the present, a team of community leaders has developed *The Circle of Wellness Program*. Their intent is to establish and sustain a physical structure, administrative infrastructure, and program support for a comprehensive health program for American Indian/Alaska Native people who live along the Wasatch Front.
5. In 2003, the IWIC submitted a proposal to the federal government to continue to coordinate and provide selected health care services in collaboration with local and state public health care providers. Census figures were updated for the purposes of this proposal..

Our purpose here is not to reprint the conclusions of these reports, but rather to build on these materials. This assessment of current and potential resources concludes with recommendations for the organization of resources to meet the **large amount of unmet health care** needs during the first decade of the new millennium for American Indian/Alaska Native people who live along the Wasatch Front.

Utah's American Indian/Alaska Native Population

According to the data collected during the 2000 Census, **Utah's American Indian/Alaska Native (AI/AN) population totaled 29,684 or 1.3% of the total population**. This contrasts to the national AI/AN population of 2,475,956 or 0.9% of the total population. Utah's AI/AN population is higher than the comparable national average.

Those who reported **AI/AN in combination with one or more race totaled 10,761 or 0.5%**. The comparable national figures for those who reported AI/AN in combination of one or more races is 1,643,345 or 0.6%. Utah's proportion in this group is slightly lower than the national average.

Utah's total of these two groups is 40,445 individuals or 1.8% of the population, while the comparable national figures for this combined group is 4,119,301 or 1.5% of the total population. Utah's total of these two groups is a higher proportion of our total population than the national average.

IWIC Target Population

The IWIC target population, however is estimated to be approximately 13,000 AI/AN people who live along the Wasatch Front, which includes the following counties: Salt Lake, Utah, Weber, Davis, and Morgan. (Source: Census 2000 and the Utah Data Guide, Winter 2002.) That population base expands during times of economic distress, with the migration of additional low-income population to the urban hub of Salt Lake City.

Extremely High Proportion of This Population Is Living at or Below Poverty Level

While the number of AI/AN population is not large in proportion to the size of the population as a whole, it is critical to acknowledge a disproportionately **high proportion of the AI/AN population lives at or below the poverty level.**

Socioeconomic status directly affects the health status of a population. According to data from the 1998 Circle of Wellness publication, 46% of Utah's AI/AN people live in poverty. **In Salt Lake County the number jumps to 64% or more than one in two of AI/AN people live in poverty.** According to the 2000 Census, that number has increased to close to 67%.

Almost half (49%) of the respondents to the 1998 Community Needs Assessment stated that their health care needs were unmet, primarily due to financial constraints (almost 60%), and that they lack access to regular, basic health care services. Of this group, approximately 22% stated that this was due to the lack of insurance for the public clinic system; 20% stated not having enough money to pay for the services; and 17% state having no insurance at all.

In this 2002-2003 survey, only approximately 20% marked "none" or "nowhere" in response to where they receive services. The survey team does not believe that the need has decreased, but that it has probably increased due to the economic situation. However, they conclude that this number is lower than the 1998 number because more than 85% of the surveys were conducted at Pow-Wows at the IWIC and the large majority of those who attended these Pow-Wows are not those who are living in extreme poverty.

The chief point of access when there is a health crisis in this population is the emergency rooms, and/or, for a small number, the Fourth St. Clinic, which delivers health care to the low income, primarily homeless population. The Fourth St. Clinic has developed and operates an excellent outreach program for the homeless population, a disproportionate number of whom are AI/AN. A Navajo woman, who was formerly employed by the IWIC, has conducted this program for seven years and is particularly sensitive to how to find and connect with the AI/AN homeless people and is effective in bringing them in for services at the Fourth St. Clinic.

Other factors compound the effect of the high level of poverty and the lack of health care insurance on the availability of adequate health care for this population:

1.) Transportation

Without a car or money for public transportation, it is difficult to reach public health clinics.

2.) Culturally Sensitive Access to Care

There are different health care seeking behaviors by those who have lacked sufficient services for multiple generations; these must be understood and appropriate outreach and multiple access systems constructed.

3.) Culturally Sensitive Provision of Care

There is a need for culturally sensitive service delivery mechanisms, including the employment of AI/AN providers;

4.) Linkages to Indian Health Service Facilities on Multiple Reservations

There are a number of people who still travel back and forth between the reservation and Salt Lake City. It is important to have portable data systems.

5.) Accurate Data on Numbers of People and Their Entitlement to Services

Many people remain uncounted in the census and it is difficult to document their needs, as well as their entitlement to services.

Clearly, a sensitive and multi-layered system of outreach, referral, collaboration with other providers of health care, and follow-up services must be tailored to the needs and culture of this group, if the health care status of the AI/AN population is to be improved.

III. SUMMARY OF KEY FINDINGS: 2002 – 2003 CONSUMER SURVEY

POPULATION SURVEYED

The *Key Findings* presented here emerged from a survey conducted from November of 2002 through May of 2003 and represents information collected from 149 consumers and 23 stakeholders at 11 service agencies.

The two community representatives surveyed a total of 149 American Indian/Alaska Native people in the Salt Lake area, primarily between the ages of 25 and 65. Gender of respondents was not tracked. These are the consumers and potential consumers of health care services at the Indian Walk-In Center. The survey consisted of 31 questions and took approximately 20 minutes to complete.

People were invited to respond to the survey while they were attending Indian Walk-in Center activities, such as Pow-Wows, Health Fairs, and during participation in Substance Abuse Treatment programs. They were also collected at a variety of off-site locations, such as the Indian Education and Training Center and the Risk Reduction program, as well as in their homes. Critical information is summarized below.

1. TRIBAL REPRESENTATION AMONG THE RESPONDENTS

Of the 149 respondents, 96 or **64%** identified themselves as being from the **Navajo Tribe**. However, many other tribes were represented, including the following: Alaska/Athabaskan, Apache, Arapahoe, Cherokee, Choctaw, Colorado River, Comanche, Crow, Goshute, Klamath, Lakota Sioux, Makah, Nez Pierce, Northern Ute, Paiute, Pueblo, Shoshone-Bannock, and Southern Ute. A number of respondents listed multiple tribes, indicating mixed parentage representing two or more tribes.

2. IDENTIFICATION OF HOME

While the majority of respondents now call the Wasatch Front (primarily Salt Lake City) their “home,” more than 80% of the consumers continue to identify with their place of birth or the location of their tribal reservation. These “homes” stretch across Salt Lake, Weber, and Davis Counties in Utah, as well as across the states of Idaho, Alaska, Oregon, Arizona, and Montana.

3. CURRENT HEALTH CARE SERVICES

While the majority of respondents traveled in the past to the reservation for health care, particularly for refills on prescription drugs, only slightly more than 30% still make this trip. Close to 60% answered “NO” in response to the question of whether or not they travel to the reservation for health care.

Since the downturn in the economy and the rise in fuel prices, many either receive care in Salt Lake or do without. **Many are doing without health care**, due to a combination of the economic downturn, shrinking financial support for health care for low income people in general and the small percentage of IHS funds available for health care for urban dwelling American Indian/Alaskan Native people.

Approximately 16% of the respondents have jobs that include health care benefits and are seen by a broad range of providers along the Wasatch Front.

Those without health insurance seek services at facilities such as the Fourth St. Clinic, Utah Diabetes Center, Job Corps, St. Mark’s Hospital, U of Utah Hospital, Davis Hospital, Central City and other Community Health Centers, and a variety of Indian Health Service clinics at the Ft. Duchesne, Ft. Hall, Pocatello, Tuba City, Shiprock, and Ouray Reservations.

Approximately 20% marked “none” or “nowhere” in response to the question about where they received services. A number of respondents turn to traditional healing approaches and participate in sweat lodge ceremonies. One woman told us, “I brew sage tea.” Another said, “I cedar myself.” Other responses included the following: “I travel [back to the reservation] as much as I can...Have to...for dental and prescription refills, even though this trip can take up to 7 hours each way.”

4. CHILDREN

The majority of respondents have young children (below 12), who live with their mother at the present time. They find health care for themselves and their children through a variety of sources, including the IWIC, the yellow pages, homeless outreach (4th St. Clinic), or through health insurance providers, such as Cigna or Altius. Child health care services are a high priority for respondents, particularly childhood immunizations and well-child care. Mothers seem to be in charge of these activities.

5. LEVEL OF SATISFACTION WITH HEALTH CARE

More than 50% of the respondents who do receive health care are fairly satisfied with the care they receive. Like other satisfied patients, they value and appreciate individual, caring attention by providers who are polite, take time to examine them, are willing to answer questions, and where there is continuity of care. One respondent wrote, “I have had the same doctor for 10 years.”

Additionally, they respond to those who “understand Native Health needs.”

Those who are not satisfied cite long waits as the chief complaint.

6. UNMET HEALTH CARE PRIORITIES

A. UNMET DENTAL CARE needs still rank at the top of the list. While they like some of the dental services they are currently receiving, there is still a huge gap between need and resources. Frequent comment: “I can’t afford this, even though I need dental services very badly.”

B. DIABETES CARE is the second highest area of high unmet need.

C. PROPER PRESCRIPTION MEDICATION USAGE

There is a high level of need for dialogue regarding refilling, updating, and adjusting medication levels to meet individual needs, as well as a need for better education about the medications themselves.

D. ALCOHOL AND DRUG ADDICTION

While there is a great need for substance abuse treatment (primarily alcohol abuse) among the American Indian/Alaska Native population, the majority of respondents to this survey were not among the population needing this service. For the indigent clients who do need these services, the Fourth St. Clinic and Risk Reduction programs are important resources. The latest abuse among the indigent seems to be with mouthwash, which has some alcohol content.

7. PRIORITIES FOR HEALTH EDUCATION CLASSES

There is a significant interest in health education classes across a wide spectrum of issues. Those that had positive responses by 20% or more respondents included the following: stress relief (more than 50%), diabetes prevention and management, nutrition and cooking, and a variety of exercise classes, including walking, aerobics, yoga, and hiking.

8. PRIORITIES FOR BASIC HEALTH CARE SERVICES

- A. DENTAL CARE (85%) and DIABETES SCREENING AND MANAGEMENT (65%)** continue to be the highest ranking unmet needs.
- B.** Other high priority services include: **IMMUNIZATIONS (flu) and Child Immunizations (62%), OB/GYN SERVICES FOR WOMEN (50%), MENTAL HEALTH COUNSELING (33%), and WELL BABY CARE (31%)**The following specific needs were also mentioned, although by 15% or fewer of the respondents: **Arthritis, Cancer Screening and Treatment, Substance Abuse, Vision Care, and Rehabilitation.**

9. PREFERRED TIMES AND DAYS FOR HEALTH CARE SERVICES

When asked to rank the best times and days for a potential clinic at the IWIC, respondents preferred **Mondays and Saturdays.**

On **Mondays**, preferences are nearly evenly split among mornings (8–12), afternoons (12–5), and evenings (5–8). There is a slight preference for mornings and afternoons. There was not as high an expressed need for late evenings (8–10:30) as had been anticipated.

The MOST PREFERRED TIME OF ALL IS SATURDAY AFTERNOONS FROM 12 – 5, with more than 30% of the respondents choosing this time. **Monday morning and afternoon and Saturday morning** are the next most preferred times, and **Friday evening** is also highly preferred.

The evenings (5-8) from Monday through Friday are the preferred time of treatment for substance abuse.

10. PREFERRED PLACE TO RECEIVE HEALTH CARE SERVICES

When asked if they would come to the IWIC if they had insurance 80% of the respondents responded in the affirmative. However, close to 50% of the respondents indicated that they do not have health insurance at this time and that they could not pay for services. Those who could pay preferred a sliding fee scale with a range from \$5 to \$100.

11. OTHER SERVICES WITH HIGH PRIORITY

Health care is the top unmet need among the respondents. Other services that are important to the respondents included: **Advocacy with the Schools (especially with youth at risk for dropping out), Outreach, Employment Services, Food Pantry, Housing, Domestic Violence, Walk-In and Emergency Services, and Parenting Classes and Support Groups.**

12. KEY ROLE FOR THE INDIAN WALK-IN CENTER

Respondents expressed the need to be professional in the delivery of services and to maintain confidentiality. They said it is an INDIAN WALK-IN CENTER, not an “anyone walk in center.”

It is very important to respondents that the Center is run by Natives and that there are Native people delivering services.

IV. SUMMARY OF KEY FINDINGS: 2003 – 2003 PROVIDER SURVEY

Interviews were conducted with 23 different providers from 11 different agencies with whom the Indian Walk-In Center might collaborate in the delivery of a broad array of health care services.

These providers identified five distinct groups of health care consumers:

- A. Employed/With Health Care Insurance;
- B. Employed/Without Health Care Insurance;
- C. Unemployed/Actively Seeking Health Care for Self or Children;
- D. Unemployed/With (can be temporary) Home/ Not Actively Seeking Care;
- E. Homeless/Living in Shelter or On the Street.

With approximately 64% of the AI/AN population in Salt Lake County living at or below the poverty level, it is not surprising that the large majority of AI/AN people who live in Salt Lake County, and who comprise the largest proportion of the Indian Walk-In Center target population, are clustered in the latter four groups defined above, while that percentage for the general population is significantly lower. This distribution has a significant impact on the structure of the most effective health care system.

1. DISTRIBUTION OF AI/AN POPULATION AMONG THESE FIVE GROUPS

The best estimates at this time suggest that BETWEEN 70 AND 75% of the AI/AN people in Salt Lake County are clustered in the latter four groups defined above, while that percentage for the general population is between 16 and 18%.

NEED FOR MULTIPLE OUTREACH AND ENTRY SYSTEMS

This distribution further explains the need to develop multiple ways of accessing public health services. The outreach, entry, and follow-up mechanisms that are attractive and would be utilized by those who are employed but do not have health insurance or are unemployed but seeking culturally sensitive services for themselves and their children through the Indian Walk-In Center are different from what would be effective with those unemployed and not seeking care or with the homeless population. Each subgroup has differing styles of accessing and utilizing health care, which further complicates the development of an effective health care system by the Indian Walk-In Center.

2. PARTICIPATION IN URBAN PUBLIC HEALTH PROGRAMS

We also know that fewer than 10% of the clients served in the primary public network of care (Community Health Clinics) in Salt Lake City are from the AI/AN population, while **25 and 30% of the homeless have been identified as being AI/AN.**

It is clear that more than half of the AI/AN population goes without any formal health care services – and that a disproportionate number need basic services such as detoxification and emergency medical services.

Multiple systems of advocacy, outreach, and ongoing support are necessary to mount a meaningful system of care that targets prevention and health care maintenance services. Key among these services are well-child care and immunizations, as well as adult clinics that target diabetes and prenatal care. In addition, there are a host of wraparound services that require significant financial resources beyond what is now available.

3. PARTICIPATION IN COMMUNITY HEALTH CENTERS SERVICES

The largest provider of services in collaboration with the Indian Walk-In Center is the Salt Lake-based network of Community Health Centers (CHCs). However, according to the records of the CHC network, only 2300 of the IWIC target population of 13,000, or 17.5 %, currently are served by this public network.

IT IS CLEAR THAT THE MAJORITY OF AI/AN PEOPLE ARE NOT RECEIVING HEALTH CARE EITHER AT URBAN PUBLIC HEALTH

CLINICS OR THROUGH INDIAN HEALTH SERVICE CLINICS AND HOSPITALS ON THE RESERVATIONS.

4. OTHER CULTURAL AND ORGANIZATIONAL CHALLENGES

There are a number of cultural and organizational challenges that are often not acknowledged in meeting the needs of the AI/AN population who seek services in Salt Lake City, Utah, area.

A. There are eight “primary” tribes from which this population originates, each with its own cultural traditions.

B. There are ten different “home” states in which these tribal headquarters are located. The distances to these places are great – and any financial negotiations related to financial support for health care services spans the eight different tribes and ten different state systems.

C. There are three different Indian Health Service (IHS) regional offices to which this array of tribes relate (Phoenix, Albuquerque, and Portland). The Navajo tribe relates to both the Phoenix and Albuquerque offices and delivers services to the Navajo, Hopi, and Zuni tribes.

D. Finally, the history of the LDS Church in this geographic area, including its complex relationship with the Native peoples of this land, contributes to both particular strengths and special challenges in organizing health care services for the AI/AN population being served in Salt Lake City. Many AI/AN people have strong ties to families from this tradition, with whom they lived as children in “foster care” arrangements. Many people have allegiance both to their tribal identities and to their affiliation with the dominant religion in this area. There are multiple resources – and traditions - upon which a system of care can draw.

The effect of all these fragmenting forces cannot be underestimated in the challenge of organizing practical and effective health care services for this growing population.

V. Preliminary Conclusions and Recommendations

This report reveals no startling “new” discoveries since the 1998 study. Basic health care needs remain unmet and continue to grow. The Indian Walk-In Center must function as a strong and resourceful hub for a continuum of health care and related services to AI/AN people who come for assistance to the Salt Lake City area.

That having been acknowledged, there are steps that the IWIC can take at this time to develop and maintain an effective, culturally responsive, and integrated system of primary, secondary, and tertiary health care services for the AI/AN people along the Wasatch Front.

A. PROFESSIONAL TEAM

The Indian Walk-In Center of Salt Lake City, Utah, must have a team of professional staff who can envision, develop, and operate access to financial support and many collaborative relationships necessary for a well-functioning network of primary, secondary, and tertiary health care services, outreach and advocacy. Such a system must be built on what is already in place that works well, but must strategically restructure these key programs so that they inter-relate to all the components of a comprehensive system. With new leadership and a team of committed professionals, comprehensive services can be systematically implemented.

B. DEVELOPMENT OF KEY RELATIONSHIPS ACROSS (AT LEAST) EIGHT PRIMARY TRIBES, TEN STATE HEALTH SYSTEMS, AND THREE IHS UNITS.

The tribal relationships must enable the merging of data from official counts, such as the census figures, with data kept by tribes on those who are not counted in the census for multiple reasons.

C. THE IWIC MUST WORK COLLABORATIVELY WITH LOCAL ORGANIZATIONS AND PROVIDERS OF CARE.

These relationships must be developed and worked continuously, with meetings held at least quarterly for all involved in care and follow-up. That would include each of the agencies interviewed for this study, as well as key leaders in the city and county health departments, the state health department, hospital emergency room and Insta-Care center personnel, and other key organizations that focus on providing health care to low-income populations.

D. STAFF MUST BE HIRED FROM THE COMMUNITY TO PERFORM KEY OUTREACH, REFERRAL, ADVOCACY, AND FOLLOW-UP FUNCTIONS.

Similar to the Fourth St. Clinic – and in collaboration with them – the IWIC Health Care System must include these key IDENTIFIABLE community members to have an ongoing system of recruitment, service provision and/or referral, and follow-up.

E. EXPANDED MANAGEMENT INFORMATION SYSTEM

There must be an expanded management information system (MIS) to facilitate ongoing effective collaboration with many community agencies on the referral and follow-up of individuals and families.

F. A WELL-DEFINED IWIC HEALTH CARE INITIATIVE

A comprehensive IWIC health care initiative must be outlined and presented to the community in a series of focus groups, revised based on this feedback, and then presented to the media in a formal ceremony with key tribal, state, and local officials in attendance.

This must be preceded by careful collaborations that have been outlined and agreed to by all parties – in order that the program becomes a reality.

THE IWIC COMPREHENSIVE HEALTH CARE INITIATIVE MUST BE LAUNCHED PUBLICALLY, AND WAYS OF ACCESSING THIS PROGRAM MUST BE CLEAR TO THE ENTIRE AI/AN COMMUNITY. THEY NEED TO HAVE CONFIDENCE THAT CULTURALLY SENSITIVE PRIMARY HEALTH CARE SERVICES ARE LINKED TO A COMPREHENSIVE SYSTEM THAT WORKS OVER TIME FOR BOTH CONSUMERS AND PROVIDERS.

POTENTIAL LEAD COMPONENTS

Lead components of the IWIC Comprehensive Health Care Initiative might consist of three visible services that respond to key unmet needs identified as priorities in this survey:

WELL FAMILY CLINIC

On site for adults and children, including diabetes treatment and management and immunizations, to be operated at the times identified in the community survey, beginning with Saturday afternoons from 12 – 5 and Monday mornings (see Chart C). This clinic could be staffed by a nurse practitioner and would be a visible and productive entry point into the more comprehensive system with multiple resources.

EYEGLOSS CLINIC

On site for adults and children in cooperation with KRCL and Donna Land Maldonado, Circle of Wellness board member, and optometrists, ophthalmologists, and providers of eyeglasses. This service would be very visible and provide an effective and noninvasive entry into the system for those who may be hesitant.

DENTAL CARE CLINIC

Either on-site or at a collaborating site for screening, referral, case management for access to services and funding, and follow-up.

STAGES OF IMPLEMENTATION: FULL COMPREHENSIVE HEALTH SERVICES

Stage I of Implementation: Part-time wellness clinic staffed by a nurse practitioner at specified times. Emphasis would be on assessment and referral. This person must be clinically skilled, as well as a good collaborator. She/he might oversee health education/health promotion programs as well.

Stage II of Implementation: This clinic would be in operation more regularly and include dental services, either on-site or by referral.

Stage III of Implementation: This full-time, comprehensive center would be located in the Circle of Wellness building. Services would span health, mental health, dental health, substance abuse, and health promotion/education programs.

PROVIDER INTERVIEW PARTICIPANTS

1. Circle of Wellness

James Floyd (Veterans Administration Medical Center)
Donna Land Maldonado (KRCL Community Radio Station)
James McCullough (University of Utah, Dept. of Anthropology)
Melissa Zito (Health Insight)

2. Community Health Centers

Dexter Pearce
Elijio White

3. Daniels Fund

Perry Mathews

4. Fourth St. Clinic

Allan Ainsworth
Lorenda Bailey
Gabriella Cetrolla

5. Indian Education and Training Center

Betty Windy Boy
Margene Elder
Janie Ridd

6. Indian Walk-In Center

Dena Ned
Anthony Smith
David Derezotes
Lorena Horse
Barbara Costello

7. Harm Reduction Program

Luciano Colonna

8. The Road Home/Volunteers of America

Mark Paoletti (Van Driver)

9. Utah State Division of Indian Affairs

Forrest Cuch

Karen Duffy

10. Valley Mental Health: Storefront Safe Haven

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11. Veterans Affairs

Mark Bigwood