



NIHB Health Reporter

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November 1977



ROSITA BROWNING, patient representative, greets a young visitor to the Phoenix Indian Medical Center. (See story beginning on page 6.)

638 Appropriations Same as Last Year

DENVER, COLO.—Each Indian Health Service area will receive the same allocation of P.L. 93-638 funds for non-recurring health projects that it received last year, it was recently announced here.

A total of \$10 million has been slated to finance one-time projects, with Alaska, at \$1.5 million, to receive the largest single share and Navajo the second largest share of \$1.3 million.

The same amount of technical assistance as provided last year is also awarded each area, according to James Meredith, USET area director and Chairman of the IHS Council of Area Directors (CADs).

Meredith briefed participants at a joint meeting of the CADs and National Indian Health Board (NIHB) here November 8 on the distribution of 93-638 funds. He informed the group that at their October meeting in Rockville, Md., the CADs recommended that each area director must have half of his/her 638 funds obligated to specific projects by February 1978. If not, the CADs

recommend that those funds be withdrawn for redistribution by IHS headquarters. They recommended the same process if the remaining 50 per cent of 638 money is not committed by April 30.

A total of \$18.5 million in 93-638 funds was received by IHS for the 1978 fiscal year. The Alaska area will receive the largest single portion, some \$2.4 million, followed by Aberdeen, Navajo, Oklahoma City and Phoenix all receiving shares of between roughly \$1.7 and \$1.8 million.

In funding deemed questionable by NIHB at its September board meeting, a portion of the 638 funds will be used to finance the Tribal Resource Assistance Information System (TRAIS) and training for project officers.

In response to NIHB's resolution questioning the appropriateness of such use of 638 funds, IHS said that the data system and project officer training are consistent with the congressional intent in use of the appropriation.

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Tribal Specific Health Plan Workshops Set

Since the enactment of the Indian Health Care Improvement Act, Dr. Emery Johnson, Director of Indian Health Service, has taken the position that development of a specific plan for each Indian community, rather than a national one, provides the best chance for accomplishing the law's objective — bringing Indian health on a par with that of other Americans within the seven-year period of its scope.

The proposal to have each tribal group develop its own specific health plan was included in the Implementation Plan approved by the Secretary of HEW and submitted to Congress in September.

It is the hope of Dr. Johnson and the group of Indian representatives (headed by Erin Forrest of NTCA) who assisted with the drafting of guidelines that tribal and urban specific plans will comprise the base of a report to be presented to Congress at the end of 94-437's first three years of operation. At the end of FY 1979, the Secretary of HEW

Mental Health Facility Awarded to Rapid City

RAPID CITY, S.D.—There is presently only one inpatient psychiatric hospital in the entire country to serve Indian people, this located in Gallup, N.M. The facility is described by IHS Mental Health Program Chief, Dr. H. C. Townsley, as "grossly inadequate."

Title II of P.L. 94-437 provides for the establishment of additional inpatient psychiatric hospitals, with one to be set up each year.

The first such facility will be established at the Rapid City Public Health Service Indian Hospital, Dr. Emery Johnson, Director of Indian Health Service, announced October 18.

The mental health facility to be located within the existing Sioux San here will serve patients from the Aberdeen, Bemidji and Billings service areas, according to Dr. Townsley.

The Dakotas are in particularly dire need of an inpatient facility, said Dr. Townsley, since the state of South Dakota will not honor a tribal court's decision to admit a person to a state psychiatric facility (claiming inability to do so due to tribes' sovereign status) and because a federal judge in South Dakota has found Indian mental health care to be a strictly federal responsibility (see separate story).

Townsley voiced his hope that within the next three or four years additional facilities might be established in southwestern Arizona and in the northwestern United States.

The Rapid City facility will not become operational until additional resources become available in FY 1979. For the current fiscal year, due to what Townsley explains as a congressional failure to appropriate enough funds and positions, only six staff people may be hired to begin the initial work.

Along with performing ongoing planning for the facility here, Dr. Townsley said the staff would likely serve in the additional capacity of providing much needed mental health staffing throughout the Dakotas until such time as adequate staff is available to operate the Rapid City unit.

is to review progress of the act and present a plan for its continuation, including recommendations for any additional authorizations.

Tribal specific health planning guidelines have been distributed by IHS to tribal groups across the U.S. Tribal health planners and leaders will have a chance to discuss them at workshops to be held in each IHS area this month and next. (See list of scheduled meeting dates for each area at end of article.)

In order to assess their health needs and plan what they want for their own comprehensive health program, tribes may request funds under P.L. 93-638 to hire consultants and/or tribal health planners to assist in developing their plans.

During the spring and summer of FY 1979, the tribal specific plans will be incorporated into IHS service unit, area and national plans. The composite plan for each IHS area must be received in IHS headquarters by August 1, 1979.

The IHS national plan will then be forwarded in October 1979 to the Secretary for consideration in his recommendations to Congress.

Scheduled workshop dates and persons to contact in each IHS area for locations and additional information are as follows: Aberdeen, dates to be determined, Hank Bowker, Aberdeen Area IHS, 115 4th Ave., Aberdeen, S.D. 57401, (605) 225-0250, Ext. 535; Alaska, November 14-16, George Mumm, Alaska Area IHS, P.O. Box 7-741, Anchorage, Alaska 99510, (907) 279-3312; Albuquerque, December 12-18, Milt Johnson, Albuquerque Area IHS, 500 Gold Ave., SW, Rm. 4005, Albuquerque, N.M. 87101, (505) 766-2152; Bemidji, December 5-8, George LeFebvre, Bemidji Area IHS, 203 Federal Building, Bemidji, Minn. 56601, (218) 751-1210; Billings, dates to be determined, Larry Thomas, Billings Area IHS, 3 Seventh W. or Box 2143, Billings, Mont. 59103, (406) 757-6403; California, December 2-3 & 9-10, Thelma Brafford, Sacramento Area IHS, Room East — 1831, 2800 Cottage Way, Sacramento, Calif. 95825, (916) 484-4836; Navajo, December 5-8, Ed Helmick, Navajo Area IHS, P.O. Box G, Window Rock, Ariz. 86515, (602) 871-5836; Oklahoma, November 14-18, Luke McIntosh, Oklahoma City Area IHS, Rm. 338 Old Post Office & Courthouse Bldg., Oklahoma City, Okla. 73102, (405) 231-4414; Phoenix, December 5-8 & 12-18, Gordon Aird, Phoenix Area IHS, 801 E. Indian School Rd., Phoenix, Ariz. 85014, (602) 261-4711; Portland, November 14-18, Al Cayous, Portland Area IHS, Federal Building, Rm. 476, 1220 SW 3rd Ave., Portland, Ore. 97204, (503) 221-2020; Tucson, December 5-8, Bob McKay, Desert Willow Training Center, P.O. Box 17510, Tucson, Ariz. 85731, (602) 792-6707; USET, December 12-18, Bill Millar/Dave Moses, United Southeastern Tribes, Oak Tower Bldg., Suite 8, 1101 Kermit Dr., Nashville, Tenn. 37217, (615) 749-5104.

Change Your Calendars!

SCOTTSDALE, ARIZ.—The next quarterly meeting of the National Indian Health Board is now scheduled to be held at the Doubletree Inn here December 12-15.

(The meeting had originally been planned for December 11-14 at the Hyatt House in Phoenix.)

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Also attending the joint NIHB-CAD meeting, Dr. Emery Johnson, IHS director, explained that the data retrieval system will provide a mechanism for tracing all tribal contracts which will help define accountability in the handling of each of them. The system will be available to each area office, he added.

Dr. Johnson pointed out that this past year, for the first time, "Congress put money in 638 not directed toward delivery of services."

638 funds are available for use in developing tribal specific health plans, which Dr. Johnson is hopeful will comprise the base of HEW Secretary Califano's plan for the continuation of P.L. 94-437. The process by which tribes may develop their own specific plans and later submit them for inclusion in IHS area-wide and national health plans was included in the 437 Implementation Plan approved by the Secretary.

However, even if Califano chooses not to follow the IHS plan or modifies it in his report to Congress in 1979, Dr. Johnson maintains that each tribe will still have gained the advantage of being able to provide Congress or the administration with its own plan if necessary. Johnson said he also feels that with the development of tribal specific plans, any distribution of funds is more likely to be based on relative need than on the political clout of a particular tribe or its congressmen.

In addition to the opportunity to develop a specific plan, tribes have the option of developing an inter-tribal plan in cooperation with neighboring groups, noted Dr. Johnson.

NIHB board member Mel Sampson of the Portland area suggested that "on or near" regulations governing the delivery of health services to persons residing either on or near a reservation are required in the development of any tribal health plan. These regulations are being developed by the HEW Office of General Counsel, said Johnson.

Dr. Johnson reported that, unaware of the existing provision for the HEW Secretary to consider the tribal health plans in making his report to Congress, Senator Abourezk has been working on legislation that would require the President to submit the plans to Congress along with his budget.

Robert Lukas of the IHS Office of Research and Development reminded those present that the deadline for tribal specific plans is July 1, 1979 and that if tribes opt not to submit a plan, IHS is committed to do so for them.

Addressing another legislative concern, Dr. Johnson urged Indian people to take action as P.L. 93-641: the National Health Planning and Resource Development Act "could be disastrous for tribes if it is not passed again with some protection for tribal integrity."

As members of the CAD and NIHB held their second joint meeting this year, the chairman of each gave a brief overview on recent activities and the direction each of their groups is assuming. Reported Howard Tommie, chairman of NIHB, "NIHB is moving in the direction of taking positions on issues such as abortion and 641."

Meredith briefed the gathering on several of the recommendations which came out of the CAD's most recent meeting. At that time, it was decided that health service delivery, which occupies 80 per cent of the IHS budget,

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"will be the number one item on our agenda from now on." Previously, less significant items had taken up a large amount of the CAD's time, he explained.

Another CAD recommendation asked that IHS headquarters make available a long-range plan before transferring or relocating any more of its staff to the IHS areas, a suggestion coming in response to concern over the planned relocation of IHS staff to Albuquerque, N.M.

Meredith said that the CADs, through one of their committees, are looking into the service population problem. The committee is directed to make sure that Indian people have input into development of the methodology to be used during the 1980 census.

Concern has arisen among both CAD and NIHB members with regard to the application of the oft-confusing financial tool, the indirect cost rate. At its last board meeting, NIHB passed a resolution inquiring about the discrepancy in rates established for individual tribes. IHS has said in explanation, that varying rates are necessary due to differences in accounting systems and the resultant treatment of costs among organizations, the base to which the rate is applied, the efficiency of operations and administration, and the total volume of business.

But recognizing this, a problem still exists as far as the CADs are concerned. Meredith said that at present, each federal agency has a different formula as to what expenses indirect cost rates may be applied.

Creating confusion for the USET area, are the area IHS office which maintains that a contracting officer is the sole person who may determine which sub-contracts indirect cost rates may be applied to and, on the other hand, the Health Services Administration, (which must perform a cost analysis for any IHS contract over \$100,000) which avers that an indirect cost rate may not be applied to any sub-contract.

Meredith contends that recommendations are needed from both CAD and NIHB asking that IHS establish a written policy as to what indirect cost rates can be applied to by the areas.

In Testimony

Strengthening of IHS Needed,

PHOENIX, ARIZ.—According to testimony given here late last month, Indian people feel they have no need for National Health Insurance as it may be proposed by the Carter administration, rather that they already have their own "NHI program" in the Indian Health Service.

Twenty-five persons spoke at a DHEW hearing held here October 26, one of more than 100 such hearings held throughout the country over the past two months, to solicit views on an NHI plan to be developed for President Carter's consideration. Co-sponsored by the Inter-Tribal Council of Arizona; Salt River Pima-Maricopa Indian Community; the Phoenix Service Unit Indian Health Advisory Board; Human Rights, Inc.; and the Arizona Central Health System, it was unique in its focus on "The Special Needs of Native Americans in a National Health Insurance Program."

Commending Congress and the administration for their efforts to make the "sorely needed" NHI program a reality, Wendell Rice of the Phoenix Service Unit board added that "the Indian Health Service is the National Health Insurance program for Indian people."

Agreed Gus Greymountain of the Affiliation of Arizona Indian Centers, "... it's my belief that we have health insurance in the Indian Health Service." He added, "I think there are too many problems right now with trying to integrate the Indian Health Service and some of the health needs of Indian people with the rest of society."

On much the same note, Elwood Saganey, Navajo tribal councilman and Chairman of the Navajo Area Indian Health Board, remarked, "action must be taken to bring the health of underprivileged Americans including American Indians up to the national status level before any such unified federal health distribution system as National Health Insurance can be applicable or meaningful."

However, recognizing what seems to be the increasing inevitability of NHI's adoption, many spoke in favor of it serving as a means to improve the health status of Native Americans, not by replacing the existing IHS system, but by strengthening it with additional funding. Speaking on behalf of the urban Indian population here, Diane Porter suggested that the present IHS structure should be kept intact and the level of health care brought up to "standards equivalent or superior to those offered under the National Health Insurance Program."

As Indian people remain hopeful about the improvement of their health status, as Rice puts it, "they question how NHI will impact on their unique trust relationship with the federal government and Indian Health Service..."

A majority of the testimony, if not in full agreement with, included at least some of the principles comprising the consensus Indian position on NHI formulated by the NHI Core Group last year.

In an effort to guard the special, legal relationship between tribes and the federal government, the first of these principles demands that "NHI legislation must specifically support the continuation of the IHS-tribal-urban Indian health system as the special federal mechanism for financing and delivering health services to Indians; and as such, NHI must not, in any way, become a substitute or supplement for this financing mechanism or be used to weaken this delivery system."

Testified Reuben Howard of the Intertribal Council of Nevada, "the Greater Nevada Health Systems Agency executive director has stated publicly that he favors and will push for the assimilation of the Indian Health Service system." Other speakers expressed similar concerns. Said Rice, "many of the proposed bills promote state control of regulations for National Health Insurance. Such state control may impose restrictions over health programs and the Indian Health Service."

Tribal governments, rather than state agencies, must be recognized as the appropriate entities to administer health programs on their reservations, testified several speakers (in agreement with another of the Indian consensus principles). Said Saganey, "health systems designed for the general citizenry of the United States will be very different from the design necessary to Indian people who are presently dreadfully far behind the rest of the nation in health status. Indian self-government is the most efficient and just method of insuring that federal monies will be equitably used."

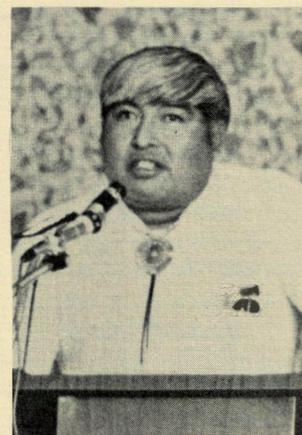
A related concern with regard to possible state administration of NHI was expressed by Cecil Williams, Chairman of the Papago Tribe, "there is the great danger that the state's responsibility in an NHI system would allow them to

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◀ *DIANE PORTER, speaking on behalf of the Phoenix Indian population, said that any NHI system must offer Indian people a comprehensive range of services, emphasizing early diagnosis screening and preventive care.*

ENACTMENT of NHI could help alleviate the U.S. maldistribution of health personnel if the Canadian experience is repeated here. As Cecil Williams, NHI Advisory Committee member explained, the committee was told by Canadian officials that under the NHI program in their country, new medical personnel, no longer forced to compete for adequate salaries, began moving to rural areas, resulting in a fairly even distribution of medical personnel throughout Canada. ▶



Not NHI

Strengthening . . .

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perform regulatory roles on the reservation. This would be in violation of the principle of tribal sovereignty . . ."

In urban areas, testified spokespeople from several urban organizations, Indian health programs must be deemed eligible for reimbursement from both IHS and NHI when their clinics provide services to eligible persons. Suggested Porter, "if national health insurance is developed it should recognize the special trust relationship and obligations of the federal government to all Indians irrespective of their residence."

"National Health Insurance could reduce basic comprehensive coverage now available to Indians through the Indian Health Service by imposing limitations on health care where none currently exist," according to Rice. As endorsed by the statements of several other speakers, the consensus Indian position on NHI demands that if NHI is adopted, the guaranteed benefit package, an individual's entitlement to that package and prospective funding to implement that guarantee be incorporated into the IHS system.

Also in line with, at a minimum, the continuation of care as presently available to Indians, several who spoke advocated that Indian people be exempted from any compulsory NHI financing charge.

Along with representing a possible threat to tribal sovereignty, the concern was expressed by several speakers that NHI could also impinge on the concept of Indian self-determination. Testimony submitted on behalf of the Papago Tribe by Williams stressed that "the spirit and intent of Indian self-determination is to allow the tribes to assume control over federal programs at a pace and timetable set by the tribes themselves. We do have some fears that an NHI system may be used by some federal policy makers to force tribes to assume responsibility for their health programs at a faster pace than that desired by the tribe."

Williams, who serves as the only Indian member on HEW Secretary Califano's Advisory Committee on National Health Insurance Issues, was asked to brief the gathering on recent activities of the group. He explained that the advisory



NIHB Program Analyst Howard Bad Hand and board member Irene Wallace, both of whom have been actively monitoring NHI legislative progress, served as panelists.

committee has been travelling around the country to listen to discussions on NHI.

For the next six months its members will meet in Washington twice a month to consider the issues which have been raised and to develop their proposals. Said Williams, "the committee is made up of different types of people and they're not of any one thinking; in fact I think we're going to have a good time discussing some of the issues that will come before us."

Asked if the advisory committee has addressed the issue of the federal government's responsibility to Indian tribes, Williams said that it hasn't been considered yet but once the committee gets into its discussions he intends "to raise that point continually."

From what he has been able to discern so far, Williams said he thinks a large majority of the committee is leaning towards the concepts contained in the National Health Security Act introduced by Senator Edward Kennedy, but feels it is too early to predict what type of plan the committee will ultimately propose.

AINA Membership

The American Indian Nurses' Association announces that its membership has increased from five persons in 1972 to over 600 members currently active.

AINA members are located in 38 states and represent 99 tribal groups. In addition to the tribes represented, many non-Indians belong to the AINA as associate members. American Indian nursing students also comprise a large portion of the organization's membership.



◀ *INDIAN PEOPLE have no need for NHI if the present IHS system is maintained and P.L. 93-638 and 94-437 are carried out to the fullest extent possible, testified Gus Grey-mountain of the Affiliation of Arizona Indian Centers.*

IN VIEW of an existing law, P.L. 93-641, Bob Crawford of the Phoenix Service Unit Indian Health Board, proposed the creation of a floating HSA to serve the smaller tribes in Arizona. ▶





ADELMA PEDRO, patient representative, provides support and interpretation as needed, to an elderly patient undergoing an eye examination.

Patients No Longer 'Lost

PHOENIX, ARIZ.—Outpatients at the Phoenix Indian Medical Center may still have to wait hours before being seen by a physician.

They may still have to wend their way from the waiting to clinic departments confusingly-situated throughout the center.

Any patient who doesn't speak English more than likely will still have his or her care administered by someone who speaks nothing but.

These situations existed in the past causing patients confusion, frustration or anger. They still exist today. So what's changed?

Plenty. According to the medical center's patients, staff and administration alike, a great difference is being made by three individuals who, for the past year, have constituted the Phoenix Service Unit Patient Representative Program.

They explain to outpatients that their long waits are necessitated by funding shortages which have forced the center to cut back its personnel force.

They explain the layout of the center or escort patients to their required stops.

And in the case of a patient unable to understand a doctor's questions or instructions in English or to communicate his ailments, a patient representative will translate.

The patient representative program was developed in response to negative feedback from the Indian community concerning its health care. Many patients complained of depersonalized health service saying they were being treated as charts rather than individuals. Coupled with this, a lack of

knowledge about IHS regulations, policies, procedures and misunderstanding of Indian people caused much confusion among medical staff and patients.

In April, 1975 three persons were selected as representatives and began intensive training in human relations, sensitization to patient needs, hospital procedures, first aid and medical terminology.

Last year the program got underway. Operated by the Phoenix Service Unit Indian Health Advisory Board, which contracts for program funding with the IHS area office, the program is available to serve patients of the Phoenix Indian Medical Center, a 200-bed hospital offering comprehensive health service.

Three persons serve as patient advocates and problem solvers: Vernon Antone of Santan, Ariz., located on the Gila River reservation about 60 miles southeast of here; Adelma Pedro of Laveen, Ariz., also located on the Gila River reservation; and Rosita Browning from the San Carlos Apache Reservation.

They work on a rotating basis with one representative assigned to the hospital's inpatient department, one to outpatient and the third serving both sections.

The program has several objectives. Philosophically, the patient representatives are the enforcers of the Patients Bill of Rights, which aims to ensure patients of the highest level of health care available, adopted as official policy of the Phoenix Area in December, 1973.

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Patients . . .

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The patient representatives are present to reinforce physician-patient relationships.

They function to recognize problems in the delivery of health care throughout the service unit.

And they are to provide the linkage mechanism and communication channel between patients, Phoenix Indian Medical Center staff, and related health care personnel and organizations.

Put into practice, all this means a wide variety of responsibilities and duties for Antone, Pedro and Browning, in aiding both patients and staff.

For patients entering the hospital for the first time, the process is eased by the representatives' assistance. Many times, referring service units call before sending a patient to the medical center and the representatives will meet those coming long distances at the airport.

Patients are provided with information on contract services, patient rights and hospital procedures in understandable terms. The latter may include procedures regarding physicians, consent forms, the appointment system, prescriptions, food and transportation.

The major thrust, according to patient representative supervisor and Phoenix Service Unit Indian Health Board Executive Director Elliott Booth, is to get patients started properly through the system. "Before, for example," he explained, "no one would tell them to go to the appointment desk first."

Procedural problems are among those most commonly dealt with by the patient representatives, especially those of understanding long waiting periods or finding proper clinic departments, explained Pedro and Antone.

They often escort elderly persons to their destinations. "We found out that in the past the elderly people were being paged but couldn't get there because they were unable to hear or unable to wheel themselves," explained Pedro, who spends a large amount of time with patients referred from nursing homes.

She has also discovered that these same persons are the least likely to "speak up for themselves" due to age or disorientation.

Besides guiding persons to appropriate departments within the medical center, the representatives possess the knowledge to refer them to additional services or agencies within the larger community as needed.

Along with assisting outpatients and attempting to help incoming ones make a smooth adjustment, the representatives remain available to answer any additional patient questions and ease their problems and concerns about their medical care. Common troubles in this regard, as noted by Antone, include abrupt treatment or lack of respect accorded by staff members.

Time in the hospital is eased by visits from the representatives, paid particularly to those patients who may be alone and hundreds of miles from home.

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in the System' at PIMC

AN ELDERLY visitor to the outpatient clinic is able to discuss his needs in his own language, Pima, with patient representative Vernon Antone.



Patients . . .

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The representatives also provide interpreting for patients and medical staff, a service especially vital in the operating room.

All in all, as one hospital administrator puts it, "people no longer get lost in the system."

Familiarity with the hospital organization and its day-to-day workings enables the representatives to recommend action for change, when they see the need. This ability, and responsibility, of the representatives made for a problem of staff acceptance when they first began.

The initial difficulty arose mainly from a lack of understanding by the staff of the representatives' responsibilities, says Dr. Carl Szuter, acting service unit and clinical director. At first, he says, "the staff felt that these people would make waves trying to affect medical practice and hospital function."

"A lot of the staff was uptight because they thought someone would be looking over their shoulder," adds Darryl Kuhlmann, Associate Director for Hospital Services.

Since that time, however, both men agree that Antone, Pedro and Browning have gained broad acceptance. As intended, the patient representative program has served as a "two-way street," for medical staff and administration as well as patients.

The representatives serve as an immediate resource to the staff in problem-solving. A patient representative office is maintained in the center of hospital activity and should a doctor or nurse experience problems communicating with a patient, all three representatives can be contacted through the hospital paging system.

Being present on the spot, the representatives are usually able to solve problems as they arise. Administratively speaking, Kuhlmann says that now days "problems don't get blown out of proportion. They are handled before they get to that level. And usually when we get a problem, we have both sides of it."

And according to Dr. Szuter, the representatives are able to provide the administration with "the kind of information we wouldn't normally have." With problems of staff discourtesy for example, he says the administration is given



PIMC PATIENTS have the benefit of being informed of their rights and normal hospital procedures. Here, Rosita Browning, goes over the Phoenix Area Bill of Rights with a new patient.

the opportunity to say, "you left a bad taste in this person's mouth. How about making some changes?"

With their ability to spot problems within the whole health delivery system and bring them to the attention of the medical center staff and the Phoenix Service Unit Indian Health Board, as a result of the representatives' efforts, changes both small and large have been made.

Instances of rudeness are documented and, as the representatives explain, if it occurs often enough "this points the finger to one person." The board has had one staff member against whom complaints built up reassigned. Explains Booth, "the person was competent but just couldn't deal with people."

There may be less need for similar actions in the future because as Kuhlmann puts it, "their awareness of the patient representatives may be causing the staff to take a little different approach to dealing with patients."

Changes are also taking place among the patients themselves. They are less reluctant to speak out for their rights as fear of retaliation had prevented them from doing in the past, say the representatives.

Their acceptance of hospital operations has grown with increased knowledge. For example, patients have expressed their distress at waiting for laboratory test results for as long as two or three hours. But when a patient understands that tests are also being done on 200 other patients at the same time the wait becomes more bearable.

The representatives have seen the need to alter certain procedures. One example involved patients confined to wheelchairs who were receiving only sack lunches because they couldn't get into the dining room. The representatives intervened with the dietary department to have a space for wheelchairs set aside.

Being constantly responsive to and aware of patient, staff and administration needs is not an easy job. Asserts Kuhlmann, "not everyone could be a patient representative. It's important to get the right kind of person." He feels the service unit board has made good choices in Pedro, Antone and Browning. "They enjoy what they're doing and go out of their way for the patients," he says of the threesome.

Not without its frustrations, Pedro complains of the job, "patients and staff are always passing the buck."

But she is quick to point out how satisfying she finds her work, as are the others. What makes the job worthwhile? Says Antone, "the satisfaction I get when I convince a person to stay. I explain to them and most of the time they calm down."

According to Browning, it is when a patient gets seen by the doctor and has good comments on his visit to the hospital. Or the nursing home patient who asked her name and said "I wish all people were like you. You have a smile on your face. That shows that you like your job. If people have long faces you don't feel they want to care for you."

Believing their program to be a success, Booth and the rest of the Phoenix Service Unit Board would like to see it expanded. So would others. At a recent meeting, the area service unit directors requested that the service unit board fund an increased number of patient representatives.

Specifically, Booth and the present representatives would like to have at least four more representatives, and preferably one for each hospital ward. They would also like to have sufficient numbers to accompany doctors on their visits to Indian elderly in area nursing homes.

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Court Finds Indian Mental Care is U.S. Responsibility

RAPID CITY, S.D.—(AP)— The federal government must accept responsibility for mental health care for Indians living on reservations, a federal judge has ruled.

In a 56-page opinion, U.S. Dist. Judge Andrew Bogue dismissed a suit filed against South Dakota and the U.S. Department of Health, Education and Welfare.

The suit was filed by the guardian of a woman the state refused to commit to the Human Services Center at Yankton, S.D.

The court also dismissed a suit filed by the federal government against the state for its refusal.

Bogue ruled that South Dakota state and county officials don't have jurisdiction to accept or act on applications for the involuntary commitment of an apparently mentally ill reservation Indian.

He warned that unless responsibilities in such cases are made clear, future controversies could have "tragic" consequences.

The guardian in the case charged that the state's refusal to commit her sister constituted discrimination based on race and place of residence, according to the opinion.

South Dakota, represented by Attn. Gen. William Janklow, said the demands on the state could only be met if state officials acted beyond their legally defined powers to assume jurisdiction over an Indian.

"The process of committing someone involuntarily brings the power of the state deep into the lives of persons involved in the commitment process," said Bogue, adding that under state commitment procedures sheriff's deputies must serve commitment petitions on persons living on the reservations.

"If the collection of taxes of any sort from Indian people in Indian country or the power to coerce them to come into state courts as defendants in civil actions would

infringe on tribal sovereignty, then there is no way that vesting state institutions would not violate that sovereignty," Bogue said.

According to Bogue, the federal Indian Health Service adopted the policy of relying on state resources for mental health treatment in 1971.

The service offered to pay South Dakota \$50 per month for the treatment. But the state continued to bill the federal government for the full cost, which Janklow said amounted to several hundred dollars a month.

Janklow said the suit was prompted when he ordered state officials not to carry further involuntary commitments "until the federal government accepts its treaty obligations."

Bogue said a law passed by Congress after the suit was filed found that federal Indian health services are required by the government's "historical and unique relationship" with Indians.

"In the wake of this history throughout which state powers have been consistently circumscribed and federal responsibility has been explicitly recognized, it would simply make no sense to hold that state officials had either the power or the duty (to treat the patient involved)," said Bogue.

"The situation that gave rise to the controversy is likely to be repeated in the near future," he said. "If the rights and responsibilities of the parties are not clear, the consequences could be tragic."

He said it would make no difference whether federal officials contracted with the state or private agencies or made commitments to federal facilities.

"In either case, commitment procedures that conform to the requirements of due process will have to be developed," he said.

Patients . . .

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According to Dr. Szuter, the Phoenix Patient Representative Program is unique. He says, "although there are other patient advocate-type programs in the country, they are primarily concerned with financial matters."

Booth and his assistant, Bob Crawford believe that the concept is adaptable to other IHS situations and say the program has generated a tremendous amount of interest and support in other parts of the country. Two areas (Alaska and Sacramento) are already recruiting for patient representatives. Other areas have asked that the Phoenix Service Unit not only provide them with information on how to operate such a program but also to make training available.

A curriculum which would offer four to six months of full-time training is being developed and according to Booth, the board intends to seek private funding for a national training program. He reported that discussions with the Ford Foundation were opened in September but nothing definite has been decided.



PAYING A VISIT to a PIMC patient is patient representative Vernon Antone of the Gila River Reservation.

Aberdeen Joins Indian NHI Effort

NIHB has a new representative from the Aberdeen Area. Harold Janis is the new acting chairman of the Four State Indian Health Board and will remain in that position at least until new elections are held, probably in March. As such, he succeeds Leonard Hare, Jr. on the national board.

Leona Claymore, Secretary of the Four State Board from McLaughlin, S.D. is the area's new NIHB alternate.

The Four State Board's activities of late have centered around hearings in the area. During the last few weeks, testimony has been presented on National Health Insurance in Rapid City and Sioux Falls, S.D. and Bismarck and Fargo, N.D. Reiterated at each location was the Consensus Indian Position on NHI developed by the NHI Core Group.

A mini-hearing on the subject of Indian Mental Health was scheduled for November 2 in Rapid City, S.D., with that

The tribes' strong stance on maintaining their individuality doesn't deter them from criticism on the present area representation on the National Indian Health Board, however. Although the Tri-State Indian Health Board lost its funding in 1974, the former chairman of that organization, Donald LaPointe continues to serve as the Bemidji representative on NIHB. According to Buckanaga, the tribes complain that LaPointe does not represent their needs and makes no effort to communicate with them regarding his board activities.

LaPointe asserts that he does make an attempt to disseminate whatever information he can about important health concerns as they arise but is severely limited by having to spend his own money to do so. He also attends numerous meetings to share such information with intertribal council and area IHS officials, with the money again coming out of his own pocket.

Disagreeing with Buckanaga, LaPointe claims that tribal people in his area do wish to form an area health board but says efforts to hold an organizational meeting have been inadequate with the wrong persons invited to attend.

Area Board Update

testimony to be submitted to the President's Commission on Mental Health via commissioner LaDonna Harris. As planners for the hearing, the Four State Board urged all area tribes to participate.

Personnel activity in the Aberdeen area has included the hiring of Enoch LaPointe as Evaluation Officer. She is assigned to develop a methodology to assess Community Health Representative programs. The board is currently seeking someone to fill the position of Area Safety Officer.

Bemidji Still Without an Area Health Board

"I've just given up talking about a health board," says Bemidji IHS Area Director John Buckanaga regarding attempts to reorganize an area-wide Indian health board for Minnesota, Wisconsin and Michigan.

"The tribes just don't want to get together," he says. As proof Buckanaga adds that only three of 27 tribes showed up for an organizational meeting funded by IHS this past June.

But lack of cooperation on the part of the Bemidji-area tribes doesn't seem to be regarded as much of a problem by the area director. He reported that he recently discussed the situation with IHS Director Dr. Emery Johnson and told him that "most of the tribal councils are running their own programs and don't want anyone else interfering."

Each of the 27 tribes employs a health planner, all provided training by IHS.

The individual tribes are also unwilling to give up any of the special pull or influence they may have achieved through their own efforts with Congress, added Buckanaga.

In summary, he suggests that "they are probably all doing their own thing better than could be done jointly and this is probably the best way to go."

Navajos Awarded \$25 Million for Sanitation

Residents on the Navajo reservation are scheduled to receive water and sanitation facilities amounting to one-third of a supplemental appropriation for sanitation facilities construction by the Indian Health Service.

Arrangements between the Navajo Area IHS and the Navajo Tribe for some \$25 million worth of projects were completed in late September. Over the next 12 months, the money will be divided among 77 projects serving an estimated 4,200 homes.

In order to manage the increased workload, the Navajo Area IHS will also receive 46 new positions for its Office of Environmental Health and Engineering.

The sanitation facilities for Navajo and other Indian homes are being made possible through Fiscal Year 1977 pre-funding of part of Title III of the Indian Health Care Improvement Act. Provided is \$75 million for sanitation facilities construction with \$46 million of this amount going to projects for existing housing and the remaining \$29 million to support projects for water distribution systems for housing projects to be built over the next year.

It's Tribes vs. Indian Preference in Phoenix

As it has in every other IHS area, the newly-instituted absolute Indian preference policy of Indian Health Service is creating confusion and disagreement in the Phoenix Area.

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Area . . .

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The area remains without an IHS director as a battle waged in recent months has found the Phoenix Area Indian Health Board in disagreement with the Hopi Tribe and more recently with the entire Intertribal Council of Arizona.

According to Hopi Vice Chairman Alvin Dashee, the Phoenix Area Board, last February lowered its qualification standards in order to utilize the absolute Indian preference policy.

The health board selected four applicants in June and submitted their names to the Phoenix Area Office for interviews along with its recommendation for the position.

It was at this point that Dashee became aware of the situation and later brought his objections before the Intertribal Council. Dashee told his fellow tribal leaders that he was not against Indian preference, but that he felt that the person who will be responsible for the health needs of the tribes must be a doctor with good field and administrative experience.

And while not in opposition to Indian preference, Dashee has expressed the fear that it will lead to a second-rate system of health care provision to Indian people as the trend among areas so far is to decrease qualification standards to the point where Indian applicants can qualify rather than hiring the most highly qualified individual.

Area health board chairman Perry Sundust agrees that whoever is finally selected as area director should have a strong professional background but says the area board did its job by submitting a recommendation to IHS. He says IHS "stalled and stalled because of the objections of one or two tribes while in the meantime the area suffers for lack of a director."

NIHB Seeking Coordinator for National Health Insurance

DENVER, COLO.—NIHB is looking for a full-time coordinator of its National Health Insurance (NHI) activities. Under the supervision of the organization's executive director, the coordinator's job would consist of gathering, disseminating and analyzing NHI information and legislation and making presentations and providing technical assistance to Indian tribes and organizations.

The position description is as follows:

Job Title: National Health Insurance (NHI)
Coordinator
Salary/Benefits: \$12,500 plus health insurance

Specific Duties:

The coordinator will perform, but is not strictly limited to, the following responsibilities:

1. Research the field of literature on National Health Insurance, writing letters, and making telephone calls and utilizing other methods to secure copies of such literature.
2. Establish and maintain contact with Indian tribes, organizations, and as practical, others with regard to determining their need for NHI information, technical or other assistance.
3. Establish and maintain a central repository of NHI information.
4. Disseminate such information to tribes, organizations and others both on a routine basis and as requests come in.

As time has run out for action on the area health board's initial selected panel of applicants, it has been decided by that body's executive committee to readvertise the position.

Sundust recently made a trip to discuss the exact qualification requirements with IHS Director Dr. Emery Johnson and says he learned that the board has three sets of qualifications, upon any of which it may base its selection.

A meeting of the full area board will be called in the near future to decide which standards will be used.

Sundust also reported that the Phoenix Service Unit Advisory Health Board has recommended Richard Urik as director of the Phoenix Indian Medical Center. His hiring pends the approval of Dr. Johnson. Presently employed by DHEW in the area of International Health, Urik has served as both an IHS service unit director and as area director for Billings.

College Credits by Exam

PRINCETON, N.J.—Dental assistants can now for the first time change their practical knowledge into college credits through a series of examinations sponsored by the College Entrance Examination Board.

As part of the board's College-Level Examination Program (CLEP), the tests are designed to measure information usually taught in a two year dental auxiliary program leading to an associate degree or a one-year dental assisting program leading to a diploma or certificate.

A booklet describing the new tests and providing sample questions is available by writing: College Board Publication Orders; Box 2815, Princeton, N.J. 08540

5. Maintain current mailing lists.
6. Analyze NHI information, constantly updating information and legislative activity.
7. When requested, travel to make presentations on NHI and provide technical assistance to tribes and organizations in possibly developing NHI positions.
8. Direct routine and assigned reports to NIHB members and Director, Indian Health Service, through the office of the Executive Director, regarding NHI's relevance to the Native American community.

Travel Requirements: Light-to-moderate

Skills Requirements:

Coordinator should have good communications and analysis skills. In addition, incumbent should have working knowledge of mass mailing and direct mail systems.

Education:

A minimum bachelor's degree in any major field suited to duties is acceptable.

How to Apply: Send a detailed resume, along with salary history and list of personal references to: John Belindo; Executive Director; National Indian Health Board, Inc.; Brooks Towers Building, Suite 4E; 1020 15th St.; Denver, Colo. 80202.

Clinical Directors Call Genocide Charges Ridiculous; Speak Out on Indian Preference

DENVER, COLO.—Who are the IHS clinical directors and what are they thinking? A partial answer to that question was provided here October 26-28 when about 35 members of the National Council of Clinical Directors came together for their annual meeting.

A predominantly youthful group, it became obvious that although they are responsible for medical care and clinical operations within IHS facilities, their concerns extend beyond strict clinical practice.

Yet, seemingly remaining uppermost in their minds is their facilities' ability to provide the best medical care possible. As expressed by the clinical directors, several obstacles help make such high level care less than easy to deliver.

The directors feel they have been wronged by press reports relating to IHS birth control practices. Media accounts based on a General Accounting Office study have alleged numerous sterilizations performed on Indian patients without their informed consent being properly obtained. Some reports have gone so far as to accuse IHS of instituting an across-the-board practice of sterilization of Indian women aimed at genocide of the Indian population.

One director called such statements "grossly inaccurate."

Council director Jock Pribnow presented a statement on family planning adopted by the IHS physicians of his area (Portland) and adopted in resolution form by the clinical directors the following day.

437 Rules and Regs Ready for Approval

ROCKVILLE, MD.—Final rules and regulations governing the implementation of P.L. 94-437 have been drafted by the HEW Office of General Counsel and only await the signature of Secretary Califano before they may be published and the Indian Health Care Improvement Act fully implemented.

Dr. Robert C. Birch, Project Manager for P.L. 94-437, reported that compared with the lengthy period spent to bring about publication of the rules in proposed form, the final regulations have been "moving like wildfire" through the DHEW clearance process and reached the Office of the Secretary November 3.

The entire regulations procedure has been delayed due to the 81-day period required for the Health Services Administration/Public Health Service/Office of the Secretary to clear, approve and publish the proposed rules and regulations.

The law required their publication by July 31 and their tardiness is effectively holding up the distribution of educational assistance under Title I and funding for urban health projects under Title V of P.L. 94-437.

Title IV is already operational and Titles II and III can be implemented now.

Expressing their concern that IHS may come to be bound by the anti-abortion policy imposed on other departments within HEW, the Portland area physicians called denial of federal money for abortions and sterilization for people under 21 "blatantly discriminatory."

Pribnow explained that HEW Secretary Califano has publicly opposed using federal funds to pay for abortions, that HEW has cut off funds for abortions and that "basically HEW is out of the abortion business." Congressional appropriations for HEW are presently being held up for lack of an agreement between House and Senate forces over Medicaid abortion policy.

Although IHS comes under HEW, it is still allowed to perform abortions due to a technicality. (It receives its funding through the Department of Interior.) But, said Pribnow, "we understand that if pressure is applied in the right places IHS could be ordered to follow HEW regulations."

Representing IHS headquarters at the meeting, James Felsen, M.D., said that IHS considers abortion to be a local medical decision between a woman and her doctor. He added that he recently told Dr. George Lythcott, Director of the Health Services Administration, that IHS is not bound by HEW's direction and plans to maintain its present policy.

Another policy creating concern among the clinical directors is one forced upon IHS as the result of a court decision several months ago, that of absolute Indian preference. Finding fault with the decision, said Felsen, "I think the tribes and everyone else are in favor of Indian preference. It's the absolute stipulation that brings up objections."

Referring to IHS, he added, "we fought like hell with the department lawyers. Many of us thought it should not be extended to physician care . . . The Tyndall case took away any reason or flexibility. Minimally-qualified is not enough in a health-care program."

Several others protesting the ruling found a sympathetic audience in the clinical directors, many of whom hold the belief that Indian preference will lead to a decline in the quality of health care delivered.

They attribute this to areas lowering their qualifications in order to achieve what is viewed as compliance with the court ruling. According to Pribnow, "... there have been people placed in jobs where they really don't belong because of Indian preference."

Health care will also suffer due to the loss of non-Indian IHS personnel, claimed others, blaming the Tyndall decision for creating job stagnation among non-Indian employees.

Asked to assess the situation, Navajo Area IHS Director Marlene Haffner predicted, "initially we will lose a large number of very qualified, very talented people that will be hard to replace . . . There is a problem of people being stuck in positions; also positions which we will be unable to fill because people are unwilling to go to 'less desirable' areas for fear of being unable to get out."

Additional factors contribute to the hand-in-hand problems of staff recruitment and retention which continue to

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Clinical . . .

Continued from Pg. 12

loom large in several IHS areas. Bill James, a clinical director from Alaska, reported that his area is simply unable to compete with the private wage scale. "We have had medical technicians quit, become dishwashers and make twice the pay," he illustrated. All of the hospitals in the Aberdeen and Bemidji areas continue to have serious staffing problems due to a lack of funding, reported Petra Warren.

Almost every other area reported recruitment or retention troubles, occurring to a greater or less degree. In Phoenix, where 99 positions remained unfilled at the end of the last fiscal year, reported Larry Moher, M.D., the situation is "very dismal," with a large number of beds closed due to lack of staff.

The area is also suffering from a vacuum in administrative leadership. At present it has no area director, deputy

area director, chief medical officer and only four service unit directors for its 10 service units, said Moher. He termed these "real losses which IHS can't afford to absorb."

The situation is aggravated by a lack of moeny. When Moher claimed that IHS headquarters has failed to come up with adequate answers, shrugged Felsen, "the Phoenix area overspent; they simply dug themselves into a hole."

IHS headquarters has looked forward to providing some relief for its areas through a large number of physicians soon to begin functioning under PHS scholarships.

And while the areas themselves look forward to receiving much needed staff to serve their Indian patients, a position paper presented by Moher at the meeting asserts that the scholarship program fails to provide a real solution for physician staffing problems.

Instead of improving, the quality of care will decline, it

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IHS Neglectful of Patients' Rights, Testifies NIHB

BETHESDA, MD.—As the Indian Health Service fights the difficult struggle to provide basic care to Indian people with the inadequate resources available, persons within its ranks may have adopted the attitude that patients' rights are a frill appropriate only for persons who already have access to adequate facilities and staff.

So, Daniel Press, Special Counsel to NIHB, told members of the National Commission for the Protection of Human Subjects during their public hearing October 14 on the ethical principles and guidelines that should apply to the delivery of health care under programs administered by the Department of Health, Education and Welfare (DHEW). The Indian Health Service is one such program.

The information and views presented at the hearing will assist the commission in its charge to make recommendations to the Secretary, DHEW, and to report to Congress regarding protection of patients receiving health services under DHEW programs.

Patients rights is a particularly critical issue for Indians using IHS, testified Press. Because they do not pay the IHS providers, Indians do not have the financial leverage to obtain respect available to other health consumers, he explained.

He went on to call Indians "captive consumers," due to the unavailability to them of alternative providers.

IHS, testified Press, has failed in what he termed its obligations to Indian patients: to insure that its providers respect the rights of Indian consumers and are sensitive to their unique cultural orientation and to educate Indian consumers on their rights as patients.

Citing specific shortcomings, Press, speaking on behalf of NIHB, said that while all IHS areas now have written bills of patients' rights, no effort has been made to implement them or to educate Indians about the rights they guarantee.

Unfortunately, none of the bills of rights make more than passing mention of the need for cultural sensitivity, said Press.

Lacking any knowledge of their rights, Indian health consumers are too often "herded through treatment" without being offered an explanation of what various procedures involve. "Particularly for older Indian people who have

begun to use Western medicine only within the last 20 years this can make a difficult situation into a traumatic one," said Press.

The most serious problem arises with contract care providers, he told the commission. He described the situation as follows: "these providers tend to look down on Indians, treat them with disrespect, etc. They have no Indian employees, no one to interpret for Indians who do not speak English well, make no effort to provide special Indian foods, etc."

While Indian patients lack adequate knowledge (or protection) of their rights, they would have little recourse if they did wish to complain for, as noted by Press, IHS has also failed to establish adequate grievance procedures. "This is perhaps the most serious of the criticism," he said, "for an effective grievance procedure is the best way to insure accountability in a system where the patient cannot take his money and purchase health care elsewhere."

In order to correct these shortcomings, NIHB requested that the commission instruct IHS to initiate, in conjunction with Indian health boards and tribal health departments, "a vigorous effort to make patients' rights a meaningful aspect of the IHS delivery system."

To achieve this, it requested (through Press) that IHS, health boards and departments jointly rewrite the existing bills of rights to reflect the unique situation of Indian patients and that IHS fulfill its responsibilities as a contractor by insuring that its contract care providers are respectful to Indians and sensitive to their special needs and cultural orientations.

It was further recommended that IHS develop effective grievance mechanisms and that NIHB be given financial and other assistance to enable it to train local boards and health departments on how to serve as patient advocates.

Although outside the IHS system, Health Systems Agencies (HSAs), created by P.L. 93-641: the National Health Planning and Resource Development Act, may come to play an ever-larger role in planning for the health care for Indians as well as other Americans. Fearing that HSAs will not be sensitive to Indians' unique needs when developing their health plans, NIHB also asked that HEW advise these bodies that they must be sensitive to the unique cultural orientation of Indians within their areas and instruct them how to carry out this requirement.

Clinical . . .

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states, maintaining that quality of care is dependent to some degree on continuity and on individual motivations in providing that care. "Returning to the 'draft mentality', where obligated physicians are sent to hard to fill areas with little or no choice, can only decrease the motivation level of the individual physicians," forecasts the paper.

Moher suggested that IHS deemphasize its scholarship program, instead devoting increased attention and resources to the retention of "good physicians."

A representative from each IHS area reported on activities over the past year. As their reports revealed, the areas vary widely both in terms of operations and facilities. Pribnow explained that in Portland IHS has outpatient

clinics only and no hospitals. In Alaska, reported a relieved James, all of the IHS hospitals have just been certified. Meanwhile the Navajo area has eight facilities, said Dan Schultz, "some accredited, some thinking about being accredited, some worried about falling down."

And while the degree of physicians' activity and interaction varies from one area to another as well, several clinical directors reported becoming increasingly involved with complex social problems, where symptoms show up for medical treatment but whose causes must be dealt with on a much broader scale. Examples include a pilot program on the Winn River Reservation offering training in parenting skills and the procurement of two psychiatrists to provide consultation work with the alcoholism program in Choctaw, Miss. Another area reported an increasing incidence of child abuse and neglect but said it has yet to develop means for dealing with the problem.

Technical Assistance for Health Consumers Asked

WASHINGTON, D.C.—The newly-formed Consumer Coalition for Health, an "umbrella" organization encompassing national and local organizations and concerned individuals including the National Indian Health Board, has asked the National Council on Health Planning and Development to shore up the amount of technical assistance provided to consumers in health planning.

The National Council, appointed to act as an advisory group to DHEW Secretary Joseph F. Califano, met at the end of October to begin developing national guidelines and policies in the delivery of health care under new laws on health planning.

Herbert Semmel, Chairperson of the Consumer Coalition for Health, asked that the National Council pass a resolution which would strengthen the role of consumers in health care planning through increased technical assistance.

P.L. 93-641, the National Health Planning and Resources Development Act, mandates that consumers control the agencies which allocate health resources. "But," notes Semmel, "intelligent decisions on health care require the consumer majorities of health planning agencies to possess the knowledge of the intricacies of health care needs, financing and organization. It demands ready access to a support staff of professional specialists."

The Consumer Coalition for Health was organized to assure that consumers in fact control the local health planning agencies (HSA's) and are effective participants in the planning process. The coalition also acts as a Washington advocate for the consumer health movement.

The NIHB Health Reporter is published monthly by the National Indian Health Board. NIHB is pleased to provide this newsletter to our readers throughout the country and welcomes the further distribution of the information contained therein. We do kindly request, however, that NIHB receive credit for articles reprinted from the NIHB Health Reporter.

Please submit all articles, correspondence and mailing requests to L. Joy Bossert; National Indian Health Board; 1020 15th St., Rm. 4E; Denver, Colo. 80202.

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