IHS Activities Re-Examined Under A-76 Mandate; No Major Changes Expected

ROCKVILLE, MD. — A recently-revised federal directive aimed at reducing certain costs associated with government activities is not expected to adversely affect Indian health operations, according to officials of the Department of Health and Human Services (DHHS).

Along with all other federal agencies, the Indian Health Service (IHS) has been instructed to reexamine which of its functions are "commercial" and which are "inherently governmental." Of those considered commercial, the agency is to examine whether they might best be performed by an outside contractor and whether any of those activities deemed governmental might be performed more efficiently by another federal agency.

The review results from a September 27 letter to all federal agencies in which Office of Management and

Budget (OMB) Deputy Director Joseph Wright outlined several revisions to Circular A-76 being made in the interest of "increased productivity." Circular A-76, first issued in 1966 and since revised, requires agencies to contract out services that can be performed by the private sector more cheaply than by governmental personnel.

Over the next three years, each agency is to conduct productivity improvement studies focusing on a list which covers 14 general categories. The categories are: automated data processing, data entry and keypunch, accounts management, loan processing, architecture and civil engineering, training, audio-visual services, food services, mail, libraries, and messenger and reference services, laundry and dry cleaning, utilities maintenance, warehousing and motor pools/vehicle maintenance. The list is not an exclusive one, said Wright. If other functions within an agency offer opportunities for savings, they too will be included on the productivity review lists, he explained.

Both IHS and Health Resources and Services Administration (HRSA) officials are predicting that the policy will have little, if any, impact on IHS. According to Jim Walsh, HRSA Associate Administrator for Operations and Management, HRSA's position is that all IHS functions are "inherently governmental" due to the unique relationship between tribes and the federal government.

This position grew out of events surrounding IHS and the A-76 circular which took place two years ago. At that time, the Department of Health and Human Services (HHS) asked that housekeeping, maintenance, and dietary services at IHS hospitals in Gallup, NM, Phoenix, AZ, and Anchorage, AK be reviewed in light of the A-76 instructions regarding "commercial" activities. It was concluded that these activities would be removed from the A-76 inventory for two reasons: first, because of special considerations of Indian language, customs, tradition, diet and required integrity of patient care that continued "in-house" performance would be necessary in the best interest of patient care and support. And secondly, that tribes have the right under P.L. 93-638 (the Indian Self-Determination Act) to contract for IHS activities which would otherwise be subject to A-76.

It was pointed out that the policies which underlie P.L. 93-638 and A-76 are quite different as are the results in terms of cost. "Contracting under P.L. 93-638 may, and usually does, cost more than in-house operation of a

Continued on page 12
The following is a regular feature of the NIHB Health Reporter. In this section we present our readers with short briefs 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 material for publication in this section. Additional information on the items mentioned here can be obtained from the NIHB Public Information Office.

WINDOW ROCK, ARIZ. — The nation's largest tribally-run home health agency is in dire need of nurses. The Navajo Home Health Agency (NHHA), part of the Navajo Tribe's Division of Health Improvement Services, is seeking qualified nursing applicants for positions to provide in-home health care services to the reservation's elderly and high-risk patients. According to NHHA Director Yvonne Peperzak-Blake, attempts to hire nurses have been unsuccessful, and the agency may be forced to close down two new home health sub-agencies in Tuba City and Chinle unless nursing positions there can be filled soon. She says that NHHA, which also administers programs in Crownpoint, Kayenta, and Winslow on the Navajo reservation, has openings for five nurses. Applicants must have at least an associate degree in nursing (a B.S. in nursing is required for the Community Health Nurse position in Kayenta), and two years experience is preferred. Starting salary is $22,128. Preference will be given to Native American applicants. For additional information, contact: Yvonne Peperzak-Blake, Director; Navajo Home Health Agency; P.O. Box 1380; Window Rock, Ariz. 86515. Phone: (602) 871-4941, ext. 1870.

SAN DIEGO, CALIF. — The National Association of Community Health Representatives has announced plans for its Fourth National Triennial Meeting to be held here next April 16-18. The group is pleased to have already confirmed Eunice Kennedy Shriver as a keynote speaker. Among the topics planned for the agenda are Maternal and Child Health, teenage pregnancy, holistic health, the revised CHR reporting system, and CHR evaluation and resource allocation methodology. The meeting is open to all CHR's and CHR program supporters. It will be held at the Bahia Resort Hotel; 998 W. Mission Bay Drive; San Diego, Calif. Phone: (619) 448-0551. For additional information, contact: Ada White; Box 201; Crow Agency, Mont. 59022. Phone: (406) 638-2302; or Connie Guillory; Box 365; Lapwai, Idaho 83540. Phone: (208) 843-2253.

WHITE EARTH, MINN. — "Health Care has been one of the reservation’s priorities, and this shows we’re fulfilling that obligation," said White Earth Tribal Chairman Darrell "Chip" Wadena following the recent accreditation of the reservation's health clinic by the Joint Commission on Accreditation of Hospitals (JCAH). The White Earth clinic is the first in the three-state Bemidji area to receive such accreditation (two area IHS hospitals are JCAH accredited). The commission, comprised of five corporate sponsors (the American Medical Association, the American Hospital Association, the College of Physicians, the College of Surgeons, and the American Dental Association), evaluates health facilities against established national health standards. The JCAH accreditation of the White Earth clinic means "they are operating a good medical facility for their people," said Dr. Robert Kelly, chief of staff at the Tanner Memorial Clinic in Layton, Utah, who helped conduct the White Earth evaluation. "The standards are quite strict and specific. Those that satisfy all the criteria can point with pride to their accreditation," he said.

OKLAHOMA CITY, OKLA. — The National Indian Board on Alcoholism and Drug Abuse (NIBADA), an organization comprised of Indian professionals involved in the treatment and prevention of substance abuse, recently announced the selection of new executive officers. The new NIBADA officers are: Wainwright Velarde (Jicarilla Apache), President; Yvette Joseph (Colville), Vice President; Francis Allen (Sac and Fox), Secretary; and Don Freeland (Navajo), Treasurer. According to NIBADA Vice President Yvette Joseph, program manager for the Colville Indian Alcoholism Program in Nespelem, Wash., NIBADA’s goals for the next year include sponsoring a national conference on Indian alcoholism; increasing the organization’s membership; and supporting the reintroduction and passage of the “Juvenile Indian Alcohol

Continued on page 3

ACTOR WILL SAMPSON is contributing his services to help raise money for the Denver Indian Health Board. Sampson, who has a strong interest in Indian health issues, is assisting the Big Wheels Dealers Association in its drive to provide DIHB with a vehicle to transport Denver-area Indian patients to medical facilities. He recently filmed a 30-second television commercial in the Mohave Desert to help promote the DIHB campaign.
HHS Task Force Seeks Ways to Improve Health of Minorities

BETHESDA, MD. — On October 3, the day the Indian Health Care Amendments of 1984 awaited a final vote in the last session of Congress, Indian Health Service Director Dr. Everett Rhoades addressed a group of top-ranking federal health officials regarding health conditions among American Indians. In an unrelated action, two weeks later Health and Human Services (HHS) Secretary Margaret Heckler was to recommend that the President veto the act whose goal is to raise the status of Indian health to the highest possible level.

Ironically, the Secretary's recommendation came even as the above-mentioned group, her own Task Force on Black and Minority Health, works to "recommend ways to redirect federal research and services programs in order to narrow the health differences between minorities and whites."

According to HHS, the task force was formed based on the recognition that "As the health status of the nation continues to improve overall, some troublesome disparities still persist between the health status of minority Americans and that of the white majority." The group is composed of 18 senior policymaking executives drawn from throughout the Department, including Dr. Rhoades and Health Resources and Services Administrator Dr. Robert Graham.

Established last March, the task force is expected to complete its work by this summer. Secretary Heckler has charged them with the responsibility to:

- Study the current health status of all minorities.
- Review minority access to and utilization of the health care system.
- Assess the factors contributing to long-term disparities in health status.
- Evaluate existing Federal research and services programs relative to minority health.
- Recommend ways to redirect Federal research and services programs in order to narrow the health differences between minorities and whites (mentioned above).

- And, suggest ways in which the public and private sectors can cooperate to bring about improvements in the health status of minorities.

In order to carry out their charge, the members are to study the interaction of biomedical, social and environmental factors that produce disparities in health status between minorities and whites. The group also has authority to commission scientific papers and special studies in matters "of particular significance" to its work. And finally, in a method which presents an opportunity for interested tribes and Indian health projects, the group is to "work closely with experts and groups from the public at large, soliciting ideas, identifying model programs, and sharing pertinent information."

In his presentation, Dr. Rhoades informed the task force that Indians are being born at a faster rate than all races and that their current median age is about 20 years. He also noted the alarming percentage distribution of deaths among the Indian population, remarking that barely over one third of Indian people have reached age 65 at their death. The group was also asked to consider the epidemic proportions of accidents and alcoholism experienced by the Indian population, and the relationship between these factors.

In addition to Dr. Rhoades' presentation, the task force heard from JoAnn Kauffman, director of the Seattle Indian Health Board and an officer with the American Indian Health Care Association (AIHCA). "The health problems of the urban Indian population are a mirror of those people residing on-reservation," Kaufman told the group. These include a high incidence of alcoholism, accidents, and diabetes, she noted.

Kauffman presented two recommendations on behalf of AIHCA. The Department was asked to recognize that Indian people fall within the existing health trends regardless of where they reside; however, when addressing the subject of accessibility there is a need to consider where an Indian person resides. Secondly, it was recommended that urban Indian health data be

Continued on page 5
Choctaw Tribe, IHS Embroiled in ‘638’ Contract Negotiations for Talihina

TALIHINA, OKLA. — Encouraged by the success of their southeastern Oklahoma tribal neighbor, the Creeks, who assumed operation of their local hospital five years ago, the Choctaw Tribe applied late last June to operate the hospital and three clinics in its own service unit. The Choctaws were motivated by the reported increase in health services which the Creeks have been able to provide and hope to duplicate that success. But this was not the only element in the tribe’s decision to submit an application to contract under P.L. 93-638 (The Indian Self-Determination and Education Assistance Act) for operations of the Talihina Service Unit.

According to Assistant Chief Greg Pyle, “We don’t see how the tribe could do any worse a job because the services being provided by IHS are so poor.” He claims that the tribe has records showing that over 3,000 of the patients who registered at the hospital and clinics here in FY 1983 were never seen. He also alleges that the meager patient load at Talihina Hospital (averaging 15 for most of 1984 in a 52-bed facility) is further proof of the poor quality of services provided by IHS.

“There is no doubt that the turmoil of the past year has had an effect” on Talihina’s patient load, says the Oklahoma Area’s Chief Medical Officer Dr. Dick Mondsager. By “turmoil” he refers to an IHS staff bailout which began last year. As described by Mondsager, a number of staff were frightened off by newspaper accounts of the Choctaws’ chief calling civil servants overpaid and less than hardworking. As many as 20 percent of the service unit’s 134 positions are now vacant with the number expected to increase.

Against such a backdrop of events, the 60 days allotted to IHS for a decision on an application from the time it is submitted has come and gone. And not surprisingly, the Choctaws and IHS have become locked in sometimes bitter negotiations.

Officially, questions remain regarding the tribe’s ability to provide adequate staffing, quality of care and appropriate administrative services, according to Dr. Robert Birch, head of IHS’ Indian Resource Liaison Staff which oversees IHS 638 efforts. The Oklahoma Area has been advised by IHS legal staff that although P.L. 93-638 gives 60 days for an application’s approval or denial this specific deadline is “a goal to be obtained if possible.” IHS feels more strongly bound by the law’s requirements that it cannot decline a tribe’s application while it (IHS) is still providing them with technical assistance. Says Area Director Dr. H. C. Townsley, “Nothing would please me more than to have a truly approvable proposal but as yet all the elements are not there.” The Choctaws’ initial application included a budget in excess of the amount prescribed by IHS, according to area staff. Submission of a “completely revised” budget proposal remains the primary missing element, they say.

According to Pyle, a revised budget has been mailed to IHS. He expects that certain elements will remain in dispute. As tribes elsewhere have discovered, IHS does not provide separate monies to cover a tribe’s indirect costs.

Contract negotiations between the Oklahoma Choctaw Tribe and the Indian Health Service for the tribal operation of this 52-bed hospital in Talihina, Okla. have, at times, been strained. A key issue in the deliberations has been the problem of funding for the tribe’s indirect costs, a problem that has surfaced in other tribal attempts to contract for IHS programs under the authority of P.L. 93-638 (the Indian Self-Determination and Education Assistance Act). The Choctaw Tribe is expected to assume control of its service unit’s programs February 1.

Continued on page 5
Chocaw Tribe . . .

Continued from page 4

costs for operating facilities. Says Pyle, "We're in a Catch-22 situation. The tribe is required to include indirect costs in its budget yet we don't have those funds available." "Where is this money supposed to come from?" he asks. "Out of an $800 million budget IHS says they don't have a dime."

IHS has also raised questions regarding the tribe's ability to staff and administer the service unit's hospital and three health clinics. The facilities which serve a predominantly Chocaw population logged 63,155 visits in FY 1983. Project Officer Bill Wilson points out, "This is a very large undertaking, all the elements of which a tribe is not always aware. Running a hospital is very complex and a tribe must be adequately prepared for the period of transition." A tribe must see fully to details such as procurement of drug licenses, accreditation, and laws which become applicable once the government pulls out, he adds.

According to some IHS staff, the Chocaw Tribe is ill-prepared to take over operations due to strained relations between Chief Hollis Roberts and the present service unit director. As a result, they claim, the tribe has been unable to learn about operations at the service unit because tribal officials refuse to enter it. "How can they learn about running a facility they won't even go into?" asks one IHS staff member.

There have been even more dramatic accounts of the chief threatening to fire IHS staff once the tribe assumes control. Because of the number of staff who have left or will soon do so, IHS estimates that of 134 positions for the Talihina Hospital only 40 will be filled by the time the tribe takes over the facility. The situation was deemed so serious that several months ago IHS feared that the hospital might be forced to shut down. Nonetheless, Dr. Townsley now claims that "There has been an element of stabilizing with the staff and we are not in imminent danger of closing."

Reports of the chief's threats to fire IHS employees have been exaggerated, says Assistant Chief Pyle. "The chief has simply told them, if you want to work we'll keep you. And if you're not doing your job we'll get rid of you." He says the tribe hopes to hire all but six to eight of the IHS employees including all of the doctors. These employees, like all others, would have the protection of tribal grievance procedures, he points out.

In further response to IHS questions about the tribe's ability to adequately staff the service unit, Pyle states that a well-experienced hospital administrator has already been hired and "with a lot of area hospitals laying people off we believe we can hire with no problem." The tribe believes that it may not be necessary to staff the hospital at its full capacity. Pyle says the facility is overstaffed and cites as an example the eight full-time dietary staff employed for a patient load which has dropped as low as seven patients. (IHS counters that a "threshold level" of staffing must be maintained to be able to serve a full patient capacity).

About the only matter on which the tribe and IHS seem to be in agreement is the need for a revision in P.L. 93-638 to provide tribes who want to contract for their health services with the financial flexibility to do so. Says Project Officer Bill Wilson, "We need additional dollars for indirect costs if Congress is really interested in seeing the legislation succeed." Pyle echoes this sentiment in even stronger terms, "If they aren't going to put teeth in the law by way of indirect costs they might as well throw it out."

How soon the parties will reach an accord on the issues remaining in the Chocaw's bid for operation of the health facilities here remains anyone's guess.

Health News . . .

Continued from page 3

alcohol and drug abuse, and poison control. For additional information about the Health Fair, write: Cochiti Health Committee; P.O. Box 105; Cochiti Pueblo, N.M. 87041.

PHILADELPHIA, MISS. — The Mississippi State Legislature recently granted the Chocaw Tribe permission to apply to build and run a nursing home on the reservation. The Mississippi Chocaw Tribe, whose successful economic enterprises were recently featured in Reader's Digest, is applying to the state for a Certificate of Need to build a 60-bed facility that the tribe will own and operate. "There is a dire need for such a facility, as elderly members of our tribe are in nursing homes scattered throughout the state, placing a hardship on them as well as their families," said Chocaw Tribal Chief Phillip Martin. "These are the very people who, because of lack of education and the language barrier, are the least acculturated to non-Indian society, and suffer the most from separation from the reservation," he said. Martin added that, if things go according to plan, the Chocaw nursing home will be ready to open in 12-18 months.

TSAILE, ARIZ. — A cultural videotape for nurses and other health care workers is available for purchase from the Navajo Community College here. Entitled "Forget the Fish . . . Cultural Aspects of Nursing Care for Navajos," the 25-minute videotape was produced by the NCC Division of Nursing and filmed at the Indian Health Service Hospital in Tuba City, Ariz. The film, which portrays the experiences of a new non-Indian nurse on the Navajo reservation, deals with such activities as establishing rapport, taking histories, and conveying information appropriately to Navajo patients. Also highlighted in the film is how nurses can work effectively with traditional medicine people in a hospital setting. For additional information, contact: Enid Rossi; Division of Nursing/Continuing Education; Navajo Community College; Tsaile, Ariz. 86556. Phone: (602) 724-6234.

SACRAMENTO, CALIF. — "California Indian Health: Our Challenge for the Future," was the theme for the first California state Indian health care conference held here January 16-18. Sponsored by the California Rural Indian Health Board and the California Urban Indian Health Council, the conference featured a number of tribal, state, and federal officials that addressed issues affecting the delivery of health services to California's Indian population. Workshop training sessions included such topics as Fetal Alcohol Syndrome, Perinatal Psychological Risk Assessment, Child Abuse and Neglect, Board Training, and Substance Abuse Prevention.
ROCKVILLE, MD. — It appears that the marriage between the Commissioned Corps and Civil Service systems within the Indian Health Service (IHS) may be headed for the rocks. As is common in long-time marriages, both partners have changed over the years and in this case neither is eager to examine what healthy compromises may be needed to save the union.

Symptomatic of the misunderstanding and tension on both sides are recent charges of preferential treatment being given to selected members of the commissioned corps. Concern has arisen over the differing qualification standards which may be applied when a civil service and a commissioned corps applicant are considered for the same position. There have also been complaints that Indian preference policies are being circumvented and established personnel policies violated, with the use of “details” and the appointment of several individuals to “acting” headquarters positions for extended periods of time without advertising or competition cited as evidence of these claims. And the recent shakeup of IHS area directors has been criticized in some circles as “discriminatory,” since it primarily involved the transfer and reassignment of Indian personnel.

IHS Director Dr. Everett Rhoades dismisses the charge that he discriminated in moving only Indian area directors as “ridiculous.” “The fact is,” he says, “Indian preference prevents me from moving non-Indians.” Rhoades adds that when he assumed the position of IHS director nearly half the area directors were non-Indian; now, partially as a result of the recent changes, “all the area directors but one are Indian.”

As for the concern that his use of lengthy “details” and “acting” assignments is a means of getting around Indian preference, Rhoades contends that he “hasn’t even been director long enough to use temporary appointments for prolonged periods.” In the opinion of IHS personnel chief Jim Sharlow, “Dr. Rhoades has been using flexibility that has always existed but has never been used.”

A review of the commissioned corps and its traditional role within IHS may offer some insights. The commissioned corps of the Public Health Service (PHS), formed in 1889, is one of seven uniformed services established under federal statute. It consists of approximately 6,200 officers ranging from grades 0-1 to 0-8, with assignment to grades above 0-6 very limited and largely political. Included within its ranks are physicians, nurses, dentists, allied health professionals, engineers and administrators, with approximately 60 percent of the Corps composed of physicians.

As a uniformed service, the Corps has the features of a military career service, designed to maintain a vigorous mobile cadre capable of responding quickly to emergency situations and constantly changing program needs. The Corps system depends on being able to attract people for the long run. In exchange they are willing to be assigned to remote areas of the country, such as Indian reservations.

Corps officers, who frequently wear their uniforms on ceremonial occasions, report symbolically to the Surgeon General. Actually, the Surgeon General, although a physician, has no line authority to command anybody.

Unconstrained by civil service pay caps, the Corps compensation system has offered PHS the flexibility to recruit and retain physicians who have at certain times in past decades been in extremely short supply. For many years, PHS has maintained a special pay program designed to increase the income of physicians.

The Corps offers employees certain other benefits different and for many individuals far more attractive than those available in civil service. For those who intend to make public health a career, commissioned officers are eligible for retirement after 20 years; in civil service the minimum retirement age is 55 with 30 years service, though retirement at age 60 with 20 years service is far more common. Commissioned officers also receive more vacation time among other benefits.

Of all IHS health professionals Corps personnel presently account for: 80 percent of physicians (567 individuals), over 80 percent of the sanitarians (138 individuals), close to 90 percent of the engineers (207 individuals), and over 90 percent of dentists (271 individuals) and pharmacists (309 individuals). 389 commissioned nurses and 194 officers in other categories also work for IHS.

**Promotion Differences**

A very distinct difference, and one which has become the subject of controversy, is the promotion concepts of each system. In civil service, an individual’s promotion is based on their duties, performance and the classification of their tasks and responsibilities: a grade-in-job system. In the commissioned corps, the grade of a job is not of primary importance. Given more weight are what an individual brings to a job in the way of education, training, and experience: a rank-in-person system.

In other words, the civil service says, “Here’s a job. Let’s see who can best fill it.” But the commissioned corps, designed to develop a multi-talented group of individuals who could fill a variety of openings, says, “Here are a group of people. What can they best do?” Thus, the groundwork for potential conflict is laid.

In being considered for the same position, PHS policy says that commissioned officers are to be matched against the Corps’ own requirements and the requirements of their “billet” for the job while civil service employees are matched against civil service qualification standards for the particular job series. They need not meet the same requirements. States the policy, “X-118 standards (civil service qualification standards) are not requirements of the commissioned corps and are not to be used to evaluate commissioned corps officers.”
As explained by Del Larson, personnel chief for the PHS commissioned corps, "When an IHS vacancy is advertised any commissioned officer is eligible for consideration. The commissioned corps prepares a billet to cover the same job. Our office reviews those interested to see who is qualified under the billet and certifies their qualifications."

With the commissioned corps' rank-in-person concept, grade and pay are based on an individual's own qualifications though not necessarily the qualifications for a particular job. An officer can be assigned above or below their grade.

According to Sharlow, the commissioned corps billet and civil service job description may differ. One may require a degree while the other does not. The Corps' billet more often imposes such a requirement while the civil service system may require experience, he says. Some civil service employees now contend that if they are required to submit an application in order to be considered for a position and a commissioned corps applicant is not, then the system discriminates in favor of the Corps. They also argue that both groups of employees should meet the same qualifications standards.

But the commissioned corps says that requiring its officers to meet the same qualifications as the civil service would unfairly subject them to two levels of requirements. The matter is currently the subject of a grievance within IHS.

Also being questioned is the policy which permits reassignment of commissioned officers at any time without a formal vacancy announcement so long as Indian preference requirements are met. Some contend that the practice is being improperly used for reassignments for positions with "promotion potential."

Prior to termination of the physician draft in 1973, IHS experienced few staffing vacancies, with two to three applicants for every available position. Since that time, the agency has experienced a chronic physician vacancy rate of 10-20 percent. Without the Corps, most agree, IHS would have severe problems recruiting adequate numbers of doctors and other health professionals, especially in the categories of pharmacy, engineering, and sanitation. As Rhoades sums it up, "We could not run the program we run without the Corps."

The advantages of the Corps to IHS are largely clear: it provides a mobile professional health corps, allowing IHS to transfer officers anywhere as its needs dictate (though it has been pointed out that this is much more often true among junior officers). Because they are part of an overall career advancement system, commissioned personnel are willing to accept positions in isolated, remote locations where persons would very likely not go otherwise. They are subject to reassignment upon a moment's notice. And an officer can receive a promotion while in the same position because of the rank-in-person concept, allowing IHS to retain an individual in a position for a longer period without the person worrying about being dead-ended as far as pay or transfers.

On the reverse side of recent complaints about the IHS director's assignment of Corps personnel to "acting" positions, commissioned officers can be placed in an acting capacity for an indefinite time period with increased responsibilities and at no additional compensation.

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Differences Between Civil Service and Commissioned Corps

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IHS Commissioned Officers Strength by Grade

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Commissioned . . .
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As much as it may be said that IHS needs the Corps it may also be argued that the Corps need IHS. The sheer numbers of commissioned personnel who have chosen IHS (over one third of all commissioned officers work for IHS) attest to the fact that, as Larson puts it, "The real bulk of business for commissioned corps people with health care is in IHS."

Indian Preference Issues

However, with the advent of Indian preference and an increasing number of Indian health professionals, numerous commissioned officers have found their career moves blocked. An IHS circular of November 1979 states that Indian preference is to apply, "... no matter how such a vacancy arises, and regardless of whether the previous incumbent was in the competitive Civil Service, excepted Civil Service, the PHS Commissioned Corps, or the position is newly created." The circular defines a vacancy as "an unencumbered position which management plans to fill" and notes that "there are no positions in the IHS reserved exclusively for Commissioned Corps . . . occupancy."

Says John Gimon, who heads IHS' physician recruitment effort, "For both commissioned corps and civil service employees, upward mobility has become blocked by Indian preference."

With specific regard to the Corps, Larson says he has some doubts about whether people's careers are being blocked. Nonetheless, as he explains, "whether the whole commissioned corps system works is predicated on gaining the trust of those in it. If you tell a person 'You are going to Barrow, Alaska for two years but will be transferred at the end of that time,' you need to be able to offer them something else when that time comes."

Those opportunities often don't exist now, according to Dr. James Felsen, an elected Commissioned Officer Association Board member and former IHS Chief Medical Officer. He says, "IHS can't just use the Corps to fill critical positions unless they can eventually offer career opportunities elsewhere. But many of the 'garden spot' opportunities have been blocked by Indian preference. So you have a growing number of commissioned officers who have paid their dues and there is nothing to offer them."

Thus, while IHS benefits from the merits of each system (commissioned corps, civil service and Indian preference), the need for a greater definition of how they all interact has become apparent.

This need grows ever pressing as matters are about to become even more complex. As a result of a court decision, the Department of Health and Human Services is taking steps to establish qualifications standards for Indians considered for jobs in the IHS excepted service. In the case of Lillian N. Preston et al vs. Margaret Heckler, the Ninth Circuit Court of Appeals ruled that IHS cannot use the generally applicable civil service standards for evaluating the qualifications of Indians for employment. The court held that the Indian preference act requires IHS to adopt separate and independent standards for Indian applicants, "standards that give sufficient weight to the unique experience and background of Indians, including their superior knowledge of Indian needs and problems."

One approach suggested for examining the civil service and commissioned corps systems is to look at them in terms of equity. What is the magnitude and frequency of differential treatment between the two personnel systems? Some would argue that a more favorable treatment of Corps personnel is warranted because they are subject to potential relocation in the event there is a hard-to-fill vacancy. Yet, as has been seen in the recent transfer of area directors, the same may hold true for civil service employees.

Sharlow suggests that "IHS needs to take another look at the commissioned corps program and what the traditional use and need for it is." "We need to define a policy for IHS detail of commissioned officers making use of their special skills and experience without circumventing Indian preference," he continues.

The situation is being partially addressed by a study group with representation from service units, areas, headquarters, the Health Resources and Services Administration, tribes and regional personnel offices appointed by the director of IHS. The group is to examine the factors affecting the implementation of Indian preference in the IHS. Among the major elements of the study is the outcome of IHS Indian preference practices, including the impact on non-Indians as well as Indians with respect to top and mid-level management positions as well as health professional positions. The group expects to complete its work later this year.

It has been suggested that any effort which fails to assemble the key players (e.g., congressional staff, top HHS personnel, the Commissioned Officers Association, and Indian organizations) in an open and thorough discussion is unlikely to resolve the major issues. Until these players with a vested interest, authority to strike a compromise as well as to effect the necessary administrative and legislative changes to bring any agreement to fruition come together, a real solution probably remains elusive. Nonetheless, the Indian preference group's findings may compel IHS to take a deeper look at these issues.

HHS Task Force . . .
Continued from page 3

incorporated into overall Indian health data considering the large percentage of Indian people who reside in urban areas.

When the task force reports to the Secretary next summer, it is to offer a wide range of short-, medium-, and long-term recommendations for ways in which the federal government may help eliminate the disparities in health status between minorities and whites.

Considered in the context of Indian health care, many of the group's responsibilities may sound familiar to tribes who have recently presented testimony and done followup work in support of reauthorization of the Indian Health Care Improvement Act. Some of the same information used in that effort may well prove useful to the task force in the course of its deliberations. Interested tribal groups or individuals may contact NIHB for additional information.
Seattle ‘TIPPS’ Program Aids Young Indian Mothers

SEATTLE, WASH. — Any woman who has ever been pregnant can well remember the experience as a time when joy, fear, feelings of inadequacy, panic, and avid curiosity present themselves in a tumble of confusion. Now picture that confusion combined with the questioning and search for an identity brought on by adolescence and you can begin to imagine the sensation of a pregnant teenage mother-to-be.

Over the past two years, staff of the Seattle Indian Health Board have learned how to deal sensitively and professionally with the problems faced by teenage Indian mothers in their area.

Funded by a grant from the Charles Stewart Mott Foundation and Washington State social services block grant money, the Teen Indian Pregnancy and Prevention Services (TIPPS) program employs two full-time counsellors, an administrative assistant and a director. TIPPS was begun in 1982 by concerned staff who recognized the issue of teen pregnancy among the local Indian population as a very real one. The program found that the percentage of live births to females under the age of 20 was 22.4 percent for Indians in the Portland IHS area in calendar year 1981 compared with 11.9 percent for the Washington state female population as a whole. (Twenty five percent of the total U.S. female population will become pregnant and give birth prior to age 20.)

They also discovered some other very interesting statistics. The younger females are when they begin to have children, the more children they are likely to have: sixty percent of females who give birth before the age of 17 will have a second birth while they are still school age. Twenty percent of those who become pregnant at the age of 17 or 18 are having at least their second child.

There are up to 30 girls on the TIPPS prenatal register at any one time, according to Director Vanessa Carter. When a girl is seen for the first time, she is interviewed in order to help the staff assess her needs, both medical and social. These include the girl’s needs for help throughout the course of her pregnancy, ranging from prenatal care to the last grade she has completed in school, her financial situation, her need for maternity and infant clothes, and followup.

In human terms, teenage pregnancy can mean an assortment of problems for mothers and their infants alike. Teen mothers are more likely to have medical problems including toxemia, anemia, inadequate health care, premature birth complications, prenatal and postnatal infections, surgical deliveries, and mortality.

Infants of teen mothers are more likely to experience medical problems including prematurity, low birth weight, and higher risk of infant mortality. Infants of mothers less than 17 years of age and of those 18 and 19 who have had multiple births have a higher proportion of neonatal mortality, low birth weight, post-neonatal mortality, rates of illness requiring hospitalization, and rates of injuries.

Fortunately, good early prenatal care can make a difference. In the TIPPS program, staff work closely with

Continued on page 10
the Seattle Indian Health Board medical team, also the source of a large number of referrals to the program. Staff counsellors work with their young clients teaching them how to get the medical services they and their infants will need, as well as the essentials of good prenatal and postpartum care.

As might be expected, teen mothers are also at high risk for experiencing a spectrum of social problems. Among them: less than a high school education, dropping out of school, lack of parenting and life survival skills, unemployment, lack of day care options, having larger families spaced closer together, being a single head of household, being poor and welfare-dependent, becoming divorced, having emotional/health problems and having higher rates of suicide.

It is in this sphere where the TIPPS program has achieved some of its proudest successes. Help ranges from assisting a client with filling out AFDC applications and gearing up to face the sometimes grueling application process at the AFDC office to exploring child care options. The topics of birth control methods, decision-making, sexuality, male responsibility, and cultural issues are discussed with counselling geared to each girl's level of maturity and understanding.

Many of the younger girls seen lack basic coping and decisionmaking skills. "Up until now some of them have never had to decide anything larger than what to eat or what to do for the weekend," says Carter. One thing stressed again and again by program staff is that they must help each girl to feel comfortable with her own decisions, whatever they may be, she adds.

Carter recounts with pleasure a high school mother who entered the program two years ago at the age of 16. The daughter of a single mother, she found herself with an unplanned pregnancy. TIPPS provided one-to-one counselling on prenatal care, childbirth, and well-child care. The girl gave birth to a healthy baby and is about to enter college this fall.

Other stories of TIPPS's ability to assist teenage mothers are not so happy. Carter tells of a family which came from a reservation some 50 miles away to bring their mentally-retarded daughter to the program. Although the girl was physically 16, her mental abilities were those of a three to four year old, recalls Carter. "The family contended that their daughter hadn't been out of their sight for a minute, yet she came in pregnant," says Carter. The girl's parents wanted an abortion and sterilization performed. Considering that the family had come from such a distance when there was a medical facility right in their local area, their claim that they had never let their daughter out of their sight, along with some other factors led the TIPPS staff to suspect sexual abuse within the family. "The girl was in need of protection and had no one there to advocate for her," remembers Carter. She and her staff feared that a sterilization would be regarded by the family as a license to continue their abusive activities. TIPPS staff contacted the state Child Protective Services agency who worked with the girl's tribe through the Indian Child Welfare Act. As it turned out, the staff's suspicions were well-founded: the family's home community was aware of the situation and the father had served time in prison for such abuse before.

Carter is also proud of the role the TIPPS program has played in getting a day care center for young mothers set up in Heritage High School, a local school attended by many of the program's clients. Last year, some 15 students dropped out of the school due to pregnancy, states Carter. Formerly, lots of these students "lacked the support of their fellow students in order to fit in," she explains. TIPPS hopes to locate one of its counsellors in the school and is presently helping Heritage High seek foundation and local business support for the day care center which plans to open this fall.

Another focus of the TIPPS program is the prevention of teen pregnancies. TIPPS is not alone in recognizing the teenage pregnancy situation and staff receive numerous requests to work with junior high and high school classes, local Health Career Opportunity Program students, and Washington tribes. Topics for workshops with teen and sometimes pre-teen students include birth control, sexuality, family planning, and decisionmaking.

To other tribal organizations and tribes who feel they would like to deal with teen pregnancy in their communities but lack the resources of the Seattle project, Carter offers encouragement. There are a number of sources around which are potentially interested in funding such projects. But setting up a full-fledged program is not always necessary, she maintains. The main thing, she says, is for a community to identify a person willing to work on the issue, perhaps as a teen advocate in the local clinic.

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Pine Ridge Suffers Critical Nursing Shortage

by Doris Giago, Associate Editor
The Lakota Times

PINE RIDGE, S.D. — A shortage of nurses has reached epidemic proportions at the Pine Ridge Hospital and there’s no relief in sight, according to the reservation’s doctors, nurses and hospital administrators.

“There has been for a long time and there continues to be a shortage of nurses at the Pine Ridge Hospital,” said Dr. Roy Maynard, pediatrician at the hospital since October 1.

Other doctors share his concern. “There just are not enough nurses,” said Dr. Pam Bucklew, general medical officer, who has been at the hospital for the last 15 months. “To be able to handle the patient flow, we need more nurses,” she said.

“I definitely agree with the doctors,” said Terry Pourier, service unit director. Pourier said he has been aware of the problem for some time and has been working on ways to solve it.

Last summer the Joint Commission on Accreditation of Hospitals evaluated the hospital. “During the July 17 accreditation survey of the Pine Ridge Hospital, the nursing surveyor (evaluator) cited that the nursing staff required additional positions,” said Dr. Donald Smith, clinical director for the hospital. “They felt the quality of nursing was very good, but we just did not have enough nurses to handle our current patient load.”

Pine Ridge has 23 beds in the medical surgical ward, 10 beds in the obstetric ward, and 11 beds in the pediatric ward, with a total of 23 registered nurses at the 54-bed hospital. “But seven of the nurses do not do patient care,” said Dorothy Lafferty, acting director of nursing. “So really, there are 17 nurses that take care of the patients in the hospital,” she said. Those 17 nurses cover 21 shifts a week. Besides the RN’s, there is one or two LPN’s and an aide on the floor at various times.

Until, and if, Pine Ridge Hospital acquires more nurses, the present nursing staff is forced to work harder and longer hours, according to Jeanne Pourier, who until recently was the director of nursing and is now director of community health nursing. “The nurses average 20 hours of overtime a week,” Pourier said. “Pine Ridge is a demanding place to work because of the shortage of nurses and the heavy patient load. The nurses are running constantly,” she said.

She added that the nurses are so busy that many times they work through their lunch break. “Nurses are in charge of everything,” she said. “I don’t think people realize the hours and the work the nurses put in.”

“We have to be the nurse, the ward clerk, the telephone operator and the buffer between the patient and the family,” said Gwen Ward, staff nurse at the hospital. She has been called in on her days off to help out the hospital and on several occasions has accompanied patients who have been transported to other hospitals for care they couldn’t receive at the hospital because of the shortage of nurses.

“I was called in on my day off to take a patient to Denver. I got back at 3:00 a.m. and had to get up to go to work by 8:00 a.m.,” she said. “I’ve stayed a good deal of time after my shift was over just to do chart work because I was too busy during my shift to get it done,” she said.

“The patients suffer because of the shortage,” said Lafferty. “It means longer waiting time for them. You don’t do as good a job as you could,” she said. “Nobody dies as a result of it because we send the patients out that we can’t care for to either Gordon or Rapid City Regional. If we had the nurses here to take care of the patients, we wouldn’t have to send them to other hospitals,” she said.

“This is inconvenient for everyone,” said Dr. Bucklew. “A patient doesn’t feel comfortable in another hospital. It creates a hardship on the family also.”

“I hate to see patients shipped out, especially the elderly patients,” said Ward. “I definitely think it plays a part in their deaths.” “When you send the elderly away from their family to a different area, there’s a language barrier, there’s a cultural difference and there’s a fear any patient has when they get sick and have to go to the hospital,” she said. “And all these compound the initial problem.”

Dr. Maynard said that since he has been at the Pine Ridge hospital he has sent six patients to the University of Minnesota in Minneapolis. Some of the patients could have stayed at the hospital in Pine Ridge if there were enough nurses to monitor them.

With the cold weather coming on, Dr. Maynard said he is concerned that there could be a real problem if the hospital can’t handle the case load. “I’ve seen more respiratory diseases here in six weeks than I’ve seen in Minneapolis in six months,” he said.

The cost of sending patients to other hospitals is enormous, the doctors said. “If a team comes in from Minneapolis to transport a patient, it costs $3,000 to $4,000,” said Darlyne Clements, contract care clerk. “If we charter a plane and send our own nurse, the cost is $800.” These amounts do not include the stay in the hospitals, she said. Clements said the budget for contract care is $2.4 million.

“The shortage of nurses is a complex problem,” Ward said. “It isn’t any one person’s fault. It’s the system’s fault. Then you compound it with a geographic factor. Who wants to come to Pine Ridge?” she asked.

And the personnel office in Aberdeen agrees. “Nursing is a shortage category and it’s difficult to attract nurses to those remote locations,” said Lee Miller, program management officer for human and manpower resources at the area office. “It’s not that efforts aren’t being made to find nurses,” Miller said. “It’s just that we aren’t getting the applicants. We have made efforts continuously but the applicants have to show an interest in Pine Ridge.”

“It’s unfortunate the way the government works,” said Pourier. “It’s costly. Many times you have the dollars to pay for nurses but it’s the position ceiling (quota of nurses) that holds us back from getting the people,” he said.

“I realize we need more nurses. I’ve done all I can,” he said. “Immediately, I don’t see anything coming down for a while, unfortunately.”
IHS Activities...

Continued from page 1

program" stated a memorandum from HRSA Administrator Dr. Robert Graham to the Assistant Secretary for Health. He continued, "The A-76 process, however, seeks to achieve at least a ten percent reduction in current operating costs according to an expedited time schedule. Under A-76 the program or service would be performed by the most efficient organization, either in-house or by a contractor."

In further explanation of HRSA's position, Dr. Graham stated, "We think that implementing A-76 may lead the tribes to believe that the government is ignoring the intent behind P.L. 93-638 and raising further barriers to the tribes' ability to administer their own programs.

"P.L. 93-638 was intended to enhance the progress of the Indian people and their communities by providing an opportunity to develop the leadership skills crucial to the realization of self-government. The A-76 process frustrates the intent of P.L. 93-638 by awarding contracts to third parties rather than transferring these activities directly to the Indian people."

Subsequently, HRSA found both the Public Health Service and HHS in agreement and the activities were removed from the A-76 inventory. Walsh predicts that it may take up to several months before HHS determines whether it will consider any of the IHS functions commercially contractible during this A-76 go-around.

Meanwhile, OMB has sent IHS a list of some 1,200 employee positions for consideration during its productivity reviews. However, Wright's memorandum excludes "small activities" maintaining fewer than 10 employees from the productivity review studies. According to Sam Elrod, special assistant to the director, at least 95 percent of IHS' activities are conducted by less than 10 people performing the same duty in any one location.

One exception is the Data Processing Support Center located in Albuquerque, NM with 31 employees. But Bill Pearson, IHS Associate Director for the Office of Administration and Management, believes that a strong argument can be made for considering DPSC a government activity as well since "it is our total repository of health care information and any loss of information could have a direct effect on patient care."

IHS is presently looking at the location of each of the positions identified by OMB along with their annual costs. Elrod says the study will then turn to whether it may be more economical to retain the "inherently government" positions within IHS or place any of them under another agency. Even if economy dictates that an activity might be performed for less cost within another government agency, Elrod says he expects very few instances where "anyone would want to bid for IHS operations." "A-76 is not really intended for IHS because of our field operations," he says. The circular is better geared to large scale operations concentrated in just one or a very few locations, maintains Elrod.

He also believes that the same argument regarding the right of tribes to override the A-76 process by submitting proposals to contract under P.L. 93-638 applies as well to any "inherently governmental" activities which might be identified for possible transfer to another agency.

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