National Indian Health Board

NIHB Health Reporter

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Backlash Could Extend to Health Legislation, Cautions McKenzie

TSAILE, ARIZ.—The deputy director of the Navajo Area Indian Health Service (IHS) recently had some harsh words for existing and pending health legislation, warning of "symptoms of Indian backlash in our own environment."

In his keynote address to participants of the Navajo Nation Health Symposium held here August 22-26, Dr. Taylor McKenzie said that Indian tribes including the Navajos have developed the sophistication to meet non-Indians on equal legal ground. As a result of their victories in regaining lost lands, public opinion has begun turning against Native Americans, he added.

With respect to health legislation and referring specifically to P.L. 93-641, the National Health Planning and Resources Development Act, asserted Dr. McKenzie, "if Indian tribes had not been vigilant they would have been swallowed up by states and other areas."

As for P.L. 94-437, the Indian Health Care Improvement Act, said Dr. McKenzie, while it provides for maximum Indian participation, Indian people have not been satisfied with the input they have had.

He called P.L. 93-638, the Indian Self-Determination Act, which allows for Indian tribes to contract for their own health services, "one way the federal government can get rid of bad programs they are having trouble with themselves."

Dr. McKenzie opposes a bill being drafted by Sen. Dennis DeConcini (D.-Ariz.) which would allow IHS hospitals on reservations to take non-Indian patients. IHS support for the draft confuses him, said Dr. McKenzie. "They (IHS) talk about maximum Indian participation; they say they want to serve as advocates, yet they give their approval

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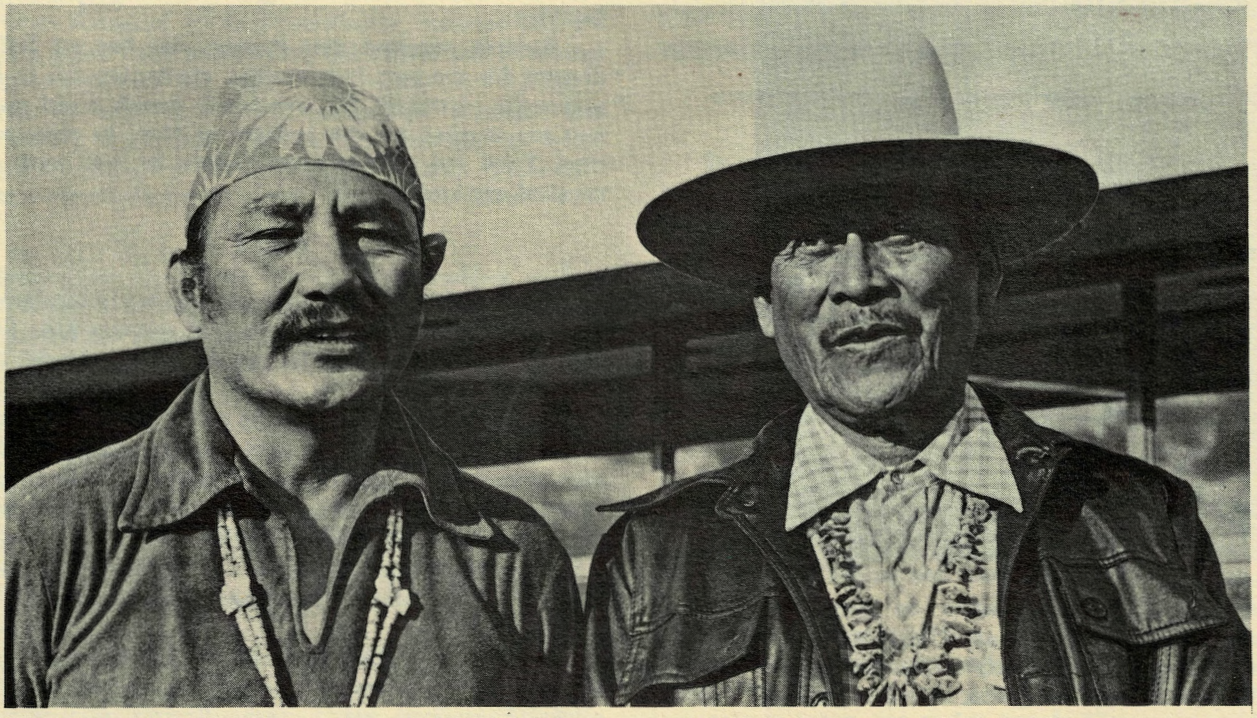


TWO KAYENTA, Ariz. service unit area gentlemen who contributed to the success of this year's Navajo Nation Health Symposium held August 22-26 at the Navajo Community College: Elwood Saganey, Chairman of the Navajo Area Indian Health Board and medicineman Buck Austin of Black Mesa, Ariz.

Involvement with 641 Vital to Protection of

BISMARCK, N.D.—When members of the National Indian Health Board (NIHB) conducted their quarterly meeting here September 6-8 their discussions centered largely around legislation impacting on Indian health.

Several representatives reported experiencing problems trying to work with laws recently enacted and executive director John Belindo warned board members of what they might expect in the future if Indian people fail to take action to protect their interests.

New Officers Selected

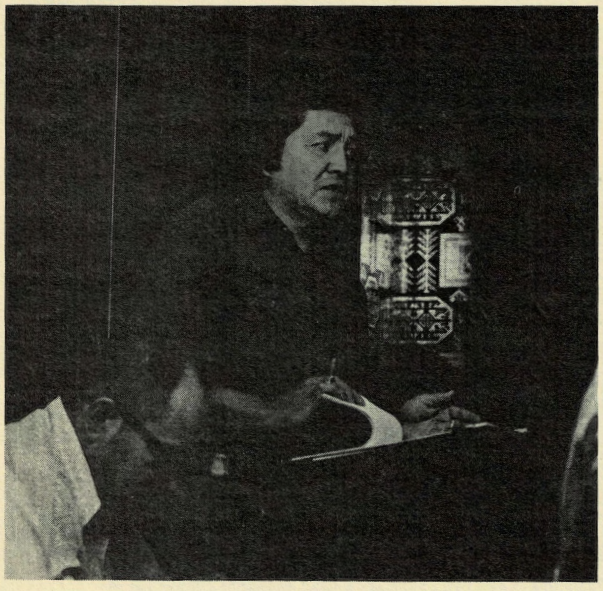
The meeting also saw the election of NIHB officers for the coming year. In a closed session, the board chose to have Howard Tommie, Chairman of the Seminole Tribe, continue as its chairman. Ada White, Chairwoman of the Billings Area Indian Health Board, who served as secretary for the past year, was selected vice-chairperson. The board chose Leonard Hare, Jr., Chairman of the Four State Indian Health Board, as its secretary-treasurer.

Area Board Activities

Board members briefed the gathering on health problems and health board activities within their own areas. Several reported encountering difficulties trying to work in cooperation with P.L. 93-641: the National Health Planning and Resources Development Act.

Enacted in 1975, the law is designed to provide health planning and development of health resources for the entire nation. The primary mechanism for carrying out the act is Health Systems Agencies (HSAs), established in every part of the country to develop health needs and services plans for their areas.

In addition to their planning function, HSAs are to provide information to the public and to review and approve all applications submitted to HEW from their area for grants for funds available under certain health acts. As the result of last minute tribal lobbying, the HSAs may only review and comment on applications submitted by tribes.



IF TRIBES don't develop an acceptable relationship with their area HSAs now, the negative effects will likely be carried over to National Health Insurance, NIHB Executive Director John Belindo warned the Bismarck gathering. At left is NIHB Alaska alternate Darryl Trigg.

Tucson

One of the first tribes to become aware of the possible implications of the law and actively involve itself with their area HSA were the Papagos, who constitute the Tucson IHS area. A member of their executive health staff sits on the HSAs governing board and has received assurances that the tribe's own health plan will be "accepted as equal."

But, according to NIHB representative Irene Wallace, the tribe now finds that the HSA feels it has the right to control the actions of the tribe's own health planner.

Also creating problems for the Papagos is Title XX, the Social Services portion of the Social Security Act. Wallace noted that many state regulations are not applicable to tribes.

The Papago Tribe has approved the first phase of a $1.2 million health program complex and Wallace said she is hopeful that construction will begin within the next two months.

Phoenix

Phoenix Area Indian Health Board Chairman Perry Sundust called P.L. 93-641 a "critical issue", explaining that the local HSA wants approval authority over construction of a new hospital in his area.

Hospital construction for Sacaton, Ariz. is being delayed by a congressional moratorium on new hospital construction imposed following a General Accounting Office (GAO) report finding an overload of hospital beds in certain IHS facilities.

Sundust reported that Phoenix has had no IHS area director for the past four months, attributing this to Indian preference. Although the area Indian health board made its two top choices for the position in May, he reported, the Hopi Tribe has protested and wants its own look at the panel of applicants.

Navajo

The Indian preference policy is creating morale problems in the Navajo area, within both IHS and the BIA, Elwood Saganey, Chairman of the Navajo Area Indian Health Board, told the gathering.

Explaining the GAO finding of an overload of hospital beds on his reservation, he said that an underutilization of beds was noted because certain portions of hospitals are closed due to a personnel shortage. In reality, he remarked, "we are in desperate need of hospital beds."

Aberdeen

Once again, a GAO study of hospital bed use is causing setbacks. In the Aberdeen area a study resulted in rejection of the Four State Indian Health Board's proposal for the third phase of its Evaluation Contract on a Major Medical

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Indian Interests Stressed at Quarterly Meeting

ANDREA FASTWOLF, Executive Director of the Four State Indian Health Board, fills the NIHB board in on recent activities of that board. Following her report were NIHB Board representatives (l-r): Perry Sundust, Ada White, Darryl Trigg, George Platero, Howard Tommie, Elwood Saganey and Donald LaPointe. The meeting was well-attended by those involved with Indian health in the Aberdeen area.

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Referral Center. (For the past two years, the evaluation project has explored the feasibility of establishing a major medical center in the Aberdeen area.)

Andrea Fastwolf, executive director of the four state board reported on these and other activities of the board during the last few months, including the handling of IHS programs through small contracts.

During the summer, the board became involved in aging activities, assisting with the first Aberdeen Area Indian Conference on Aging. Following that, noted Fastwolf, the four state board is presently working with the State of South Dakota to explore the possibility of hiring an Aging Programs Coordinator to work with programs of concern to the Indian elderly.

Morgan Garreaux, training coordinator, reported that the four state board has trained 118 tribal leaders and 781 tribal employees within the last year. Tribal leaders were trained in the areas of proposal writing, management processes and Indian health legislation. The training emphasis for tribal employees training is on Emergency Medical Technician training, alcoholism counseling and health board management.

USET

Speaking for his area on the unpopular subject of P.L. 93-641, NIHB Board Chairman Howard Tommie, maintained that since the law's enactment, "the state has been infringing on the rights of Indian people to build their own hospitals and facilities."

The USET board plans to take a strong position on this and on possible violations occurring under P.L. 93-638. USET strongly protests 638 indirect cost dollars being held back for possible use for IHS pay increases, a matter still unresolved.

Tommie reported that his board is also concerned with what effect recent congressional abortion action will have on IHS facilities.

Albuquerque

George Platero, Chairman of the Albuquerque Area Indian Health Board, reported that his board has received IHS approval of its 638 contract.

Platero also reported that he participated in hearings held by the President's Commission on Mental Health in Albuquerque, N.M.

Alaska

The Alaska Native Health Board has not met since NIHB's last quarterly board meeting, Darryl Trigg of the Norton Sound Health Corporation and Alaska area alternate, told the gathering.

He reported that his own region will soon be getting a new hospital to be owned by its consumers.

Bemidji

The Bemidji area is still attempting to pull an area health board together again and has a promise of funding once this is accomplished, stated Donald LaPointe, NIHB representative.

Billings

In an attempt to increase awareness and help its board develop specific stands on health issues, the Billings Area Indian Health Board has assigned each of its members a specific health issue. Chairman of that board, Ada White, explained that each member will keep track of developments and report on their assigned subject at each board meeting.

No report was given by the Portland area delegate and neither California nor Oklahoma were represented at the meeting.

Suggestions as to how Indian country and NIHB in particular might make P.L. 93-641 more workable were included in a presentation of several legislative issues to the board by Belindo.

Tribes Face 'Vexing and Unresolved' Problems with 641

Citing a status report on the law submitted by NIHB counsel Daniel Press, reported Belindo, three years after its passage, "641 still presents a range of unresolved and vexing problems to tribes and health boards. While individual tribes

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have been able to work out some acceptable solutions to these problems, there is still no national policy on how 641 should apply to Indian tribes."

Press suggests that the HSAs are still in the process of putting their houses in order and have "really not begun to flex the substantial muscle the act offers them."

Also, if and when National Health Insurance (NHI) is passed, he predicts, the HSAs will probably play a major role in determining how NHI funds are allocated at the local level. "If tribes do not develop an acceptable arrangement with the HSAs now," warns Press, "the negative aspects of the relationship between tribes and HSAs will probably be carried over to NHI – where the stakes will be much higher."

HSAs May Pose Threat to Tribal Sovereignty

There are some very basic "Indian" concerns regarding HSAs, one very important one being that if HSAs seek to plan for reservation areas (even though the plan is only advisory) it may pose a serious threat to tribal sovereignty and self-determination.

There are areas in which an HSA could potentially exercise some authority over reservation health activities. For example, each HSA is empowered to develop a health systems plan that sets out the gaps and duplications in services in its area and recommendations for correcting these problems.

Remaining unanswered, as Belindo noted Press' report, are such crucial questions as: Can the HSA plan cover activities on a reservation? Can it recommend the closing of an

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Tribes' Involvement Needed with Tri-Agency Housing

BISMARCK, N.D.–If reservation housing needs are not addressed as part of concerted economic development programs, public housing already built or currently under construction will be substandard within a few years.

This was the gloomy forecast of William Hallett, Assistant Regional Administrator for HUD's Office of Indian Programs – Region VIII, at the National Indian Health Board's recent meeting here. Hallett's message echoes a broader one recently expressed by numerous others involved with tribal health: the need for tribes to develop comprehensive economic development plans as a prerequisite to meeting housing and other health problems.

At present, maintains Hallett, the public housing program, which deals with low-income housing needs on reservations, addresses the housing shortage but ignores the cause by failing to address the social or economic problems facing Indian communities.

This is just one of the ways in which Hallett faults the public housing program, which he describes as the only major resource available affecting housing in Indian communities. With 27,000 units currently under management and another 4,000 in the construction stage, says Hallett, it is "becoming the major program to impact Indian families."

Some 130-140 tribal housing authorities have been formed across the country, with eligibility determined by a tribe's possession of the appropriate public powers such as police and safety.

Originating with the Housing Act of 1937, explains Hallett, the public housing program was created to provide housing resources for low income families and to stimulate the economy.

Indian tribes were not eligible to receive such housing until 1961, their earlier exclusion marking the beginning of the program's shortcomings in their regard, allowing, as Hallett maintains, the program to be designed with non-Indian communities in mind.

When the tribes were later included, exceptions to the cultural traditions of Indian communities were required. For instance, tribal councils, theretofore considered the communities' supreme governing bodies, were asked to form public housing authorities. This tends to undermine the councils' own jurisdiction, says Hallett.

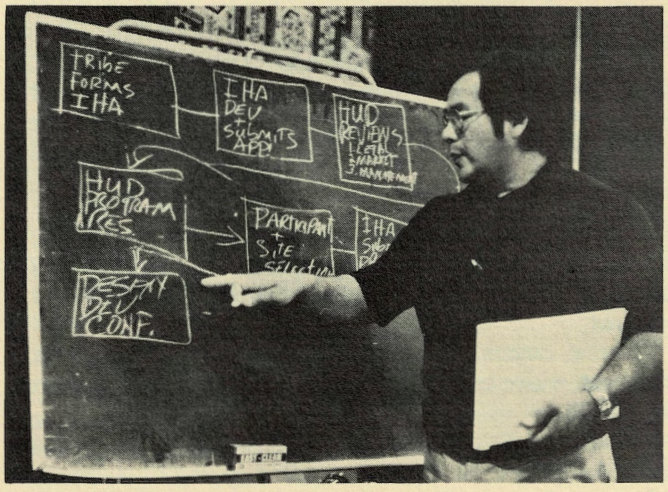
Unfortunately, he adds, in some localities, that being subject to the determination of local housing authorities, selection of tenants has become a "political football."

At the same time, the tribe is excluded from the tri-agency (HUD, IHS and BIA) agreement to provide Indian housing. Yet the housing authorities "lack adequate weight to deal with the BIA," comments Hallett.

Can the Indian housing program be improved? Hallett suggests several ways of working toward that objective. He encourages communities to develop their own tenant selection systems, rent collection systems, eviction policies, etc. "Right now such policies are little understood," he notes.

One of the most time-consuming stages of the housing process is site selection. Hallett suggests that this situation can be changed through tribal identification of priority sites.

On a broader basis, he suggests that the date for establishment of prototype costs be changed to "something more realistic with the construction season."



WILLIAM HALLETT, Region VIII assistant administrator for Indian housing explains how the public housing application process works.

Califano Signs 437 Implementation Plan; Regulations Still Delayed

BISMARCK, N.D.—According to the director of Indian Health Service (IHS) it may take a congressional hearing to get regulations governing the Indian Health Care Improvement Act, P.L. 94-437, out of the "works" at the Department of Health, Education and Welfare.

Although the law required publication of the regulations in final form by July 31 they remain in the Office of HEW's General Counsel, reported Dr. Emery Johnson at NIHB's meeting here September 8.

As one result, students who wished to apply for scholarships to attend school fall quarter under Title I of the act, the Health Manpower and Scholarship Program, were unable to do so. Dr. Johnson said he is hopeful that winter quarter scholarships will be provided.

The Implementation Plan for the law, mandated for presentation to Congress no later than May 28, was finally signed by HEW Secretary Califano September 15.

Already being put to use is the supplemental appropriation for the current year to provide water and sanitation facilities for existing homes. "Every area has a significant program going on for existing homes right now with about two and a half times as much construction going on as in a normal year," noted Dr. Johnson.

Planning funds for new hospitals in several Indian communities were also appropriated under the act. While it has declared a moratorium on the construction of new hospitals as the result of a General Accounting Office study finding an overload of hospital beds in certain IHS facilities, Congress has allowed such planning to continue.

Dr. Johnson called the standard formula for determining the number of hospital beds "not applicable to the changing bed needs of Indian reservations" and said IHS has submitted a revised formula to the areas for comment.

Included in the Implementation Plan for 94-437 is the provision for development of tribal specific health plans. "As far as we know," said Dr. Johnson, "most tribes have picked up the idea."

In order to do so, he added, most tribes are using funds available through the other major law affecting delivery of health care to Indian people, P.L. 93-638: the Indian Self Determination and Education Assistance Act.

This month marks the completion of the first year of funding under 93-638 with 130 tribal projects funded, noted Dr. Johnson.

By and large such projects have been in the area of development of tribal health management capacities, he said.

In an attempt to meet indirect costs, tribes have also been aided by $3-1/2—4 million added to the contracts to cover administrative costs. The same process will be continued next year, added Dr. Johnson.

However, as brought up by NIHB's Billings area representative, Ada White, it remains to be determined which agency is responsible for establishing and changing indirect cost rates.

Admitting that this does pose a problem for tribes, Dr. Johnson reported that IHS is devising a process acceptable to all federal agencies involved, thereby saving the tribes from having to establish separate rates with four or five departments.

Reporting on the activities of IHS, Dr. Johnson said that to the best of his knowledge the agency is complying fully with recently adopted Indian preference statutes. This has created problems when on occasion a tribe prefers that a certain Indian not be hired. In such instances, said Dr. Johnson, the tribe then claims that IHS is not complying with Indian preference.

Activities of the Desert Willow Training Center, an IHS facility, have been relocated on the Papago reservation, he reported. While this will continue to serve as the national training center for Community Health Representatives (CHR's), training will be done increasingly in the field, he said.

Some 250 CHR slots will be made available in October with funding to be divided among IHS areas allowing tribes to negotiate with their own areas and work training out at the local level, he added.

IHS Facilities Eligible for Solar Equipment

HYATTSVILLE, MD.—As part of an effort to determine how solar energy might be applied in health care delivery situations, the Health Resources Administration (HRA) of HEW is soliciting proposals from IHS facilities including hospitals, long term facilities, health clinics and hospital laundries for retrofit hot water heating equipment.

As part of HRA's research effort, explained project director Dick Riemensnider, those facilities funded will be required to supply energy data for at least three years. The demonstration projects are part of the overall solar demonstration projects program of the Energy Research and Development Administration (ERDA) of which HRA handles the health sector portion.

HRA hopes to find some 60 facilities over a four-year period, said Riemensnider, with a minimum of one demonstration per state and the remaining projects to be distributed throughout the country. Of the total number, he estimated, a maximum of six IHS facilities will receive monies. No federal facilities were funded for the current year, he reported.

Indian hospitals or other Indian health facilities wishing to receive a demonstration project should apply through IHS. Funding agreements will be made on a contract basis. IHS facilities will be selected through an on-going process, separate from the general selection process. The deadline for application acceptance for the next round of projects will be in late February or early March.

Copies of the applicable regulations and additional information may be obtained from: Dick Riemensnider; HRA; 3700 East-West Highway; Center Building; Energy Action Office; Room 10-22; Hyattsville, Md. 20783.

Large Number of Indian Deaths Called Preventable

TSAILE, ARIZ.—With U.S. health costs in a seemingly endless upward spiral one Indian health advocate recently offered this comment: "The dominant society argues that utilization review and avoiding construction of unneeded facilities can be effective methods of cost reduction, but the most effective method of cost control is to prevent illness."

These were the words of John Belindo, Executive Director of the National Indian Health Board, as he addressed banquet participants at the 4th Annual Navajo Nation Health Symposium here August 24. Belindo, half Navajo himself, went on to say that much needs to be done in the area of education and preventive medicine.

The primary causes of death for Indian people of all ages, in addition to violence, are heart disease, diabetes, lung cancer and cirrohsis of the liver (usually attributable to alcohol), noted Belindo. High blood pressure and gall bladder disease are also on the climb, he added.

Such diseases, often preventable, contribute significantly to the high cost of medical care, said Belindo. For the U.S., in 1971, he cited, out of total hospital costs of $31 billion, over $5 billion was needed for the treatment of illness directly related to alcohol abuve.

Remarking on the contribution of cigarettes to lung cancer and heart disease, he said, "From a medical standpoint it does not make sense to spend millions of dollars in subsidies for tobacco growers, millions more for cigarettes (including advertising) and still more millions in trying to cure or soften the side effects of life-long cigarette smoking."

"A major part of the problem arises," siad Belindo, "with the driver who does not buckle his seatbelt and who pollutes the air with his dirty auto engine. It arises with the person who abuses his liver with alcohol or drives when intoxicated. It arises with the cigarette smoker or the careless coal companies and power generating plants who pollute the air and water supply."

But he acknowledged, resistance to good, anti-alcohol, anti-smoking and other health education efforts is strong and represents only part of the problem faced with prevention in health care. "Modifying the health habits of the Navajo people is a huge, maybe impossible task," he admitted.

And in addition to preventive measures, Belindo told the gathering, "it must be recognized that the health problems of the Navajo reservation cannot be solved on a solely medical plane.

Echoing sentiments voiced by Dr. Taylor McKenzie, Deputy Director of the Navajo Area IHS, earlier in the week, continued Belindo, "Health care, nutrition and sanitation are an integral part of economic development and must be improved simultaneously and in conjunction with improvement of the education and livelihood of the Navajo people."

NIHB's executive director also informed those present of recent developments in Indian health on a national scope, including the efforts to ensure Indian input on National Health Insurance legislation.

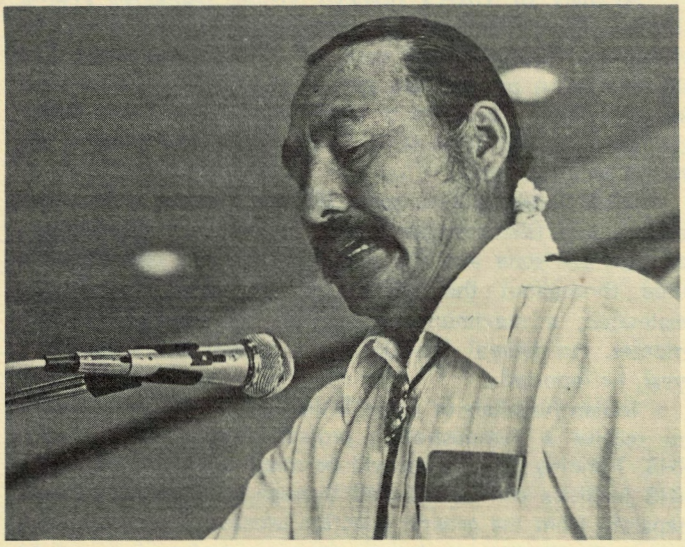
Commission Asks Significant Mental Health Increases

WASHINGTON, D.C.—Significant increases in mental health research outlays were recommended in the first report of the President's Commission on Mental Health, submitted to President Carter earlier this month.

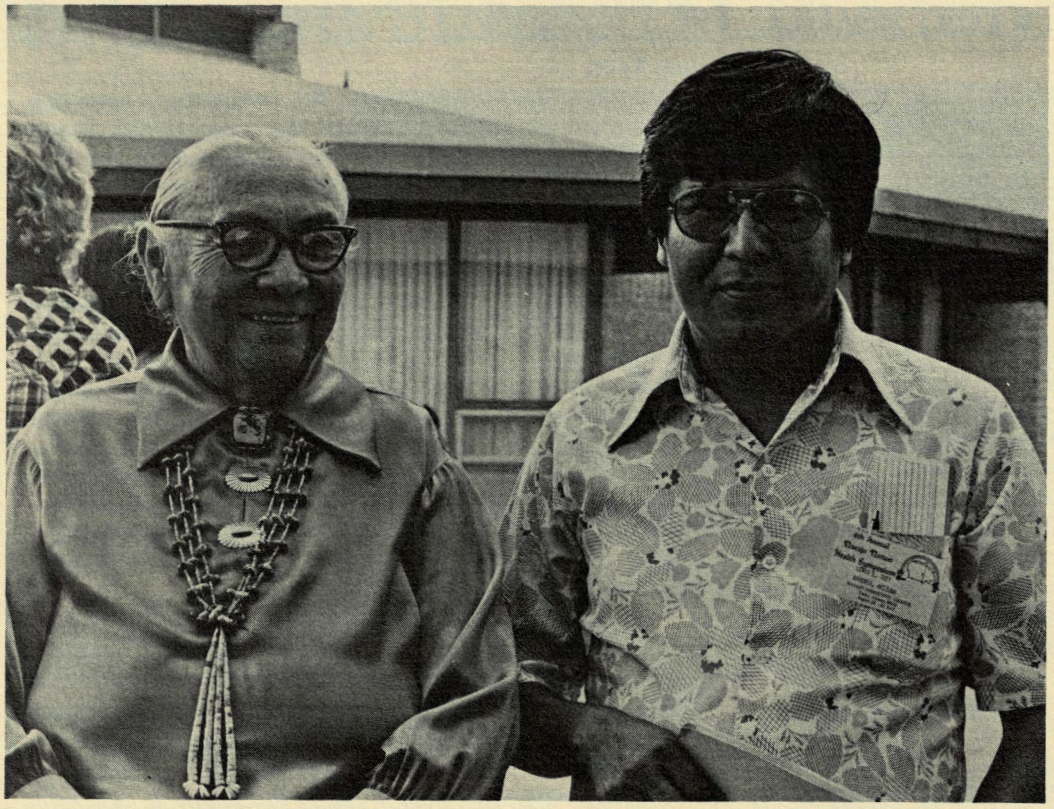
The recommendation is understood to be directly contrary to the initial budget proposals of HEW Secretary Joseph Califano and Dr. Julius Richmond, assistant secretary of HEW for health, which asked bare-cupboard amounts for health research including mental health.

As a result of the mental health commission report, the prospect is for upward revisions as the budget figures are worked out.

DR. JACK LEWIN, Director of the Navajo Tribe's Office of Health Improvement Services chats with IHS Director Dr. Emery Johnson.



NIHB board member Elwood Saganey serves his own people as chairman of the Navajo Area Indian Health Board; as tribal councilman from his area of Kayenta, Ariz. and as chairman of the Navajo Tribal Council Health Committee



NATIONALLY-RENOWNED health advocate, Dr. Annie Wauneka and Lewis Tutt, Director of Community Services for the Kayenta, Ariz. Service Unit were among guests at the symposium's banquet.

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before Indian people have even had a chance to discuss the issue."

He warned that, if carried out, the provisions of the proposed legislation, "will impact on the very sovereignty of the Navajo Nation."

Delivering an address on behalf of Navajo Tribal Chairman Peter MacDonald, Arizona state legislator Daniel Peaches was also critical of certain health legislation affecting Indians. "By passing P.L. 94-437 on the heels of P.L. 93-638," he contended, "Congress seemed to undo the intent of 638, that of self-determination, by giving the authority back to IHS."

Speaking of the virtues of Public Laws 94-437 and 93-638, on the other hand, was Dr. Emery Johnson, Director of IHS.

He explained that with 638, tribes may obtain grants or contracts to engage in tribal health management, development and evaluation. Within the available framework, he said, a tribe has a broad spectrum of choices ranging from "doing nothing" to operating its entire health program.

However, he admitted, "some tribes feel the law represents termination and have chosen not to contract."

And responding to the criticism that the law is a means for the government to shove unsuccessful programs onto tribes, he said "Congress realized that the tribes would not choose to get bogged down in unsuccessful operations."

Aside from their differences, one point on which the speakers seemed to agree was the need for increased participation of Indian tribes in and closer tribal coordination of health planning activities.

Dr. Johnson explained that with the enactment of P.L. 94-437, Congress intended to have a benefit package in place for all tribes by the end of the act's seven year scope. With the objective of having each tribe develop its own comprehensive health plan, he said, 437 provides the mechanism and 638 the tools including money, to accomplish this.

On much the same note, Peaches told the gathering that in order to make past legislation work each tribe must now develop a plan to meet its own specific needs.

"The time has come for Navajo people to participate in health planning. This is the crux of health self-determination," he added.

Indian people further need to address Congress with their own legislative proposals and carefully review those introduced by others in order to assure that their real health needs are met, advised Peaches.

Chairman MacDonald is also concerned about the coordination of health activities "in a cooperative spirit" on the vast Navajo reservation, said Peaches. He contended that the multitude of services now performed by numerous agencies need be coordinated through the tribal council and the tribe's newly-formed Office of Health Improvement Services.

Director of that office, Dr. Jack Lewin said that those involved with Navajo health are in a "planning crisis." In the past, he remarked, health planners for the Navajo reservation "haven't done our homework."

This has unfortunately, explained Lewin, resulted in such situations as a General Accounting Office audit finding the Navajo Nation to be overbedded. Yet Navajo people are turned away from hospitals for the lack of beds. The discrepancy arises, he explained, from the lack of planning in failing to locate beds where most needed.

Lewin suggested that is used wisely, P.L. 93-638 can serve as a tool for Navajo self-government and self-

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IHS hospital because it duplicates services provided by a nearby non-Indian facility? Does the tribe have veto power over the reservation portion of the HSA plan? While the HSA would not have the power to actually close an IHS hospital, Press suggests, its recommendation could create "all kinds of problems for the tribes – in HEW, Congress, etc."

How 641 actually impacts Indian health programs, says Press in his report, will depend on how effectively the Indian health community can develop a position on those issues that is favorable to Indians and push that position on HEW and the individual HSAs in Indian country.

641 is up for renewal by Congress next summer. As Belindo reported, HEW has already put together its legislative package for recommended amendments to the law, none of which address Indian concerns.

Upon his analysis, Press sees a need to provide tribes with information, advocacy, and technical assistance; a need to educate HEW to the unique needs of Indians and a need for legislative changes to make the act more responsive to Indian needs; and he recommends that NIHB assume responsibility for these activities.

Consumer Coalition for Health Asks NIHB Participation

Press further suggested that NIHB might join forces with a new Washington-based organization called the Consumer Coalition for Health.

Charles Conrad, executive director of the coalition, was present at NIHB's meeting September 8 and informed the gathering that his group, made up of some of the leading advocacy organizations in the country, is seeking to improve 641 so that the health care system is more responsive to consumer control. It is interested in and willing to support Indian concerns regarding 641; and in turn he asked for Indian participation to help strengthen the organization.

NIHB'S Legislative Involvement

Reporting on additional areas of NIHB's legislative involvement, Belindo told the gathering that there is no significant action taking place at present with NHI proposals; rather that all eyes are on HEW Secretary Califano's NHI task force.

He also informed the board that reports by a consulting firm and by the Bureau of Health Manpower (BHM), Health Resources Administration, determining the need for and feasilibity of establishing an Indian school of medicine were completed in August.

Belindo chaired the Feasibility Study Group, composed of representatives from several Indian organizations, a representative of traditional Indian medicine, an Indian medical student and four medical educators, which monitored the study throughout its course.

He added that the FSG accepted the contractor and BHM final reports and developed its own final recommendations, included in the BHM report.

A separate effort by the Navajo Tribe to establish an American Indian School of Medicine will be affected by congressional action regarding the reports, predicted Belindo, adding, "we're being very careful not to undermine each other."

In other recent activities, NIHB submitted testimony on S. 1214: the Indian Child Welfare Act of 1977, reported Belindo. He asked the board to support the proposed legislation, which he termed "one of the most significant pieces of legislation ever submitted regarding Indian child custody and welfare."

NIHB may also present joint testimony in the near future along with NTCA, NCAI and the American Indian Health Care Association on Federal Domestic Assistance Programs.

'Credibility Improving'

Earlier in the three-day session Belindo gave his official executive director's report briefing the board members on additional NIHB activities and commenting that he senses "a rapid improvement and restoration of credibility within the organization."

He added, "NCAI and seemingly more so, NTCA are looking to NIHB to identify the health needs of Indian people. NIHB should be the major spokesman for national Indian health concerns."

Health Board Training Proposal Adopted

One of the organization's priorities this year, he said, is establishment of a health board training program. NIHB Deputy Director Herschel Sahmaunt has revised an earlier proposal, taking into consideration the unique training needs of each area.

The NIHB board adopted the revised proposal, a major emphasis of which is to train Indian people to train Indian health boards, committees and departments in the basic areas of communication skills and boardsmanship; orientation to IHS; national health issues and management and administration.

Funding from a variety of sources will be sought for the proposal.

Chairman's Report

Board chairman Howard Tommie spoke about the involvement of several NIHB members with the President's Commission on Mental Health. In the past, George Platero of the Albuquerque area, Perry Sundust of the Phoenix area and Ethel Gonzales from Alaska have given testimony.

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WORKSHOPS on topics ranging from aging to assertive communication were a popular part of symposium offerings. Here, participants attend an environmental health session on "Happiness Through Better Housing."

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sufficiency in health care. Along with working toward these goals, he said, the tribe is also striving for decreased state control of tribal health plans and added that he would like to see the tribe receive direct federal funding.

The theme of this year's health symposium was "Prevention: In Happiness It Is Done." Addressing that thought, Dr. McKenzie advised that ill health among Indian people can be prevented by both maintenance measures such as retaining an adequate supply of wood and water and by preventing bodily harm through avoidance of adverse physical and environmental conditions.

He said that accompanying the changing lifestyle and diet of the Navajo people over the years have come diabetes, heart disease, gall bladder disease and high blood pressure.

Navajo people have also been the victims of a high incidence of what he called "poverty diseases," those infectious diseases resulting from unsanitary reservation conditions.

"The big factor to turn all this around," asserted Dr. McKenzie "is the improvement of the living standard and economic development on the reservation."

Among other distinguished speakers to address the more than 300 persons who attended this year's symposium were Dr. George Lythcott, recently-appointed director of the Health Services Administration and Dr. Karl Meninger, founder and chief of staff of the Meninger Foundation.

Dr. Lythcott said he intends to keep in close touch with Indian health programs through consultation with Dr. Johnson.

Meninger, who played an instrumental part in starting the Rough Rock Demonstration School and Navajo Community College, spoke in accordance with the symposium's theme of prevention. As an expert on psychological and psychiatric care, he offered his observations on the traditional strength of the Navajo family.

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Tommie reported that he and LaPointe were participants at a more recent hearing held in Albuquerque, N.M. by commission member LaDonna Harris.

NIHB Business

A total of nine resolutions on a broad range of topics were adopted by the board. These included:

– Supporting the Billings Area Indian Health Board in its concern over a substantial amount of 638 funds being taken from appropriations for Indian tribes for use to establish a Data Retrieval System in Albuquerque, N.M. and for training of project officers to administer 638 projects.

– Supporting the Billings Area Indian Health Board in its request that P.L. 94-437 scholarship monies be used as

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Elderly Institutionalization: Tuba City Offers Alternative

TSAILE, ARIZ.—In the past, in planning for the care of their ailing elderly, Indian communities have often considered the only alternatives available to be construction of either a nursing home or extended care facility, although neither was particularly desirable. Now, the Tuba City, Ariz. Service Unit, which serves a predominantly Navajo and partly Hopi population, has demonstrated that another option exists.

Two years ago, the Tuba City Service Unit initiated a home health care program, the only such program within and funded by the Indian Health Service. (The program was the subject of discussion at a workshop on aging held at the recent Navajo Nation Health Symposium here.)

Through it, persons are provided with comprehensive health care for specific medical, restorative, curative and preventive needs right in their own homes. Although the service is available to any patient residing within the Tuba City Service Unit who has been in the Tuba City Hospital as an in- or out-patient, regardless of age, Nina Huete, director of the home health care staff estimates that perhaps 90 per cent of those served are senior citizens.

This approach to care for the elderly offers important advantages to the individual's family and community and most importantly, to the patient himself. A patient's hospital stay is shortened and hospital costs reduced without minimizing comprehensive care.

Upon discharge from the hospital, the patient and his family follow a care plan outlined by the hospital and home care staff. Needed equipment such as beds, walkers and wheelchairs is provided by the program.

As Huete puts it, "patients are happier at home and recover faster there" and through the program they are encouraged to achieve the highest level of independence possible. Family interaction and community involvement in health care are also fostered.

Home health care staff visit the patient and provide assistance in addition to the program practiced by him and his family. Services which may be provided include: skilled nursing care; physician services; social, economic and rehabilitative care; physical therapy services; and patient and family counseling in the areas of alcohol/drug abuse, nutrition, social service, mental health, pharmacy and health education.

Amendments to Housing Regulations being Readied

WASHINGTON, D.C.—As a result of the findings of Counselor to the Secretary of HUD Joseph Burstein, existing regulations for HUD's Indian housing programs are to be amended.

According to his program assistant, Burstein assumed temporary supervision of the department's Indian housing programs this spring at the direction of HUD Secretary Patricia Roberts Harris and was further asked to determine what improvements might be made.

Based upon comments and complaints received since that time from every sector involved in Indian housing, the amendments have been drafted. They are tentatively scheduled to be sent out to Indian housing authorities and tribal governments at the beginning of October, according to the program assistant.

HUD regional offices will hold hearings and working sessions approximately three weeks after distribution. The department also plans to involve the Bureau of Indian Affairs and the Indian Health Service at the local level, said the spokeswoman. Following this working period, the amendments will be published in the federal register for public comment.

Further information or copies of the proposed amendments may be obtained by writing: Joseph Burstein; Counselor to the Secretary; Department of HUD; Room 10140; Washington, D.C. 20410.

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supplemental to the Bureau of Indian Affairs Educational Grant.

– Recommending that consideration be given to the Billings Area Indian Health Board's request for location of a proposed mental health facility in its area.

– Supporting the efforts of the Shoshone-Bannock tribe in obtaining specialized training from the IHS Office of Research and Development.

– Supporting the efforts of the Shoshone-Bannock Tribe in obtaining funding for its proposed expanded mental health facilities at Fort Hall Reservation.

– Supporting the passage and enactment of S. 1214, the Indian Child Welfare Act of 1977 and recommending that it contain language respecting children's rights in the final determination of child placements in retrocession cases.

– Applying for NIHB membership in the Consumer Coalition for Health.

– Supporting the efforts of the Shoshone-Bannock Tribe in obtaining funding from the National Institute on Alcoholism and Alcohol Abuse.

– Supporting the efforts of the Billings Area in obtaining necessary procedures in the establishment of indirect cost rates to the best interests of its tribal peoples.

Next Board Meeting, Health Conference Scheduled

Finally, board members elected to hold their next quarterly meeting in Phoenix, Ariz. sometime in December. They also rescheduled the Second Annual Indian/Alaska Native Health Conference for February 12-18 in Albuquerque, N.M.

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