IHS Issues Major Policy Change in ‘638’ Contracting Process

ROCKVILLE, MD.—For years, Indian leaders have argued that the intent of the Indian Self-Determination and Education Assistance Act (P.L. 93-638) has been stifled by the federal bureaucracy. More specifically, they have contended that tribal efforts to contract under the act for programs serving Indian people—including those programs of the Indian Health Service (IHS)—have floundered in a maze of federal rules, regulations, and policies.

In an effort to respond to such concerns, the Indian Health Service (IHS) has issued an important policy change aimed at improving and simplifying the P.L. 93-638 contracting process. The policy change, which became effective February 1, is part of an IHS policy package that includes requirements for compliance with P.L. 93-638 contracting regulations; guidelines for a new IHS “team approach” to 638 contracting; and a “sample 638 cost reimbursement contract” with related documents.

The package is the result of several months’ work by the IHS Indian Resource Liaison Staff (IRLS) (see related article pg. 3), which worked on developing the changes in coordination with government contracting officials, project officers, federal attorneys, tribal health officials, tribal lawyers, national Indian organizations, and other interested parties.

In explaining the new policy at a meeting of IHS contracting officers in Denver January 19, IHS Director Dr. Emery Johnson said that the term “contracting,” as applied to P.L. 93-638, is misleading because it suggests the federal procurement of goods and services. This was never the intent of the law, Johnson said.

“What the Act really provides for is the transfer of the authority, the responsibility, and the funding from the federal government to tribal governments. Maybe if we had used some other term than ‘contract’ we would not have gotten ourselves tangled up in five years of agony with the federal contracting process,” he said.

The special nature of P.L. 93-638 contracting is referenced in the new IHS policy document, which states that “P.L. 93-638 contracting is a completely different form of contracting from the usual federal procurement contracting.” “The law and regulations recognize that, when so requested by a tribe, a tribal organization . . . has the right to administer the hospital. IHS officials are hoping that such problems will be eliminated under a new policy directive regarding IHS “638 contracting.”
IHS DIRECTOR DR. Emery Johnson addresses a meeting of IHS contracting officers in Denver January 13. In explaining the new IHS policy for P.L. 93-638 contracting, Johnson said that the Indian Self-Determination and Education Assistance Act "provides for the transfer of the authority, the responsibility, and the funding from the federal government to the tribal governments." The IHS policy became effective February 1.

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to contract an IHS program and that its proposal must be accepted" unless specific grounds can be established for declining the contract.

The problem in using the normal federal procurement contracting process for P.L. 93-638 programs is that it opened the door for contracting officers to incorporate into tribal contracts a seemingly endless number of provisions from what Johnson refers to as the contractors' "35-foot shelf of manuals."

The result has often been complex contracting documents that many tribal officials feel are unnecessarily restrictive, making it difficult for tribal contractors to carry out their responsibilities. As suggested by one tribal health official at the Denver meeting, the administrative complexities of P.L. 93-638 contracting have become so great that the real issue — improving the health care of Indian people — has been overshadowed by the process.

According to Johnson, the new IHS policy is an attempt to reverse that trend, to simplify the P.L. 93-638 contracting process, and place the focus of tribal contracting on the delivery of quality health care services to Indian people.

Policy

Specifically, the new policy limits the discretion of federal officials in P.L. 93-638 contracting, and sets forth administrative requirements to be used in that process.

As stated in the policy, "no administrative articles other than those included in the 'Sample Contract' or Contracting Desk Reference, amended as necessary from time to time, shall be used in any '638' contract unless agreed to by the contractor."

The policy also prohibits IHS officials from making changes in the contractor's proposal unless the changes are necessary: (a) to describe adequately the scope of the work to be undertaken; (b) to assure compliance with the authorized contracting clauses or requirements applicable to the contract; (c) to assure conformance of projected costs to the cost principles applicable to the determination of allowable costs under clause 4(b)(1) of the General Provisions; or (d) to address directly a declination issue.

When a declination issue is raised, the director of the IHS Area/Program Office will be required to inform the tribal contractor in writing of the specific declination criteria being applied. The director will also be required to provide the tribal contractor with technical assistance to correct the noted deficiency.

The policy further states that tribal contract proposals must be approved or disapproved within 60 days after receipt of the proposal. If the area office fails to meet this deadline, the contractor may agree to extend the time or may request that the proposal be transferred to the Indian Resource Liaison Staff at IHS headquarters for further action.

Sample Contract

As part of its effort to simplify the P.L. 93-638 contracting process, IHS has prepared a "638 Sample Cost Reimbursement Contract" that contains the provisions necessary for most 638 contracts. According to the new IHS policy, no administrative provisions other than those specified in the Sample Contract may be used in any 638 contract unless the provisions are agreed to by the tribal contractor.

The IHS 638 sample contract consists of: (1) a cover page; (2) 11 administrative articles; and (3) 41 general provisions for cost reimbursement contracts under P.L. 93-638.

Each article in the sample contract includes actual article language or an example of the article format. The 11 administrative articles identified in the sample contract are: Scope of Work; Period of Performance; Payment; Reporting Requirements; Designation of Project Officer; Savings and Program Income Under the Contract; Use of GSA Supply Sources; Privacy Act Notification; Prohibition Against the Use of Federal Funds to Pay for Costs of Influencing Legislation; Disputes Clause; and Administration of Government Property.

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In addition to the sample contract, the IHS package includes two documents directly related to the sample contract. The first, “Applicable Articles for Specific Purposes,” includes provisions that do not apply to every 638 cost reimbursement contract, but are necessary under certain circumstances. The second document is included to provide clarification for some of the general provisions.

Planning and “The Team Approach”

Because of the policy change for P.L. 93-638 contracting, IHS is projecting an increased future need for involvement of IHS personnel in 638 contract operations. To meet this anticipated need, IHS is proposing a “team approach” to 638 contracting to utilize various professional disciplines, technical expertise, and managerial skills in the process.

As outlined in Indian Self-Determination Memorandum No. 81-2, a series of training workshops will be conducted for each IHS area office on the 638 contracting program and the responsibilities of different IHS personnel in this team approach. The training program is being coordinated by the IHS Indian Resource Liaison Staff, and it is expected that the first session of training will be completed by July 1, 1981.

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IRLS Serves as Focal Point
For IHS Policy Guidance

ROCKVILLE, MD.—Much of the preparation of the recent IHS policy on P.L. 93-638 contracting procedures was coordinated by a relatively new component of the Indian Health Service (IHS) that is responsible for developing policy initiatives and providing policy guidance to tribes, tribal organizations, urban Indian organizations, and IHS staff.

Established several months ago to serve as a national focal point for IHS policy development and guidance, the IHS Indian Resource Liaison Staff (IRLS) works on policy issues related to Indian health legislation and administrative management systems including contracts, grants, personnel, manpower, and leasing.

As its first major task, the IRLS has been coordinating the development of the new IHS “638 contracting” package, which is supposed to improve and simplify contracting under the Indian Self-Determination and Education Assistance Act.

Although the IRLS itself is comprised of only a few key staff members, it has the authority to pull together the expertise that is needed to address particular policy issues, according to IRLS Chief Leah Exendine. For example, in preparing the P.L. 93-638 policy documents, the IRLS brought together a number of contracting experts from different backgrounds, including tribal attorneys, IHS contracting project officers, government lawyers, tribal health representatives, and other interested parties. “We wanted an actual working group that would sit down, roll up their sleeves, and address these issues,” she said.

Another important aspect of IRLS’ responsibilities is its role as a liaison to tribes and Indian organizations when serious concerns about IHS policy arise. While explaining the new “638 contracting” process to the National Indian Health Board (NIHB) at the Board’s recent quarterly meeting here, Exendine was asked about possible communications problems between IHS headquarters and IHS area offices regarding the new policy.

“People on the reservation get all excited by what they hear at IHS headquarters, but then they go to the area office and are told something else,” asserted Mel Sampson, NIHB Portland area representative. “What assurances do people out on the reservation have that area offices will comply with those policy guidelines?” he asked.

Exendine responded that IRLS is “a focal point where people can call or write when they are having problems in relation to policy issuances.” Exendine added that IRLS is not intended to be used as a “hotline” for every problem that arises in the field, and that every attempt should be made to resolve such difficulties at the area office. However, if a problem regarding IHS policy is of such a nature that it cannot be resolved at the area level, the IRLS will look into the matter, Exendine said.

At the present time, IRLS is continuing its work on P.L. 93-638 contracting by developing a series of workshops designed to train IHS personnel on their roles and responsibilities in the IHS “638 contracting” operation. The projected date for completing the first part of this training is July 1, 1981.

While most of its activity has centered on issues related to P.L. 93-638 contracting, the IRLS will eventually become involved in other policy matters, Exendine said. Possible future activities of the IRLS include working on the development of agency-wide procedures for Medicare/Medicaid payments under Title IV of P.L. 94-437 (The Indian Health Care Improvement Act), and preparing an IHS policy for working with newly federally-recognized tribes.

To contact IRLS call or write: Leah Exendine; Indian Resource Liaison Staff; Indian Health Service; Room 5A-35; 5600 Fishers Lane; Rockville, MD. 20857. Phone: (301) 443-1108.
Health News Across the Nation

The following is a regular feature of the NIHB Health Reporter. In this section, we present our readers with short, concise briefs on issues and activities from around the country that are related to Indian health care, including such topics as conference and workshop dates, legislative notices, news on local events, etc. Further information on items mentioned here can be obtained from the NIHB Public Information Office.

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WASHINGTON, D.C.—The 97th Congress convened here January 5 and moved quickly to approve two resolutions establishing membership of most of its committees. Membership of the Senate Select Committee on Indian Affairs includes: William Cohen (R-Maine), Chairman; Barry Goldwater (R-Ariz.); Slade Gorton (R-Wash.); Mark Andrews (R-N.D.); John Melcher (D-Mont.); Daniel Inouye (D-Hawaii); and Dennis DeConcini (D-Ariz.).

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WASHINGTON, D.C.—On January 21, the Senate voted 99-0 to confirm Richard S. Schweiker as the new Secretary of Health and Human Services. During confirmation hearings before the Senate Finance Committee, Schweiker stated that he intends to emphasize "cost-effective, preventive health care strategies," and that he would like to see health promotion and disease prevention placed at the top of the DHHS priority list.

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OKLAHOMA CITY, OKLA.—The University of Oklahoma School of Public Health has a Health Professions Recruitment Program for Native Americans designed to assist Indian students in enrolling and graduating with Masters degrees in Public Health. Admission applications are taken on a continual basis for entry into the Fall, Spring, or Summer semesters. Additionally, the Health Administration Department is offering a Summer Fellowship Retention Program in Health Administration for American Indians. Junior and senior undergraduates are eligible for this program, and they can secure summer employment in the health care institution while receiving a weekly stipend and academic credit. For further information on these programs, contact: Rodney W. Sumner; College of Health; P.O. Box 26901; Oklahoma City, Oklahoma 73190.

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WASHINGTON, D.C.—Persons interested in presenting papers on the subject of Indian health care at the 109th Annual Meeting of the American Public Health Association (APHA) must submit abstracts of their presentations by March 14. This year's meeting is scheduled for Los Angeles, Calif., November 1-5 (See pg. 16 for related article on APHA Indian Caucus). For details on submitting abstracts, contact (as soon as possible) Margo Kerrigan; 2422 Arden Way, Suite 30; Sacramento, California 95825. Phone: (916) 484-4041/(FTS) 468-4041.

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LAS VEGAS, NEVADA—The National Indian Food and Nutrition Resource Center (NIFNRC) will sponsor a national symposium on Indian food and nutrition issues here March 9-13. The symposium will feature workshops on such issues as the Women, Infants, and Children (WIC) nutrition programs; food distribution programs; the Food Stamp program; and nutrition for the elderly. The symposium is open to all interested persons. For further information, contact: The National Indian Food and Nutrition Resource Center; 1602 S. Parker Rd., Suite 212; Denver, Colorado 80231. Phone: (303) 755-9191.

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OREM, UTAH—Over the next several months, the MESA Corporation, an Indian-owned company, will conduct a series of six two-day workshops to train the disabled, parents of the disabled, advocates, tribal leaders and health professionals who provide services to disabled Native Americans, in the law and content of Section 504 of the Rehabilitation Act of 1973. The workshops, which are free with meals provided to participants, are scheduled for: March 5-6 in Chicago, Ill.; March 25-26 in Riverton, Wyo.; April 8-9 in Helena, Mont.; April 22-23 in Wolf Point, Mont.; May 7-8 in Ignoa, Colo.; and May 27-28 in St. George, Utah. For more information contact: MESA Corp.; Project 504; 1156 So. State Street; Orem, Utah 84057. Phone: (801) 224-4674, or Toll Free (800) 453-1183.

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DENVER, COLO.—The National Indian Board on Alcoholism and Drug Abuse (NIBADA) will meet here April 13-15 at the Continental Denver Motor Hotel. The meeting will address different issues related to alcoholism and drug abuse among Indian populations, and will feature speakers from several different government agencies and national Indian organizations. For further information, contact Ozzie Williamson, Vice-President, NIBADA; Inter-Tribal Alcoholism Treatment Center, Bldg. 13; VA Hospital; Sheridan, Wyoming 82801. Phone: (307) 672-3484.

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FARMINGTON, N.M.—The Navajo Tribe officially accepted control of a $1.3 million alcoholism program developed and administered by the Office of Economic Opportunity for the past 14 years. The physical facilities to be transferred include outreach programs at Shiprock, Crownpoint, Fort Defiance, Chinle, Tuba City, and two Local Alcoholism Recovery Centers at Lupton and Page. The alcoholism program will be administered by the tribe's Division of Health Improvement Services (DHIS).

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SEATTLE, WASH.—The Seattle Indian Health Board will sponsor a six week summer program at the University of Washington for those American Indian and Alaskan Native, Aleut and Eskimo persons interested in pursuing a professional career in medicine, osteopathy, dentistry, optometry, podiatry, pharmacy, veterinary medicine, or health planning and health administration. Each participant Continued on Pg. 5
SALT LAKE CITY, UTAH—The Graduate School of Social Work at the University of Utah is encouraging American Indian students to submit their applications for admission to the School of Social Work for the 1981-1982 school year. The American Indian Social Work Training Program is currently in its tenth year of operation at the Graduate School of Social Work. A special emphasis in the area of health and mental health is offered by the Graduate School of Social Work. For further information, contact: Dr. E. Daniel Edwards, Director; American Indian Social Work Career Training Program; Graduate School of Social Work; University of Utah; Salt Lake City, Utah 84114. Phone: (801) 581-8903.

GANADA, ARIZ.—The Navajo Health Foundation here has been awarded a $41,000 grant from the William Payne Blair Estate to help prevent and treat blindness among Navajos. The money will be used to conduct expanded eye clinics, provide eye care to the elderly and free eyeglasses when the need is demonstrated.

RENO, NEVADA—The Western Center for Health Planning will sponsor a workshop on the relationship between Health Systems Agencies and tribal health planning here March 5-6. The aim of the workshop is to bring HSA staff together with members of the Indian health community to work on mutual problems. For additional information, contact: Vivian Lin; Western Center for Health Planning; 703 Market St., Suite 535; San Francisco, California 94103. Phone: (415) 546-7601.

NORMAN, OKLA.—An Oklahoma Indian Alcohol and Drug Abuse Training Conference will be held here March 9-11 at the University of Oklahoma. The purpose of the training conference is to inform Indian people of the extent and prevalence of chemical dependency problems, and to identify state and federal resources for combatting such problems. For more information, contact Travis Jackson; P.O. Box 1332; Tablequah, Okla. 74464. Phone: (918) 456-0053.

WASHINGTON, D.C.—In an effort to limit the sugar and salt content for Women, Infants and Children (WIC) programs, the USDA’s Food and Nutrition Service (FNS) has announced new rules that will expand the food packages presently allotted from three to six packages and decrease the sugar content of WIC cereals to six grams per ounce, or no more than 21 percent by weight. The new food categories will serve infants up to three months old; infants from four through 12 months; women with special and dietary needs; children from one to five years; pregnant and breastfeeding women, and post-partum women who are not breastfeeding. According to USDA, state agencies have a full year to implement the new rules.

DENVER, COLO.—The National Rural Primary Care Association will sponsor a national conference on rural health care issues here March 8-11. The conference will feature nearly 50 workshops and education courses on different aspects of health care for rural areas. For additional information, contact the National Rural Primary Care Association; P.O. Box 1211; Waterville, Maine 04901.

TUBA CITY, AZ.—The Navajo Tribe has received a special three-year grant from the Rehabilitation Services Administration (RSA) that will help establish a cooperative program aimed at assisting the severely handicapped to move from a school environment to gainful employment, according to Special Education Coordinator Sherry Holland. Holland reports that there will be two demonstration areas involved in the program, one located in Tuba City and one in Shiprock. Previously, said Holland, coordination was lacking between the various voc-rehabilitation and voc-education agencies, and that now the program will attempt to end duplication of services and reach as many handicapped people as possible.

TOPPENISH, WASH.—A seminar on “Indian Family—A Way of Life” will be held March 6 and 7 at the Heritage Center on the Yakima Reservation and will include two days of discussion on: Indian healing, health, children, family survival, ceremonies and memorials, ecology, alcoholism, depression, death and dying, aging and senior citizens. According to Eleanor Bill, Yakima Patient Representative, the seminar is part of a continuing effort in helping the local hospital personnel and Indian patients adjust to one another and to educate people in Indian culture. The Yakima Patient Representative Program not only represents patients, but also serves as a liaison between Indian people and hospital personnel, said Bill. For further information, contact either Eleanor Bill or Phyllis Little Bull; Box 1104; Yakima Indian Health Clinic; Toppenish, Wash. 98948.

TUCSON, ARIZ.—The Tribal Management Support Center (TMSC), a division of the Indian Health Service that provides free training to tribal managers in different aspects of health administration, recently announced its schedule of courses to be held here in FY 1981. The schedule pertains only to those courses that will be held in Tucson, and does not reflect TMSC training services in the field. The schedule, which runs through September, 1981, includes such courses as: Principles of Management and Leadership; Administration of Grants; Development of Grant Applications; Word Processing; and Health Planning. All courses are offered to tribes and urban health projects free of charge. For further information, contact: Jack Knight, Director; TMSC, P.O. Box 11340, Tucson, Ariz. 85734.
Notes From the Executive Director:

During the week of January 19-23, the National Indian Health Board met with Dr. Emery Johnson, Director of Indian Health Service, and his special staff on Finance, Planning, Construction, Alcohol and Administration. This meeting was to be the culmination of a year's work to encourage American Indians and Alaska Natives to become involved, for the first time in the history of the Indian Health Service, in developing the national budget for Indian health care.

Planning for the 1983 Fiscal Year budget had its beginning last April under the Zero Base Budgeting (ZBB) process. NIHB agreed to work with IHS in encouraging and training tribes and tribal organizations in the ZBB process. NIHB took the IHS manuals on Zero Base Budgeting and revised them to be more appropriate at all levels of understanding. Training sessions were started in October and, at last, we began getting a few people involved in this important process. Those persons receiving that training were to go back home and work with their Service Unit Director to prepare their budget request for FY 1983. They would then know their total needs to operate at that level, including their unmet needs.

Those Service Unit budgets were then to be transmitted to the respective Area Office where the Area Director and his staff, along with the Area Board members, were to make sure that every tribe was represented by their official representative in preparing their Area's FY 1983 budget request. This budget was to be completed and forwarded to IHS Headquarters in Rockville, Maryland, by January 1, 1981.

Following receipt of all area budgets, NIHB members, along with representatives from other national Indian/Alaska Native organizations, were to come together with IHS personnel, consolidate the area budgets, and help prepare the national FY 1983 budget request.

This is the way it was planned, but as good old Murphy says in his law, the best made plans will go wrong. In fact, I believe he said, "If anything can go wrong, it will!"

Something went wrong because very little of the planned operation took place at the Service Unit or Area Office level.

NIHB, along with representatives from NCAI and NICA, met their responsibilities with IHS personnel as best as they could. Since we could not break down the "Line Items" in the Budgets at each level, and no one with us had any idea how the Area Budget was developed, we were more or less at a loss.

I must say that NIHB, NICA, and NCAI are working to make this process an annual endeavor for tribes and health boards, and it is absolutely imperative that as many of the responsible parties become involved as possible. We have begun, but we have only scratched the surface of the job ahead. We need all of you working at the level where you receive your direct health care if we are to see this process work.

NIHB is working with IHS to improve our health care delivery system, and having community participation in the budget process is an important aspect of this work. This is what NIHB is all about. Now we say, what is NIHB? Well, NIHB is a national Indian organization made up of those tribes and Alaska villages that participate in their Area Health Boards. For the purposes of administering Indian health programs, the United States is divided into 12 areas, and tribes and villages in each of those areas are encouraged to take the opportunity to participate with the Area Health Board.

I urge each of you to contact your health board member at your Service Unit whenever you have a concern about your health care services. They will try to resolve those problems locally. If they can't, then they will take them to the Area health board and again try to resolve them. In the event they are unable to resolve problems locally through hearings and negotiation, then they are brought to NIHB.

This is how NIHB operates, by responding to requests from those people we serve. We hear them at our quarterly meetings and very shortly, you will have the opportunity of "Sounding Off" your problems in resolution form.

NIHB is getting ready to sponsor the Fourth National American Indian/Alaska Native Health Conference in San Diego, California. The dates are April 7-10, 1981, at the San Diego Convention Center. We are encouraging every American Indian and Alaska Native that can possibly arrange the travel and time to attend this conference. We are going to be assisted in this conference by other national Indian organizations, who will be conducting various workshops in special areas of involvement.

Each of you will be receiving a special invitation and necessary forms to register at this conference. If you haven't received one yet or if you know someone whom you think needs to attend, let us know. We will give them their special invite. We even consider this issue of the Health Reporter as your special invitation. If you need forms, call or write us.

See you in San Diego.

j.w.

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NATIONAL INDIAN HEALTH BOARD
1602 South Parker Road, Suite 200
Denver, Colorado 80231

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Important Individuals, Organizations in Indian Health Field to be Honored by NIHB

DENVER, COLO.—Although the overall health care status of American Indians and Alaska Native populations remains below national standards, it is generally acknowledged that major improvements have been made in Indian health care over the last 10-15 years.

Much of this progress has been the result of determined efforts on the part of tribal health officials, doctors, nurses, administrators, elected officials, tribal governments, health boards, and many others to improve the quality of health care services received by Indian people.

Five Areas Appoint New Representatives to NIHB

DENVER, COLO.—As part of the continual changing makeup of its elected membership, the National Indian Health Board (NIHB) announced changes in its representation from the United South and Eastern Tribes (USET), Alaska, Billings, Bemidji and Tucson areas.

The new USET area representative, Maxine Dixon, a member of the Choctaw tribe, comes to the NIHB with extensive experience in tribal health affairs. She has served on the tribal council as chairperson of the health committee and as tribal health coordinator. On her appointment as USET area representative, Dixon said she sees NIHB as “a cohesive group of people whose goals and ideals will benefit all Indian people. I have good feelings when I attend the meetings, and know that when we get together something will get done.”

Alaska representative Kenneth Charlie, an Athabaskan, is presently serving as Chairman of the Alaska Native Health Board in the health field and has extensive state, regional and local experience. Charlie, who now lives in Fairbanks, was born and raised in Minto Village, located 50 miles west of Fairbanks. Besides serving as Chief of his village (pop. 200), he is also presently serving on a state committee that assists pregnant women who may experience pre-birth and birth complications.

Jesse James, the new Billings area representative, is from the Ft. Belknap Reservation and chairs the Montana Indian Health Board. James, who received her bachelors degree in social work from the University of Montana, says she wants to carry over to the NIHB her deep concerns with cancer, particularly leukemia. “I also hope the board will look into the holistic health care areas and preventative medicine. The more independent and self-sufficient Indian people can be in the health area, the better off they will be,” James said.

Ken Andrews, a member of the Chippewa tribe and the new Bemidji area representative, has been the Executive Director of the Great Lakes Inter-tribal Council for two years and tribal manager for the Red Cliff Band of Lake Superior Chipewas for one year. Andrews says that he would like to help all Indian regions with funding problems of Indian alcoholism programs.

New Tucson area representative Muriel Ortega has had experience as a member of the Papago Executive Health Staff. She is presently the Director of the Papago Disease Control Program in Sells, Arizona.

In an effort to acknowledge the work and dedication of some of these special individuals and organizations, the National Indian Health Board (NIHB) has established an awards process that will allow such persons or organizations to receive special recognition for their work in the area of Indian health care.

It is hoped that this awards process will help bring to the attention of the Indian Community the efforts of certain individuals and organizations whose work — whether on the local or national level — has significantly contributed toward improving the health care of Indian people.

Any person or organization is eligible for nomination and will be considered for recognition provided their work in the area of Indian health care meets with the specific criteria outlined below. Nominations may be submitted to any area NIHB representative, or may be sent directly to the NIHB central office in Denver, Colorado. Each nomination should include a detailed description of the nominee’s activities in the health field, with specific mention as to why the nominee deserves special recognition for those activities.

All nominations will be reviewed initially by the NIHB Awards Committee, with the final determination to be made by the full Board. Persons or organizations to be considered under this process may include (but are not necessarily limited to): physicians, nurses, Community Health Representatives, and all other health professionals serving Indian people; health administrators; tribal council members; health educators; researchers; tribal health and social workers; elected officials; health boards and other health organizations; and any other individual whose work has helped improve the health care of Indian people.

More specifically, persons, tribes, or organizations nominated in this process should have contributed in a

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OKLAHOMA CITY, OKLA—The pathway for an American Indian and Alaska Native undergraduate student in a health career can be a rocky one, filled with obstacles that are not necessarily faced by individuals with broader cultural advantages.

In an effort to smooth out potential barriers, such as the deficiency of appropriate counseling, the shortage of role models, and the serious lack of necessary financial resources, the Association of American Indian Physicians (AAIP) has for the past two years sponsored several pre-admission workshops for Indian undergraduate students who are preparing for health professions careers.

Four new workshops have been scheduled for 1980-81, the first of which took place here November 8-9 at the University of Oklahoma School of Nursing. The workshops, presently funded by the Office of Health Resources Opportunity, are now being scheduled on a permanent, year-round basis, according to AAIP.

The development of the workshops occurred when a significant need for Indian undergraduate students to become better prepared for entry into health professions schools became apparent, says AAIP Executive Director Bill Wilson. "We found that many of the MODVOPP students (undergraduates planning to study either medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry or pharmacy) didn't know how to select a health professions school, how many pre-admissions tests they had to take, how the interview process worked, how the application process worked, how the financial assistance worked and had an overall lack of knowledge of how the 'system' worked," said Wilson.

Questions were addressed at the workshop concerning a student's possible acceptance into medical school, possible rejections, alternative pathways, instructions on how to prepare written biographies for medical school applications, financial assistance strategies and counseling assistance on medical school rejections.

Day One

The first day of the workshop began with personal introductions of 10 selected Indian undergraduate students, aged 19 to 43. The students represented tribes from several geographic areas including New Mexico, Arizona, New York, Oklahoma, North Dakota, and Montana.

According to Wilson, 30 students were chosen from a pool of 140 applicants and were selected on the basis of grade point average, academic classification and recommendations. The recruitment was accomplished by sending out workshop announcements to Indian community newsletters and newspapers, health career opportunity projects, higher education offices and national student councils.

During the two-day workshop, various reasons for attending surfaced. Clarence Hacker, 20, Sioux, and a junior at the University of North Dakota, said he thought the workshop would help him increase his incentive. Charlene Avery, 19, a member of the Navajo tribe and a junior at Harvard University, said she was there because she wanted to be able to present herself "in the very best possible way." Other students indicated that they wanted to understand more about what is asked of a medical student and to learn more about the strain of four years in medical school.

According to AAIP, not only were students carefully selected, the workshops themselves were designed and tailored to meet the specific needs of the students.

"We tried to make the workshop compliment the students by looking at the schools they attended, how many..."
Helps Prepare Students Health Professionals
dependents they had, what year of college they were in and whether or not they were single or married,” said AAIP workshop facilitator Bernard Kahrahrah, a private consultant and former director of the Indians Into Medicine (INMED) program at the University of North Dakota.

“By perceiving their needs, it gave me an idea what direction the workshop could take,” said Kahrahrah. Kahrahrah also discussed the selection of a professional school with an emphasis on the following: geographic location, curriculum, support services, Indian Studies Programs, availability of housing, residence requirements, population served, faculty, and grading procedures.

A major emphasis of the workshop dealt with the formal application process for entering medical school. Forms must be completed and sent in by the established deadlines, said Kahrahrah. Standardized tests, such as the Medical College Admission Test (MCAT) must be taken. An interview follows these initial steps. According to Kahrahrah, if a student fails the admissions test, he or she should have alternative career plans (e.g. medical technician, laboratory technician, community health medic, etc.)

Kahrahrah also emphasized that within the application, a written biography was required by each applicant. The biography, a “critical” component of the application according to Kahrahrah, could be an important vehicle for the students, especially for conveying their cultural background and interests to school admissions committees.

“Not everybody has had the same life experiences. People who will review your application will look closely at the language used, activities, and leadership roles, thus giving them an in-depth view of the American Indian culture,” said Kahrahrah. “You must tell them your capabilities, because no one else will.”

Another component of the admission process into medical school covered at the workshop was the pre-admission interview. “The interview reveals how you deal with people, how sincere you are, how committed you are to medicine and your overall philosophy of why you want to be a doctor,” said Kahrahrah.

Kahrahrah added that medical schools are looking for specific factors that are reflected in the application and admissions process, especially in the areas of maturity, confidence, and leadership qualities.

Another important part of the first day discussion centered on the accessibility to financial resources for Indian undergraduate students, particularly in the area of P.L. 94-437, under Section 103. The Bureau of Indian Affairs and the Office of Indian Education have also listed five priority fields of education funding: medicine, business, law, forestry and natural resources, said Kahrahrah.

Other financial resource areas cited were National Medical Fellowships (a fund for minority students), state scholarships, foundation grants, the National Health Service Corps, and the U.S. Armed Forces Scholarships. Student loans discussed included the Health Professions Student Loan Program ($5,000 per year) and the National Direct Student Loan ($2,500 a year).

Day Two

The second day of the workshop was spent almost entirely with a succession of “mock” interviews established to simulate the actual medical school admissions interviews. These interviews were staged by four AAIP doctors participating at the workshop. According to Dr. Wesley Parkhurst, an AAIP Executive Board member and a member of the Choctaw tribe, “the mock interview will help the students think about the pertinent questions. Some students may be reinforced by this, and others may get discouraged — not everybody would be happy as a physician,” said Parkhurst.

During one of the interviews, Patricia Hawk, 27, Cherokee and a junior at Oklahoma’s Oscar Rose College, said that she had planned to get her bachelors and a masters degree in hospital administration, but because of a college counselor’s interest she was encouraged to apply to medical school instead. “I hadn’t set my goals any higher,” said Hawk.

The participating AAIP physician who interviewed Hawk, Dr. Ed Work, said that Hawk’s answers to his questions were both revealing and to the point. “She did real well in her responses and did not add more than I asked

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DR. WESLEY PARKHURST (foreground) AND Clarence Hacker, a junior at the University of North Dakota, trade questions and answers during the mock interview portion of the workshop. Hacker, who is considering a career in veterinary medicine, said he attended the workshop in order to build up his confidence for applying to medical school.
Despite Success, ‘Section 102’ Recruitment Program Faces Possible Cutback in FY ‘81

DENVER, CO.—While there has been some progress in increasing the number of American Indian health professionals, there is still a severe underrepresentation of Indian practitioners in the various health fields, according to the Association of American Indian Physicians (AAIP).

This disparity, along with the commitment to raise the level of Indian health care by the development of Indian health manpower professionals, has prompted tribal governments, urban Indian health boards, and national Indian organizations to utilize federal and private grants as an aid in recruiting, identifying and encouraging Indians with a potential for education and training in the health professions.

Grants provided by Section 102 of the Indian Health Care Improvement Act (P.L. 94-437) have become an important funding resource used in this recruitment process. According to Kay Carpentier, Indian Health Service (IHS) Grants Management Officer (IHS approves and implements Section 102 grants), over 18 grantees received Section 102 grants in 1980, ranging from $20,000 to $60,000 per grant.

“These programs have been most successful over the past three years, especially when you consider the small amounts they have had to work with,” said Carpentier. “Every year the proposals have gotten better. The process for awards is very competitive — last year we had over 40 applications and only 18 awards were given.”

Separate recruitment grants were also made in 1980 to the University of North Dakota, IHS program and Masters of Public Health (MPH) programs at the University of Hawaii, the University of California at Berkeley, the University of Oklahoma and the University of North Carolina.

Unfortunately, 1981 funding for Section 102 grants may be in jeopardy, mainly due to a $1 million cut in appropriated funds, according to IHS. “Last year $6.6 million was appropriated for Title I, and this year only $5.7 million was funded,” said Carpentier.

The impact of these cuts has not been felt as yet, according to various Section 102 recipients. What the recipients do report, however, are recruitment programs that have proven to be most successful in their respective areas.

According to Wayne Stein, deputy director of the Navajo Health Authority (NHA), the NHA has designed and packaged most of the recruitment and scholarship programs for the Navajo Nation.

The NHA recruitment programs have mainly focused on high school students and consist of academic and social enrichment preparation, said Stein. “The students need to know how the system works to survive. The funding for these recruitment programs allows us to aid the students in identifying an area of specialization and to provide information on financial resources, help with application deadlines and counseling,” said Stein.

With the knowledge that federal grants and outside funding for Indian health manpower recruitment programs are becoming scarce, Stein reports the Navajo Nation will continue to “scramble for funds wherever we can.”

“People are out there with talent, but lack the social and financial resources mandated by higher education,” Stein says. “Most of the students have family responsibilities above ordinary college students and are expected to contribute to the family unit, especially financially.”

NHA has tried to supply the students with enough money and pre-professional courses to help them keep going in the right direction, says Stein. “Approximately 88 percent of the students who have received scholarships for health-related careers are either working with the Navajo tribe or for some other tribal entity,” Stein said. “We try to help them maintain ties with their family and community — and because of this, they come back.”

In the Northwest, the Montana Indian Health Board, another Section 102 grantee of 1980, reports progress in their health manpower recruitment programs. According to Lazona Bailey, Health Careers Supervisor for the Montana Indian Health Board health careers recruitment program, their program was entirely funded by a Section 102 grant.

“We had absolutely no health manpower recruitment program before this grant,” said Bailey, “but now are able to go out to the schools and provide grades kindergarten through eleven with information on health careers.” Bailey also reports that the children are beginning to realize all the opportunities open to them.

“This program is like planting a seed — not only with the children but with the tribal people as well,” Bailey said. “It funds are cut, we are hopeful that the schools and the tribes in our region of Montana and Wyoming will pick up where we started.”

In the Northeast, the St. Regis Mohawk tribe of Akwesasne, N.Y., reports encouraging signs of health career awareness with their Section 102 grant programs, said Eric Herne, Health Care Recruitment Program Director for the Mohawk Tribe. “When I go into the high schools, I just don’t talk about becoming a doctor. I also try to inform the students of other health related career opportunities,” said Herne.

“We place particular emphasis on helping them to explore their field of interest and how it could somehow relate to health careers,” says Herne. “If a student is interested in art, we inform them of a possible career as an art illustrator, or if a student has an interest in engineering and biology, we introduce them to what a bio-medical engineer does,” said Herne.

Section 102 funds have also aided the Mohawk health manpower recruitment program in supplying to the students, via a tribal newspaper, with up-to-date information on health-related jobs, academic programs, financial assistance resources and counseling services, says Herne.

After only three months as program director, Herne reports that several high school students have already approached him about pursuing careers as medical doctors. “I was quite pleased,” said Herne.

In California, the California Rural Indian Health Board (CRIHB) chose an alternative funding route, according to Maria Carillo, Health Careers Awareness Program counsel for CRIHB.

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Despite Success

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"CRIHB received a three-year grant from the Health Resource Administration that has enabled us to reach more than 7,000 area students," said Carillo. "We meet with the students and present information on health careers, present role models, and distribute posters, brochures and calendars — practically anything that would help to motivate them."

CRIHB also reports that they keep follow-up lists of students who show an interest in a health career. "We contact them twice a year and continue to supply counseling and encouragement," said Carillo. "Our program has helped over 800 students who are now attending schools with health-related majors."

But, despite such reports of successful Section 102 grant programs and the use of alternative funding successes, Carpenter predicts that for 1981 most of the Section 102 will cease.

"We are hopeful, though, that some way of funding for these programs will come about," said Carpenter. "All we can do now is wait and see."

Indian Physicians

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for," said Work. He encouraged her to proceed in applying to medical school, noting medicine has a shortage of women, especially Indian women.

Besides a verbal evaluation after each interview, each student received a written evaluation that is intended for AAIP files, said Wilson. "Students who do not receive high marks from the evaluations are encouraged to pursue alternative health careers. Some of them won't make it," said Wilson.

The mock interviews received praise from the students. According to Ronn Moccasin, 43, a member of the Assiniboine tribe in Montana, "the interview challenged me to be more specific and helped me to confirm my goals and aspirations," said Moccasin. "I have the potential to do it, I just have to become better prepared."

According to John Farris, 22, and a member of the Cherokee tribe in Oklahoma, the interview helped him gain insight into the type of questions that will be asked. "This interview helped me improve my answers, making them clear-cut instead of ambiguous."

Baptiste Shunatona, 21, a member of the Cree-Otoe-Missouri-Pawnee tribes in Oklahoma, said he was glad the doctor "worked him over during his interview."

"I had to think on some of the answers. He asked me questions I never considered. I now need to say 'I plan' rather than 'I think' next time," said Shunatona. "I guess I haven't put enough thought into why I want to become a doctor."

According to Kahrahrah, the students were subtly reminded throughout the two-day workshop of their commitment to work with Indian people. "I don't try to provide a mandate as to where they will eventually practice medicine, but I provide information as to the specific needs of Indian people."

Kahrahrah also stressed the importance of providing an Indian community with a family doctor who stays on for a longer period of time. "The family doctor is practically non-existent on reservations and is a vitally important asset to the Indian community," said Kahrahrah. "If a doctor stays on, it will help to establish trust and strong psychological ties."

Parting thoughts and advice were also given by Dr. Parkhurst:

"Don't get discouraged. I applied to 12 medical schools and was turned down. It is not uncommon to receive rejections, eventually you will get in."

Further workshops planned by AAIP for Seattle, Wash., March 21-22 and Pembrooke, N.C. on March 28-29. Further information about these workshops can be obtained from the Association of American Indian Physicians, 6801 So. Western, Suite 206, Oklahoma City, OK. 73139; or phone: (405) 561-0447.

IHS Issues

Continued from Pg. 3

Copies of the IHS P.L. 93-638 policy statement and related documents were mailed to all IHS area offices January 30, with instructions that the documents be copied and sent to the tribal leadership of each area. According to an IHS headquarters official, copies of the policy document can be obtained from IHS Area/Program Offices upon request.

PATRICIA HAWK (right) AND LINDA GOURNEAU (left) go over a workshop pre-test, designed to inform and challenge the participants on questions such as: medical school testing, admissions interviews, support systems, and biographical material presentation. The participating students were tested at the beginning and end of the two days.
DENVER, COLO.—Tribes, Indian organizations, health professionals, and other persons planning to attend the Fourth National Indian/Alaska Native Health Conference in San Diego, Calif., April 7-10, are being urged to make their arrangements as soon as possible in order to avoid a last-minute rush for limited hotel and travel accommodations.

The conference, which has a theme of "The 1980's: A Decade of Indian Health Initiatives," is being held to provide American Indians and Alaska Natives with a forum to discuss and learn about many of the most pressing health problems in today's Indian communities.

A conference agenda, registration form ($35 fee), and information on hotel and travel accommodations have been prepared by the National Indian Health Board (NIHB) and distributed nationwide. These materials can be obtained from the NIHB Public Information Office.

According to NIHB staff person Linda Standing, who is coordinating conference housing arrangements with the San Diego Visitors and Convention Bureau, a limited number of rooms have been blocked off for the conference and will be held until March 7. Rooms not reserved by this time will be released. Persons interested in obtaining hotel reservation forms should contact Linda Standing at the NIHB central office in Denver, Colo.

In making final preparations for the conference, the NIHB planning committee has made several additions to the workshop schedule and other conference activities. Because the conference is focusing particular attention on Indian Self-Determination in the health sphere, the committee added a workshop designed to explain the responsibilities of the new IHS Indian Resource Liaison Staff (IRLS) (for separate article on IRLS, see pg. 3).

In all the conference will sponsor 17 workshops, each of which will be held twice to ensure that conference attendees will be able to take part in as many sessions as possible. The workshops will be facilitated by highly-knowledgeable professionals who will be able to provide participants with the most up-to-date information in their respective fields. Workshop participants will also be encouraged to present their own views about the topics being discussed.

Workshops slated for April 8 are: the Mental Health Systems Act (P.L. 96-398); Nutrition; the Health Maintenance Organization Act (P.L. 93-222); the IHS Budget Process; the National Health Service Corps; Funding Alternatives; Title V. P.L. 94-347 Issues; Environmental Concerns; and the IHS Indian Resource Liaison Staff.

On April 9, the workshops will include: Community Health Representative Programs; Indian Health Manpower; Alcohol and Drug Abuse; Emergency Medical Services; Chronic Diseases (Diabetes, Cancer, Hypertension, etc.); Indian Youth; Indian Elderly; and Otitis Media.

In addition to these smaller workshop sessions, the conference will feature two major presentations before general assembly audiences. On the morning of April 8, a special panel of government officials, tribal attorneys, and other legal experts will examine "Legal Issues and Answers to P.L. 93-638 (the Indian Self-Determination and Education Assistance Act)." This panel discussion will focus primarily on the new P.L. 93-638 initiatives within the Indian Health Service.

The following morning, April 9, a panel of Indian medicine men and other health professionals will address the topic of "Traditional Indian Medicine and Holistic Health." The session on P.L. 93-638 and the one on traditional Indian medicine have been scheduled before general assembly audiences to allow as many individuals as possible to attend. Conference will also be encouraged to ask questions of the panel members at both sessions.

In dealing with other conference activities, the NIHB planning committee set the following fee schedule for conference exhibits: commercial—$400; non-profit—$300; Indian non-profit—$200; individual Indians—$100. The fee will cover the costs of city licenses, booth materials and set up, and other services. Because of the high demand anticipated for booth space, exhibitors are being encouraged to send in their requests as soon as possible. Application forms and additional material on conference exhibits can be obtained from Howard Bad Hand at the NIHB central office.

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Final... 

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In addition, the conference planning committee finalized preparations for a dance Tuesday night, April 8, at the Holiday Inn Embarcadero Ballroom. Admission is $3, with music performed by the Merv George IV, a California Indian band that plays a variety of music styles.

Arrangements are also being finalized for a pow-wow Thursday evening, April 9. Conference participants are invited to bring their costumes for traditional dancing. An awards ceremony is planned for the pow-wow.

In order to assist conference attendees with their travel arrangements to San Diego, NIHB is working with Free Spirit Travel and United Airlines in providing a toll-free number for persons making airline reservations. For all locations except Illinois, call (800) 323-0639. In Illinois, call (312) 589-3375.

For additional information on the Fourth National Indian/Alaska Native Health Conference, contact: the National Indian Health Board; 1602 S. Parker Rd., Suite 200; Denver, Colo. 80221. Phone: (303) 752-0931.

NIHB Science Center Begins Operation

FT. COLLINS, Colo.—The National Indian Health Board (NIHB) Public Service Science Center has begun its first phase of operation with the production of tape recorded health education packages and a national search for scientists with expertise in the areas of drug abuse, nutrition, community development and occupational health and safety.

The center's operations consist of providing Indian communities with scientific expertise and information on nutrition and health. The health education materials produced by the center are designed to be highly entertaining audio messages which can help motivate listeners to improve their health care.

The first health education package produced by the center presents information on breastfeeding and infant feeding practices, and addresses topics such as: working while breastfeeding; how does breastfeeding help the mother; how does breastfeeding help the baby; peer support for breastfeeding; introduction of solid foods at six months of age; how to wean the baby, and feeding an infant with a spoon.

The breastfeeding and infant feeding health education package is divided into four parts. The first, titled "How Do You Want to Feed Your Baby?", is intended for Women, Infants and Children (WIC) clinics, prenatal classes, and for use by Community Health Representatives (CHR's) or other health professionals. This part of the program has been prepared specifically for women in their fifth through ninth month of pregnancy.

The second segment, titled "Successful Breastfeeding", is intended for use in the last month of pregnancy through the first weeks following birth and is aimed at promoting behaviors which can lead to breastfeeding that is both successful and enjoyable. This section can be used in hospitals, prenatal clinics, Lamaze-type classes and by health professionals.

The third segment, called "Feed Me", is intended to demonstrate correct behavior and needs of infant feeding and can be used in well-baby clinic settings, WIC programs and by CHR's and other health professionals.

The fourth part of the package was designed for use in radio broadcasts in an Indian or Alaska Native environment to promote the idea that breastfeeding is one of the best ways to provide love and care to an infant.

In addition, a special presentation is included for health workers on how to best use this information. Written material on the importance of breastfeeding, technical material for health professionals, and complete scripts are also provided. Drawings of American Indian faces accompany the audio tapes and add informative suggestions for successful breastfeeding and infant feeding. The music used on the tapes is performed by American Indians, and the voices of Indian characters are played by Indian actresses and actors.

The NIHB Science Center is also compiling a resource directory of scientists who can assist American Indian communities in health issues. Scientists with expertise in drug abuse, nutrition and community development or occupational health and safety are being sought at the present time. Scientists who wish to apply for membership in the center should submit a resume and letter to the center describing what he or she considers important issues to be addressed in an American Indian setting. The names and resumes of member scientists will be included in a resource directory of scientists which will be distributed to tribal governments.

Future issues of the NIHB Health Reporter will describe the center's diabetes materials and materials on traditional food production.

Important...

Continued from Pg. 7

significant and demonstrable manner to the following:
— to furthering the goal of Indian Self-Determination in the area of health care for American Indians and Alaska Natives
— to improving the health care services and benefits to American Indians and Alaska Natives as provided under the treaty rights and/or laws of the United States
— to enlighten and give the public a better understanding of matters and problems of health affecting American Indians and Alaska Natives
— to enhance and promote the education and understanding of members of American Indian tribes and Alaska Native villages in matters pertaining to their health and welfare
— to seek an equitable adjustment of public health services among participating Indian tribes and Alaska Native villages
— to otherwise promote the common welfare and health of American Indian and Alaska Native people.

Persons or organizations determined by NIHB to have met these criteria in such a manner will be presented one of these awards: an NIHB Certificate of Appreciation; an inscribed bronze NIHB Medallion; or (in exceptional cases) a specially-designed NIHB Plaque.

The first major presentation of these awards will be made at the upcoming Fourth National Indian/Alaska Native Health Conference in San Diego, California, April 7-10, 1981.

Persons interested in making a nomination for these awards, or in obtaining further details about this process, should contact: Awards Committee; National Indian Health Board; 1602 S. Parker Rd., Suite 200; Denver, Colorado, 80221.
Proposed Rule Change Would Include Non-Indian Husbands for IHS Services

ROCKVILLE, MD.—The Indian Health Service (IHS) has proposed a major revision in the federal regulations governing eligibility for the agency's health care services.

Under the proposed revision, eligibility for services from IHS would be expanded to include the non-Indian spouse (husband or wife) of an eligible Indian residing in the Indian's household.

The proposal would update current regulations that extend eligibility to the non-Indian wife of an eligible Indian, but exclude the non-Indian husband from such services. Pending issuance of final regulations on the matter, "the IHS will consider the non-Indian husband of an eligible Indian residing with the Indian as eligible for services, despite exclusion of non-Indian husbands under the current regulations."

The proposed amendment would also provide eligibility to other non-Indian members of the Indian's immediate family (stepchildren, adopted children, and the separated or divorced parent in the case of an Indian child) who are residing with the Indian. In addition, the proposal specifically extends eligibility for IHS services to surviving non-Indian spouses of eligible Indians who continue to live in the Indian community served by IHS and who have not remarried an ineligible person.

As stated in the proposed revision, "serving non-Indians under this authority is justified in those situations where the health of the non-Indian is so closely interrelated with the health of Indian persons that serving the non-Indian may be viewed as furthering the statutory purpose of conserving the health of Indians."

Specifically, the proposed regulation states: "(2) You are eligible for available services, as medically indicated, if you are (a) the non-Indian spouse of an eligible Indian and reside in the household of that eligible Indian; or (b) you are a non-Indian member of an eligible Indian's immediate family and reside in the household of that eligible Indian; or (c) you are the surviving non-Indian spouse of an eligible Indian and you continue to live in the community served by the local facilities and program and have not remarried a non-eligible individual."

The proposal also stipulates that other non-Indians residing in an eligible Indian's household may be eligible for available services if, in the determination of the IHS medical officer in charge, the provision of such services will aid in conserving the health of Indians in that household.

Applicants Sought for NIH General Counsel

DENVER, COLO.—In conjunction with its new contract beginning March 1, 1981, the National Indian Health Board (NIHB) is accepting bids from attorneys and law firms to serve as the organization's General Counsel.

In this capacity, incumbent will provide a variety of legal services to NIHB, including: counsel on all NIHB corporate and contract matters; preparation of legal documents related to NIHB goals and objectives; review and analysis of legislative issues affecting Indian health care; serve as Washington, D.C. liaison for NIHB; and other legal services requested by the organization.

Indian preference will be applied to this notice, but NIHB encourages all interested attorneys to submit their bids, along with resumes and other information, to: Executive Director; National Indian Health Board; 1602 S. Parker Rd., Suite 200; Denver, Colo. 80231. Phone: (303) 752-0931.

Closing date for receipt of all bids and proposals is March 1, 1981.
INTERIOR SECRETARY
JAMES Watt (right), pictured here with his wife Leilani and NIHB California Alternate Dennis Hendricks, made a surprise appearance at the National Congress of American Indians (NCAI) Inauguration Ball in Washington, D.C. January 20. Watt told attendees of the NCAI Inauguration Ball that he looked forward to working in consultation with tribal leaders in carrying out the trust responsibility of his office.

Tribes Concerned Over Possible Funding Plan for Mental Health Programs

(EDITOR'S NOTE: One of the proposals contained in President Ronald Reagan's FY 1982 budget request is reported to be a funding system that would provide block grants to state governments for health programs, including those programs of the National Institute of Mental Health. If a block grant system is adopted, the NIMH funding process discussed in the following article, along with the alternative proposed by the National Indian Health Board, would be eliminated. Details on the Reagan budget request, and its potential effect on Indian health programs, will appear in our next issue.)

ROCKVILLE, MD.—When the Mental Health Systems Act (P.L. 96-398) was signed into law last October, Indian tribes and inter-tribal organizations were optimistic that certain programs contained in the legislation would help improve mental health services for Indian people. However, such programs may never get off the ground if a funding allocation plan now being considered by officials at the National Institute of Mental Health (NIMH) is adopted.

Under this plan, monies anticipated for certain programs in the act would be distributed solely on the basis of population. Using this population-based formula, a special fund would be established for applications made under Section 308 of the act, which permits Indian tribes and inter-tribal organizations to apply directly to the Secretary of Health and Human Services for grants under the act.

This "Indian set-aside," which comes to one-half of one percent (.005) of the available funding, would amount to $250,000 under the FY 1982 budget request by former President Jimmy Carter earlier this year. In light of President Ronald Reagan's planned budget reductions, funding for Section 308 applications could be reduced even further.

According to Daniel Press, General Counsel for the National Indian Health Board (NIHB), the projected $250,000 funding level for all applications under Section 308 is woefully inadequate for starting up mental health services in Indian communities, especially considering the higher costs of delivering such services in rural and reservation areas.

In addition, Press contends that allocating funds for Section 308 applications solely on the basis of population ignores the congressional intent of the act. As stated in a report by the Senate Committee on Labor and Human Resources, Section 308 "... does not create any special entitlement program for Indian tribes. The Congress expects the Secretary to fund tribal Indian programs at a level commensurate with their needs relative to the needs of all other populations eligible for funding and services under this Act ..."

In response to the suggested NIMH allocation plan, a number of tribal representatives have reportedly contacted Senator Harrison Schmitt (R-N.M.), Chairman of the Senate Appropriations Subcommittee on Labor, HHS, and Education, to voice their concern over the possibility of a limited Indian set-aside for Section 308.

As an alternative to allocating funds on the basis of population, NIHB is recommending that a specific number of program activities be funded under Section 308. This recommendation calls for eight projects for the chronically mentally ill (Section 202); one grant each for services to severely mentally disturbed children and adolescents (Section 203), elderly individuals (Section 240a), and priority populations (Section 204b); and eight "linkage" grants (Section 205) to provide for mental health professionals and expanded services in existing health facilities. In total, NIHB is recommending that a minimum 20 projects be funded, at an estimated cost of $2 million.

As provided under Section 308 of the act, tribes and inter-tribal organizations may apply directly to the Secretary for these grants rather than having to go through a designated state mental health authority as required of all other applicants. The law requires, however, that applications made directly to the Secretary must be certified by the Indian Health Service (IHS) as being consistent with the Tribal Specific Health Plan (TSHP) of the tribe or tribes served by the grant.
New APHA Caucus to Focus on Indian Health Concerns

By Dr. Robert Birch

DETROIT, MICH—The 108th Annual Meeting of the American Public Health Association (APHA) here October 19-23 was the site of another milestone in Indian health. A group of concerned members of APHA met together and began the process of forming the American Indian and Alaska Native Caucus.

A Steering Committee co-chaired by Margo Kerrigan, M.P.H., and Robert Nakai, (M.P.H. student, UC Berkeley), made preparations for submitting the application for recognition of the Caucus to the APHA Governing Council.

The overall purpose of the American Indian and Alaska Native Caucus is to promote Indian health concerns within and through APHA and, in turn, bring the many resources of APHA to bear on these concerns. As with any organization, the Caucus will only be effective if it has an active, enthusiastic, informed membership of persons vitally concerned about, and willing to work to improve, Indian health.

While official APHA action regarding the proposed caucus is awaited, the Steering Committee is: (1) planning a business meeting and scientific session to be sponsored by the Caucus at the 109th Annual Meeting of APHA in Los Angeles in 1981; (2) refining a list of long-range objectives for the Caucus; (3) developing a resolution process for the Caucus meeting in Los Angeles, and; (4) recruiting members for the Caucus.

You must be an APHA member to join the Caucus. Benefits of APHA membership include the monthly American Journal of Public Health; the monthly newsletter, The Nation’s Health; Washington New Letter; registration discount at the Annual Meeting; APHA section activities; optional low cost insurance; 20 percent discount on APHA publications; APHA representation at the federal, state, and local governmental levels and to industry and the general public; professional advancement; voting privileges; and leadership and employment opportunities. Regular APHA membership dues are $40 per year.

We will keep you informed through the NIHB Health Reporter of actions of the APHA Governing Council regarding recognition of the Caucus. Meanwhile let’s take advantage of this opportunity to work together to help improve Indian health through the APHA American Indian and Alaska Native Caucus. If you will help and want to join, please contact: Margo Kerrigan; Indian Health Service; 2422 Arden Way, Suite 30; Sacramento, California 95825. Phone: (916) 484-4041/(FTS) 468-4041; or call Robert Nakai (415) 642-3228.

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Please submit all articles, correspondence and mailing requests to John P. O’Connor, National Indian Health Board; 1602 S. Parker Rd., Suite 200, Denver, Colo. 80231.

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