House Committee Votes to Continue Four Key Indian Health Programs in ’85

WASHINGTON, D.C.—Once again Congressman Sidney Yates (D-Ill.) has come to the rescue of an Indian health care budget targeted for drastic cuts by the Reagan Administration. Congressman Yates and his Interior Appropriations Subcommittee have come up with recommendations amounting to a $172 million increase over the Administration’s request for the Indian Health Service (IHS) next year.

However, even though it has provided such a significant boost, the committee’s accompanying report states, “...the Committee has been made aware through testimony from departmental witnesses that this budget will still fall short of providing the unmet health care needs of the Indian people, as well as continuing a pattern of providing a lower level of health care services, on a per capita basis, than is available to the U.S. population as a whole.”

A total of $818 million is recommended for Indian health services, an increase of $76.04 million over the President’s budget. And the committee would provide some $96.14 million for Indian health facilities in the absence of any request by the Administration for facilities money.

In the hospitals and clinics category of the IHS budget, the committee recommends an increase of $22.43 million (above the Administration figures) which consists of $500,000 for the model diabetes programs, $4 million for emergency medical services, $17.48 million in mandatory cost increases and $447,000 to provide staff for new facilities. The increase for the model diabetes program will allow two new model sites to be established, as well as strengthening the program at existing sites and providing additional outreach.

The Administration has stated that IHS plans to collect $55.4 million from Medicare and Medicaid in FY 1985 in an effort to increase the portion of services

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TRIBAL EMERGENCY MEDICAL programs have evolved tremendously over the past decade and are now a critical part of the Indian health care delivery system, responding to thousands of emergencies on reservations each year. Pictured above is Nathan Navasie, a certified EMT with the Hopi Emergency Medical Program in Keams Canyon, Ariz., cleaning a wound on a small child before suturing in the hospital emergency room. For an in-depth look at Indian EMS programs, please see article on pg. 6. (Photo by Gilbert Roland)
supported by reimbursements. (Additional collections are projected from private insurers.) The amount recommended for mandatory cost increases by the committee was, in the Administration's budget request, to have been made available from such reimbursements. Calling past estimates of Medicare and Medicaid reimbursements "optimistic," the committee recommended direct appropriation of the funds required to meet mandatory cost increases.

The committee recommends an increase of $2.2 million above the President's request of contract care, including $500,000 for the "highest priority non-emergency backlog cases" of deferred surgery.

Funding for the Community Health Representative program, targeted for elimination in the President's budget, would be restored at $27 million. This will allow a 4 per cent increase over the 1984 level. The program is currently funded at $30 million, with $26 million in direct appropriations and an additional $4 million designated for Emergency Medical Services provided by CHRIs. The $4 million included by the committee for EMS is assumed to be used to allow continuation of the program at slightly above its present level.

The urban health program, proposed for elimination by the Administration for the fourth year in a row, is recommended to receive $10 million. This amount includes a 4 per cent increase for existing projects with the balance of $640,000 to be used for upgrading of health care levels in existing programs where warranted.

The Administration's FY 1985 budget request would provide scholarship funding for 416 continuing students and 50 extern placements. Nonetheless, funding would not be provided for approximately 63 continuing students and support for the Indians Into Medicine (INMED) and the four Indian MPH programs would be discontinued.

By contrast, the committee recommends an increase of $2 million over the Administration's request to provide continued funding for both ongoing and new scholarships. Also included are $275,000 for administrative of INMED and $220,000 for the MPH programs.

The committee also recommends an increase of $2.63 million over the President's budget for the tribal management program, allowing the program to continue at its current level. Designed to help promote capacity-building activities for tribal health programs, especially with new tribes with few or no resources for development, the tribal management program would be eliminated in FY 1985 under the President's proposed budget.

In addition to the issue of the overall level of funding, the committee notes in its report that "...many tribes and tribal groups continue to raise questions regarding the methodology used by IHS in allocating the funds available to it." The President's budget request included no additional money for the Equity Fund, and the committee has not recommended an increase for this purpose. "However," notes its report, the committee is "...concerned that IHS' handling of this issue has not addressed adequately the concerns of various tribal groups on the equity of its allocation methodology." Therefore, the committee has asked that IHS work with those tribes or groups and submit a report by December 31, 1984, "reporting on the results of their joint efforts, and what changes, if any, will be made to the allocation methodology to reflect tribal concerns."

In explanation of its recommendation of an increase of more than $96 million above the President's budget for facilities, the committee states, "Unfortunately, the committee can take no direct action to

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The following is a regular feature of the NIHB Health Reporter. In this section we present our readers with short descriptions on issues and activities from around the country, including such topics as conference and workshop dates, legislative notices, news on local events, etc. We invite our readers to submit materials for publication. For information on the items mentioned here can be obtained from the NIHB Public Information Office.

WASHINGTON, D.C.—Tribes applying for first-time grants in FY 1984 to provide nutrition and other services to the Indian elderly under Title VI of the Older Americans Act will have an additional six weeks to file their applications with the Administration on Aging. The agency extended its deadline for first-time tribal applicants from June 29 to August 15; applications from current grantees were due June 29. As explained in the Federal Register June 26, "The reason for the extension is to allow more time to small tribes to make certain arrangements with regard to eligibility for a grant. Many small tribes do not represent the required number of 75 Indians age 60 or over and can meet this requirement only by forming a consortium of two or more Tribes," which requires formal tribal resolutions and the development of cooperative arrangements to prepare service programs. For additional information about the grant, contact: Michio Suzuki, Office of State and Tribal Programs, Administration on Aging, Office of Human Development Services, Rm 4282, 330 Independence Avenue S.W., Washington, D.C. 20201. Phone: (202) 245-0011.

WHITE EARTH, MINN.—A one-year diabetic educational program here designed to increase Indian diabetics' ability to monitor their illness is among eight innovative diabetes projects funded recently by the Indian Health Service. The White Earth project has three basic components: meal preparation counseling, educational materials, and special home glucose monitoring devises that will enable diabetics to better understand what happens to their blood sugar levels over a 24-hour period. According to project co-director Chris Jones, "The key to controlling and preventing diabetes is to get the patient to administer the care for his own disease and learn to manage it with some assistance from clinic staff." The seven other short-term projects, funded by IHS to examine different approaches to the prevention and treatment of diabetes, include IHS service units in Ada, Okla.; Belcourt, N.D.; Fort Berthold, N.D.; Fort Yuma, Calif.; Rosebud, S.D., and San Carlos, Ariz.; and the IHS area office in Portland, Ore.

WASHINGTON, D.C.—Tribes applying for direct funding under Title IVB, Section 428 of the Social Security Act have until August 15 to submit their final proposals to regional offices of the Administration for Children, Youth, and Families. Notice of intent to apply for direct funding was required by May 30 and is a required part of the grant process. Under Title IVB grants, tribes can provide a wide range of health-related services to children and families, including protecting and promoting the welfare of the handicapped, homeless, dependent or neglected children; preventing or assisting in the treatment of problems related to abuse, neglect, exploitation, or delinquency of children; placing children in appropriate adoptive homes, when necessary; and assuring adequate care for children in cases where they cannot be returned home or cannot be placed for adoption. In Fiscal Year 1983, 23 tribes received direct funds totaling $242,740 under Title IVB.

ROSEBUD, S.D.—Indian Health Management, Inc., a private health firm serving reservation residents here, recently named Ken Packard as its Employee of the Year of 1984. Packard, who has been the finance officer for IHMI since its origin 10 years ago, "has been one of the keys to IHMI's success and has given years of dedicated service to the Rosebud Sioux people," notes IHMI President Sonny Waln. The award was presented June 29.

TUCSON, ARIZ.—The University of Arizona's American Indian Professional Training Program in Speech Pathology is encouraging undergraduate Native American students interested in serving the needs of communicatively impaired American Indian children and adults to complete and submit applications to the program for the 1984 fall semester. Needed in the field of speech pathology are American Indian professionals knowledgeable in the normal development of speech and language as it is affected by cultural and ethnic influences and trained in the prevention and treatment of communication disorders among American Indians. Completion of the American Indian Professional Training Program in Speech Pathology will qualify individuals for a Master's degree in the field. Financial assistance is available to qualified applicants. For additional information contact: Gail Harris, Director, American Indian Professional Training Program in Speech Pathology; Department of Speech and Hearing Sciences; University of Arizona; Tucson, Ariz. 85721. Phone (602) 621-5075.

TSAILE, ARIZ.—Three workshops designed to improve communication and understanding between Navajo area nurses and Indian patients will be sponsored by the Navajo Community College this fall. The three workshops will examine such issues as anxieties, misperception, and counterproductive attitudes related to an Anglo-Indian working setting; establishing rapport, history-taking, conveying information, and other aspects of working with and through Navajo translators; and integrating Navajo concepts of health and illness with the Western medical model. For additional information about the workshops, contact: Enid Rossi, Division of Nursing, Navajo Community College, Tsaille, Ariz. 86556. Phone: (602) 724-6234.
October, the Hospital Board Executive Committee Signs cooperation. T.A. Coochyouma, hospital administrator, stated that the Hopi people themselves encouraged us to develop this practice that promotes healthy living. The policy would not be possible without their cooperation. The Stanford University award is the first ever presented to a federal health facility.

ROCKVILLE, MD—The life expectancy at birth for Indians and Alaska Natives during 1979-1981 was 71.1 years, up 6 years from 1969-71, according to a recently-released report from the Program Statistics Branch of the Indian Health Service. The trend in life expectancy for Indians and Alaska Natives has been rising for the past four decades, the report states. Despite these gains, Indian and Alaska Native life expectancy still lagged behind that of all races in 1980. Copies of the 1979-81 Life Expectancy Report may be obtained from the Indian Health Service, Rm. 6A-30, Rockville, MD 20857.

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**House Committee**

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force the Administration, including the Department and Office of Management and Budget, to recognize their responsibilities to request adequate funding for the design and construction of facilities to meet the health care needs of the Indian people. Therefore, the Committee has found it necessary to recommend total funding of $96,137,000 compared to the budget request of zero.

Funding for Phase I construction for both the Rosebud, S.D. and Sacaton, Ariz. hospitals is recommended in the expectation that the design phase will be completed in time to allow construction to begin by the end of the fiscal year.

No funds have been included for planning and design for the next hospitals or ambulatory facilities on the IHS construction priority lists, as revised in 1984. The committee states that, in line with testimony of department officials, it would like to "give the department the opportunity to show its good faith by completing expeditiously the necessary program information documents on the top priority projects, and coming forward to the Congress with recommendations as to facility construction and related funding requests."

A $30 million appropriation is recommended for sanitation facilities. This is intended to provide service to approximately 4,000 Indian homes under construction by the Bureau of Indian Affairs, tribes, or other groups, or already existing homes with service. The Interior Appropriations recommendations were adopted by the full House Appropriations Committee on June 28 and now await action on the House floor.

A complete comparison of the committee recommendations and the President's budget is as follows:

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<th>President's Budget ($ in thous.)</th>
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H.R. 4567 Amendments May Pave Way for New Indian Alcoholism Bill

RENO, NEV. — Both versions of the bill to reauthorize the Indian Health Care Improvement Act now under consideration in the House of Representatives include amendments relating to prevention of alcohol and drug abuse.

Under the amendments, the Departments of Interior and Health and Human Services are required to enter into a Memorandum of Agreement to coordinate efforts in the area of education regarding juvenile alcohol and drug abuse prevention. The amendments require both the Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA) to compile existing studies and literature, including school curricula, relevant to juvenile Indian alcohol and drug abuse. The departments are also required to incorporate a training program for teachers, administrators and counsellors in alcohol and drug abuse. Further, the amendments would statutorily establish the Office of Alcohol Programs within IHS and provide funding for additional staff.

In testimony before the House Interior Committee on April 12, Congressman Tom Daschle (D-S.D) stated, "The Administration has requested $26 million to combat alcoholism among Indian people in its fiscal year 1985 budget . . . Little of these financial resources, however, go to efforts designed to prevent alcohol and drug abuse." He continued, "While it is difficult to calculate the costs of effectively preventing and combating alcohol and drug abuse, common sense would dictate that the cost of doing something about the problem will be much less expensive than costs of alcohol-related diseases, child and spouse abuse, incarceration, court costs, public assistance and unemployment due to alcohol or drug addiction."

Appearing before the committee on the same day, Congressman Doug Bereuter (R-Neb.) told those present, "Last November, Mr. Daschle and I began to research the problem. To our great dismay, we discovered that out of 179 IHS alcohol treatment programs, only two were equipped to deal with the special problems of the juvenile victims of alcoholism. Upon further investigation, we discovered that the majority of children apprehended during the commission of a crime are intoxicated. But the true horror of the situation is that most of these children are then incarcerated in jails with adult offenders, and their chances of receiving appropriate care and services are minimal." Added Bereuter, "Without special treatment resources for them, and without a system of referral among Indian Health Service personnel, BIA Education and Social Services staff, juvenile authorities and tribal officials, these children may languish in jail instead of receiving treatment for their illness."

In a workshop session titled "Future Directions in Indian Alcoholism" held here June 6 during the Sixth National Indian/Alaska Native Health Conference, Frank Ducheneaux, staff director for the House Interior Committee, said he is certain that the provisions will be enacted into law. The amendments are regarded as "a down payment on what's coming," he says.

His statement was a reference to plans by Congressmen Daschle and Bereuter to introduce a bill on adolescent Indian alcohol and drug abuse within the next few months. Karen Funk, staff member for Daschle, expects that after its introduction the bill will be revised, reintroduced in January, and enacted in FY 1985.

She discussed with workshop participants several provisions being considered for inclusion:
- a Memorandum of Agreement between HHS and the Interior departments regarding coordination and cooperation in efforts dealing with alcohol/drug education, counselling and treatment. This provision would be an extension and expansion of what is contained in the IHICIA reauthorization bills.
- requiring tribal alcohol/drug plans regarding coordination of existing resources plus those resources contained in this bill. The tribe would work with federal agencies in directing them how to implement alcohol/drug abuse efforts at the agency level.
- requiring BIA/contract schools to put alcohol/drug education curricula in place at all grade levels.
- expansion of Title IV (of the Indian Education Act) for these efforts to reach urban Indian adolescents. Part A would provide money for counsellors at schools with large numbers of Indian students. Within Part B, a number of fellowships for trained alcohol/drug counsellors would be earmarked. Part C would make money available to urban Indian centers for trained alcohol/drug counsellors. Schools without trained counsellors could refer students to these centers. Counsellors would also serve the adult population which uses the centers.
- funding of more alcohol programs through IHS with the focus on juvenile substance abuse prevention. Pilot projects for juvenile treatment and/or detention programs would also be provided.
- money for summer recreation programs designed by tribes/schools would be provided.
- money for summer counselling of adolescents would be available. Use of school facilities would be made for both summer recreation and summer counselling programs.
- provision of summer jobs would be made either through this bill or other legislation.

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ROCKVILLE, MD. — Before the Indian Health Service began its Emergency Medical Services (EMS) program in 1977 it was not unusual for an accident victim to lie on a remote road for hours before receiving medical attention. Hundreds of lives were lost or needlessly impaired. Today, some seven years later, the program can boast of dramatic improvements. A recent analysis reveals that the number of lives lost as a result of accidents has declined steadily from 176 per 100,000 population in 1977 to 114 in 1981, a 35 percent reduction. The number of these deaths caused by motor vehicle accidents fell from 103.9 per 100,000 population in 1977 to 67 in 1981, a 36 percent reduction.

IHS and tribal EMS staff point to a number of factors contributing to EMS' success. Probably the most indisputable factor contributing to the saving of lives is the reduction in response time to emergencies. The need for effective emergency medical response and transportation is especially acute in Indian and Alaska Native areas due to the large number of accidents and other emergencies and the long distances which must be travelled.

In the late 1970's, EMS programs were serving only 50 percent of the reservation population. Today, according to former EMS Program Director John Emelio there are some 65 tribal ambulance services (excluding Alaska), another 20 sophisticated “First Responder” systems linked with contract service, and the remaining areas use other available community services. With many tribal ambulance services located an hour or more away from the remote communities they serve, one significant objective of the EMS program is the further reduction of response time to emergency sites. The current target is 15 minutes to respond to a report of a medical emergency with the average around 30 minutes.

Trauma means injury or wound, whether caused by accident or personal violence. In trauma care, the system must think and act because the patient cannot. The system must treat the patient at the scene, assess his injuries, and take him to the hospital, where doctors must make quick decisions. Speed is very important in trauma care. Lengthy emergency response times become particularly unsettling considering that irreversible brain damage can begin just six minutes after cardiac arrest. In addition to saving lives, proper handling and care in the first minutes following an accident or illness can lessen the patient's suffering, shorten the period of hospitalization, and reduce the period of recuperation.

One means of reducing response time adopted by IHS and tribal staffs and local community people in a number of areas is the “First Responder” system. First Responders are volunteers trained in basic life support and emergency care who will respond to an emergency and stabilize the patient until an ambulance arrives. When an emergency occurs, the First Responder is contacted through a radio communications network or telephone.

Linda Ford, who is working to put such a system in place in several of Oklahoma's Cherokee communities, states that First Responders have assisted a number of heart attack and stroke victims since the first community began using the system a year ago.

On the Hopi reservation, EMS director Phil Johnson has become a strong advocate of the First Responder system.
Programs Provide Critical Care to Indian Communities, Hospitals

program. "Eighty percent of what kills people on the reservation is trauma," he estimates. He says of the tribe's First Responder program, "Out here we train everyone under the sun because there are so few people living in such a large area. There is a good chance that if an accident occurs, no one will be around. This way we greatly improve the chances of someone with some knowledge being around."

Johnson's belief is based on personal experience. One evening he was driving home with his family when they came upon the scene of an automobile accident. He started working and before long others trained as First Responders came by including a physician and a former Emergency Medical Technician (EMT). Two lives were saved as a result.

In another occurrence, a housewife and a police officer trained as First Responders helped stop bleeding in a patient shot with a deer rifle. Johnson describes such a feat as part of a "tiered approach." He explains, "You need to have the big picture. The only reason surgeons could save the man was because the EMT's were able to deliver a live patient. And before them the efforts of the First Responders were critical."

Another invaluable component in the success of tribal EMS is better trained staff. "Training is the backbone of any EMS program," states Jerry Rousseau, IHS EMS training coordinator. "These particular skills we teach do save lives," he adds.

Not only must training be provided for tribal emergency staff but for IHS doctors and nurses as well. According to Dr. Jack Porvaznik, medical director for the IHS EMS program and chief of surgery at the Gallup Indian Medical Center, "One of the major challenges is that most physicians have had little experience in managing emergency or trauma patients. And yet within IHS that's the name of the game." He explains that IHS works intensively with its physicians and nurses to give them both practical and theoretical experience in handling emergencies. With the high turnover rate of IHS physicians and nurses training must be an ongoing effort, states Porvaznik.

With tribal EMS personnel, emphasis was initially on training of EMT's and First Responders. Such efforts must also be ongoing in order to train about 250 tribal members per year, says Rousseau. But more promising is the shift in emphasis of IHS' training to development of Indian EMT instructors to do training in their own communities. Another encouraging development was the first advanced EMT training course offered by IHS earlier this year. The course came about as the result of requests by tribal ambulance directors. The 18 EMT's who participated were trained to perform shock and IV therapy. Their new skills have already had an impact in reducing morbidity and mortality on their reservations, says Rousseau.

IHS plans to expand the availability of such training this year and the increased knowledge imparted should be a real boon for remote reservation areas.

Finally, says Emelio, "In Indian communities accidents affect every family. Tribal governments have a real awareness of the seriousness of the issue and a high commitment and dedication to the program; that's why they have such a fine program." He adds, "Other rural areas have a program nowhere near the same quality."

He also attributes the program's success, in part, to the joint effort between IHS and the tribes in building local programs. "All other programs were built by the

IHS EMS Director Retires

Last month marked a major change for Indian Health Service Emergency Medical Services (EMS) as the program saw its founding director, John Emelio retire. Emelio, 45, guided the program since its inception in 1977 and indeed had led the fight to establish the program on a national level. From that time, Indian country has seen emergency medical services in their communities grow from non-existent to a situation where emergency victims are now reached within half an hour.

Emelio assumed directorship of the IHS EMS program in 1977. He says that in every community he visited to talk about putting an EMS system in place he knew there would be a person who would emerge and put the program together. "It never failed, that person was there in every community," he comments. "It may sound cliched but the experience taught me that an individual can make a difference," he adds.

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TRAINING IN EMERGENCY procedures is a critical part of any successful emergency services program. Eugene Koster (left), an EMT with the Ft. Thompson, S.D. ambulance program and Brenda Swepton, an EMT with the Cherokee Nation Health Department in Oklahoma, practice inserting the endotracheal tube.
EMERGENCY MEDICAL TECHNICIANS must possess a broad range of skills and emergency knowledge in order to properly treat victims of a medical crisis. Here, Gilbert Roland processes skull x-rays of a patient suffering head injuries. Hopi EMT's also assist in lab procedures.

Tribal Emergency...

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government. In the case of EMS, tribes were told that if they put up the manpower IHS would help get the ambulances," says Emelio.

The theme of success attributable to working cooperatively is echoed in locations across the country. In the southwestern Navajo and Hopi tribes are proud of their largely hospital-based ambulance crews. Hopi EMS staff work in hospital emergency departments on a regular basis taking blood pressures, starting IV's, and performing other medical duties. As Johnson describes the interaction, the EMT's have an intimate working knowledge of the medical staff they are working with. And a physician giving instruction via radio to EMS staff in the field knows the capabilities and limitations of individual EMT's.

Porvaznik regards it as his role to "erase any line between tribal and IHS care of a patient." "Indeed," he says, "the pre-hospital phase is an extension of IHS emergency rooms."

He advises doctors and nurses to treat the EMT as "another staff member who works outside the hospital and is part of the emergency team." In the Navajo area, relations were also improved between tribal and IHS EMS staff at local hospital facilities through regular meetings with the EMT's to discuss difficult cases.

On South Dakota's Pine Ridge reservation, one of three tribal EMS units is hospital-based. All EMT's spend a share of their time assisting in the emergency room because the local hospital is so short of staff. The work includes assisting with cardiac arrest patients as well as those from multiple-patient accidents.

Another task which falls to the tribe's EMS workers, according to director Essie Kirk, is that of educating new IHS medical staff. Pine Ridge suffers from a high physician turnover rate. "It takes about 2-3 months each time a new staff person arrives to convince them of the contribution made by the EMT's. New doctors must learn to do something with nothing, something we've been doing for a long time," explains Kirk.

The advances in Indian emergency medical care have not come with ease. A continuing barrier to reducing the amount of response time to emergency victims in remote reservation areas is the time lost before an emergency situation is ever reported. On Pine Ridge, for example, few telephones are available. Says Kirk, "With the long distances, it can be a long time before anyone ever calls us or before the person is found."

She estimates that as many as 99 percent of calls to the emergency staff come from the local police department. "We have a big problem with the dispatchers not calling in time," she reports. And on a reservation where unemployment rates are extremely high, the EMS staff also must deal with people wanting them "to serve as a taxi service."

Lack of telephones is also a fact in other tribal communities. Although the Hopi EMS program boasts a response time to most emergency sites within 10 minutes of notification, with the shortage of telephones again it can be some time before the EMS staff learns of an emergency. For example, on Third Mesa, a community of 1,500 people, there are next to no telephones.

Since its beginnings in 1977, the EMS Program has continued at a minimal funding level utilizing IHS funding, tribal funding, the Emergency Medical Services Act and the National Highway Traffic Safety Act. Manpower needs have been answered through the Community Health Representative program, as well as numerous community volunteers. The program currently operates with $3 million in direct appropriations, $2 million from elsewhere within the IHS budget, $4 million specified in CHR funds, and approximately $2 million in tribal (none-IHS) funds, for a total of $11 million. Yet the annual estimated need to operate a program at every reservation in line with national standards amounts to $24 million.

Program progress nearly ground to a halt in FY 1981 with the loss of the CETA (Comprehensive Employment Training Act) personnel formerly utilized and other drastic budget cuts made by the new Administration. Tribes were forced to reduce their staffs or operate with increased numbers of volunteers.

The Pine Ridge program, for example, with a service population of 12-13,000, made 1,545 calls last year. Their EMS program began in 1971 with "nothing for vehicles and very little personnel," says tribal EMS director Kirk. Over the last four years the amount of trauma the Pine Ridge staff take care of has increased yet funding has remained the same, she complains. Kirk estimates that her reservation is 20 EMT's short to run the service "like it should be run."

It was through such commitment on the part of the tribes that local efforts continued, says Emelio. And the EMS funding crunch now appears to be easing up a bit. With year end funds from FY 1983, IHS was able to replace a large number of tribal ambulances and upgrade radio communications. And at the urging of tribes, the National Indian Health Board (NINB) and others EMS is included in legislation now pending for reauthorization of the Indian Health Care Improvement Act.
New CHR Contract Guidelines, Reporting System Nearly Complete

ROCKVILLE, MD. — In order to receive continued funding for their Community Health Representative programs the year after next, tribes will need to take special care in preparing next year’s contract scopes of work, a process currently getting underway in most Indian Health Service areas. In addition to following newly-devised scope of work guidelines, tribal CHR programs will be required to participate in a revamped reporting system.

Although the CHR program has won continued congressional support, in granting appropriations nearly two years ago the House Appropriations report stated: “The program has come into question again because IHS has not fulfilled its management responsibility by establishing guidelines and goals, and setting up evaluation standards for these projects that would ensure these goals are being met . . . Under no conditions should IHS merely allocate the total recommended funding to existing projects until the guidelines have been established and project eligibility determined. Clear evaluation standards should also be included, and provision for a regular evaluation standard established.”

In response, the director of IHS appointed a task force made up of representatives from national Indian organizations and IHS leadership. This group, in turn, made a number of recommendations (later adopted) including the present intended scope of the program and criteria to be considered in developing an evaluation methodology and reporting system.

Historically, CHR program resources have been allocated on the basis of a single criterion: service population size. After considerable discussion, the task force recommended that future resource allocation be based on three parameters: individual program compliance with “scope” criteria, individual program compliance with “effectiveness” standards, and relative unmet community health service needs among tribal communities.

Over the next year, each program will be measured in terms of its compliance with “scope” criteria and its cost effectiveness. If a program is found to fall within such criteria, it will be included in the resource allocation process and continue to receive a portion of the total CHR resources in FY 1986.

Each CHR program will be expected to draft its scope of work for next year in terms of work to be done in specific health care “areas,” “functions,” and “settings” (i.e., categories of service) which it chooses as most appropriate for its population. As delineated by the task force, there are six specific health care delivery areas: general health, dental, maternal and child health, gerontological, mental health, and environmental health services. Within these are a total of 108 possible categories of health care services which may now be provided with CHR resources.

The task force also recommended that IHS continue its policy allowing each tribe to determine its CHR program scope at the local level, based on locally-identified health needs, the availability of alternate resources and health care priorities as long as it falls within the acceptable program functions, areas and settings. Accordingly, notes CHR National Program Coordinator Nicky Solomon, “A CHR program can use all of its resources to work in a single function within a single health care delivery area, or it may work in all of the health care delivery areas.”

To fall within the scope criteria of the evaluation standards, a CHR program must also show the portion of its resources to be spent on each service category chosen for inclusion. Further, each contract scope must be directly related to a high priority health need of a community as identified in its tribal specific health plan or other mutually agreed-upon means to identify health care priorities. Guidelines providing instruction on CHR project proposal and scope of work formulation were mailed to tribes, contracting officers and area CHR coordinators the week of March 5.

In evaluating a CHR program’s cost effectiveness, IHS will measure each of the 108 possible categories of service a tribe might include in its scope of work. Specific health care activities which might be performed by CHR’s in each category have been developed by groups comprised of CHR and IHS health care providers in each of the health care delivery areas.

Dr. Tom Bonifield, IHS Senior Medical Scientist, describes the overall approach to the effectiveness measurements as follows: “This listing of appropriate activities is based on the assumption that a health care program’s effectiveness can be indicated by the degree to which it contributes to fulfillment of the care indicated for the prevention and cure of relevant health problems. The methodology . . . for the measurement of CHR program effectiveness is based on the assumption that the listed activities form a critical portion of the total process of care.”

He adds, “This methodology is based on the idea that the CHR program provides an integral portion of the total health care delivered to the American Indian people. Therefore, if a CHR program is accomplishing the activities agreed upon as being a critical portion of the total process of health care, it may be judged effective in realizing its ultimate goal of improving the health status of the population it serves.”

Program effectiveness will be measured in terms of both medical and cost criteria. Once a community has determined which of the appropriate health care activities it would like to accomplish and how much of its program funds it wants to commit to them, effectiveness will be measured in terms of the amount of staff time spent in proportion to the amount of funds committed to accomplishing the given activities. Thus, the cost of accomplishing an activity will be considered as well as its effectiveness as part of the total process of health care.

Any variances in the efficacy and cost effectiveness with which different functions are accomplished in the different areas will be identified. This will help pinpoint a program’s relative strengths and weaknesses on a health care delivery function and area specific basis, aiding in more effective program management and resource allocation.

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Conquering Cancer Among Indians Requires Education, Lifestyle Changes

Although federal health statistics indicate that American Indians and Alaska Natives have a relatively low incidence of cancer when compared to the general population, many Indian communities have expressed concern that the occurrence of this deadly disease appears to be rising among their Indian populations. To address this issue, we asked James W. Hampton, M.D., a cancer specialist and Director of Medical Oncology at the Baptist Medical Center in Oklahoma City, to share with our readers some of the broad concerns related to the treatment and control of cancer in the Indian population. Dr. Hampton has worked with tribes and Indian organizations in the past, and his presentation on cancer issues at the Fifth National Indian/Alaska Native Health Conference in 1982 was well received. In the following article Dr. Hampton discusses different types of cancer and recommends that a national study be undertaken to provide scientific evidence on the levels of cancer in the Indian population. Dr. Hampton also stresses the need for more education, screening programs and changes in lifestyle as the best means for reducing cancer among Indian patients. We are grateful to Dr. Hampton for submitting his article and we invite our readers to respond to his discussion. Comments may be addressed to the NIH office in Denver.

As evidenced during last year's landmark "Silver Anniversary" of the American Cancer Society Science Writers' seminar, major advances have been recorded in the treatment and control of cancer. Almost half of all cancer patients can now be cured, and at least 14 different types of cancer are now considered curable, including Hodgkin's disease, breast cancer confined to the breast, testicular and ovarian cancer, Ewing's sarcoma, Wilm's tumor, osteogenic sarcoma and some adult and childhood leukemias.

Many cancers which were formerly not treatable can now be discovered at an extremely early and often curable state. Mammography, for example, can detect a cancer too small to be felt by physical examination. As a result, breast cancer survival has improved by nearly 25 percent. Survival rates and quality of life have also been substantially improved for patients with other common types of cancer, including endometrium, uterine cervix, colon, rectum, urinary bladder, and prostate gland.

American Indians in the past have always been reported as having a low incidence of cancer. The most recent statistics available from the National Cancer Institute, for example, showed American Indian males and females ninth. However, there seems to be a general opinion among the Indian community that there is an increase in their incidence of cancer.

Unfortunately, this increase has not been formally recognized and documented, nor has it been dealt with specifically. Epidemiology comparisons between the incidence of cancer in Native American and Caucasian populations of the United States have been remarkably lacking. Previous reports have primarily dealt with isolated and relatively homogenous Native American populations in the American Southwest and in Alaska. There have been virtually no attempts to correlate this data with the disease patterns of American Indians in other parts of the United States.

In a survey conducted in Oklahoma in 1975 and reported in the Proceedings of the Third International Symposium on Detection and Prevention of Cancer in 1976, the high incidence of carcinoma of the uterine cervix was noted. The high incidence of biliary and adenocarcinoma of the stomach diagnosed in southwestern Indian tribes was not adequately explained. Eskimo populations have been found to have a high incidence of esophageal cancer as well as adenocarcinoma of the rectum and colon. Although Native American men initially were thought to have a low incidence of lung cancer, this has been found to be on the increase. Other studies have indicated that adenocarcinoma of the female breast is also increasing in Native American women.

Additional Research and Education Needed

A national epidemiological study is definitely warranted at this time to prove the real increase of cancer in Native American populations. The previously reported low incidence of cancer in Native Americans is incorrect. A thorough study on the incidence of cancer would provide the health care systems, including the Indian Health Service, with data to plan for the total care of Native Americans and would provide the tribal governments responsible for the care of their people with data for future financial considerations. A more accurate accounting of the incidence of cancer in Native American populations would also provide improved referral and treatment.

One of the main problems for the American Indian health worker has been the lack of education of Indian people on the incidence of cancer and its warning symptoms. Due to this general lack of understanding about cancer and the limitation of Indian health resources, it is apparent that education about the disease must receive greater emphasis in Indian communities. Indian communities need better education in the basic knowledge of cancer, its signs and symptoms and the accepted practices of treatment and screening clinics for prevention. The generally low economic status of Native Americans and the lack of specialized professional service by the Indian Health Service for the treatment of cancer indicates a special need of financial support for Native Americans in the treatment and control of cancer.

The classical "cancer signs" distributed by the American Cancer Society should be revised and restated to encompass the different incidences of cancer among American Indian populations (see chart). For example, in the Southwestern population where the incidence of carcinoma of the gallbladder and of the stomach is increased, efforts must be made to educate those populations to look for the early signs. By the time jaundice or...
the vomiting of blood has developed, it may be too late for the cancer to be cured.

Screening of asymptomatic patients at risk is potentially the most effective means for detecting early colorectal carcinoma. Sensitive and specific tests are available for this purpose. An aggressive approach by physicians and compliance by the potential patient population are necessary for the proper institution of a screening program. The factors responsible for the pathogenesis of colorectal carcinoma are poorly defined. Screening of those groups at risk is presently our best means of curtailing the deaths due to this disease.

In addition, a mass screening program should be developed by the Indian Health Service and Indian communities for early detection of uterine cervical cancer, which is a primary cancer among American Indian women.

Changes in Lifestyle

As with Caucasian patterns of lifestyle, the lifestyle of the Native American must be altered in order to reduce the increasing incidence of cancer. Cigarette smoking, obesity, and ethanol abuse are all associated with the increased incidence of cancer in the Caucasian population and also health problems of the Native American population. Lung cancer, which is the most common cancer in both sexes and ethnic groups and is increasing at an alarming rate, is largely preventable. Cigarette smoking is still the leading cause of cancer of the lung as well as other organs, and a campaign to discourage cigarette smoking among American Indian populations should be undertaken.

Dietary factors and ethanol abuse in the Southwestern Indian population may contribute to the frequent occurrence of carcinoma of the gastrointestinal tract and biliary tree. The increased incidence of cirrhosis in the American Indian population may have also resulted in an increase in the primary hepatic tumors associated with that chronic condition.

Cancer specialists all over the world are improving diagnostic techniques, learning more about the nature of “early” or “minimal cancer,” and developing more effective combinations of treatments. Early recognition is the key to the treatment and potential cure of this disease, and an aggressive cancer education and screening campaign in Native American communities is essential to effectively address this health problem. Cancer prevention is still the best means for controlling cancer.

Know Cancer’s Seven Warning Signals

1. Unusual vaginal bleeding or discharge (all Native Americans)
2. Indigestion or difficulty swallowing (Southwestern tribes and Eskimos)
3. Nagging cough or hoarseness (all Native Americans)
4. Change in bowel or bladder habits (Southwestern tribes and Eskimos)
5. A sore that does not heal (all Native Americans)
6. Thickening or lump in the breast or elsewhere (all Native Americans)
7. Obvious change in wart or mole (More Caucasians but can occur in Native Americans)

If You Have A Warning Signal See Your Doctor!

Conquering Cancer…

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New Chr…

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IHS currently plans to base the resource allocation process upon the degree of need for Community Health Service of a program's population and the degree of effectiveness with which the program delivers health care. The intention is that those projects serving the population with the greatest need and those which are most effective receive the greatest resources.

According to IHS, the amount of Community Health Services needs can be determined for each community by applying the Resource Requirement Methodology. Moreover, the amount of current resources (including CHR resources) directed to meet these needs (and the "unmet need") can also be determined.

The first working prototype of the process (to be put in place for FY 1986) has just been completed and is now being applied to tribal data. The exact arithmetic of how to weight the variables of "unmet need" and "cost effectiveness" have not been determined, says Bonifield.

The national task force also recommended to the director of IHS that a CHR reporting system be reinstated and its use made mandatory by all CHR programs.

Pursuing this recommendation, IHS contracted with the National Association of Community Health Representatives (NACHR) to develop an appropriate system. The association wanted to examine the needs of individual CHR program directors as well as the information needs for IHS evaluation and program management.

The reporting system previously used was looked at for appropriate elements, plus some additional ones were built in, says Ada White, NACHR president. "We want the system to be easy to learn and use, not burdensome," she adds. A final format is now being developed.

White says the previous reporting system came under attack because it failed to adequately reflect the work performed by CHR’s. Also, the turnaround time between a tribe submitting its report and receiving information in return was lengthy. Added to this, says White, the printouts received were difficult to interpret at best. She also said the new format will be much more comprehensive in reflecting work done and estimates that a turnaround time as short as two weeks is not inconceivable.

According to Solomon, the new system is being designed to show tribes whether “they are really doing what they plan to in terms of program management, utilization of time, and whether they are really meeting their goals.”
Tribal Emergency...

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Despite the problems, dedicated tribal EMS staff appear determined to make their programs work even better in the future. Asked why she and her staff stick it out despite the demanding work and low pay, Essie Kirk says, “For the excitement; this is where the action is... We all feel like we’re accomplishing something. There is a lot of satisfaction in knowing that someone lived because of your efforts.”

Perhaps the biggest challenge remains in reducing the tremendous need for EMS itself. The largest number of deaths in Indian communities occur as a result of automobile accidents, with the highest occurrence striking those in their most productive years, the ages of 15-45. (Other emergencies often seen result from cardial problems, acute poisonings, pregnancy and new-born complications.) Porvaznik calls automobile accidents in Indian communities “a medical epidemic.” “EMS is a treatment but we've got to develop a vaccine,” he asserts. He maintains that getting the drunk driver off the road will once again require state, county, and tribal governments to work together.

H.R. 4567 Amendments...

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— funding for ongoing alcohol training of school counsellors, law enforcement personnel, Community Health Representatives, social workers, IHS medical personnel.

Ducheneaux cautions against expecting “massive amounts of new money with this bill.” Rather, he advises, “there are existing resources that could be brought to bear which now lack coordination.”

Dr. Dennis Fox, assistant director of the BIA Office of Indian Education, told workshop attendees of the Bureau’s interest in the developing bill. He noted that, as part of its academic standards, the Bureau will require its schools to provide instruction regarding alcohol and drug abuse.

News of the potential bill was greeted here with enthusiasm. A number of participants spoke of preventive efforts being made by their tribes and offered suggestions for the legislation.

One consideration expressed was the need to train medical and nursing staffs to reflect alcohol and drug-related incidents in the course of their patient reporting. It was also suggested that inpatient programs for youths are needed and ought to include a component allowing clients to continue their school instruction while in residence.

Additional comments and recommendations are being sought regarding the bill on adolescent Indian alcohol and drug abuse. These can be addressed to: Congressman Tom Daschle, attn: Karen Funk, 439 Cannon HOB, Washington, D.C. 20515; or to Congressman Doug Bereuter, attn: Wrexie Agan, 1314 Longworth HOB, Washington, D.C. 20515.

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NIHB encourages readers to submit articles and comments for publication. Please send correspondence and mailing requests to John P. O’Connor, National Indian Health Board; 1602 S. Parker Rd., Suite 200; Denver, Colorado 80231.

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