INDIAN HEALTH CARE, 1977

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

OF THE

COMMITTEE ON HUMAN RESOURCES UNITED STATES SENATE

NINETY-FIFTH CONGRESS

FIRST SESSION

ON

EXAMINATION OF THE PROBLEMS ENCOUNTERED IN INDIAN HEALTH CARE

NOVEMBER 11, 1977
ISLETA, N. MEX.

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FRIDAY, NOVEMBER 11, 1977

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE COMMITTEE ON HUMAN RESOURCES,
Isleta, N. Mex.

The subcommittee met, pursuant to notice at Isleta Pueblo Indian Reservation at 9 a.m., Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senator Kennedy.

Also present: Senators Domenici and Schmitt.

Senator KENNEDY. We will come to order.

We have a very full agenda this morning, and the primary purpose of this particular meeting is to give people in this pueblo and those concerned about Indian health issues the opportunity to speak. And so I will be very brief in terms of my comments.

But first of all, I want to thank the Isleta Pueblo and the members of the tribal council and the members of the other pueblos who met with us earlier this morning to consider a wide range of different interests that our Indian friends have on their agenda.

We cannot consider just Indian health without considering a variety of different other issues which matter very deeply to the people here in New Mexico and are a common concern to Indian people all over this country, and I found that exchange useful and helpful to me.

There are issues which I have tried to follow over a period of time and I welcome the constructive comments that were made and the informed way in which they were presented indicated that I as an individual Member of the U.S. Senate will look forward to working and continuing to work on these particular issues. We were joined at that meeting by Senator Domenici and Senator Schmitt, and, in just a moment or two, I will ask Senator Domenici and Senator Schmitt if they would say just a word as well.

Coming back to New Mexico is always a very special set of circumstances for me. Five years ago, I was here as chairman of an Administrative Practices Committee of the Judiciary Committee. We were looking into the issue of mineral rights, water rights, and the procedures that were being followed by the Bureau of Indian Affairs on these particular issues. We were out at Window Rock and, at that time, we had one of the most severe blizzards of the winter and it took us 8 hours to drive back to Albuquerque; and we commenced our hearing.

Every witness remained for our hearing, and a hearing that was supposed to start at 6 o'clock started at 1 o'clock in the morning. But

it was a very clear indication to me about the seriousness with which these issues are addressed by the Indian people.

And now I have come to New Mexico again as part of a trip that we have been conducting as the health subcommittee. We have traveled down to Atlanta, Ga., to the center for disease control. We visited some of our senior citizens in Miami and then went out to the migrant camps on the issues of migrant health; yesterday, into the great biomedical research centers in Houston, the M. D. Anderson Centers; later on today, out to visit the DNA research facilities in Stanford and then health delivery in southern California, in Los Angeles.

But when we announced that I had made the decision to come to New Mexico, my niece gave birth to a wonderful 8-pound 9-ounce baby girl. The next generation of Kennedys is starting, not in Massachusetts, but is starting right here in New Mexico, and we are delighted. [Applause.]

And I do not know whether it is appropriate, but perhaps it is, to introduce her grandmother, my sister-in-law, Ethel, Mrs. Robert Kennedy, who is——[Applause.]

And I think that many of our friends here remember very clearly the work that was done in the area of Indian education by Senator Robert Kennedy. Still, many of those recommendations remain to be—fulfilled. Some progress was made but, still, as in all of these problems, much remains to be done.

Now, at the outset, I would like to pay tribute to the Indian health service individuals. I have had the opportunity to meet with them, to talk with them, to counsel with them, to learn from them and, I think, as individuals, they have been enormously dedicated and committed; and I think as a result of much of their work, we can see on a chart that is over here on your left and on our right, we see some important progress that has been made in Indian health over the period of recent years.

And I think that is a very clear indication—with the drop in suicides, some reduction in infant mortality, some success with pneumonia, influenza, and in the problems of suicide, we see some degree of progress.

But we measure that against the next chart, which shows a continuing problem of a significant growth in a variety of different areas that significantly exceed the national averages, and it reminds us of how much further we have to go.

I hope you will review these figures and statistics as we hear the comments. They give a fairly clear indication of the continued serious problems that our Indian people are facing in terms of life expectancy, anywhere from 20 to 23 years less than the rest of the population. There has been a significant reduction in infant mortality, but still it remains substantially higher than the rest of the population; still we are not providing the kinds of either resources, in terms of meeting health-care needs that we do in terms of the rest of the population; and it reminds us of the unfulfilled promises, in terms of trying to provide decent quality health care to all the peoples of this great nation.

I am mindful of the position that has been taken by your council in terms of national health insurance and health security. And I believe, as we hopefully will get a debate and discussion on that issue in the

next session of Congress, these kinds of requests that you have made, the issues that you have identified, are not greatly dissimilar from what adjustments we have made in the veterans program.

And I welcome the opportunity to work with your people. We have gotten a good collection of material and I think it is important that we bring that to the attention of the national administration, as they are proposing their particular programs.

Just a final comment.

The good news of today is, at last the Department of Health, Education, and Welfare has issued the Indian Health Care Improvement Act regulations. And Emery Johnson the Director of the Indian Health Service, will remain here during the day to work with the representatives of the different pueblos in the interest of the $6 million that have already been appropriated and are available to your communities in these areas of Indian health profession recruitment and scholarship grant programs. This program is intended to encourage Indians to enter the health professions and insure the availability of the Indian health professions to serve Indians.

The regulations also address the category of continuing education allowances for employees of Indian Health Services—a matter of very great importance in encouraging Indian people to continue to work in the Indian health field; contracts with urban Indian organizations to assist those organizations carry out programs in urban centers to make health services more accessible; and, finally, leasing from Indian tribes of land and facilities which the Indian Health Service would otherwise be authorized to acquire or build.

It has been too long in coming into development. We are glad that the Secretary of HEW had signed off on these programs. Dr. Johnson brought these. This, I believe, is the only copy that he has with him today, but they have just been signed off in the past few hours and are going, I think, to provide some important opportunities to the tribes and the Pueblos to move ahead in some of these important areas.

[The prepared statement of Senator Kennedy and the charts referred to follow:]

PREPARED STATEMENT OF SENATOR EDWARD M. KENNEDY, A U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Senator Kennedy. I want to open this hearing of the Senate Health Subcommittee by extending my special thanks to the people of Isleta and Gov. John Jojola for their warm welcome this morning. I also want to express my appreciation to the Chairman Del Lovato and the members of the All Indian Pueblo Council. Their support and assistance made this hearing possible.

Our hearing this morning will focus on health care. The Nation has a legal and moral commitment to provide Indians with the best possible health care and to provide for your full participation in the development and delivery of those services. But despite the dedicated efforts of the Indian Health Service and its personnel the Nation has failed to meet those commitments. This is a matter of grave concern to me as chairman of the Health Subcommittee; it is a matter of grave concern to Senator James Abourezk, chairman of the Select Committee on Indian Affairs; it must be brought to the attention of every member of Congress and to the American people.

The charts in our meeting room this morning document the problems you know only too well. The story they tell about the Albuquerque area mirrors the situation as it exists for Indians throughout the country.

There have been some significant improvements in the health status, among New Mexico's Indians. Those improvements are an outstanding tribute to the Indian Health Service.

The incidence of alcoholism, and related deaths and disease, however, continues at a very high rate. The toll this has placed on human lives and well-being is beyond measure.

Now let's turn to the resources which exist in New Mexico to deal with these problems.

In New Mexico the Indian Health Service can meet only 37 percent of the demand for mental health workers; only 29 percent of the demand for community health nurses; only 17 percent of the demand for public health and nutrition workers; and only 37 percent of the demand for environmental health workers. The Indian Health Service simply does not have the personnel required to provide the physicians and health care workers you need.

Nor does the Indian Health Service have the money it needs to provide contract care for Indians in New Mexico—the care which the Indian Health Service cannot furnish in its own facilities. The Albuquerque Indian Hospital, for example, has no surgical suite and its staff is so limited that it cannot provide inpatient care for young children. All these services must be provided by other facilties which are then reimbursed by the IHS. But only two-thirds of the $5.3 million needed to provide contract care in the Albuquerque service area is presently available. For the Zuni-Ramah unit the deficiency is 68 percent.

Let me tell you what I think this means. It means you may have to wait for years for hospital services; dollars and cents are determining whether you and your children can see a doctor and get followup care; money is the determining factor in deciding whether your hospitals and clinics will be able to meet even minimal standards. This is a national disgrace of alarming proportions.

And what is the situation right here at Isleta? You have a brand new clinic which meets the finest structural and medical standards. It was built through the dedicated efforts of your tribal leadership and the special help of Senator Joe Montoya. But the facility itself is not enough. The Indian Health Service doesn't have the staff it needs to put this clinic into full operation. A single physician and a minimal support staff are handling 6,500 patient visits a year. Yet, in spite of these problems, they have developed a promising program of preventive care—especially for women and young children. We can only imagine what could be accomplished with adequate staffing.

Two new hospital construction projects are underway to serve you in New Mexico—one at Acomita and one at Santa Fe. Other facilities are being discussed and planned. I expect we will hear more about them today and the problems they are facing.

With us this morning we are fortunate to have tribal leaders, consumers and physicians with extensive firsthand involvement in the needs of New Mexico's Indians, in the programs of the Indian Health Service, and in the physical and mental health needs of your community. Dr. Emery Johnson, Director of the Indian Health Service,

has made a special trip from Washington to be with us and contribute to the hearing.

I expect that we will hear testimony on a wide range of health care problems and possible solutions to those problems. We also want to hear from our witnesses on pending national health insurance proposals. Indians have a very special stake in that legislation. I want to know what you feel needs to be done to make health security legislation fully responsive to Indian health care concerns.

I look forward to your comments and to responding to your concerns. I will take this information back to Washington. I will work at every level to reinforce and strengthen our national commitment to bringing Indian health care to the highest possible level and to providing and encouraging maximum participation of the Indian people in the planning and management of those services.

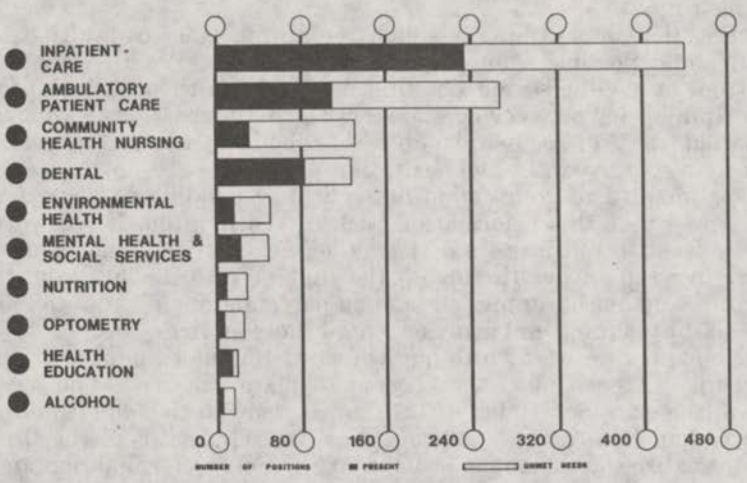
And now, before we turn to our witnesses this morning, there is a special item of good news that I want to share with you. You have been waiting since September of 1976 for implementation and funding of the Indian Health Care Improvement Act. This act is essential in order to realize the enormous promise of the Self-Determination and Education Assistance Act which became law in January of 1975.

The Health Care Improvement Act includes resources for training, to improve and increase services, to provide facilities, for participation in medicare and medicaid and funding for programs in urban areas. The Congress authorized $145 million for the first year of this program—but only a fraction of that amount has been appropriated. A major barrier has been the delay in getting approval of the necessary regulations.

I am pleased, therefore, to announce this morning that your long wait is over. The Indian health care improvement regulations were signed by Secretary Califano.

We can now focus our efforts on the administration, the Department of Health, Education, and Welfare, the Office of Management and Budget, and the Congress to win approval for the additional funding needed to fully fund these programs.

[The charts referred to follow:]

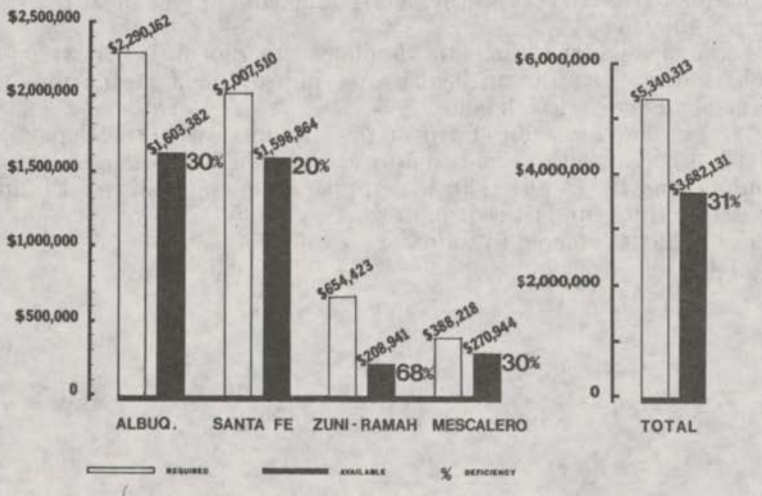


HEALTH SERVICE POSITIONS · UNMET NEEDS

ALBUQUERQUE AREA

U.S. DEPT. OF HEALTH, EDUCATION, & WELFARE
INDIAN HEALTH SERVICE

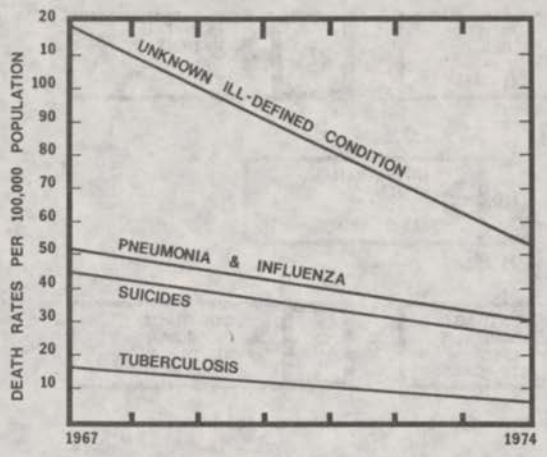
U.S. PUBLIC HEALTH SERVICE
ALBUQUERQUE AREA

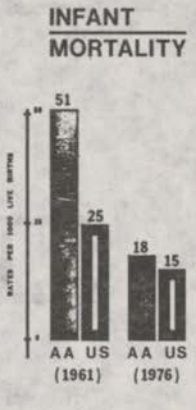


CONTRACT HEALTH SERVICES FOR ALBUQUERQUE SERVICE UNITS ←

U.S. DEPT. OF HEALTH, EDUCATION, & WELFARE
INDIAN HEALTH SERVICE

U.S. PUBLIC HEALTH SERVICE
ALBUQUERQUE AREA

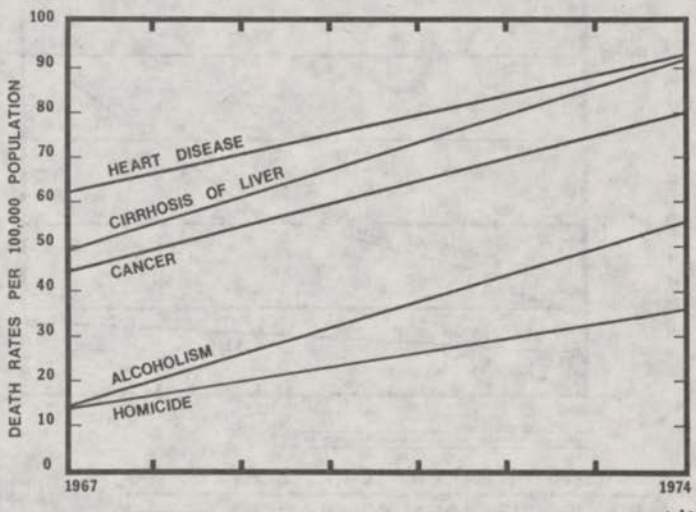




MORTALITY TRENDS FOR INDIAN RESIDENTS
(DECREASING) ←

U.S. DEPT. OF HEALTH, EDUCATION, & WELFARE
INDIAN HEALTH SERVICE

U.S. PUBLIC HEALTH SERVICE
ALBUQUERQUE AREA



MORTALITY TRENDS FOR INDIAN RESIDENTS
(INCREASING) ←

U.S. DEPT. OF HEALTH, EDUCATION, & WELFARE
INDIAN HEALTH SERVICE

U.S. PUBLIC HEALTH SERVICE
ALBUQUERQUE AREA

35% → HOSPITAL CASES 1124 - CASES

I.H.S.

31% → HOSPITAL PATIENT DAYS 7352

I.H.S.

18% → OUTPATIENT VISITS 32,593 - VISITS

I.H.S.

35% → CONTRACT HOSPITAL CASES 1076 - CASES

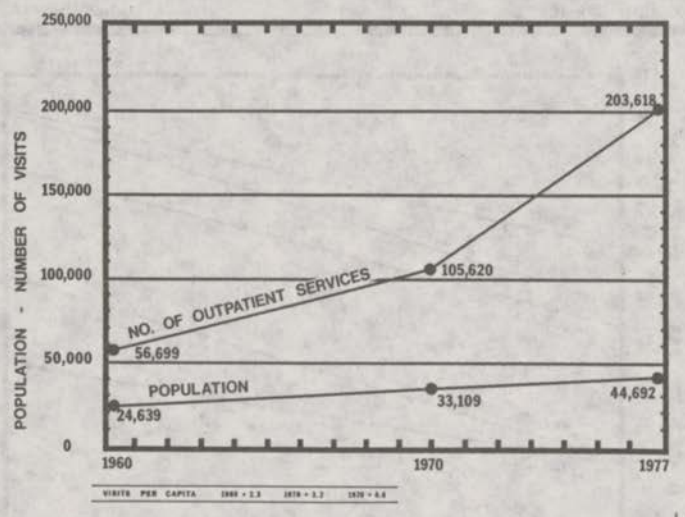
25% → CONTRACT PHYSICIAN VISITS 2680 - VISITS

PERCENT (%) OF SERVICES DIRECTED TOWARD ALCOHOLISM

THE IMPACT OF ALCOHOLISM ON ALBUQ. AREA HEALTH SERVICES

U.S. DEPT. OF HEALTH, EDUCATION, & WELFARE
INDIAN HEALTH SERVICE

U.S. PUBLIC HEALTH SERVICE
ALBUQUERQUE AREA



AMBULATORY PATIENT CARE SERVICES TO ALBUQUERQUE AREA POPULATION

U.S. DEPT. OF HEALTH, EDUCATION, & WELFARE
INDIAN HEALTH SERVICE

U.S. PUBLIC HEALTH SERVICE
ALBUQUERQUE AREA

Senator KENNEDY. I would ask perhaps Senator Domenici if he would like to say a word of welcome.

STATEMENT OF HON. PETE V. DOMENICI, A U.S. SENATOR FROM THE STATE OF NEW MEXICO

Senator DOMENICI. Well, Senator Kennedy, I will be brief.

I want to join with our Indian people in welcoming you. They have done that this morning in the meeting with you, but I want to do it publicly. We need your help and support in the many areas of Indian concern. We are all aware of your genuine and abiding interest in the field of health care, and we know that that extends across the spectrum and that it also includes the many and significant health needs of our Indian people.

We hope that once again you leave our State fully aware that while Americans have health problems, the Indian people have the most severe and significant health problems of any group of people living in America. The Indian people, are living examples of our not being able to help as we should.

I want to thank you for help in the past. I want to thank Dr. Emery Johnson for his continued support for our projects in New Mexico.

We are opening two new hospitals, Senator Kennedy; one in Acoma; one in Santa Fe. We have a few more that are high on the priority list. His professionals work hard; they work with us. It is indeed not only good news but great news that the regulations are out on the Indian Health Care Improvement Act, our first effort at comprehensive Indian health delivery. I hope that the regulations will really carry out the effect and that Congress will live up to the commitment made in the words of that act.

I want to close by saying that we in New Mexico are very proud of the first of the new generation of Kennedys—we will have to still call her "No Name," and that sounds pretty good; sounds kind of Indian—will reside in New Mexico. Also, we do thank you, and I appreciate the opportunity to be with you here for a moment. I will not be able to stay for the entire hearing, as you know, but I am glad to be here with you this morning.

Thank you very much. [Applause.]

Senator KENNEDY. Thank you very much, Senator.

Senator Schmitt, if you would like to say a word now.

STATEMENT OF HON. HARRISON H. SCHMITT, A U.S. SENATOR FROM THE STATE OF NEW MEXICO

Senator SCHMITT. Hardly more than a word, Senator.

Again, let me welcome you to what we think is the most beautiful State in the Union. All of us, Indian and non-Indian alike, wish you well in this visit. We know what motivates it. We agree, I think, almost entirely on the nature of the problems that have to be solved. We may find ourselves disagreeing among ourselves on the best way to solve them, but there is no question, as you can witness by the crowd here this morning, that we here in New Mexico have a tremendous concern about health problems, rural health care, and the unique problems of the Indian people.

Washington is not where the real problems are. The real problems are here and elsewhere in this country where people are faced every day with the kind of health problems, the kinds of educational problems, that are going to be discussed with you in this hearing.

I hope that as we try to solve our problems, and invest in what we commonly call "plant," that is, we build a hospital—let's not forget that it takes something to operate it. A hospital without operating funds is just another building, but a hospital with operating funds is something that can truly help people; that can truly go to the core and the heart of the kinds of problems that our friends here today will be discussing with you. So let us not just leave it at the point of having built the hospital.

It is good to have you here, Ethel. I congratulate your family again on a new arrival. We hope that they will decide to become New Mexico citizens now that they have been born in this great State. We allow that, you know. [Laughter.]

You can take up citizenship here any time. I understand that New Mexico is becoming attractive to the number of former politicians and maybe even present politicians. Our friend, Senator Abourezk, told me the other day that he might join us out here in his retirement. He promised not to run against either Domenici or myself. [Laughter.]

I told him not to make any rash promises, that it was never safe in politics.

Thank you again for coming to New Mexico. We are looking forward to more of these discussions. [Applause.]

Senator KENNEDY. We shall start off with Governor Paytiamo; and if he would be kind enough to make his comments and then we will continue with our other witnesses.

I know my colleagues will not be able to remain during the course of the hearing, so they will have to withdraw.

But we appreciate very much their words of welcome and joining with us.

Governor?

STATEMENT OF HON. STANLEY PAYTIAMO, GOVERNOR, ACOMA PUEBLO, ACOMITA, N. MEX.

Governor PAYTIAMO. Thank you very much, Senator.

How is everybody this morning, my Indian people?

I am glad to see that everybody is here.

Senators Domenici, Schmitt, the Indian Health Service, the All Indian Pueblo Council, Chairman Lovato, and officers of the All Indian Pueblo Council, my fellow governors we are glad that we are able to meet on these occasions. There are a lot of things that we would like to say. I will try and summarize my statements so that I can give the opportunity for those Indian people that are here to make some statements that they would like to make; because we have some people that work out in the field and that are really knowledgeable about some of the things that we are concerned about; and I am glad that some of you people are interested; and I hope, Senators, that you will give us support on the House resolution in particular, House Reso-

lution 9054, and any other bills that may come up that may be working against the Indian people.

To start off with, I know that when our Indian elderlies, when they hear this termination bill, I know what they are going to say. I know what statements that they have made.

On the humorous side, to start off, I think that our President is giving some of our land that used to belong to us—especially I am talking about the Panama Canal—as we all know, we are landlords of the whole Western Hemisphere, and I am all in favor of, instead of giving the land back to the people down there, they ought to give it back to us Indians. [Applause.]

I know also that since the—some of our people in Washington are introducing such silly bills that I know our elderlies will also comment and say that I think what we ought to do is send all the blacks back to Africa and all the Europeans back to Europe and let us have our land that used to belong to us.

Senator KENNEDY. Could the Irish stay if we——[Laughter.]

And add that to the treaty?

Senator SCHMITT. If they send the Germans back, I am sorry, the Irish have got to go. [Laughter.]

Governor PAYTIAMO. That is something over on the humorous side. Now, more on the serious side.

My name is Stanley Paytiamo. I am the governor of the Pueblo of Acoma and the chairman of the Ten Southern Pueblo Governors organization.

Your interest in the health and well-being of our Pueblo people is encouraging. In my capacity as the leader of my pueblo, I would like to present the following facts, findings and recommendations:

As the Pueblo people become more involved in the planning and delivery of health-care services, it has become evident that there have been misplaced energies and resources in providing for the health care of the Pueblo people. Evaluation and feasibility studies have done little to improve the direct medical care provided to our people.

The planning effort has been previously guided by the Indian Health Service with little regard for tribal concerns. In our present level of involvement, we have identified and determined major areas of health care which require additional support resources, attention, from this committee.

I would like to at this time say that—and I know that there are going to be some statements made by other people on this subject—and that is the item of the Indian burial services, which is covered under Public Law 94–165.

I know there is a lot of problem in this area, and I will just stop here and other people will also touch on this.

Under facilities construction, the construction of health facilities is an important consideration to our people. The Acoma-Canoncito (Navajo)-Laguna 40-bed hospital facility now under construction on our reservation was funded for construction without operating funds. This problem was alleviated, but the hospital board recently discovered that no major surgical capabilities are incorporated within the facility. This means that all surgical cases will still have to be transported to Albuquerque, 65 miles distant.

The provision of surgical services is a major need and must be considered in future appropriations. This facility will serve approximately 10,000 Pueblo and Navajo people. Also, professional staffing will be difficult for the new facility because of a lack of housing. An earlier agreement between the Acoma Tribe and the Albuquerque Area Indian Health Service stated that Acoma would build 50 housing units and then rent these units to the professional staff. The Albuquerque Area Indian Health Service has reneged on this agreement. We are therefore asking for your support and assistance in obtaining these funds for construction of these units.

The next item is the Albuquerque Indian Hospital.

The Albuquerque Indian Hospital provides inpatient and outpatient services for seven pueblos, two Navajo chapters, students at two Indian schools located in Albuquerque, and also the urban Indian population.

Senator, there has been a deficit in the Indian Health Service funding because of our urban people, or more of our urban are moving to the cities and the only headcount that is made are for those people that are resident. But because of the Indians moving out into Albuquerque area from all areas in the country, there is not enough money to go along. And I would like to see some consideration made on that area. This 54-bed facility is outdated and inadequate. It has only seven examining rooms to serve 100 to 200 patients daily. The average waiting period for a patient is 30 minutes to 3 hours. The staff is overloaded in all areas. Our outpatient services are not available after 4:30 p.m., or on weekends.

Senator, I have been the subject, where I have come to the hospital, bringing my family, and there was no emergency service. As a result, I had to take my daughter all the way to the Indian Health Service in Gallup. And I was lucky that I was able to do this, but considering those people, especially the Indian poor people who do not have the kind of transportation, what if this was the case?

Senator KENNEDY. One of the key problems is the shortage of personnel, and that is, as I understand it, not the Indian Health Service.

Isn't this, Dr. Johnson—don't you run into the—isn't that a key factor in terms of——

Dr. JOHNSON. Yes; this—a number of things that the Governor is talking about we have been over many, many times.

Senator KENNEDY. Fine. Sure.

Dr. JOHNSON. It is a matter of where do you get the resources to provide the service. The staff are more than—not only willing to but anxious to provide the service.

Senator SCHMITT. Senator, there is a problem of how the funds are utilized. I think the Governor is mentioning that at this time, a lot of the funds that would normally go to the more rural Indian population—the indigenous population, by a quirk in the law or regulations, are being used up by this increasing population of urban Indians from all over the country. We need to not neglect either group, but make sure that adequate funds are available for each one.

Is that correct, Governor?

Governor PAYTIAMO. That is correct.

The major areas of concern center about an ever increasing demand for services that has strained the personnel budget and physical plant

to its limits. Because of the above, we recommend a major medical center for the Albuquerque area.

An $18,000 feasibility study has provided the necessary support to implement this facility. This medical center for Albuquerque area is needed to provide a comprehensive approach to quality health care for all Indian people.

Although a system of contract care provides a majority of direct care for these services unavailable through the present Indian Health Service facilities, the cost is staggering. There will not be any method for controlling these rising costs in the next 20 years and it is recommended that the concurrently increasing Indian Health Service contract health care budget be analyzed for possible redirection into the construction of a major referral center for this area. Estimated cost is $45 million.

Another item is the Santa Fe Indian Hospital.

The new 55-bed Santa Fe Indian Hospital has also had its share of problems. Two problems at this point in time are: (1) that funding is not yet released by the Indian Health Service Headquarters for many of the new professional and support personnel positions and (2) most of the new equipment that has been ordered is delayed because it has not been manufactured yet.

Under the subject of the national Indian health insurance, the All Indian Pueblo Council's consensus position is that the Indians should not be included in the basic national health insurance program so that Indians may continue to build their own unique programs.

The Indian Health Service acknowledges the primary role of the Indian people in the planning, development, and delivery of health services to the tribal members. The national health insurance legislation must specifically address, recognize, and preserve the principles of tribal sovereignty and tribal self determination. The Pueblo people are especially concerned in the following areas:

(1) Language contained in any national health insurance legislation must support existing Indian Health Service delivery system for American Indians.

The Indian Health Service must remain the Federal mechanism through which financing and health care delivery is implemented.

The national health insurance legislation must not substitute, replace, or jeopardize services to our Indian people. Financing from Congress must continue to come directly to the Indian Health Service, thereby allowing Indian tribes to build their own health programs.

(2) Pueblo people must be exempted from any compulsory NHI financing charges, should a national health insurance program become a reality. We are recipients of Federal health services because of our unique trust responsibility with the Federal Government and have been exempted from payment for Indian health services.

A majority of the Nation's population does not realize the contributions in natural resources made by the Indian people. Resources such as land and water are considered by the Federal Government to be prepayment for all health care provided.

(3) If a national health insurance program is adopted, any supplemental elements not provided by the Indian Health Service should be incorporated into the Indian Health Service system. I am speaking

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here of the guaranteed benefit package that each person would be entitled to and the prospective funding to implement that guarantee.

(4) Tribal governments must be recognized as appropriate entities for the administration of these health programs. We, the 19 pueblos of New Mexico, have a proven record of being able to conduct our own business. If the national health insurance program is implemented, the tribal governments need to be involved totally in the administration of these programs at the reservation level.

(5) Indian self-determination is also a very important consideration in any national health insurance legislation. Any national health insurance legislation must insure that Indian self determination is not diminished in any way.

Under the Environment Health, in the environmental health areas we have concerns also. Two concerns are:

(1) The need for solid waste disposal systems at the pueblos. Many pueblos have sanitary landfills but the advantages and disadvantages of other waste disposal systems need to be considered.

(2) Water quality is also a problem of the reservation. Two major problems areas are: the content of hard minerals within the water and the lack of sufficient water. Senator, in fact, we went to one of the pueblos just recently and the water was so hard that the water corroded the system, and when we took a bath, we thought it was going to come out red. [Laughter.]

Under Public Law 93–638, the Indian Self-Determination and Education Assistance Act provides the opportunity for all our people to assume more responsibility for their health. Yet, there is agency backlash in its implementation.

Contracts and grant mechanisms were not fully explained prior to implementation. I think in some areas that the Indian people knew more about Public Law 93–638 than those who were the funding agencies. Tribal contractors are flooded with technicalities which delay and confuse, rather than assist, in the self-determination process.

There is a lack of leadership at the Albuquerque Area Indian Health Service in regard to Public Law 93–638. The law became effective approximately 2 years ago. The first formal training session provided by the Indian Health Service was during the first week of November of this year. The rules and regulations of Public Law 93–638 have been misinterpreted by the Indian Health Service field staff on several occasions.

When funds became available under Public Law 93–638, there were very few Pueblo Indians placed in position at the Indian Health Service area office. These Pueblo people would have been trained in all phases of Public Law 93–638. They, in turn, would provide training to the Pueblo people.

Most of the Indian Health Service personnel in these positions are non-Pueblo Indians or non-Indians. And we would like to see a lot of our Indian people from this area fit into those positions because, after all, the Pueblo people are going to be the only ones that are going to be running the programs.

We do not like to see the people from other areas coming here because after they get that training we are going to lose all of that. At least,

if the Pueblo people from this area were trained, at least these people are going to be here.

In summary, I would like to recommend that a closer look at the tribal-Indian Health Services, Bureau of Indian Affairs, relationship be analyzed. In order to achieve the goal of self-determination, these things must occur:

1. The role of the tribe, the Bureau of Indian Affairs, Indian Health Service, must be defined;

2. Cooperation between agencies and tribes must be effected; and

3. The United States must stand firm in its commitment to the Pueblo people and all Indian people of our country.

Senator, I know that there are other Pueblo governors here. I know that the statement that I have made has been very general, and I wish I could—and you have a copy of this?

I wish we could go right through all of these documents and make some comments on it individually. I know the governors will be making other detailed, specific points that apply to them in different areas, and we do have some of the other health boards here and they will also be making some other more specific points.

I will be glad to answer any questions, if you have any, Senator.

Senator KENNEDY. Thank you very much.

We will include your statement in its entirety in the record in the supplementary information, which we will obviously take back with us and have a chance to get into with a careful review.

I think, with regard to the health insurance legislation, what I would like to do is have someone on my staff come out and spend some time with the Pueblos and go over the details of this particular concern, and then we will take that back and work with the administration on this.

But I think we have got some very important recommendations which I think it is very important to get in at the very earliest level. We will have someone come out here and sit down with you people and go over in great detail those particular provisions. What I would like to do is see if we could go through with the witnesses and come back to some of the general questions, and we will include the statement in its entirely.

[The prepared statement of Governor Paytiamo follows:]

IN REPLY REFER TO:

PUEBLO DE ACOMA

"THE SKY CITY"
P. O. Box 309
ACOMITA, NEW MEXICO 87034

OFFICE OF THE GOVERNOR

TELEPHONE 552-6606

STATEMENT
OF
GOVERNOR STANLEY PAYTIAMO OF ACOMA
ON BEHALF OF THE NINETEEN PUEBLOS
BEFORE
SENATOR TED KENNEDY, CHAIRMAN
SENATE SUBCOMMITTEE ON HEALTH
NOVEMBER 11, 1977
ISLETA PUEBLO, NEW MEXICO

My name is Stanley Paytiamo, I am the Governor of the Pueblo of Acoma. Chairman, Ten Southern Pueblo Governor's. Your interest in the health and well being of our Pueblo people is encouraging. In my capacity as the leader of my Pueblo I would like to present the following facts, findings and recommendations.

As the Pueblo people become more involved in the planning and delivery of health care services, it has become evident that there have been misplaced energies and resources in providing for the health care of the Publoe people. Evaluation and feasibility studies have done little to improve the direct medical care provided to our people. The planning effort has been previously guided by the Indian Health Service, with little regard for tribal concerns. In our present level of involvement, we have identified and determined major areas of health care which requires additional support resources, attention from this committee.

Facilities Construction: The Construction of Health Facilities is an important consideration to our people. The new Acoma - Canoncito (Navajo) - Laguna 40-bed hospital facility now under construction on our reservation was funded for construction without operational funds. This problem was

alleviated, but the hospital board recently discovered that no major surgical capabilities are incorporated within the facility. This means that all surgical cases will still have to be transported to Albuquerque, 65 miles distant. The provision of surgical services is a major need and must be considered in future appropriations. This facility will serve approximately 10,000 Pueblo and Navajo. Also, provessional staffing will be difficulty for the new facility because of the lack of housing. An earlier agreement between the Acoma tribe and Albuquerque Area Indian Health Service stated that Acoma would build 50 housing units and then rent these units to the professional staff. The Albuquerque Area Indian Health Service has reneged on this agreement. We are therefore, asking for your support and assist in obtaining funds for construction of the units. (attached Resolution No. TC-OCT-19-77)

Albuquerque Indian Hospital

The Albuquerque Indian Hospital provides inpatient and outpatient services for seven Pueblos, two Navajo Chapters, students at two Indian schools located in Albuquerque, and also the urban Indian population.

This 54-bed facility is outdated and inadequate. It has only 7 examining rooms to serve 100 - 200 patients daily, the average wating period for a patient is 30 minutes to 3 hours; the staff is overloaded in all areas. Out-patient services are not available after 4:30 pm or on weekends. Outpatient utilization has increased rapidly since the facility was opened (from 3,648 in FY 1971 to 31,431 in FY 1976). The major areas of concern center about an ever increasing demand for services that has strained the personnel, budget and physical plant to its limits. Because of the facts above, we recommend a major medical center for the Albuquerque Area. An $18,000 feasibility study has provided the necessary support to implement this facility. This medical

center for the Albuquerque Area is needed to provide a comprehensive approach to quality health care for all Indian people. Although a system of contract care provides a majority of direct care for these services unavilable through the present IHS facilities, the cost is staggering. There will not be any method of controlling these rising costs in the next 20 years and it is recommended that the concurrently increasing IHS contract health care budge be analyzed for possible redirection into the contruction of a major referal center for this area. Estimated costs is 45 million dollars.

Santa Fe Indian Hospital

The new 55 bed Santa Fe Indian Hospital has also had its share of problems. Two problems at this point in time are: (1) that funding is not yet released by the Indian Health Service Headquarters for many of the new professional and support personnel positions, and (2) must of the new equipment that has been ordered is delayed because it has not been manufactured.

National Health Insurance

The All Indian Pueblo Council's consensus position is that Indians should not be included in the basic National Health Insurance program, so that Indians may continue to build their own unique health programs. The Indian Health Service acknowledges the primary role of Pueblo people in the planning, development and delivery of health services to tribal members. The National Health Insurance legislation must specifically address, recognize and preserve the principles of tribal soverignty and tribal self-determination.
The Pueblo people are especially concerned in the following five areas:

1. Languate contained in any National Health Insurance legislation must support the existing Indian Health Service delivery system for American Indians. The Indian Health Service must remain the federal mechanism through which

financing and health care delivery is implemented. The National Health Insurance legislation must not substitute, replace, or jopardize services to our Indian people. Financing from Congress must continue to come directly to the Indian Health Service, Thereby allowing Indian tribes to build their own health programs.

2. Pueblo people must be exempted from any compulsory NHI financing charges, should a National Health Insurance program become a reality. We are recipients of federal health services because of our unique trust relationship with the federal government and have been exempted from payment for IHS services. A majority of the nation's population does not realize the contributions in natural resources made by the Indian people. Resources such as land and water are considered by the federal government to be prepayment for all health care provided.

3. If a National Health Insurance program is adopted, any supplemental elements not provided by the Indian Health Service should be incorporated into IHS system. I am speaking here of the guaranteed benefit package that each person would be entitled to and the prospective funding to implement that guarantee.

4. Tribal governments must be recognized as appropriate entities for the administration of health programs. We, the 19 Pueblos of New Mexico, have a proven record of being able to conduct our own business. If the NHI program is implemented, the tribal governments need to be involved totally in the administration of these programs at the reservation level.

5. Indian Self-Determination is also a very important consideration in any NHI legislation, there, any NHI legislation must insure that Indian Self-Determination is not diminished in any way.

Environmental Health

In the environmental health areas we have concerns also. Two concerns are:

1. The need for solid waste disposal systems at the Pueblos. Many Pueblos have sanitary landfills bur the advantages and disadvantages of other waste disposal system need to be considered.

2. Water quality is also a problem on Pueblo reservations. Two major problem areas are the content of hard minerals within the water and the lack of sufficient water resources.

Public Law 93-638

Public Law 93-638, the Indian Self-Determination and Education Assistance Act, provides the opportunities for our people to assume more responsibility for their health. Yet there is agency backlash in its implementation, contracts and grant mechanisms were not fully explained prior to implementation. Tribal contractors are flooded with technicalities which delay and confuse rather than assist in the self-determination process.

There is a lack of leadership at the Albuquerque Area Indian Health Service in regard to Public Law 93-638. The law became effective approximately two years ago. The first formal training session provided by IHS was during the first week of November, 1977.

The fules and regulations of P.L. 93-638 have been misinterpreted by the IHS field staff on several occassions.

When funds became available under P.L.93-638 there were few Pueblo Indians placed in positions at the IHS Area Office. These Pueblo people would have been trained in all phases of P.L. 93-638, they in turn would provide training to the Pueblo people. Most of the IHS personnel in these position are Non-Pueblo Indians of Non-Indians. In summary, I would like to recommend that a closer look at the tribal-Indian Health Service - Bureau of Indian Affairs relationship

be analyzed. In order to achieve the goal of self-determination these things must occure: (1) The role of the tribe, the Bureau of Indian Affairs, Indian Health Service must be defined. (2) Cooperation between agencies and tribes must be effected. (3) The United States must stand firm in its commitment to the Pueblo people and all Indian people of our country.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

TO : Director, Indian Health Service

DATE: November 7, 1977

FROM : Director, Albuquerque Area
Indian Health Service

SUBJECT: Acoma Tribe's desire to Guaranteed Lease of Proposed Housing for Acoma, Laguna, Canoncito Hospital.

Please find attached a resolution passed by the Tribal Council of the Acoma Pueblo, which indicates a definite desire to lease 25 units instead of the original 50 units to the Government under conditions of Title 7 of PL94-437.

As indicated by the Resolution the only way the Tribe does desire to lease is if they can make a reasonable return on their money as they are currently realizing by investment in long term certificates of deposit.

T. J. Harwood

cc & Enclosure
Will Frazier
Harold Savage
Dr. Robert Vanderwagen
Governor, Stanley Paytiamo
Arturo Ortega, Law Offices

LAW OFFICES
ORTEGA AND SNEAD

ARTURO G. ORTEGA
WILLIAM E. SNEAD

CHARLES P. REYNOLDS
MICHAEL D. BUSTAMANTE

TWO HUNDRED ONE TWELFTH STREET, N.W.
POST OFFICE BOX 2226
ALBUQUERQUE, NEW MEXICO 87103
TELEPHONE (505) 842-8177

October 28, 1977

George Fries
U.S.P.H.S./I.H.S.
Room 4005
500 Gold Avenue SW
Albuquerque, New Mexico 87101

Re: Pueblo Of Acoma-Resolution /

Dear Mr. Fries:

Enclosed please find original of Resolution in the above cause.

Very truly yours,

Charles P. Reynolds

CHARLES P. REYNOLDS
Attorney at Law

CPR/dm
Enclosure (1)

PUEBLO OF ACOMA
P.O. Box 309
Acomita, , New Mexico 87034
Telephone 552-6606

RESOLUTION

No.TC-Oct-19-77

At a duly called meeting of the Acoma Tribal Council, held on the 19th day of October, 1977, the following resolution was adopted:

WHEREAS, the Pueblo of Acoma has received information from the Director of the Indian Health Service, Health Services Administration, Public Health Service, United States Department of Health, Education, and Welfare, that the Indian Health Service will support a supplemental request to the Congress of the United States for funds to construct quarters at Acomita, New Mexico for the personnel to be employed at the Acoma-Canoncito-Laguna Indian Health Services Hospital, because of the difficulties encountered by the Pueblo of Acoma for construction of these quarters and;

WHEREAS, the Indian Health Service has requested that the Pueblo of Acoma provide IHS with a justification for the request including facts concerning the lack of adequate housing in Acomita and surrounding areas such as San Fidel, Grants, McCarty's and Cubero, and;

WHEREAS, the Indian Health Service has requested clearance from the Tribal Council to investigate the possibility of entering into a lease-guarantee arrangement whereby the Pueblo of Acoma would be guaranteed a fair return on their investment into the construction of housing quarters;

NOW THEREFORE BE IT RESOLVED, that the Tribal Council direct the Tribal Attorney to prepare the justification requested by the Indian Health Services to support the supplemental requests to the Congress of the United States for quarters at Acomita for the Acoma-Canoncito-Laguna Indian Health Services hospital personnel.

BE IT FURTHER RESOLVED, that the Pueblo of Acoma Tribal Council hereby gives clearance to the Indian Health Service to explore the possibility of entering into a guaranteed lease arrangement, provided, however, that the Pueblo of Acoma will be able to construct only twenty-five (25) units of housing under such a guaranteed lease arrangement should it be entered into.

Governor, Pueblo de Acoma

1st. Lieutenant Governor

2nd Lieutenant Governor

Head Councilman

Councilman

Councilman

ATTEST:

Secretary, Pueblo de Acoma

CERTIFICATION

The foregoing resolution was duly adopted by the Acoma Tribal Council, at a regular meeting held on the 19th day of October, 1977 at the Acoma Tribal Council Room at which 12 members voted for, 0 members voted against, and 0 members abstained from voting.

Stanley Paytiamo
GOVERNOR STANLEY PAYTIAMO

ATTEST:
CONROY CHINO, Secretary
PUEBLO OF ACOMA

Senator KENNEDY. Paul Bernal is vice chairman, All Indian Pueblo Council.

Paul?

STATEMENT OF PAUL BERNAL, VICE CHAIRMAN, ALL INDIAN PUEBLO COUNCIL

Mr. BERNAL. Senator, I will read the following statement prepared by the All Indian Pueblo Council:

Senator Kennedy, my name is Paul Bernal. I am the vice chairman of the All Indian Pueblo Council, Inc., and a member of Taos Pueblo. My Governor is here with me.

Senator Kennedy, we certainly do appreciate your time coming over and we wish you well, your new Kennedy family, and also we wish the youngsters, as they become old as we are, maybe older than we are, they get acquainted with Indian problems.

I would like to give you the summary because my colleague over here has spoken, not touching many areas that—which are pertinent to Indian health that we have in the State of Mexico among the Pueblo Indians.

Our common objective is quality health care that is comprehensive in approach, and responsive to our needs. Our needs do not focus just on more money. We realize that utilization of resources is a vital aspect of health-care operations. We also understand that a coordinated system is required to provide comprehensive health care.

Within this context, we consider the development of additional resources—funds, manpower, facilities—a high priority; but do not forget that the effective use of resources mandate the involvement of those people served, in this case the Pueblo people. As part of the self-determination process we have identified particular health problems and barriers to good health for all our pueblos. I would like to address these issues today.

1. Public Law 94–437, the Indian Health Care Improvement Act: Since its enactment into law in 1976, we have been waiting for $145 million authorized for the first year of the program. To date, we have not even seen the publication of the final regulations. As a result, the funds appropriated in fiscal year 1978 budget cannot be spent for much-needed services and facilities.

2. Contract medical care: Due to inadequate staff, facilities, and funding, many of the services IHS cannot provide directly to Indian people are provided through contracts with private physicians and hospitals. These services generally include dental care, eye care, and surgical care. While the services provided are satisfactory, the funding is totally inadequate. In some cases, Indian patients must wait several weeks and up to months for appointments. If services must be contracted out, then sufficient funds should be provided for adequate service.

3. Manpower: Professional personnel are becoming harder and harder to find and keep. There is a shortage of Indian paraprofessionals. Although there is training available at various agencies and institutions, they are fragmented. These types of programs must be coordinated and the Indian Health Service should lead the way in effecting these relationships. Developing Pueblo professionals, job

placement efforts, and a clearinghouse for Indian health manpower are additional areas which need to be improved.

4. Alcoholism and drug abuse: Alcoholism is a great health problem within our communities. While a great impact is being made by special alcoholism projects such as detoxification programs, halfway houses, and counseling programs, funds and qualified personnel are becoming scarce. Problems of drug abuse evolve in much the same manner as alcoholism problems.

5. Other health needs:

(*a*) Emergency medical services: Emergency medical services are limited in scope and fragmented in effort. There are no funds for training tribal members and no funds for developing emergency medical services systems—vehicles, personnel, communications.

(*b*) Preventive health service: Preventive health services must be expanded to provide community awareness, home health assistance, coordinated screening clinic, immunization system and educational programs in child abuse.

(*c*) Elderly care: The young and the elderly people of the pueblo are a most valuable asset. Experience in trying to receive adequate medical care has been frustrating to our elderly. Most important, the elderly do not have an advocate for their individual and collective needs.

The Bureau of Indian Affairs and Indian Health Service are established specifically for the provision of services to Pueblo people. Why cannot these agencies work together in bringing about more efficient, effective services? Instead, they compete for funds and programs, disregarding Indian concerns. As with all people, health and medical care for the Pueblo elderly is a right and not a privilege.

(*d*) General medical services: While some improvements have been made in the health care of American Indians, the demand and needs far exceed available services, facilities and resources. Services for dental care are limited to extraction in many cases. Dentures and orthodontic care is nonexistent. The same is true in eye-care services. The surgical needs of many patients must wait because of inadequate funding or lack of facilities.

These require the facilities I have been mentioning to you, Senator, that today we are waiting, we have been waiting too long, and I think that we are compelled to wait much longer. I, for one, have been speaking in behalf of the All Indian Pueblo Council more than 15 years in health improvement. I have been to Washington and testified before the corporation committee, and tried to increase the Indian Health Service Corporation.

We have been doing the same thing—the Acoma-Laguna Hospital and the Santa Fe Indian Hospital. The All Indian Pueblo Council and the Indian leaders implement their thought and their words to be carried out and honored and keep them alive in records, and not to put up on the shelf No. 13 over there and forget it.

And I do not think that is the way the American Indian should be treated. And we talk about paper talks. We tell you and we expect ourself what we want the U.S. Government—remind them of their responsibility to the Indian people. This has kind of been a forgotten thing—a forgotten pattern that we have been experiencing.

We are talking about Public Law 93–638. Too much technical assistance has been provided, but there is not enough money to play with.

We got to play with money and at the same time, we have got to provide technical assistance. Two things make a quality service—contract medical care services.

The All Indian Pueblo Council and other Indian tribes in the State of New Mexico have great desire to see this facility come up, and today, that Santa Fe Indian Hospital is taking space, is still prolonging. The construction is there, the wall is there, the roof is up, but we are facing a shortage of the money. Like someone said, you have got to have money to get the function of the things going.

We need your assistance. We have asked you to provide funds to get these two facilities to get to use as soon as possible.

Some of the things that have been mentioned, that the Intertribal Health Authority and the All Indian Pueblo Council, that the two facilities, because of lack of money, that they cannot complete those hospitals this year. Maybe another 6 months, maybe another year again.

Senator Schmitt is here, from the State of New Mexico. I am pretty sure that he is acquainted with the kind of health problems that we have. I do think that the Indian people in the State of New Mexico are entitled to live in a good place, entitled to receive the first-class medical care and up-to-date medical capabilities—new medicine, new equipment.

I think we as human beings not to be treated as such. For many, many years, that I know of, calling attention to Dr. Emery Johnson, about Santa Fe Indian Hospital—used to be only one lavatory for men and only one lavatory for women. I was a patient one time and we had to stand in line to go into these lavatories.

I think that kind of treatment is incredible. Sorry about this, but there comes a time that we become a little bit emotional, sir.

We do have alcoholic problems. Indian Health Service is not able to provide sufficient service for alcoholic prevention programs. So the Indian himself is not able—if you can be able to come on and help us on that, we do appreciate it.

Our elders need facilities. These are the people who were the one-time constitutional body in our area; these are the ones become idle and sent back home. When there is no facilities available at the community level, they have been sent to the homes—places where they had been kept alive. I do feel that the senior citizens should be treated equal.

Senators, we need your help in that area.

I have only one copy of this statement. I certainly appreciate it. Thank you in behalf of All Indian Pueblo Council for your time and effort.

Thank you, sir. [Applause.]

Senator KENNEDY. Thank you, Paul.

Ernest Jaramillo is the second lieutenant governor of Isleta Pueblo.

Ernest?

STATEMENT OF ERNEST JARAMILLO, SECOND LIEUTENANT GOVERNOR, ISLETA PUEBLO

Mr. JARAMILLO. Senator Kennedy, Senator Schmitt, other distinguished guests:

Let me welcome you to the Pueblo Isleta. And certainly the rest of the people that are here today, let me welcome everyone to the Pueblo Isleta. I am Lt. Gov. Ernest C. Jaramillio, Isleta Pueblo.

First, let me express our gratitude for the health services that have been provided for my Pueblo throughout the years. Along with my expressions of gratitude for the health services come the concerns of inadequacies in our Indian Health Services because of a lack of communication between the Indian Health Service and the various Indian communities.

This communication I speak of must be established and strengthened if the Federal Government is to fulfill its obligations in accordance with the dictates of the Indian Health Act, which specifically states that Congress, through the Indian Health Service, must provide for maximum Indian participation in all health programs and services conducted by the Federal Government.

In the recent past, we have had difficulty in negotiating contracts to provide community health services to our people—a seemingly simple task. However, we have been met with attitudes that seem to offer an atmosphere of austerity that contributes to the impediment of our programs. Cutbacks in funds is usually the reason given us, although we never know if this is really the case or not.

On the other hand, our quest for funds is based on need, and I emphasize "need" simply because we do need what we ask for.

Our figures are not padded nor are they theorized. It is simply need. This may be corrected in the appropriations and allotments that can be provided through Congress.

And let me point out an article in the newspaper that I read recently, where a man back East, by the name of Rockefeller, evidently sold 25 acres of land for development at the nominal fee of $5.5 million for residential development. And some groups in Washington found out that the cost of homes that were to be built in this area was in the neighborhood of $300,000 per unit. And these people snubbed their noses at these houses. And I am wondering what kind of people we have that live back East that would be shocked at such a shanty.

In our health clinic—it is a beautiful facility. It is well built structurally. However, we are lacking in the professional doctors and dentists that are needed to take care of the health needs of our people. These doctors must be assigned if the facility is to reach its optimum effectiveness and if it is to provide the education to our people for the improvement of our health standards.

Alcoholism is our No. 1 health problem; 95 percent of our criminal cases in tribal court stem from alcohol and drug abuse. Thanks to our American progress, we are in the middle of the greatest construction boom in the Southwest. It has brought with it the drug traffic that threatens our most important recourse—our youth.

With alcohol and drugs, both easily obtainable, staring our kids in the face, most fall prey to them than not. It is for this reason we desperately need professional counseling and treatment facilities right here, where the problem breeds. Even the Bureau of Indian Affairs Law Enforcement Agency in lackadaisical in the law enforcement assistance in this matter of legal complications.

We have sent a proposal in to the Public Health Service to fight these alcohol problems and drug abuse problems. For at least 6 or 7

months now we have had no response as to whether it is a good idea, a bad idea, it is not worth anything, no funds available, or nothing. We have had no response at all.

Alcohol and drug abuse has brought about mental health cases. Many cases that have been referred to the Mental Health Division of our Indian Health Service for psychological evaluation from our tribal courts because of criminal acts stemming from alcohol and drug abuse——

Senator KENNEDY. Maybe I would ask Dr. Johnson, have you received the correspondence on these requests, in terms of alcoholism and——

Dr. JOHNSON. Yes; Senator.

The issue on alcoholism, as you may recall, 1 year ago, Congress made a decision to change the way in which Indian alcohol programs were being handled.

Up until the present time, all Indian alcohol programs are funded by the National Institute on Alcohol Abuse and Alcoholism, which is not the Indian Health Service.

Congress, recognizing that the NIAAA approach, which says that after a period of 6 years, the funding is to be taken over by State and local government, recognize that this was not a rational input for Indian alcohol programs.

So beginning this June of this next year, the Indian Health Service will begin to fund those projects originally started by NIAAA. which have received years of NIAAA funding.

However, under the agreement reached within the Congress between the various—the two committees, the responsibility for funding new projects remains with the National Institute of Alcohol Abuse and Alcoholism. And we have been working with Dr. Ernest Melville, who is the director of the institute; as a matter of fact, I met with him just 1 week ago to try to sort out some of the responsibilities between the two agencies and to get an assurance from the National Institute that their support for starting new Indian alcohol programs and innovations and expansions will continue. And we will keep you advised as this goes on.

But that would be the mechanism through which the project that he is talking about would be funded—through the National Institute on Alcohol Abuse and Alcoholism.

Senator KENNEDY. Does it make a great deal of sense for one agency to start it and go for a certain period of time and then turn it over to the other agency?

Dr. JOHNSON. Well, I——

Senator KENNEDY. I don't want to get far away from the point, but I am just wondering.

Dr. JOHNSON. I think it is sort of a, you know, lesser of several evils. One is that the administration felt that you could not, in the National Institute on Alcoholism, support Indian projects at 100-percent levels of Federal financing indefinitely.

When the legislation—and the intent of that legislation—is to have a Federal startup and then a gradually spinning off of those to other funding sources, basically State and local government.

And what really has happened here is they have substituted the Indian Health Service as that State and local governments funding

source. So I think it is consistent in that sense, Senator. We could go with this either way. I have thoughts on both sides of this.

Senator SCHMITT. Senator——

Senator KENNEDY. I wonder if you would continue it and find out—just before yielding—I would be glad to inquire where this is now. We will be back in touch with you.

Mr. JARAMILLO. Thank you, Senator.

Senator SCHMITT. Senator, I think this discussion of alcoholism is the tip of the iceberg of the core of the solution to a great deal of Indian health problems and health problems throughout the country. Prevention—disease and injury prevention—could be the solution to our health problems.

Most of what we have talked about so far this morning has been about health care. That is extremely important. One reason we have to talk about it is that people get sick and they get hurt. If we can start to focus a good deal of our attention also on the prevention of injury and the prevention of disease, we will start to see some of these other health-care costs come under control and the needs come under control. I think that that is what Mr. Jaramillo is talking about when he talks about alcoholism. It is a cause of disease and other disease and other injury.

It is a disease in itself, and must be treated as such. There are many other such situations that affect the Indian people where, if we can focus some more attention on prevention, we will have solved a great deal of the problems of health care. I hope that this hearing will continue to explore those two sides of the issue—prevention and care.

Thank you.

Mr. JARAMILLO. We have also been met with negativism from the Mental Health Division when the patients are referred from our tribal courts to the mental health facilities; they are met with negativism.

These people need evaluation, psychological evaluation. However, the public health service has refused on numerous instances to accept these patients for psychological evaluation. And I would hope that they recognize our tribal court orders and recognize the need for such evaluation when they are brought into the mental facilities. Negativism breeds contempt. Contempt breeds dissension and dissension brings total failure.

The mechanism for the proper administration of the Indian Health Service is there, but we have got to work together. Just as in any other organization, communication—the lines of communication is the first link between two agencies that hope to accomplish any kind of noteworthy results in their endeavors.

That is all I have, sir.

Senator KENNEDY. Fine. Agnes Dill, Isleta Pueblo.

STATEMENT OF AGNES DILL, ISLETA PUEBLO

Mrs. DILL. First of all, I want to congratulate Senator Kennedy upon being the first uncle here in New Mexico of the Kennedys, and Mrs. Kennedy on being the first grandmother in New Mexico. And I think, since you are in Isleta, that you should name your baby after an Isleta name. [Laughter.]

I have been asked, and I see I am the only female here and I am very glad of that——[Laughter.]

I have been asked by our governor to testify today on the health status of the Isleta Pueblo. Any discussion of health problems includes health needs and health resources available to meet these needs. So I shall try in the few minutes alloted to me to relate some of the specifics. Since some of the general things have been related, I will try to relate some of the specifics.

In talking with some of the people within the pueblo and with the health clinic and other programs here, I have discovered a few things that needed to be brought to the attention of this meeting.

First of all, I have the Isleta Clinic.

Isleta people are appreciative of the much-needed health clinic and the improvement in clinical services. However, there are still a lot of shortages which prevent adequate services to the people. There is a great need for more staffing and equipment. I know there is going to be some overlapping here, but nevertheless this will emphasize the things that are needed here.

One doctor serves 4 days a week; one nurse who also serves triple duties as a laboratory technician and a pharmacist; and a nurse's aide who also does custodial services between patients because there is no custodial services within the clinic. There is one nurse-practitioner who serves 2 days a week—this is mainly for women—but could spend more time if she did not have to go to the other pueblos. This is a woman practitioner, as I said, which deals with women's health problems, which is very much needed.

Government regulations of hiring need to be changed to allow the hiring of more personnel, as there is a limitation on the number of people to be hired. This came from Dr. Kotomori yesterday. There is a need for more laboratory facilities and X-ray units, plus personnel to operate this phase.

Patients have to be transported to Albuquerque Indian Hospital and to the BCMC Hospital, which creates problems for patients, especially those who cannot be moved very well. More funding is needed to meet these needs as well as more training of Indian doctors, nurses, technicians, et cetera, and hiring of qualified Indian personnel.

Then the number of people requiring dental services has increased markedly and there is a tremendous need for more personnel. There is one dentist, also, who operates 4 days a week in Isleta Clinic with one dental assistant. This is a great need for funds.

There is a great need for funds to contract for orthodontic services for children—that is for braces and denture work for children; because we do have some children who do need braces. There is a cost of $2,000 per patient for braces, and there are no funds at all available for children who are needing this service.

The Indian hospital in Albuquerque was once a tubercular hospital, built in the late 1930's, and is very old and inadequate for today's health care.

Personnel and equipment is inadequate for inpatient care as well as outpatient care. There is a definite growth of outpatients.

In 1972, according to figures, there were only 40 patients a day. This was given to me by one of the doctors. In 1977, there are 150 patients to 200 patients and, according to statistics, there are more

Isleta people using this hospital than any other Pueblo Tribe. And, of course, as has been said already, there are a lot of urban Indians who prevent some of our reservation Indians from getting services.

There are not enough examining rooms. A proposal has been written to provide for new facilities, including 16 examining rooms instead of the 6 now in use. And I guess this is where the students are examined; I don't know. But I know that I have been there and I have seen these overcrowded conditions. According to these observations, there is a need for much improvement. Isleta people would recommend a new hospital for pueblos to meet the needs of our Indian people.

More funding and training is needed also to operate these facilities in operation now. Unless we can get a hospital soon, then we do not have to worry about these old facilities.

CONTRACT HOSPITAL SERVICES

Medical funds are constantly inadequate—they are consistently inadequate. A very crucial period is the last quarter of the fiscal year when only dire emergencies can be taken care of. Increased funds are needed for inpatient care and ambulatory care. Patients are made to wait long hours, sometimes all day, before services are rendered at the Bernalillo County Medical Center as well as the Indian hospital.

The first priority set by the Indian Health Service is for school children to get dental and eye services. Because of the lack of funds, adults are serviced only in case of emergencies. Therefore, there is a great need also for funds for adult programs in dental and eye care.

ENVIRONMENTAL HEALTH

Isletans are fortunate in having sewage and water systems and other conveniences, including automobiles. These have created health hazards which call for certain needs: Improvement in sewage and water systems, accident prevention and an orientation and training program for the people.

Many people suffer from sinus and respiratory infection due to the dust pollution created by the many cars on the dirt roads in the pueblo. There is a great need for paved roads or streets and the main thoroughfares but, again, there is no funding for this.

Alcoholism has already been mentioned. It is still one of the leading health problems. Drugs, marijuana and sniffing among young people is becoming quite prevalent, with all the things that Ernest mentioned. There is a great need for a strong program in the areas of prevention, counseling, et cetera.

And, last but not least, our senior citizens, or the elderly.

According to statistics, there are 339 senior citizens here from ages 55 to 75 years plus. There is a senior citizens' feeding program and a very limited arts and crafts program attended by 12 elderly ladies at the present time. I visited them yesterday when I was trying to get some information on senior citizens. They have a very nice lunch program, but there are still a lot of citizens; as you see, 339, and only 12 of them are taken care of in the room right next door here. There is much that can be said as to the needs of the elderly, but since this is a health hearing, this is what we will deal with here.

There have never been enough funds for the care of diseases for the aged or sufficient funds to meet the total health needs. Each Indian health service should implement programs for geriatric medical care. There are no Indian professionals to give medical services to the elderly.

The major problem in Isleta, as the people told me—the ladies told me, is a lack of transportation to take people to clinics, hospitals and wherever they want to go. Many of the elderly have expressed the desire to have a nursing or sheltered-care facility right here in the pueblo. More and more of our elderly are needing this type of care facility.

But Indian people have very little chance of obtaining these facilities. States refuse to license nursing homes on reservations due to the question of jurisdiction, and the Federal funds are not authorized unless the facilities are licensed by the State. Federal funds should be made available directly to Indian tribes for the operation of such homes on the pueblo level and regulations of the Government should be changed.

These are some of the things, Senator, that I picked up from the people themselves and put them down in here and some of my own observations. And we are very thankful that you are here today and we really do need your support.

Thank you. [Applause.]

Senator KENNEDY. Thank you.

I learned this morning that this clinic in effect was just operated out of a living room here in the pueblo, a little over 1 year ago; is that right?

Mrs. DILL. Yes; that is right.

Senator KENNEDY. And now it is an important addition to the pueblo. But I think, as you point out, the understaffing and the tremendous demands upon the people in that center reminds us of our responsibilities to insure adequate staffing.

And I think this has been something that has been talked about earlier in the hearing—the time, the delay, the increase in outpatient utilization and still there has not been the corresponding increase in terms of personnel in the Albuquerque facility and other factors.

Why do not we keep moving and then we will come back to some questions.

Mr. Kotomori, the service unit director, the Albuquerque Service Unit, Indian Health Service.

STATEMENT OF RICHARD KOTOMORI, SERVICE UNIT DIRECTOR, ALBUQUERQUE SERVICE UNIT, INDIAN HEALTH SERVICE

Dr. KOTOMORI. I also would like to congratulate you and Ethel on the new addition to your line. I would like to thank you and Senator Schmitt for allowing me to speak and present my views of the Indian Health Service from the direct-care level—from the frontline, so to speak.

We have heard testimony from several individuals here about the shortcomings in the Indian Health Service health-care system. I think the fact that these shortcomings are recognized are evidence of the

fact that the Indian Health Service has been a viable force as far as health-care is concerned within the communities.

The seed of health awareness has been planted and now we are reaping an unexpected harvest—a demand for complete, qualified services by an informed populace.

The Indian Health Service has contracted indigenous health workers—community health representatives—to form an outreach task within the community. They have done their job. Case finding and identification has increased and this has, again, increased the demand on the Indian Health Service facilities.

They spoke of the waiting time, the lack of funds, the lack of personnel. This is all true. It exists within most of our community clinics and especially at the Albuquerque Indian Hospital. I do not know whether you could say we created a monster or perhaps a force for improved medical care within the Indian population.

The CHR will find the patients in need of care. They are then referred to our facility. When they hit our system they are met by a 2- to 3-hour wait in our waiting room. If they need any contract health service care, they will be sent out if they are an emergency. Depending on the part of the funding cycle during the year, if they have an elective procedure to be done, or they have to see a contract specialist, this will be deferred to the following fiscal year.

Lieutenant Governor Jaramillo mentioned a case about a mental health patient that we were unable to fund. This probably occurred during the last quarter of the fiscal year when we had no funds. When my financial management officer is calling me, saying, "We have no funds; you have to restrict services." We generally restrict services to nothing but emergency medical care at that time.

The shortfall on contract care funds is evident by the graph over there, which demonstrates that we have approximately a 30-percent shortfall. Interestingly enough, that graph was drawn during fiscal year 1976, and the amount of projected need was just about what we spent in fiscal year 1977.

The reason for the waiting times here, again, is evident by the graph on the ambulatory patient-care services.

Indian people are demanding more in the way of medical services. They expect to receive this. They have been told by the CHR's that we are available and can provide the service. However, the staffing of the Indian Health Service facilities are extremely limited.

Agnes mentioned the fact that she had called me yesterday about why the staff number is limited. I tried to explain the position-ceiling concept to her. This is extremely difficult to do.

My own physicians cannot even understand the position-ceiling concept. We feel that if there is a need, if we are seeing more patients, then all you should do is hire more people to meet the need. We can see if we were not doing the job, or did not have the demand, that perhaps you could reduce services—zero-based budgeting, I think they call it.

However, we are continually being met with an increased demand and we are being advised to reprogram, redirect, reorganize, find some other way of giving services with less and less. This is poor for staff morale as well as for the quality of medical services we are giving.

Staff morale at the Albuquerque Indian Hospital has dropped to an all-time low, as evidenced by a recent union election that took place.

In the past, the union was rejected on two previous occasions. In the last election, they won in a two-to-one vote. And this I think is a reflection of job dissatisfaction. You can get just so much work out of individuals. You can reprogram, redirect just so much, and then they reach the breaking point.

The ambulatory care center was alluded to by several speakers.

The present outpatient department in the Indian hospital was built to service a maximum of 20,000 visits a year. It was built at the request of the All Indian Pueblo Council in 1971. Presently, we are seeing approximately 35,000 outpatient visits a year and it is increasing about 20 percent a year. It is impossible for us to meet this need with the amount of staff we have and, as a result, we have been shifting staff from inpatient services and other community clinics to cover the need.

This shifting of staff here, again results in reduced services in community clinics, in the hospital, and elsewhere.

If there were some way of adjusting the budget to meet the needs so that we can provide adequate staffing when the demand arises, it would be a lot simpler than operating with a fixed position ceiling and a minimum amount of increase in staff, regardless of what the needs are.

Senator KENNEDY. Perhaps Dr. Johnson can respond to this.

As I understand, there are some resources that are available, but you have this restriction in terms of existing legislation for supplementary personnel?

Do I understand that—part of the difficulty is in the recruitment of personnel under the current law? Am I correct in that understanding?

Dr. JOHNSON. Yes; there are several pieces to it, Senator Kennedy.

One, obviously, is that there are certain health categories that are in short supply, physicians being the most common one. And this is not a problem limited to the Indian Health Service. That is true in rural areas, in the military, in the Veterans' Administration and so forth.

But I think that what Dr. Kotomori is suggesting and what some of the others have suggested is that even if you had people to recruit, you cannot recruit them if you are under a position ceiling, which has been established—it says, "Regardless of your need, you cannot hire any more people."

Now, that puts you in the anomalous situation of spending large amounts of money for contract health care services because you can buy outside services but you cannot hire staff for your own facility. And that, to my way of thinking—and I am obviously not speaking for the administration on this one—it seems to me that the dollar ought to be the mechanism that controls the cost, not the position ceiling. It forces you to become less cost effective when you have to manipulate your program within a fixed-position ceiling.

Senator KENNEDY. Now, a part of the difficulty was the—in terms of the contract of the physician and in the legislation that we passed last Friday evening. We provided greater flexibility to your office in terms of being able to obtain those physicians, I understand. And will you just make a comment on that in terms of explanation?

Dr. JOHNSON. Well, there are—one major source that we have for recruiting physicians at the moment—and I believe this is what you are referring to—is under the national health service or public health

service scholarship program. And under that program, we do have the opportunity to select physicians who want to serve Indian people and pay for their way through medical school in return for which they will come back and serve a specified period of time, depending upon the number of years that they were supported.

In addition to that, with the signing of the regulations by the Secretary yesterday, we will now be able to implement the Indian health scholarship program, which will supplement—not replace—these other scholarship programs. That will permit us to assist tribes when the tribe finds members of their community who have the capacity and desire to gain health—professional training and a need in the community for that kind of a person; and this has been brought out a number of places here. We will now be able to target scholarship resources to that kind of an individual. It does not require trickling down through some sort of national program where the Indian may or may not get in. And I think that is a very significant concept in the Indian Health Care Improvement Act—Health Manpower Act.

It is a unique scholarship program, and we are very, very happy to have the regulations now, and look forward to being able to implement it, start the implementation during this fiscal year.

Senator KENNEDY. This is still a lead-time problem we are talking about here. We should not be under any illusions about that. And it is important lead time; but in terms of responding to some of these particular questions in terms of your supply, this will be useful.

Dr. JOHNSON. That is correct.

That legislation really targeted in on one of the great gaps in the ability to develop appropriate health manpower for the reservations.

Now, it will be some years, unfortunately, before it really—the impact. If you are going to train a physician, of course, we are talking about, 5, 6, 7 or 8 years before those physicians are going to be back home to serve, depending upon their stage of training at the moment.

Senator KENNEDY. Good.

Dr. Kotomori?

Dr. KOTOMORI. Additional positions have been added in the area of community health medics and physicians. However, there is a failure to recognize the fact that the increased number of primary care providers necessitates support personnel.

Medical records, laboratory and X-ray is barely able to meet the demands at our hospital at present and, right now, we are a little bit concerned that we may lose our accreditation by the Joint Commission of Accreditation of Hospitals because we are unable to meet the requirements that timely reporting of test results be posted in the laboratory records on the medical file.

Janitors in our hospital are required to transport patients to contract facilities. This leads then to neglected janitorial duties, custodial duties not being done adequately. All of this could be solved if we could have some way of hiring people based on present needs. And I think you probably got the message that what we need is a larger budget and more personnel; and I won't go on any further.

Senator KENNEDY. OK. Fine.

Dr. Andre, who is the psychiatric consultant for Alcoholism and Alcohol Abuse, Indian Health Service.

STATEMENT OF JAMES ANDRE, M.D., AREA PSYCHIATRIC CONSULTANT FOR ALCOHOLISM AND ALCOHOL ABUSE, ALBUQUERQUE AREA INDIAN HEALTH SERVICE

Dr. ANDRE. Thank you, Senator Kennedy, for the opportunity to testify about what I consider to be the major public health problem among the native Americans. I think it is among all Americans, for that fact. I am speaking about the abuse of alcohol and the tragic impact it is having on the native American individual, on his family and on his community.

I am going to confine my remarks to illness, to death, to general misery that alcoholism visits upon the Indian people, but I would like to mention that this particular problem, alcoholism, also is having a devastating effect on mental and emotional health, on social health and on economic health.

It is also producing problems in the area of law enforcement as well for the native American. Many people that I see and have seen over the past 10 years are nervous and depressed. Their families are becoming disorganized and broken. Jobs, which are very difficult to find in the first place for Indian people, are being lost, people are being incarcerated, people are being fined, and all of that, in my judgment, is a direct consequence of alcohol.

Now, the problem, I think is growing worse, as some of these charts reflect, and it is growing worse among the people who I think can least afford it. The native American already has many inroads on his health and his well-being.

Among the 26 tribes that are served by this area of Indian Health Service—and none of the charts up there reflect this—but it might be worth mentioning—five, 5 of the 10 leading causes of death among the American Indian people are alcohol related—half of the 10 leading causes. And they are accidents, cirrhosis of the liver, homicide, suicide, and alcoholism as a primary diagnosis.

Of the top five causes of death—and they are reflected in a second graph up there—I would call your attention to the fact that they are rising at an alarming rate, and three of those are alcohol related. They are alcoholism, cirrhosis of the liver and homicide. All three of those are alcohol relatde, and are among the top five causes of death.

To be a bit more specific, in the latest period for which figures are available, and they are reflected here, 220 Indian people in this area lost their lives from these five alcohol-related problems. And that is just in this area alone.

Of the total deaths that occurred in this are, that is a staggering 35 percent which are alcohol related. And it does not even include deaths from other diseases where alchol plays a role, such as heart disease, stroke, diabetes, and so on.

One indication of what the actual mortality might be, Senator, from alcohol-related diseases, the actual mortality, is a study that was done in a single pueblo in this area in which 57 persons died in a 54-week period. Of these, 34 or 60 percent, were directly attributable to alcohol abuse.

In another study of a pueblo, three out of every four persons who committed suicide were known to have been under the influence of

alcohol at or just prior to the time that they took their lives. In 90 percent of the homicides, either the perpetrator or the victim or both were intoxicated at the time of the homicides.

Now, I think that that is cause for alarm, but something that concerns me even more so is that that is the toll among young Indian people, and that is the greatest resource that the Indian community has. When I took my medical training, I saw cirrhosis of the liver primarily in men over the age of 40. Since I have joined the Indian Health Service 10 years ago, I have had the occasion to stand at the bedside of Indian men and Indian women who were in the final stages of cirrhosis of the liver and under the age of 25. Now, it is not taught that that would occur when I went to medical school, but I have seen it.

Senator KENNEDY. Now, the significance of that fact from a health point of view is that cirrhosis of the liver is basically irreversible?

Dr. ANDRE. It is.

Senator KENNEDY. And even once it begins to see a deterioration of the liver function among the younger people even if they cease the utilization of alcohol, the damage is effectively done, with all the implications and potential danger that it provides. I think the statement that you made, that this is increasingly a problem among the young Indians is a matter of grave concern as well.

I do not know whether there is anything that you want to elaborate in terms of this question of alcoholism among the young. I think that we generally see an explosion in the country of, for example, smoking in teenage girls, which will have all kinds of implications in terms of that chart up there and cancer and heart disease and illness.

But I would be interested, from your own review, in whether you have been able to detect a similar kind of development of alcoholism among the young?

Dr. ANDRE. I think there is an explosion. The thing that concerns me as someone who works on the frontline, if you will, with these kinds of problems is that they are starting drinking younger, at a younger age; they are starting to drink in greater quantities. I know that is going on in the country as well.

I think what we are seeing is a reflection. At least insofar as Indian people are concerned, the problem is that thi does make an impact on people who already have problems, difficulty finding jobs and any sphere that you want to consider, including health—other problems than alcohol or drug problems; respiratory problems and so on.

And I think for this problem to rage out of control, as I believe it is, just worsens an already bad situation. I think we really have to make some sort of preventive effort.

May I continue?

Senator KENNEDY. Sure.

Dr. ANDRE. Now, up to this point, I have talked about mortality, about alcoholism as a killer of Indian people; but I think it is a lot more than that.

Those health problems which cause pain and suffering which cause chronic disability, general misery, and so on, many of these are directly related to alcohol use and abuse.

For example, injuries from which people do not die and show up as a mortality statistic, nevertheless, produce a great deal of pain and suffering. Gastrointestinal hemmorhage—I have seen more than I have ever seen anywhere in my work. Heart and brain disease, malnutrition, damage to the unborn fetus—and that is just to name a few.

There is a third chart up on the right there that just capsulizes—that indicates some drain on our limited IHS resources, that all of the Indian people here are well aware of and that many of the leaders have spoken of; 35 percent of the admissions to our four IHS hospitals are alcohol-related admissions. A third, or almost a third—31 percent, of all the hospital days—alcohol related.

Eighteen percent of all people that show up at the clinics have an alcohol-related problem. One thing that is not on the third chart, Senator, a part of it isn't—those 35 percent of our admissions to contract hospitals for alcohol-related disease is true, but it eats up 56 percent of the contract health care funds.

I think many of these problems are, as you indicated, advanced problems, like cirrhosis of the liver, and the cost of treatment is extensive.

Well, enough statistics. I don't really need them to know that alcoholism is really a major cause of death and illness among Indian people. I know it; my fellow health workers know it; and the Indian people knew it. I am sure all in this room know that.

We are not struggling with this problem alone; that is, IRS is not. Indian leaders have been trying to establish prevention and treatment programs in their communities, I think, for a very long time. But even where they have succeeded in getting programs, the programs are funded at what I consider to be such an inadequate level that it is difficult to operate. I can just give you a case I am aware of.

One pueblo has just now opened a detox center and they are trying to serve eight other Indian communities with a staff of four. I have real concerns for the energies of the people who are going to be working in those centers.

I think the Indian people deserve a better chance to show that they can bring Indian ways and Indian means and methods to this particular problem than that kind of funding will support.

We have been operating on a shoestring or as we often talk about it, we—myself and Indian alcoholics and counselors—is that it is very much like fighting a forest fire with a bucket brigade. No matter how hard you try, you are still losing the fight—the fire is still raging out of control.

We have been reacting rather than acting. And I think what needs to be done is we will have to hit this thing head-on in a deliberately planned program.

Senator KENNEDY. Thanks for your comments. That is very helpful and sobering testimony.

In the area of prevention, as I understand, there are steps that can be taken in terms of education, but that basically it is family example that has an extremely important impact on the younger people.

Am I correct about examples?

Dr. ANDRE. Yes; that is true.

Senator KENNEDY. And so it is really a vicious cycle. It is a real catch 22 in terms of the whole evaluation of this problem?

Dr. ANDRE. I think what can be done, Senator, is that Indian youth can be shown that there are other alternatives than drinking, that there are other examples in the Indian communities, that there are good examples that can be followed. But you need people to get out there and work at this.

Senator KENNEDY. We had an amendment I introduced on the Indian Health Care Improvement Act last year, dealing with alcoholism no pains. It authorized $4 million but only $1 million was appropriated. That level of funding for a nationwide program is simply an inadequate response.

The Congress and the administration have failed to address this aspect of social policy—especially as it affects Indian health. It is replicated in other areas, too, but it is a tragic reminder of what needs to be done.

Before hearing from—we are beginning to run into a timeframe. I had a message from the Santo Domingo Tribe who want to make a brief statement. I am going to take the time out of Emery Johnson, who is an old friend I know here. We will hear from you, Emery, but I want to make sure that we will hear from them briefly. Emery is very helpful to us in making the arrangements here earlier this morning and we are very much in his debt.

STATEMENT OF ERNEST LAVATO, SANTO DOMINGO PUEBLO

Mr. LAVATO. Senator, it is part of our tradition I believe that we are taught to stand when we speak, if you want to get there. I have learned this philosophy from my ancestors of several years, and it is a habit for me that I must speak of this respect.

I had hoped that other New Mexico congressional delegation would be here to perhaps hear this very to-the-point message of the people concerned. Perhaps this people will carry the message to the—both to the halls of Congress in Washington and to the President's office to the White House.

This whole thing must be treated with concern. It must be carried with great concern and serious issue at hand. In other words, we are seeking for action. There is no time for tomorrow.

As Governor Paytiamo has stated earlier, we have waited long enough to receive adequate care.

Just yesterday, one of the hired physicians in the Federal Government in the field of health happened to run into me in Santa Fe and said, "Ernie Lavato, what do you think for you is the most needed of Indian reservation." In other words, he said to me, "Ernest, what do you need the most in area of health?" And I replied, "Sir, the most we need now is lots of aspirins, and I will tell you why. There are a lot of headaches in the Federal Government." So there is my reaction to them. [Laughter.]

Senator, I would like to be the first to compliment you on your statement in Florida.

"Certain parties of the Nation's Capital receive a vast health care without cost." And that is true. Free. What about the first Americans of this continent? What about the Pueblo Indians of this country? We need that free service and better health care, better funding and

better health; in other words, better and the first of all things in the Pueblo country.

I might point out at this point, Mrs. Kennedy and Senator Kennedy and all the family of the Kennedys, I want to again congratulate you. You have been congratulated by everyone else, but we, too, would like to take that opportunity as well.

I would like to counteract over what Agnes Dill said: you must consider giving this lad a Pueblo name. But I would say you must consider all the Pueblo names for consideration. She is one of us now. [Laughter.]

Much has been said throughout the morning session and much is going to be said throughout—as long as we can live.

Lots of hearings have been held in the Nation's Capital at Washington. Lots of hearings have been held throughout the Indian country, throughout the various States.

Lots of things have been said for the record over the years. Where are we at today? And I believe the answer is there—that the Congress of the United States must now pay a particular attention, in other words, alertness, the quickness, the sincerity.

We are not asking for sympathy. All we want is better health care, better appropriations, better hospitals, better staff. Above and beyond, we refuse to be practiced on by interns. But whether we want the true, certified physicians, the qualified physicians that can be employed at the Santa Fe service unit, BCMC, at the local clinics and everywhere we have hospitals, we have gone beyond that. And we are the ones that have gone through lots of misery.

Those of us who have to live with it 24 hours a day on the reservation, we know what the problems are. And yet we are at the mercy of the Federal Government, the public health officials, of course, realizing they have a lot of books—the irregularities of the Federal regulations, that those things must be changed.

And those changes can come about through the efforts of the Congress of the United States in order to fulfill the obligation and mission of the first Americans, that we are entitled to. Let us face it, we gave up our land. I take it back. We never gave up our land; it was taken from us illegally. But whether we are going to regain—or we are going to recontrol eventually. On top of that, Federal Government said to us, by peace treaties, there shall be forever lasting free commitment to the Indians.

Dental care, cataract work—it is a great emphasis now. There are a lot of people on the reservations that we know of. We need this adequate care in cataract cases as well as the dental work. We need a direct service, better water and sewerlines system in our public communities. We have been after the public health officials for a great number of years and their excuse was that, "Ernest, no money." Go to the Congress and applicate in the Congress. Maybe somewhere this Congress—some Member of Congress will give you adequate attention.

Well, those things have done, many times, but we are not going to give up. We are going after it yet. Health funding at the Santa Fe service unit, those pueblos that we are connected to—a number of us are connected to Santa Fe service unit, but look at the distance that we have to travel.

We need a greater outlet services or rather we could stand to the local clinics with adequate funding. What I am saying, or advocating now is we are self-determined. We want a direct funding to our res-

ervation communities; because oftentimes when the Congress appropriates certain funds, it is the same old history: money channels into so many bureaucracy process, and that is where they chop off our administrative overhead to gain the great, great, great empire building process for greater employment, and all we are getting now is nothing but retirement, sick leave and all kinds of things. But what about on the reservation?

We need that greater attention on our pueblo communities. That is the reason for direct funding to the pueblos. We are capable. We have got a lot of young people coming up that would like to assume this responsibilities—expansion of clinic.

There should be greater emphasis and advocacy in the Congress of the United States for better attention to our elders, the senior citizens. These are the people who have been neglected for 100 years or more. We need to give a greater attention to our elders. Who is more important in our Indian nation? The older people. They are the ones who have survived to protect our land base, natural resources and many other things. The young coming up, we need to educate them through professional college training and so on, to assume future responsibility for Indian health care.

So, Senator, I think what I am advocating here and too I hope that the New Mexico congressional delegation and other Congress of the United States will take this message with great concern, with a sincere heart, because we as an Indian people, so-called, Indian leaders in their communities expect to perform, and that performance must be fulfilled.

And if we fail now, rest assured, when our next generation of Indian youth will say to us, "Where were you in 1977? How come we still have this inadequacy?"

But it is not our fault. It is somebody else—the Nation's Capital.

So what I am saying here, Senator, and I know that you are very much dear at heart to our Indian people because you have demonstrated your interest; and we must compliment you that we will do everything possible to go side by side with you in whatever endeavor to help you to voice our opinion when the time comes for showdown in the Congress of the United States for better appropriation.

And I want to thank you very much, Senator, for coming to New Mexico as well as your aides, staff and certainly the members of the Kennedy family. We have always had a great faith and trust in your family, and I mean this from the bottom of my heart.

What I say I do not go by statistics. I do not go by charts. I speak from my heart as I feel you—as I do everyone. Because we are the ones who live with it, night and day. And I think I have been honest about what I am saying. And no disgrace to the U.S. Public Health officials, you need our help. [Laughter.]

We will help you, if you will help us. And thank you very much. And if I have gone beyond the way, this is the way I am and because I am sincere and I am very concerned. It is the way that I voice my opinions in every minute. But we have got to shake up this United States to fulfill that mission.

Thank you very much. [Applause.]

Senator KENNEDY. Thank you very much.

Well, we have just missed our plane out, so we are going to stay here for another 3 more hours. [Applause.]

I will ask Dr. Johnson who is going to remain here to just say a brief word. Then I will make an extremely brief comment and we will adjourn.

I give you—Dr. Johnson, I give you about a minute and a half. The important thing is that he is going to stay here and go on over these regulations. So I would hope that the representatives of the tribes and the pueblos would remain behind. That is when the real work is going to be done. But I would like to see if Dr. Johnson could just take a minute.

Dr. JOHNSON. Thank you, Senator Kennedy.

Obviously, the fact that we have been communicating and working together is exemplified by the opportunity to have this kind of a meeting, where we can all, quite frankly and honestly, express our opinions and our desires.

I certainly would agree in general with the comments that we all understand, the needs—I think the Congress of the United States understands the needs. I think in passing Public Law 94–437 they clearly addressed and admitted to the kinds of problems that have been brought up today by the tribal leaders and also by our own staff.

I think the process has been put in place, Senator Kennedy, where if the Indian people and the Indian Health Service, the administration and the Congress address the road map that has been placed before us through the laws, Public Law 93–638 and Public Law 94–437 we can, in fact, address and deal with and solve the problems that we are talking about.

I would only add one last caution.

We cannot solve all health problems through a health program. Many of the problems that we are talking about here are problems related to the community itself and human behavior. And those are not, in fact, amenable to the ministrations of doctors, nurses, and so forth.

So here again as Ernie said we really have to deal with this through the tribal community itself. That is the key to the success of this program.

And I appreciate again, Senator, your support, your being here, providing this forum for us.

Senator KENNEDY. Thanks, Dr. Johnson.

Dr. Johnson will remain behind.

I, first of all, want to express my very deep sense of appreciation to the Isleta Pueblo for their kindness and hospitality in greeting us here this morning and making this marvelous room available to the U.S. Senate Health Subcommittee, and thank all of those who have been good enough to join us during this particular session—for your patience and your understanding, and to thank our witnesses. We will include their statements in the record.

We will take them back; we will analyze them; we will work on them and we will continue the process that has begun this morning and also has existed in the past in a number of different areas.

In this trip that we have taken across the country, we have focused on the areas of indifference by national policy leaders. We have focused on the health-care needs of our elderly people and the migrant workers, on the problems of Indians—and there has been no place, that I can think of, that there is a greater responsibility and a greater need than in this area of Indian health.

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It is a complex issue that involves many different factors, as Dr. Johnson has said, beyond just the narrow reaches of health and health care. But what we have seen in the past is on an important Indian health issue, passed and signed into law in October of 1976; yet the regulations come out over a year later, in November of 1977—that has to alter and the priorities have to change.

And what I do pledge and commit to you is my continuing interest and desire to work with your people to see that that priority is changed. No one has magic wands. No one has magic solutions to the problems that we are facing. These issues, as your leaders have pointed out, take time and commitment and dedication and step-by-step progress. That is what I hope all of us will pledge ourselves to do.

I want to also—in the important area of tribal sovereignty and Indian self-determination—give my full and complete and wholehearted support. [Applause.]

We have not had the chance to get into these issues in the course of the morning, but I did not want to leave this particular meeting without indicating very clearly to the members of the pueblo and to others my position on these issues.

President Kennedy, when he would have to leave a meeting, quoted those lovely lines of Robert Frost, who was a New England poet, who said: "The woods are lovely, dark and deep, and I have promises to keep, and miles to go before I sleep, and miles to go before I sleep."

So I hope you will excuse Ethel and myself because we have miles to go before we sleep.

[The report and supplements A, B, C, D, E, and F supplied for the record follow:]

Albuquerque Area Indian Health
Service Data Report

(provided by the Indian Health
Service)

VITAL STATISTICS

ALBUQUERQUE AREA REVIEW

The Albuquerque Indian Health Service Area includes the states of Colorado and New Mexico. A total of four service units are within the Area. The FY 1977 service population is estimated to be 43,202 persons for the Albuquerque Area using the new population projection methodology. Individual Service Unit estimates are as follows:

Service Unit	FY 1977 Service Population
TOTAL	43,202
Albuquerque Service Unit	20,146
Mescalero Service Unit	1,887
Santa Fe Service Unit	13,812
Zuni-Ramah Service Unit	7,357

Detailed social and economic data for the state of New Mexico are available from the 1970 Census. These data are based on the twenty percent sample of the 1970 Census. The attached table shows social and economic characteristics of the 1970 Census for the total U.S. population, the total U.S. Indian population, the total IHS Service population, and for Indians in New Mexico.

This table indicates that Indians residing in New Mexico were slightly worse off than most Indians in the U.S. and the total IHS Service population in 1970. The median age of the New Mexico Indians was 17.1 with a median income of $4,327 while the total U.S. population was 28.1 and $9,590, respectively. The table also indicates that the Indians in New Mexico were younger and poorer in comparison with the other populations.

The median years of school completed was lower and they also had fewer college graduates. In addition, they had more persons "not in the labor force" and their housing conditions were equivalent to the conditions of the IHS Service population.

Population Statistic Branch
OPS/DRC/IHS
November 1, 1977

Three Leading Causes of Hospitalization For
the Albuquerque Area
FY 1976

1 - Accidents, Poisonings and Violence (3,890 Inpatient Days)

2 - Special Conditions and Exams Without Sickness (3,850 Inpatient Days)
Specific Areas are:

Medical or Special Exams Without Sickness
TB in Transient
TB Follow-up Examination
Pre-Natal Care
Post-Partum Observation
Medical and Surgical After Care
Other Special Conditions and Exams

3 - Digestive System (2,100 Inpatient Days)

Office of Program Statistics, DRC, IHS
November, 1977

Indian Health Service - Employee Patient Ratios
for the Albuquerque Area

		FY 72	FY 73	FY 74	FY 75	FY 76
IHS Hospitals,	Inpatient Employee-Patient ratios	2.10	2.40	2.81	3.16	2.91
	Outpatient Ratios (staff/ 1000 visits)	.50	.40	.40	.57	.53
IHS Field Clinics,	Outpatient Ratios	-	-	-	.98	.99
IHS Ambulatory Care Budget Activity						
	Outpatient Ratio	-	-	-	.83	.81
	Hospital	-	-	-	.57	.53
	Clinic	-	-	-	.98	.99

Hospital Care Administration Branch
Indian Health Service
11/7/77

Accreditation Status of Hospitals in Albuquerque Area

Santa Fe Hospital - This is a new, replacement facility, scheduled to be in operation by the beginning of Calendar Year 1978. The JCAH survey will take place once the facility is operational.

Mescalero Hospital - This facility is not accredited by JCAH due to staffing deficiencies in every department except physicians. There are no deficiencies in the physical plant. The latest application of the Indian Health Service Resource Allocation Criteria * shows this facility to be 60% deficient.

Albuquerque Hospital - This facility has been accredited by JCAH. However, due to an increase of outpatient visits from 20,000 to 35,000, there is inadequate space in the outpatient department. The latest application of the Resource Allocation Criteria (RAC) shows this facility to be 60% deficient.

Zuni Hospital - This facility is accredited by JCAH but there is a shortage of storage space for supplies. The latest application of the Resource Allocation Criteria shows this facility to be 20% deficient.

Acoma-Laguna Hos. - This facility is now under construction with a tentative completion date of Spring, 1978. The JCAH survey will be done once the facility is operational.

* The Resource Allocation Criteria (RAC) establishes a more equitable standard for manpower planning based on actual or projected workloads, and allocates resources based on the identified need as reflected by the Criteria. The RAC includes most of the program elements of the Indian Health Service and is essentially based on demand and/or utilization as demonstrated by actual workload. The RAC has received provisional certification from the Department as IHS's Work Measurement System.

Physician Encounters

For the Albuquerque Area the average number of patient encounters per physician is 25 - 30 patients per day. Of the total 185,698 outpatient visits for the Albuquerque Area for FY 1976, 50 percent or 91,903 were classified as physician visits.

Office of Program Statistics,DRC, IHS
November, 1977

Table 1

POPULATION CHARACTERISTICS--TOTAL U.S. POPULATION, U.S. INDIAN POPULATION, IHS SERVICE POPULATION, AND NEW MEXICO INDIANS

	TOTAL U.S. POPULATION	U.S. INDIAN POPULATION 1/	IHS SERVICE POPULATION 2/	NEW MEXICO INDIANS
Indian Age of Population	28.1	20.4	18.6	17.1
Average Number of Persons Per Family	3.57	4.46	4.83	5.45
Percent Enrolled in School (3-34 Years Old)	54.3	52.9	56.4	57.1
Indian School Years Completed	12.1	9.8	8.2	8.1
Percent High School Graduates	52.3	33.3	29.2	24.8
Percent College Graduates (25+)	10.7	3.8	2.5	1.8
Indian Family Income	$9,590	$5,832	$4,885	$4,327
Percent of All Persons Under Poverty Level	13.7	38.3	55.3	53.6
Percent of All Families Under Poverty Level	10.7	33.3	42.7	51.8
Percent in Labor Force, 16 Years and Over:				
Male, 16 Years and Over	76.6	63.4	55.8	50.2
Female, 16 Years and Over	41.4	35.3	31.3	29.9
Percent of Civilian Labor Force Unemployed, 16 Years and Over :				
Male 16 Years and Over	3.9	11.6	14.6	13.1
Female, 16 Years and Over	5.2	10.2	10.9	8.1
Indian Persons Income:				
Male, 16 Years and Over	$7,609	$3,509	$2,834	$2,529
Female, 16 Years and Over	$3,649	$1,697	$1,494	$1,385
Percent Household Occupied by Owner	62.9	49.8	62.9	62.6
Indian Number of Rooms	5.0	4.2	4.4	2.9
Indian Persons Per Unit (Owner Occupied Units)	3.0	3.6	4.2	4.7
Percent Structures Built 30 Years Ago	40.6	40.6	39.6	27.8
Percent Complete Bathroom	92.5	72.0	61.1	39.0
Percent No Automobile Available	17.5	29.5	33.8	42.5
Indian Value Household Unit	$17,100	$9,000	$5,953	$4,400
Indian Contract Rent	$89	$73	$74	$56

Does not include Aleuts and Eskimos.
IHS Service Population estimated using available data for 11 States.

Source: 1970 U.S. Census--
PC (1)-B-1 U.S. Summary General Population Characteristics
PC (1)-C-1 U.S. Summary General Social and Economic Characteristics
PC (2)-1-F American Indian
HC (1)-B-1 Detailed Housing Characteristics

Population Statistics Branch, Office of
Program Statistics, Indian Health Service

Selected Causes of Death

Albuquerque Area

	CY 1973-75 Number	Rate Per 100,000 Population	CY 1963-65 Number	Rate Per 100,000 Population	Percent Change
All Causes	885	715.0	651.	774.3	- 7.7
Accidents	193	155.9	124	147.5	+ 5.7
Malignant Neoplasms	65	52.5	47	55.9	- 6.1
Diseases of Heart	93	75.1	97	115.4	-34.9
Cardiovascular Disease	38	30.7	--	--	--
Influenza and Pneumonia	33	26.7	63	74.9	64.4
Certain Causes of Mortality in Early Infancy	13	10.5	46	54.7	-80.8
Symptoms and Ill-Defined	76	61.4	87	103.5	-40.7
Homicide	31	25.0	11	13.1	+90.8
Suicide	32	25.9	11	13.1	+97.7
Cirrhosis of Liver	65	52.5	11	13.1	+300.8
Tuberculosis	13	10.5	13	15.5	-32.3
Congenital Anomalies	5	4.0	18	21.4	-81.3
All Other Causes	228	184.2	123	146.3	+25.9

Selected Vital Statistics Rates

Albuquerque Area

	Birth Rate	Infant Death Rates			Crude Death Rate
		Total	Neonatal	Postneonatal	
1975	31.3	18.5	8.5	10.0	7.4
1974	30.7	20.0	8.3	12.6	7.7
1973	31.8	25.9	10.7	14.3	7.8
1972	30.4	25.4	12.7	12.7	6.6
1971	33.0	27.0	15.9	11.1	7.3
1970	34.0	22.4	11.2	11.2	6.9
1969	32.7	27.5	12.9	14.6	7.2
1968	30.0	31.9	15.5	16.4	7.7
1967	29.9	37.1	13.1	24.1	7.1
1966	33.2	41.2	15.0	26.2	
1965	38.2	35.7	12.8	22.9	
1964	41.1	48.8	17.8	31.1	
1963	35.9	46.4	23.7	22.7	
1962	41.4	43.0	11.0	31.1	
1961	38.5	39.2	17.1	22.1	
1960	39.1	43.4	20.2	23.2	
1959	40.5	38.5	19.8	18.8	
1958	31.5	68.7	28.5	40.2	
1957	34.8	NA	NA	NA	
1956	35.2	57.3	20.3	37.0	
1955	33.4	86.8	27.2	59.6	

Birth rates and crude death rates are per 1,000 population.

Infant death rates are per 1,000 live births.

Vital Events Branch
OPS/DRC/IHS
November 1, 1977

Incidence Rates of Reported New Cases of Notifiable Diseas
Albuquerque Area
Calendar Years 1965-1974

	1974	1973	1972	1971	1970	1969	1968	1967	1966	1965
					Rates per 100,000 Population					
Chickenpox	776.3	892.0	882.8	389.6	425.9	265.9	659.0	451.4	426.4	375.3
Diphtheria	2.8	*	*	-	*	-	-	-	-	-
Amebiasis Dysentary	2.8	*	*	-	-	-	-	-	-	-
Bacillary Dysentary	270.8	364.1	536.8	537.2	531.6	114.4	278.8	168.9	296.5	546.2
Viral Encephalitis	8.3	-	*	*	21.1	-	-	-	-	*
Gastroenteritis Diarrhea	8114.0	7,034.6	7,458.8	5,717.1	5,786.9	7,681.6	5,917.9	5,387.8	4,453.7	5,397.0
Gonococcal Infections	1591.3	1,606.2	1,714.1	879.5	715.8	745.3	567.1	402.7	433.0	403.4
Hepatitis	262.5	149.6	337.6	578.5	66.4	99.0	190.1	185.1	443.0	82.1
Influenza	2787.6	3,548.3	4,409.4	3,426.7	2,232.0	1,023.6	2,610.5	721.0	2,948.0	3,784.9
Measles (Rubeola)	63.6	96.0	57.7	97.4	93.6	64.9	19.0	617.0	373.1	1,169.3
Meningitis, Aseptic	11.1	*	28.9	*	33.2	27.8	*	*	*	27.4
Meningococcal Infections	-	*	-	-	*	-	-	-	*	*
Mumps	94.0	245.6	418.4	218.4	274.8	525.7	320.0	665.8	209.9	352.2
Otitis Media	9713.6	12,663.4	11,049.5	7,024.6	7,789.4	7,196.1	6,491.4	6,189.9	4,966.7	5,439.7
Plague	-	-	-	-	-	-	-	-	-	-
Pneumonia	2906.4	2,870.9	2,545.2	2,057.2	2,639.8	2,736.8	2,341.2	1,695.2	2,115.3	2,542.9
Poliomyelitis	-	-	-	-	-	-	-	-	-	-
Puerperal Septicemia	16.6	19.8	*	-	-	*	22.2	39.0	*	51.3
Rabies	2.8	-	-	-	-	-	-	-	-	-
Relapsing Fever	-	-	-	-	-	-	-	-	-	-
Rheumatic Fever	116.1	39.5	54.8	56.1	*	74.2	85.5	39.0	20.0	75.2
Rocky Mt. Spotted Fever	-	*	*	*	-	-	-	-	-	-
Salmonellosis	13.9	*	*	*	-	27.8	*	48.7	*	30.8
Strep Throat, Scarlet Fever	8666.5	10,286.5	10,068.4	6,584.8	4,125.8	4,873.7	4,935.8	3,082.0	2,821.5	5,000.4
Syphilis, Prim., Secondary, Early Latent	138.2	90.3	184.7	215.5	181.2	262.9	95.0	55.2	23.3	20.5
Syphilis, Other	140.9	79.0	121.2	100.4	33.2	86.6	101.4	*	30.0	*
Trachoma	373.0	765.0	510.8	525.4	1,078.3	1,666.8	139.4	71.4	123.3	129.9
Trichinosis	-	-	-	-	*	-	*	*	-	-
Tuberculosis, New Active	-	101.6	92.3	112.2	226.5	126.8	57.0	48.7	60.0	78.6
Tularemia	-	-	-	-	-	-	-	-	*	-
Typhoid Fever	-	-	-	-	-	18.6	-	*	-	-
Whooping Cough	-	-	*	-	-	*	*	*	*	-
Rubella	44.2	48.0	86.6	88.5	66.4	-	-	-	-	-

- Quantity is zero
* Less tahn 5 cases reported

Reported New Cases of Notifiable Diseases
Albuquerque Area

CY 1965-1974

	1974	1973	1972	1971	1970	1969	1968	1967	1966	1965
Chickenpox	281	316	299	132	141	86	208	139	128	256
Diphtheria	1	2	4	-	1	-	-	-	-	-
Amebiasis Dysentary	1	4	1	-	-	-	-	-	-	-
Bacillary Dysentary	98	129	186	182	174	37	88	52	89	189
Viral Encephalitis	3	-	1	1	7	-	-	-	-	2
Gastroenteritis, Diarrhea	2,937	2,492	2,584	1,937	1,916	2,484	1,868	1,659	1,337	1,754
Gonococcal Infections	576	569	594	298	237	241	179	124	130	118
Heaptitis	95	53	117	196	22	32	60	57	133	24
Influenza	1,009	1,257	1,528	1,161	739	331	824	222	885	1,107
Measles(Rubeola)	23	34	20	33	31	21	6	190	112	342
Meningitis, Aseptic	4	1	10	1	11	9	5	2	5	8
Meningococcal Infections	-	1	-	-	3	-	-	-	1	2
Mumps	34	87	145	74	91	170	101	205	63	103
Otitis Media	3,516	5,037	3,829	2,380	2,579	2,327	2,049	1,906	1,491	1,591
Plague	-	0	-	-	-	-	-	-	-	-
Pneumonia	1,052	1,524	882	697	874	885	739	522	635	773
Poliomyelitis	-	0	-	-	-	-	-	-	-	-
Pureperal Septicemia	6	7	4	-	-	1	7	12	4	15
Rabies	1	-	-	-	-	-	-	-	-	-
Relapsing Fever	-	-	-	-	-	-	-	-	-	-
Rheumatic Fever	42	14	19	19	3	24	27	12	6	22
Rocky Mt. Spotted Fever	-	2	3	-	-	-	-	-	-	-
Salmonellosis	5	3	2	2	-	9	4	15	5	9
Strep Throat, Scarlet Fever	3,137	3,644	3,489	2,231	1,366	1,576	1,558	949	847	1,638
Syphilis,Prim.,Secondary, Early Latent	50	32	64	73	60	85	30	17	7	6
Syphilis, Other	51	28	42	34	11	28	32	1	9	1
Trachoma	135	271	177	178	357	539	44	22	37	38
Trichinosis	-	-	-	-	2	-	1	1	-	-
Tuberculosis, New Active	-	36	32	38	75	41	18	15	18	23
Tularemia	-	-	-	-	-	-	-	-	1	-
Typhoid Fever	-	-	-	-	-	6	-	1	-	-
Whooping Cough	-	-	1	-	-	2	2	1	2	-
Rubella	16	17	30	30	22	-	-	-	-	-

- Quantity is zero

UNMET NEEDS

SUMMARY OF APPLICATION OF RESOURCE ALLOCATION CRITERIA BY IHS AREA AND PROGRAM ELEMENT 1/
(FY 1977)

PROGRAM ELEMENT	Required	Available	Additional Need		Staffing Deficiency
	Positions	Positions	Positions	$(000)	(Percent)
Inpatient Care	405	269	136	2,855	34
Ambulatory Care	223	110	113	2,373	51
Dental	94	62	32	672	34
Community Health Nursing	107	31	76	1,596	71
Health Education	21	9	12	252	57
Environmental Health	50	16	34	714	68
.l Services/ Mental Health	62	23	39	819	63
Public Health Nutrition	31	5	26	546	83
Optometry	21	6	15	315	71
TOTAL	1,014	531	483	10,143	48

1/ Excludes Contract Health Services and Area Office.

Revised 7/77

CONTRACT HEALTH SERVICES
RESULTS OF APPLICATION OF RESOURCE ALLOCATION
CRITERIA BY IHS AREA AND SERVICE UNIT

RVICE UNIT	PROGRAM ELEMENT: Total Contract Health Service			
	Required	Available	Additional Need	Deficiency (Percent)
Albuquerque	$ 2,290,162	$ 1,603,382	$ 686,780	30
Santa Fe	2,007,510	1,598,864	408,646	20
Zuni-Ramah	654,423	208,941	445,482	68
Mescalero	388,218	270,944	117,274	30
	$5,340,313	$ 3,682,131	$ 1,658,182	31

NOTE: FY 76 figures have been used, FY 77 not available

RESULTS OF APPLICATION OF RESOURCE ALLOCATION
BY IHS AREA, SERVICE UNIT AND PROGRAM ELEMENT
(FY 1977)

Service Unit	Program Element: Inpatient				
	Required	Available	Additional Need		Percent Deficient
	Positions	Positions	Pos.	$(000)	
Albuquerque	161.2	94	67.2	1,411.2	41.7
Santa Fe	83.7	58.1	25.6	537.6	30.6
Mescalero	66.2	30.0	36.2	760.2	54.7
Zuni-Ramah	86.2	87.0	- .8	- 16.8	.9
Sub total	397.3	269.1	128.2	2,692.2	32.3
Biomed. Engineering	8.0	0	8.0	168.0	100.0
Total	405.3	269.1	136.2	2,860.2	33.6

RESULTS OF APPLICATION OF RESOURCE ALLOCATION
BY IHS AREA, SERVICE UNIT AND PROGRAM ELEMENT
(FY 1977)

Service Unit	Program Element: Ambulatory Care				
	Required	Available	Additional Need		Percent Deficient
	Positions	Positions	Pos.	$(000)	
buquerque	100.4	45.5	54.9	1,152.9	54.7
nta Fe	76.7	29.0	47.7	1,001.7	62.2
scalero	15.5	3.0	12.5	262.5	80.6
ni-Ramah	29.9	32.0	- 2.1	- 44.1	- 7.0
Total	222.5	109.5	113.0	2,373.0	50.8

NOTE: Maintenance and housekeeping not verified

CONTRACT HEALTH SERVICES
RESULTS OF APPLICATION OF RESOURCE ALLOCATION
CRITERIA BY IHS AREA AND SERVICE UNIT

SERVICE UNIT	PROGRAM ELEMENT: Contract Health Service - Dental			
	Required	Available	Additional Need	Deficiency (Percent)
Albuquerque	$ 181,300	$ 56,500	$ 124,800	69
Santa Fe	228,100	118,200	109,900	48
Zuni-Ramah	42,100	500	41,600	99
Mescalero	13,900	500	13,400	96
	$ 465,400	$175,700	$ 289,700	62

NOTE: FY 76 figures have been used, FY 77 figures not available

RESULTS OF APPLICATION OF RESOURCE ALLOCATION
BY IHS AREA, SERVICE UNIT AND PROGRAM ELEMENT
(FY 1977)

Service Unit	Program Element: Community Health Nursing				
	Required	Available	Additional Need		Percent Deficien
	Positions	Positions	Pos.	$(000)	
Albuquerque	54	11	43	903	79.6
Sante Fe	27	9	18	378	66.7
Mescalero	5	2	3	63	60.0
Zuni-Ramah	21	9	12	252	57.1
Total	107	31	76	1,596	71

RESULTS OF APPLICATION OF RESOURCE ALLOCATION
BY IHS AREA, SERVICE UNIT AND PROGRAM ELEMENT
(FY 1977)

Service Unit	Program Element: Health Education				
	Required	Available	Additional Need		Percent Deficien
	Positions	Positions	Pos.	$(000)	
Albuquerque	9	4	5	105	55.6
Sante Fe	6	3	3	63	50
Mescalero	1.5	0	1.5	31.5	100
Zuni-Ramah	4.5	2	2.5	52.5	55.6
Total	21.0	9	12.0	252.0	57.1

AREA: Albuquerque

RESULTS OF APPLICATION OF RESOURCE ALLOCATION
BY IHS AREA, SERVICE UNIT AND PROGRAM ELEMENT
(FY 1977)

Service Unit	Program Element: Environmental Health				
	Required	Available	Additional Need		Percent Deficier
	Positions	Positions	Pos.	$(000)	
Albuquerque	19.5	8	11.5	241.5	59
Sante Fe	13.5	4	4	84.0	70
Mescalero	6	2	9.5	199.5	67
Zuni-Ramah	10.5	2	8.5	178.5	81
Total	49.5	16	33.5	703.5	68

AREA: Albuquerque

RESULTS OF APPLICATION OF RESOURCE ALLOCATION
BY IHS AREA, SERVICE UNIT AND PROGRAM ELEMENT
(FY 1977)

Service Unit	Program Element: Social Services/Mental Health				
	Required	Available	Additional Need		Percent Deficien
	Positions	Positions	Pos.	$(000)	
Albuquerque	24	8	16	336	66.7
Sante Fe	18	8	10	210	55.6
Mescalero	6	3	3	63	50.0
Zuni-Ramah	13.5	4	9.5	199.5	70.4
Total	61.5	23	38.5	808.5	62.6

AREA: Albuquerque

RESULTS OF APPLICATION OF RESOURCE ALLOCATION
BY IHS AREA, SERVICE UNIT AND PROGRAM ELEMENT
(FY 1977)

Service Unit	Program Element: Public Health Nutrition				
	Required	Available	Additional Need		Percent Deficier
	Positions	Positions	Pos.	$(000)	
Albuquerque	12	2	10	210	83.3
Sante Fe	12	2	10	210	83.3
Mescalero	1.5	0	1.5	31.5	100
Zuni-Ramah	6	1.5	4.5	94.5	75
Total	31.5	5.5	26.0	546.0	82.5

RESULTS OF APPLICATION OF RESOURCE ALLOCATION
BY IHS AREA, SERVICE UNIT AND PROGRAM ELEMENT
(FY 1977)

Service Unit	Program Element: Optometry				
	Required	Available	Additional Need		Percent Deficie
	Positions	Positions	Pos.	$(000)	
Albuquerque	9	2	7	147	77.8
Sante Fe	8	2	6	126	75
Mescalero	2	0	2	42	100
Zuni-Ramah	2	2	0	0	0
Total	21	6	15	315	71.4

CONTRACT HEALTH SERVICES
RESULTS OF APPLICATION OF RESOURCE ALLOCATION
CRITERIA BY IHS AREA AND SERVICE UNIT

SERVICE UNIT	PROGRAM ELEMENT: Contract Health Service - Excluding Dental			
	Required	Available	Additional Need	Deficiency (Percent)
Albuquerque	$ 2,108,862	$ 1,546,882	$ 561,980	27
Santa Fe	1,779,410	1,480,664	298,746	17
Zuni-Ramah	612,323	208,441	403,882	66
Mescalero	374,318	270,444	103,874	28
	$ 4,874,913	$ 3,506,431	$ 1,368,482	28

NOTE: FY 76 figures have been used, FY 77 figures not available

22-796-023

FACILITIES/CONSTRUCTION

CONSTRUCTION PROGRESS REPORT

INDIAN HEALTH SERVICE FACILITIES PLANNING AND CONSTRUCTION

ALBUQUERQUE AREA

HOSPITALS, NEW AND REPLACEMENT:

ACOMA-LAGUNA-CANONCITO COMPREHENSIVE HEALTH FACILITY (ALBUQUERQUE AREA)
Acomita, New Mexico, (New 30-40 bed)

Ground breaking ceremonies were held in June 1976. Construction is ahead of schedule and predicting February 1978 completion although contract calls for May 1, 1978 completion. Balance of construction funds ($3,100,000) were appropriated in first quarter of 1977, and equipment funds ($1,110,000) in fiscal year 1978.

SANTA FE COMPREHENSIVE HEALTH FACILITY (ALBUQUERQUE AREA)
Santa Fe, New Mexico, (Repl. 45-55 Bed)

Ground breaking ceremonies were held in June 1976. Construction is on schedule and should be completed by November 1977. Construction funds ($5,400,000) were appropriated in first quarter of 1977, and $2,100,000 for equipment in fiscal year 1978.

P.L. 85-151 Projects

SOUTHWEST MEMORIAL HOSPITAL
Cortez, Colorado (Albuquerque Area)

IHS is providing nine of the 53 beds for Indian patients. Opening date is expected September 1, 1977, is about 90% complete at this time. Apportionment of $625,000 in the first quarter 1977 was made for this purpose.

11/1/77

Staffing for the Ramah Clinic and Santa Fe Hospital
Albuquerque Area

In the 1978 Presidential budget neither positions nor monies were made available for the Ramah Clinic, New Mexico or the Sante Fe Hospital, New Mexico. These requirements represented unfunded mandatory increases for these new facilities. (See attachment - 1978 Congressional Action) However, the House and Senate added the required positions and funds. For the Ramah Clinic, the Congress appropriated 17 positions and $355,000 and 111 positions and $1,875.000 for Santa Fe. In essence the Congress restored the necessary positions to open and operate the new facilities at Ramah and Santa Fe.

ISLETA PUEBLO HEALTH STATUS

Health Status

The perception of health and health care is different from the general American medical model. These perceptions are frequently different for each Pueblo group: The Isletans have a traditional interpretation of health which includes social as well as physical well-being. These divergent perceptions not only influence the utilization of available services, but also complicate treatment of an Indian patient by a non-Indian physician.

The tribal religion at this point of time is very active. Approximately 95% of all tribal members are involved with the practice of the tribal belief. Within this 95%, there is a large percentage of people who believe that illness is primarily caused by some force from within the Pueblo, such as evil, chaos, etc. This force is only known to the American Indians, and modern medical knowledge will not help alleviate this problem. Indian Medicine Men are the dominant healers for diseases of this etiology. However, there are some cases that the medicine man may judge are not due to this force, and these patients are referred to the medical doctor to be cured. There are cases in which the medical doctors treatment is unsuccessful, and the patients are released from that medication or observation. At this point, thepatient proceeds to make arrangements to see a Indian Medicine Man. Often, the patient will come out well and cured of the illness.

With a mortality rate of 202.0/100,000 population in 1971, accidents remain the leading cause of death among Albuquerque Area Indians. In most cases, liquor is involved. In FY 1974, there were 343 new cases, and 61 hospital admissions from Isleta for conditions in this category.

Home accidents are a frequent occurrence among the Indian population. There are a few Indian homes heated with open stoves, and the use of kerosene or gasoline to ignite fires is common. Not only is the use of these substances in the home responsible for serious burns, but their presence often results in accidental ingestation by children.

Motor vehicle accidents are a frequent cause of injury and death. In 1973 there were 35 injuries in Isleta resulting from motor vehicle accidents. Accidents involving one or mre motor vehicles occupied with family members is a common occurrence. Alcoholism is a contributing factor in 10.0% of these accidents.

Safety problems are also classified as a primary problem. About 20% of all health treatments are directed towards the safety problems, such as falls, cuts (puncture wounds), fire hazards, animal bites, automobile accidents, poisonings, and drownings.

Suicide has developed into a major area of concern (the Indian rate is twice as high as the rate for the total U.S. Population). A noticeable correlation exists between alcoholic abuse and suicide, both being identified as methods of self-destruction. The total number of reported suicides, assaults, and similar accidents in the tribe of Isleta during FY 1973 were 126, of which seven were alcohol-related.

Alcoholism seems to be the most apparent manifestation of emotional disruption. Multiple counseling programs are being devised to focus on the drinking problems of Isleta. An alcoholism program began in August of 1974. The development of this alcoholism program will provide the basis for the prevention,

Diabetes Mellitus, Otitis Media, and Drug Abuse, also fall in the category of primary concern because the rate is increasing at a constant rate in Isleta.

In addition to health statistics, 13 health providers and 20 health consumers were consulted to ascertain the leading health problems, in their opinion. The following results were obtained:

Health Priorities at Isleta Pueblo According to Health Providers

1. Primary Problem Areas (in descending order or importance)
   - A. Mental Health
     1. Alcoholism
     2. Drug Abuse among youth
     3. Suicides, assaults, etc.
   - B. Home, automobile, and occupational safety problems
   - C. Hypertension and associated problems of nutrition
   - D. Diabetes Mellitus
   - E. Otitis Media

2. Secondary Problem Areas (not in order ot importance)
   - A. Sanitation
   - B. Incomplete understanding of structure and policies of health delivery system
   - C. Malignant neoplasm, and associated fears
   - D. Inadequate school health education curriculum, including sex education.
   - E. Maternal and child health and family planning
   - F. Dental problems
   - G. Nutritional and home care problems of the elderly
   - H. Child abuse

Health Priorities at Isleta Pueblo According to Health Consumers

The primary, and for the most part only, health problem identified by health consumers is alcoholism. The fact that other health problems weren't identified is due to a lack of awareness of the type or meaning of medical terms or conditions, because of lack of education and the influence of the tribal religion.

ISLETA HEALTH CENTER

Chronology of Planning Events

1. The present building was constructed in 1933 as a residence and "dispensary."

2. May, 1971 the Regional Office of Federal Engineers inspected the building and recommended that it be replaced with a new clinic building.

3. In August, 1971 a Preliminary Facility Justification Survey was developed by the Albuquerque Area Office in response to a Tribal Resolution. The survey justified the need for a new health center. (Juan Abcita was Governor at that time.)

4. The Indian Health Service was unable to secure funds for construction of the health center through normal appropriation channels, so discussions were started in 1973 to explore the possibility of the Isleta Tribe constructing the Health Center and IHS leasing the facility.

   (Through the efforts of Governor Alvino Lucero and the Isleta Tribal Council, working with their congressional delegation, particulary Senator Joseph Montoya) an appropriation of $111,000 was secured to lease, equip and staff the proposed Health Center.)

5. Mr. Seferino Lente who was then Tribal Planner and Secretary worked closely with IHS Area and Service Unit staff to develop initial plans.

6. Mr. Earl Mayne, Architect for the Tribe worked closely with IHS Area staff to incorporate ideas and needs for functional space and equipment in the clinic.

7. Several follow-up meetings were held with Governor Seferino Lente and his staff to review plans and discuss lease arrangements.

8. In June, 1975 a Space Acquisition schedule was developed and negotiations began soon after between the General Services Administration - Ft. Worth, Texas and the Isleta Tribe toward a lease agreement.

9. A lease agreement was reached in January, 1976 and a construction contract was awarded in February.

10. July 24, 1976 was the scheduled completion date.

11. The Health Center was occupied by the Isleta Tribe in September, 1976.

SUPPLEMENT A

Title--Albuquerque Area India Health Service Data Report

Staffing of Health Programs
Unmet Needs

The Resource Allocation Methodology is used by the Indian Health Service to identify unmet needs in staffing of health services and programs. The methodology assures equitable distribution of resources, provides standard staffing criteria, stimulates the development and documentation of standards of care and determines the most efficient and effective manner of delivery of health care.

The Fiscal Year 1977 application of the Resources Allocation Criteria showed serious shortages in the Albuquerque Area in several important staff categories as follows:

	Available Staff	RAC Requirement	Unmet Need
Inpatient Care	232	439	206
Ambulatory Patient Care	106	266	159
Community Health Nursing	30	131	101
Dental	81	126	45
Environmental Health	16	50	34
MH & Social Services	23	49	26
Nutrition	5	27	22
Optometry	6	24	18
Health Education	9	14	5
Alcoholism Control	3	8	8
TOTALS	511	1134	623

PROPOSED AMBULATORY PATIENT CARE CENTER

One of the major health management problems and unmet needs is the inadequate facility serving as the Outpatient Clinic in the Albuquerque Indian Hospital.

It is an on-going program that is barely able to meet the present needs of the Indian people and is rapidly being overwhelmed by the demand for services.

Our goal, as stated by the Indian Health Service Director, Dr. Emery Johnson, and T. J. Harwood, Albuquerque Area Director, is to deliver the best possible health care to Indian people. Therefore, our objective, in order to implement this goal, is to plan, build, and develop an ambulatory patient care center for the Albuquerque Service Unit, and possibly a referral center for the other service units of the Albuquerque Area.

A new, modern and efficient Ambulatory Patient Care Center is needed to accomplish one of the primary goals of the Indian Health Service in Albuquerque. The goal is competent and compassionate medical service to the Indian people in the Albuquerque Service Unit.

The bulk of the direct patient care done by the Albuquerque Service Unit is done in the Outpatient Department of the Albuquerque Indian Hospital. The total number of Outpatient Department visits last year was 32,000. This year it will be about 36,000. Over the past 6 years there has been a mean increase of about 20% in the total number of OPD visits per year.

The following figures are the workload as experienced in the Outpatient Department of the Albuquerque Indian Hospital which acts not only as a direct primary care provider, but also as the referral center for the outlying community health clinics.

AIH-OPD

FY 1973 16,441
FY 1974 22,962
FY 1975 24,531
FY 1976 32,031

According to these figures we can conservatively estimate about a 15% annual increase in OPD visits.

FY 1977 36,000
FY 1978 41,000
FY 1979 47,000
FY 1980 52,000
FY 1981 60,000

The populations that occupy the constituent communities of the Albuquerque Service Unit have grown only slightly. This is because many of the people have moved into the City of Albuquerque to seek housing and employment. Agriculture, pottery and Indian jewelry making are not sufficient to economically sustain the local Indian communities. This,

together with other migrant Indians, has swelled the Indian urban population. The U.S. government, through Congressional legislation and court decisions, has been obligated to furnish health care to these people. Publicity concerning recent court ruling has resulted in increasing numbers of patients seeking health care.

It has been the experience of the Albuquerque Service Unit that whenever inadequate facilities were improved in the communities, projected patient load increased immediately. Therefore, it is anticipated that the projected OPD visits will become a reality.

The present OPD in the hospital is already inadequate to handle the day-to-day patient load. Not only is the space inadequate, but also there is an insufficient number of physicians, nurses and equipment. All practicing physicians average over 60 hours of work covering the hospital and the clinics.

The following personnel are needed to handle 50,000 and 80,000 OPD visits according to the Resource Allocation Criteria (RAC) document.

	50,000	80,000
Primary Care Providers	6	9
Registered Nurses	5	7
Licensed Practical Nurses	5	8
Nursing Assistants	2	3
X-Ray Personnel	1.5	2
Laboratory Personnel	5.5	9
Pharmacy Personnel	6	9
General Clerks, Personnel	3	6
Administrative Clerks	3	3
Medical Records Personnel	3.5	5
Housekeeping Personnel	2.5	4
Supply Personnel	2	3.5
Drivers	1.5	2.5
Examining Rooms	14	21

Adequate staffing and facilities may reduce the amount of hospital care through the increased availability of primary care.

PLAN OF ACTION

In July, 1976, the service unit administrative staff, with the assistance of the Area Office Construction and Maintenance Branch, developed an initial proposal for an Albuquerque Hospital program to meet the Ambulatory Patient Care needs for about ten (10) years. This included an Ambulatory Patient Care facility, a new Medical Records Department, and a larger Supply warehouse. In February, 1977, Dr. Todd advised us that he would seek the initial $13,000. Architectural and Engineering funds for a feasibility study. In August, the funds were received and the initial stages of the plan for development was begun.

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The Service Unit Health Board, as well as the Urban Indian Coalition, is very much interested in improving the Ambulatory Patient Care capacity of the Albuquerque Indian Hospital. Both parties should be involved in any additional funding requests.

PROJECTED FUNDING NEEDS FOR AMBULATORY PATIENT CARE CENTER

Construction	$1,292,000
Staff (one year - 47 positions)	824,000
Equipment (15% estimated construction cost)	194,000
Supplies and Drugs	40,000
Operational Expenses	50,000
TOTAL	$2,400,000.

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COST ESTIMATE | Date Prepared 10-14-77 | Sheet 2 of 3

Project: Albuquerque Indian Hospital
Location: Albuquerque, New Mexico
FY | Project No.

Basis for Estimate
- ☐ Code A (No design completed)
- ☒ Code B (Preliminary design)
- ☐ Code C (Final design)
- ☐ Other (Specify)

Drawing No. | Estimator GH | Checked By

ITEM	UNIT	QUANTITY	COST	AMOUNT
Outpatient Facility:				
Site	Yd	2200	5	11,000
Foundation	SF	7200	8	57,600
Building System	SF	7200	29	208,000
Interior Finish	SF	7200	7.50	54,000
Specialties		Job		15,000
Mechanical	SF	7200	4.20	30,240
Plumbing	SF	7200	3.30	23,760
Electrical	SF	7200	4.05	29,160
Equipment		Lump		22,240
Contiengency		Lump		35,000
		Total		486,000
Ramp Structure:				
Ramp	CY	36	380	13,680
Column Support	CY	33	210	6,930
Footings	CY	38	250	9,500
Finish		Job		5,000
Canopy	CY	72	190	13,680
Roof	SQ	11	100	1,100
Specialties		Job		5,000
Contiengency		Lump		7,200
		TOTAL		62,090

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architect/planners architect/planners architect/planners
1505-255-4864

COST ESTIMATE	Date Prepared 10-14-77	Sheet 3 Of 3
Project Albuquerque Indian Hospital	Basis for Estimate ☐ Code A (No design completed) ☒ Code B (Preliminary design) ☐ Code C (Final design) ☐ Other (Specify)	
Location Albuquerque, New Mexico		
FY Project No.		
Drawing No.	Estimator GH	Checked By

ITEM	UNIT	QUANTITY	COST	AMOUNT
Basement Remodel:				
Demolition	SF	672	2	1344
New Partitioning	LF	87	25	2175
New Ceiling	SF	672	1.50	1008
New Flooring	SF	672	1.50	1008
Finishes	SF	672	2.50	1680
Elect.	SF	672	4.50	3024
HVAC	SF	672	6.75	4200
Contiengency		Lump		2500
		TOTAL		16,939
Pharmacy Remodel:				
Demolition	SF	2184	1.25	2730
Partitioning	LF	117	19	2223
Flooring	SF	1216	1.50	1824
Ceiling	SF	1400	1.56	2184
Finishes	SF	9040	.75	6780
Carpentry		Job		2500
Casework	FF	137	100	13,700
Specialties	Unit	L.S.		3000
HVAC	SF	2144	7.50	16080
Plumbing	SF	2144	6.50	13936
Electrical	SF	2144	6.25	13400
Contiengency		LS	1	10,000
		TOTAL		88,357

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albuquerque new mexico 87108

COST ESTIMATE | Date Prepared 10-14-77 | Sheet Of

Project: Albuquerque Indian Hospital
Location:
FY Project No.

Basis for Estimate
- ☐ Code A (No design completed)
- ☒ Code B (Preliminary design)
- ☐ Code C (Final design)
- ☐ Other (Specify)

Drawing No. | Estimator GH | Checked By

ITEM	UNIT	BUDGET	COST	SCHEMATIC
Outpatient Facilities		486,000		486,000
Site Work				
Building				
Utilities				
Ramp Facility		64,800		62,090
Basement Remodel		129,600		16,939
Pharmacy Remodel		32,400		88,357
Remodel Laboratory		21,600		78,500
Portable Supply Building		162,000		152,000
Demolish Existing Shops		32,400		22,815
Supply to Maintenance Shop		27,000		27,000
Officer of the Day		16,200		
Move 2 Dental Buildings		25,000		25,000
New Parking Lot		80,000		79,200
TOTAL		1,077,000		1,037,901
20% Inflation cost pending approval for construction		215,000.		
TOTAL		1,292,000.		

Albuquerque Area

Alcoholism & Morbidity

Alcoholism and Morbidity

Among the health problems affecting the American Indian in this area, many are directly related to the abuse of alcohol. These include diseases which cause acute pain and suffering, chronic disability, loss of productive time and earning capacity, family disruption for the individual. On IHS staff time, resources and contract health funds the impact is a major one indeed.

Such causes of morbidity which are directly related to alcohol abuse but which do not immediately (but often eventually) result in death are the following:

- Accidental injuries
- Cirrhosis of the liver
- Alcoholism as a primary diagnosis
- Attempted homocides
- Attempted suicides
- Malnutrition
- Pancreatitis
- Gastrointestinal bleeding
- Fetal alcohol deformities
- Mental and emotional disorders
- Organic brain syndrome
- Alcoholic heart disease

When morbidity from both direct and indirect alcohol-related diseases are considered a conservative estimate of impact on health and on available IHS resources can be made.

In a recent report (FY 1976) in which just five catagories of disease are considered the impact is significant:

- 1,124 of 3,238 PHS Hospital discharges were alcohol-related (35%)
- 7,352 of 24,040 hospital days were alcohol-related (31%)
- 32,593 of 183,121 clinic visits were alcohol-related (18%).
- 1,076 of 3,033 contract hospital discharges were alcohol-related (35%) but consumed $1.8 million out of a total contract budget of $3.2 million (56%)
- 2,680 contract clinic visits were alcohol-related (25%) and consumed $48,800 out of a total contract budget for this purpose of $174,800 (28%).

ALCOHOLISM AS A HEALTH AND SOCIAL PROBLEM IN THE ALBUQUERQUE AREA INDIAN HEALTH SERVICE

James Andre, M.D., M.P.H.
Albuquerque Area IHS

Alcoholism and Alcohol Abuse has long been recognized as a major health and social problem among Native Americans. Hard data has often been lacking to support what health personnel, tribal leaders and the Indian people themselves already know - that alcoholism and alcohol abuse is the major cause of illness, death, social disruption, and general misery among Native Americans.

Statistical and impressionistic evidence however is accumulating from a wide variety of sources and this evidence is cause for alarm among all who are concerned with the health and well-being of Native Americans.

I. Alcoholism and Mortality

Five of the ten (10) leading causes of death among Indian persons in this area are alcohol-related!

These five alcohol-related causes of death and their ranking as killers of Indian people are:

Accidents	No. 1
Cirrhosis	3
Alcoholism	6
Homocide	8
Suicide	10

This data from the area's vital statistics report for 1973 - 74 is the latest mortality data available. Changes that may have occurred between that period and 1977 would certainly show worsening, not improvement in the problem.

Accidents

In the two-year period cited, 125 Indian persons died by accidental causes in the Albuquerque Area. This represents 21% of the total number of deaths (619). Eighty-four (84) of these deaths were Motor-Vehicle fatalities and of these, tribal police and other officials conservatively estimate that 75% or 63 deaths were directly due to alcohol abuse.

Of the remaining 41 deaths by accidental means, a conservative estimate is that one-third or 14 deaths are directly due to alcohol abuse.

Cirrhosis

In the same two-year period, 58 Indian persons in this area lost their lives due to cirrhosis of the liver and 100% of these were alcohol-related. These figures in no way reflect the extensive morbidity and the drain on IHS resources of those with cirrhosis who did not die in that period of time but who may well be part of future mortality statistics.

Alcoholism

Again, in the same period there were 39 Indian persons who died with a primary diagnosis of alcoholism and in whom none of the other four alcohol-related causes of death listed here was a factor. Examples of precipating causes of death in this catagory would include pancreatitis, gastrointestinal hemmorrhage and pneumonia.

Homicide

Twenty-five (25) Indian persons were victims of homocide in the same period and of these, law enforcement authorities conservatively estimate that in 90% of these either the perpetrator, the victim or both were intoxicated at the time of the homicide. In the remaining 10% there is strong evidence that alcohol abuse is a related factor e.g., arguments over the recurrent drinking behavior of a family member.

Suicide

In this period there were 21 deaths attributable to self inflicted wounds among Indian persons in the Albuquerque Area, IHS and the vast majority of these were among young people - the Indian community's greatest resource.

Without hesitation, and based on ten years of experience in this area, I say that all of these deaths by suicide were alcohol-related.

A four-year concurrent study (1971-1974) of completed suicides in one Pueblo lends strong support to this impression. Of the nine completed suicides in this community, seven (78%) were known to have been drinking at or just prior to the time they took their lives. Of the remaining suicides, alcoholism abuse was known to be a disruptive factor in their lives even though they were not drinking at the time of their death. More than half (55%) of these suicides were under the age of 30.

Since these are mortality figures, they do not include non-fatal suicide attempts many of which were serious and life-threatening. (In this one Pueblo alone, in a four-year period there were 83 such attempts and 69 of these or 83% were known to have been drinking at or just prior to the suicide attempt. Eighty-seven percent (87%) of these attempts were by persons under the age of 30.)

A most conservative estimate of the number of deaths of Indian persons in the Albuquerque Area IHS (1973-74) which are directly related to alcoholism and alcohol abuse is 220 (63 + 14 + 58 + 39 + 25 + 21).

Of the total deaths (619) this represents a staggering 35%. And, it does not even include those deaths among all other causes of death that are, directly or indirectly related to alcoholism e.g., heart disease, stroke, diabetes, etc.

As an indication of what the actual mortality from alcohol-related diseases may be is a study of a single pueblo (1972 - 1973) in which 57 persons died during a 54 week period. Of these deaths 34 or 60% were directly attributed to alcohol abuse.

II. Alcoholism and Morbidity

Among the health problems affecting the American Indian in this area, many are directly related to the abuse of alcohol. These include diseases which cause acute pain and suffering, chronic disability, loss of productive time and earning capacity, family disruption for the individual. On IHS staff time, resources and contract health funds the impact is a major one indeed.

Such causes of morbidity which are directly related to alcohol abuse but which do not immediately (but often eventually) result in death are the following:

- Accidental injuries
- Cirrhosis of the liver
- Alcoholism as a primary diagnosis
- Attempted homocides
- Attempted suicides
- Malnutrition
- Pancreatitis
- Gastrointestinal bleeding
- Fetal alcohol deformities
- Mental and emotional disorders
- Organic brain syndrome
- Alcoholic heart disease

While morbidity statistics are not available to clearly link alcohol abuse with these health problems, experience in our hospitals and clinics certainly do support the link. In just one pueblo in this area, in just one year (1975), there were 258 admissions to the IHS hospital (23% of total admissions) for alcohol-related disorders additionally, there were 4,951 visits to the clinic (18% of total visits) for alcohol-related disorders. Also in addition, in the same pueblo, for a four-month period, $78,731 or 50% of the contract budget for that community was spent just for alcohol-related disorders.

If to these morbidity figures are added, those conditions which are <u>indirectly</u> related to alcohol abuse, the impact on the health and well-being of Indian persons becomes one of greatest concern to us all. Such conditions, which are indirectly related to alcohol abuse include:

- Infections including veneral disease
- Diabetes Mellitus
- Infant malnutrition
- Convulsive disorders
- Hypertension and heart disease
- Respiratory disorders
- Child abuse and neglect
- Neuritis

When morbidity from both direct and indirect alcohol-related diseases are considered a conservative estimate of impact on health and on available IHS resources can be made.

In a recent report (FY 1976) in which just five catagories of disease are considered the impact is significant:

- 1,124 of 3,238 PHS Hospital discharges were alcohol-related (35%)
- 7,352 of 24,040 hospital days were alcohol-related (31%)
- 32,593 of 183,121 clinic visits were alcohol-related (18%).
- 1,076 of 3,033 contract hospital discharges were alcohol-related (35%) but consumed $1.8 million out of a total contract budget of $3.2 million (56%)
- 2,680 contract clinic visits were alcohol-related (25%) and consumed $48,800 out of a total contract budget for this purpose of $174,800 (28%).

III. Alcoholism and the Law

While it is not, strictly speaking, a health problem the impact of arrests, incarceration and fines on the mental health, social stability of the American Indian and his family is significant.

Since many of the offenses committed by Indian persons are indeed alcohol-related and since some hard data is available, this section is included. It should be noted that the arrest data for Indian persons presented here are only arrests off-reservation (CY-1976) . Arrest data occurring on-reservation by tribal police and other authorities are not yet available. But reports by BIA law enforcement specialists and tribal police consistently point out that 90% of all arrests on reservation are a direct result of alcoholism and alcohol abuse.

The figures which are available for Indian arrests off-reservation show the following:

- 7,716 total offenses by American Indians CY-1976
  - 978 offenses against property (13%)
  - 473 offenses against persons (6%)
  - 6,265 offenses against public safety (81%)

In the largest catagory (offenses against public safety) are those offenses which are clearly alcohol-related:

Driving under the influence

Liquor law violations

Disorderly conduct

Curfew and loitering violations

Drunkenness is not reported since it is no longer considered a reportable offense. If it were still reported, the total numbers would be staggering.

IV Inadequacy of Alcoholism Program Staff

It must be mentioned briefly that the current Albuquerque Area professional staff assigned to address the problems of alcoholism and alcohol abuse consist of a Psychiatrist, half-time and one full-time Nurse.

This staff is responsible for providing technical assistance to all four service unit hospital and clinic staff, tribal governments and courts, law enforcement officers and the staff of fifteen (15) Indian community alcoholism programs throughout the area.

There is an urgent need for an immediate increase of 3 professional staff at the area level and one each at each of the four service units - total of seven.

There is an additional need for adequate funding of the 15 existing Indian alcoholism programs, none of which is complete and all of which are under serious strain to provide service. Alcoholism should be, in my judgment, a line item within the IHS budget if we are ever going to meet this problem with any chance of success.

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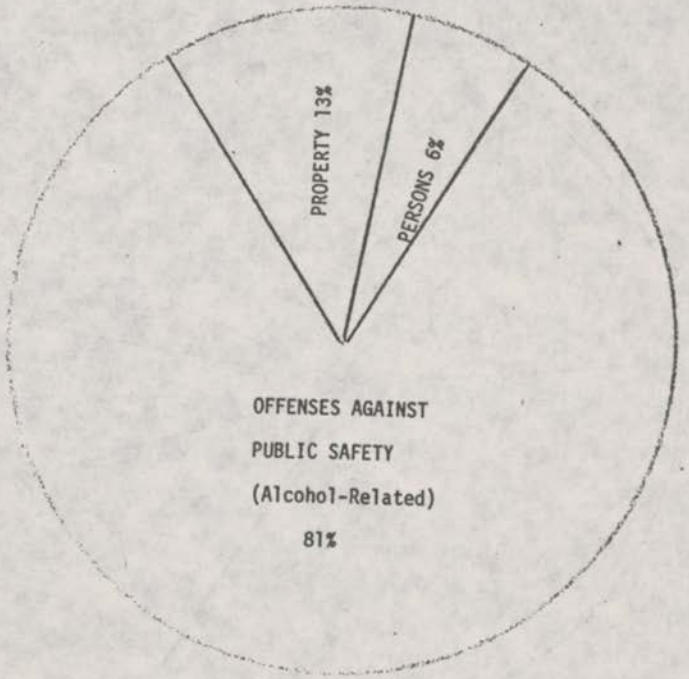
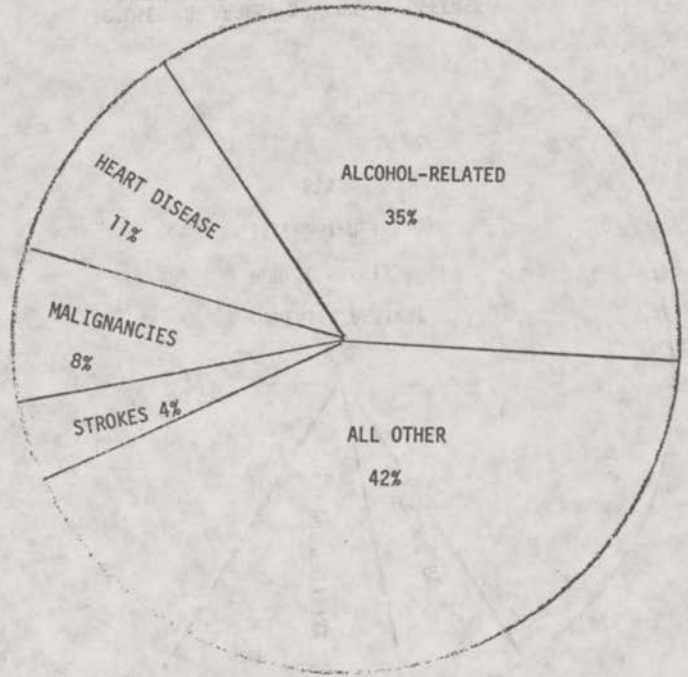


CAUSES OF ARREST BY TYPE OF OFFENSE
(JUVENILE AND ADULT) CY-1976
STATE OF NEW MEXICO EXCLUDING INDIAN LAND



CAUSES OF DEATH

VITAL STATISTICS
INDIAN HEALTH SERVICE
1973-74

ALBUQUERQUE AREA INDIAN HEALTH SERVICE

MENTAL HEALTH BRANCH

The following description of the Mental Health Program in the Albuquerque Area attempts to incorporate information which relates not only to content, specifically elements of service delivery, and structure, specifically operational principles and characteristics, but the programmatic, or management philosophy which provides overall program development guidelines as well. In addition, some developmental perspective will be included when it helps clarify a point or concept.

The Albuquerque Area Mental Health Branch operates with three primary types of organizational foci: the Indian communities, Service Unit hospitals, and the Area Office, with paraprofessional mental health technicians in the communities interacting with a multi-disciplinary team of professional mental health consultants based in the Area Office and Service Unit hospitals. With such an organizational structure, working within the comprehensive IHS health program and supplemented by such other resources as exist or can be developed in the area, the Albuquerque Area Mental Health Branch attempts to approach the goal of providing a comprehensive community mental health service for the 35,000 or more American Indians residing in this area: in the cities of Albuquerque and Santa Fe, and in twenty-six tribal communities served by the four Albuquerque Area Service Units.

Since 1966, the Mental Health Branch staff has grown from one psychiatrist to a current staff of twenty-four. This includes seven professional positions, thirteen mental health technicians positions, and four clerical positions. Each professional consultant is responsible for a geographical area encompassing several tribal reservations, while each mental health technician is

resident within and a member of a single reservation community. Since there are twenty-six reservations in the Albuquerque Area, it is apparent that half are without the services of a mental health technician, while each consultant must attempt to provide services to as many as six reservations, with distinct cultures and languages.

Because of the nature and distribution of the Albuquerque Area Indian populations, it would be desirable eventually to place a mental health technician with each tribe, since even when adjoining tribes speak idential languages, their cultures and social organizations may be so different as to render a technician from one tribe ineffective in the other. Since some of the tribes in the area are quite small, a goal of one mental health technician for each tribe of 500 or more population has been approached, backed up by one consultant for every two technicians. Nine of the tribes, however, have populations of less than 500, based on 1975 census figures.

The program delivery philosophy is to pair a mental health professional with a mental health worker who is a resident participating member of the community where he, or she, works. This team approach generally facilitates the integration of both perspectives and results in what we believe is a more appropriate program response. The co-professional relationships that have developed between the team members are based on mutual respect, shared interests and genuine friendships. These factors, as a basis, allow for a more open exchange of information, a clearer collective delineation of problems, and the more precise integration of theoretical, conceptual, technical, social and cultural information. In this respect, the product of each collaborative effort results from an attempt to tailor the response to the needs of the individual(s), within a specific social setting in a unique cultural context,

i.e. a psycho-socio-culture specific response. This may sound presumptious but we nevertheless believe it to be, for the most part, true. Frequently, a major portion of this effort is spent in determining what "can" be done within the framework of what "needs" to be done. This is generally the case whether the effort is educational, programmatic or case specific.

It must be borne in mind that community mental health workers, both consultants and technicians, must spend about half or more of their time in the following essential non-direct patient care activity categories...

Proceeding from the more general, diffuse activities in which the nonprofessional, or personality, or previous life experience attributes of the mental health worker, professional or nonprofessional, have greater importance than the more specific, focused, professional activities:

1. Getting acquainted and establishing working relationships: both initial contacts with agencies, organizations, community representatives and groups, and other workers, and later contacts also which have no direct or specific program content, but do have implications or potential for programs and are, in fact, a necessary preliminary to developing programs in areas with administrative, political, socio-economic, cross-agency, cross-cultural or regligious sensitivity. Such contacts may occasionally be social in nature ostensibly, but are nontheless essential.
2. Facilitating or developing interagency communication, referrals, and coordination of existing resources: taking the initiative in making such a network effective often playing a catalytic role. Many individuals in our area, not necessarily identified as patients, experience significant impairment in carrying out many of the usual functions of living, for which mobilization of a support network is

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often more relevant than direct care or for which optimal care will more likely result from identification and intervention in a variety of community contexts, such as schools, workplace or in the home.

4. Conducting case consultation: indirect service, assisting physicians, teachers, etc., in their provision of direct service.
5. Providing mental health information or conducting education and training programs with tribal groups, teachers or counselors, hospital staff, other agency staff, etc.
6. Helping develop mental health or mental health-related programs and facilities: assisting via committee meetings, discussions, etc., in planning, organizing, developing or stabilizing, for example, non-IHS alcoholism programs, treatment centers for the handicapped, etc.

The seventh category of community mental health service activity is direct patient care. This is a high priority category, of course, but even if we had adequate staff to provide direct patient care whenever needed for all age groups and problems, we encounter so many individuals and problems requiring multi-agency and multi-disciplinary input, that the need is inescapable to expand much or most of our time and energy in the first six categories.

Incidentally, in this regard, mental health services and medical social services may be identical in all categories except direct patient care and perhaps case consultation. Mental health workers are expected not just to assist, but to take charge with as full responsibility as necessary and possible of patients considered emotionally disturbed, of any degree of difficulty or complexity. While this is especially true in a hospital setting, it is also true in the field where a mental health worker is ex-

pected to take charge in getting such a patient into a hospital if necessary. In other words, the difference between mental health services and social services is less a matter of different training, skills, or functions than of different expectations by others in the health system, especially physicians and administrators, and of different degrees or channels of direct patient care authority and responsibility. In crisis situations, the mental health service is perceived as a medical service and cannot evade medical responsibility. In non-crisis situations, this is less so; in fact, it is often essential in non-crisis situations to avoid being perceived as too medically oriented.

During FY 1977, Mental Health Services data show 3,852 patient contacts, representing over a thousand patients seen by the Albuquerque Area Mental Health Staff. In excess of 75% of these contacts specified the following four problem areas as the primary reason for the contact.

	Number Contacts	% of Total
Individual problems	1,779	46.2
Alcoholism - Drugs	536	13.9
Family Services	365	9.5
Med. Liaison	294	7.6
	2,974	77.2%

More interesting perhaps is the fact that six specific problem codes of the 83 possible account for 60% of the contacts.

	Number Contacts	% of Total
Depressed	667	17.3
Anxiety	532	13.8
Alcohol Problem	473	12.3
Adult-child Relationships	237	6.2

Marital Conflict	202	5.2
Confused-disoriented	183	4.8
	3,852	59.5%

If the data included those contacts where alcohol problems were secondary or contributing, we estiamte that about 75% of all contacts would be included.

It is of interest to note that when percentages of total patient contacts by age category are compared with percentages of population by age category, only about 11% of the patients seen were under 15 years of age -- a category that makes up almost 44% (43.6) of the total service population.

What the data do not show is the amount of time expended in making many of these contacts in the field; the missed appointments, the telephone calls, the discussions and consultations with others working on the same case or with family members. There are few "fifty-minute hours" in Indian mental health practice, and few patients are seen in the therapist's office.

The data also do not indicate time spent visiting about fifty schools and dormitories with some degree of regularity, from weekly or monthly, to whenever called on, and making patient care services or referrals available thus to about 16,000 school age children.

The overall program effort is establishing and maintaining a services delivery network and facilitating responses within that network. Toward this end the branch has developed and helped maintain a series of contracts with appropriate resources outside PHS. These include contracts for services from specialized programs, and individuals with specialized skills. Examples would include the resources of the Albuquerque Child Guidance Center, a facility which provides special evaluative, diagnostic and therapuetic services to children and adolescents, and their families; the school of social work in the College of Santa Fe which has maintained an educational and counseling mental health program at Saint Catherine's Indian School in Santa Fe for the past three years; and the several individual contracts with specialist, e.g. speech therapist, child psychologist and educational diagnosticians. In addition to these contracted resources, the branch has made a special effort to locate and use, on an as needed basis, resource people who have interests, skills, and sensitivities appropriate to the problems of Indian people and Indian communities. In this effort the evaluations of these resources made by the mental health worker has been quite important.

Equally important is the explicit recognition that this process is of necessity dynamic and require constant reassessment, evaluation and reformulation. As new programs within other services or agencies develop, and as directions, philosophies or personnel change in existing programs, attempts are made by branch personnel to restructure the network to fill the "gaps", to respond to newly defined or re-defined problems and to develop, strengthen or integrate appropriate resources.

This concious effort by branch staff to recognize the programmatic need to remain flexible, to avoid "closure", to clarify ambiguity, and to constantly

examine our assumptions has in, and of, itself created some problems for our program, since it sometimes makes it difficult to make general statements about program content. Careful attention to process in program development and maintenance is not necessarily an accepted practice in a bureaucratic system.

It is important to understand that in the early developmental phase of the program, services delivery were emphasized over program definition. The staff felt that the latter could only come from acquired experience in the former. In addition, it was felt that in order to facilitate community acceptance and use, the effort should be directed primarily at responding to community definitions of need. In this respect, the program was responsive but generally passive, maintained a relatively low profile, and was careful not to imply or promise more than could reasonably be delivered. This is not to say that the program was not active, rather that this activity was focused on trying to find solutions, not on trying to find, or define problems for the community. Generally, it was felt that this approach would result in a program that was specifically responsive to a given community. We believe that this approach generally paid off in the development of acceptable, responsive solution oriented community mental health programs. The term "programs" is used advisedly since we have recognized that in some respects our current program is an aggregate of community specific programs operating within the framework of an overall effort. While this has resulted in a more responsive and flexible program at an overall level, it also means that any community specific program component is primarily defined by that community on the basis of the program's ability to respond to that community's definition of need and demand. Consequently, any programmatic shift in a specific community will have to be accompanied by an acceptable justification. This is especially

true when the proposed shift in program focus will necessitate a reduction in some kinds of services currently being provided in that community.

One increasingly obvious problem in our programmatic effort is that unless we are able to develop more acceptable and effective methods of earlier intervention and prevention we will remain on the "backside of the power curve" in effectively meeting the mental health needs of the communities. The preponderance of our current case load is made up of adult patients with problems of some time depth. Many of these problems are complex and difficult to deal with, requiring a considerable investment of effort and energy. It is probable that some of this effort and energy could be more effectively used if we re-focused on a younger segment of the population. We are aware of, but currently unable to get much of a purchase on, instances where adolescents and teenagers are beginning to have difficulties. We can anticipate that some of these kids will be our next round of patients but right now they are in the background, the issues not quite serious enough for our network of services to be called into the situation or low priority problems in a system where increasing crisis demands are made on a limited resource network.

There are several inter-related problems involved in attempting to deal with this situation. Since the communities themselves are an important recognized element of our current system, some shift in community perception and utilization of the mental health services will have to occur. As noted above, our program, of necessity, developed its essential character as a result of demand, i.e., ability and willingness to respond to requests for services, and since the program's community perception, and credibility is linked to what we are currently doing, some careful thought will have to be given to how we justify, without loss of credibility, a major or minor shift of effort.

In addition, the increase in the number of community based programs over the past three or four years has been accompanied by a steadily growing number of referrals to, and requests for services from, our Mental Health program. This increasing workload has caused us considerable concern about the appropriateness of allocations of effort and monies in the program. All of us have, at one time or another, wondered about how well our efforts actually meet the needs of the communities. We are increasingly busy, but we wonder whether what we are doing is what we should be doing. Not satisfied that we currently have the information on hand to attempt to answer the questions that these concerns generate, we have initiated a project designed to develop the appropriate materials from which to be able to approach the problem. The first phase of this project is directed at establishing an ongoing data base including more objective measures of the problems on a community basis, of sufficient time-depth that the numbers involved are statistically meaningful, and organized in such a way that a clear distinction between people and problems can be carefully maintained. We expect to be able to use this material for program evaluation and resource allocation; as a base from which to begin a more serious discussion of the development of standards of care; and eventually as a means of gaining a better understanding of the processes involved in the development of the problems we are asked to deal with, hopefully such that we could intervene earlier, more effectively and conceivably more efficiently.

We do not necessarily expect this material to provide answers to questions relating to the status of the mental health of New Mexico Indian populations, rather, we see it as a context within which other sources of data, e.g., Social Services and Mental Health report materials, APC information may be interpreted and assessed. Since our overall aim is to carefully evaluate our mental health program in IHS, this effort is seen as establishing a base-line

of quantifiable, statistically valid, information sufficient to assess, evaluate, and more appropriately determine program priorities.

Clearly part of the answer would be to increase manpower and monies in the program. These are limits, however, to the amount of additional resources our program could effectively integrate and still maintain its essential character.

As the foregoing discussion indicates, we do not expect to deal with the issue of improved mental health care solely on the basis of additional resources, rather, we are currently in a phase of reassessment and redefinition, directed at a new synthesis within a more appropriately defined set of program goals, strategies and priorities. Some changes in what we are doing and how we are doing it are both clearly needed, but we intend to attempt to formulate these changes from a more definitive picture of needs, resources and priorities.

One issue that has recently developed is derived from the complex set of problems involved in the states rights vs tribal sovereignty conflict. Since we expect that it is only the forerunner of a series of jurisdictional problems which will effect program development and patient care, it is worth including here.

During the 1976 session of the State legislative, a new Mental Health Code was adopted for the State. It is in keeping with the current concerns for patients' rights and clearly defines the procedures for involuntary hospitalizations. Our problem with the code derives from the fact that the only court recognized as legitimate in this process is the state court. A recent federal court decision in South Dakota held that under a similar set of circumstances, i.e., involuntary hospitalization of an Indian patient, the state did not have the authority to legitimize the process. Fortunately, we have not had a large number of Indian patients who required involuntary hospitalization. However,

the code specifies this same process for all placements of adolescents and children under 16 years of age in any state operated facility. This particular section for all intents, effectively denies access to state facilities or residential programs to all Indian children and adolescents who reside on reservations.

We have generally been able to work out alternative methods of dealing with those adult patients who might be effected by this legislation, but have yet to work out satisfactory solutions to deal with adolescents.

Development of the Indian Children's Village, the diagnostic and treatment program included in the comprehensive Indian Health Act and designated for development in the Albuquerque Area, will undoubtedly help in the resolution of these problems.

NOTE: The term Native American as herein used applies equally to U.S. Indian and Eskimo population

Indian Health Service Mental Health Program

In contrast to the terrible conditions on and around reservations today, centuries ago the original inhabitants of this country possessed a social order of unsurpassed strength and harmony. The first Europeans to meet Native Americans were fascinated by their ability to govern themselves, to raise their children, and to care for their sick and disabled. The adults were dignified, self respecting and productive; the children were well cared for and educated within stable families; the old people were venerated for their wisdom and leadership. Complex and subtle medical systems from which European medicine is still learning cared effectively for a variety of physical and mental illnesses. Crime, child abuse or neglect, and the misuse of intoxicants were virtually unknown in a society without police, jails, or institutionalized welfare support. Cooperation and generosity were universal in coherent communities that lived in balance with nature.

It is a sign of the great strength of these people that they and part of the way of their life have survived the countless factors impacting on their survival. Military conquests, diseases, and the introduction of alcohol as a means of exploitation and subjugation, either destroyed or were destructive to communities and their way of living. Supposedly well meaning attempts to educate Native people undermined family relationships, destroyed self-respect, and introduced new conflicts. In spite of all this, Native

American people have endured. This survival, although meager in many instances, is due to the continuous efforts of tribes and other groups to heal their sick and resolve their own conflicts. Until quite recently, they received more hindrance than help in these efforts. In the last decade however, there has been some recognition by the federal government that it has responsibilities for helping Native Americans to cope with problems of alcohol abuse, family disorganization, delinquency, depression, suicide, and other facets of mental illness. The Office of Economic Opportunity, the National Institute on Alcohol Abuse and Alcoholism, NIDA, NIMH, and the Indian Health Service have provided varying degrees of support for treatment and prevention programs. Many of these are largely staffed and directed by the communities themselves and the success of these programs has again demonstrated the resiliency and endurance of the Native American people. However, because of inadequate support, many communities still have tremendous unmet needs, and unresolved chronic mental health problems.

The Indian Health Service has begun to solve the problems of providing good mental health services to the American Indians. In all areas, programs are developing that have shown the possibility of overcoming the barriers of language, cultural difference, mutual misunderstanding and prejudice. If the mental health program can grow to the point where it can reach all of our patients, we will have the chance to find and demonstrate methods that will be of use to the vast portion of mankind also living in tribal groups in conditions of rural poverty. The Indian service mental health

program can be a model for ways of reaching millions of people in Asia, Africa, Australia and South America. This would strengthen the philosophy of respecting humankinds, human and unalienable rights.

Before the beginning of the Indian Health Service mental health program, Indian people in need of psychiatric care, were referred to psychiatrists and other professionals most of whom were lacking in knowledge and acquaintance with the realities of Indian life. The resulting encounters were usually confusing and discouraging to both patient and physician. We have found that greater acquaintance with Indian language, customs, and conditions relieves this confusion and enables us to see that our psychiatric patients are more similar to us than otherwise, and that cooperative work is quite possible.

Two basic requirements for mental health work with Indian groups have become clear: A continuing effort to understand Indian life, ideas, and language; and the participation of Indian people in our programs. If these requirements are met and are supported by adequate appropriations by the government, it becomes possible to solve the difficult problems of serving an impoverished, scattered and often isolated population. The solutions to these problems necessarily vary from one reservation to another, but the basic requirements remain the same.

The development of the mental health program to an adequate level is essential to raising the general health standards of the Indian people and to helping them to fulfill the potential worth of their society.

The Indian Health Service Mental Health Program is basically teams of mental health professionals, strategically located throughout an

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Indian Health Area who train, supervise and back-up the work of a large number of Indian paraprofessional mental health workers. In addition to providing direct services to psychotic or other severely disturbed patients, these professionals and paraprofessionals provide consultation Services to service unit personnel, Bureau of Indian Affairs boarding schools, Tribal governments, law enforcement and other local agencies.

The objective of the program is not only to provide services to the mentally ill, but also to assist the mentally well by presenting alternatives to secure the greatest possible mental health advantages.

The ideal is to have at least one professional in each large Indian reservation community, and an Indian mental health worker in each reservation community thereby expanding the services of the professional through trained paraprofessionals. The model provides multiple access points to services since all act as "gate keepers". The mental health program based on this network of available services can be described as a program of support, constructive intervention, and prevention planned specifically for the community it serves with the advice and involvement of the leaders of that community. The goal of the IHS mental health program is to assist the Indian person in reaching or maintaining an acceptable level of mental health.

The Indian population of federal reservations is approximately 576,000. There are in excess of 500 Indian, Eskimo and Aleut communities speaking 300 languages. Many of these communities still receive no or only sporadic mental health service. Alcohol abuse, suicide, family disorganization, violence, depression, apathy and dependence are problems which are still far

too common. In the past decade, the Indian Health Service with the assistance of various federal agencies has set up a variety of mental health programs largely staffed by Native American people and especially suitable to the needs of Native American patients. These programs have demonstrated the possibility of meeting Native American mental health needs. They have not, however, reached all of the people who need them because resources have so far been too limited. If additional resources are made available, it would make possible a very large step toward fulfilling the needs of the Native Americans by improving boarding school conditions which now produce mental illness, by setting up diagnostic, evaluation and treatment centers for disturbed Indian children, by providing inpatient psychiatric care to meet the specialized needs of severely disturbed Native American patients, by expanding the field mental health programs of the Indian Health Service so that they can reach communities not served, by helping to preserve Native American healing traditions which have been serving their people well for centuries, and by increasing the number of, and expanding present Indian alcoholism and drug treatment and prevention programs.

One additional equally and badly needed service is in the Area of Community Mental Health Centers. Of the 547 Community Mental Health Centers through out our country, not a single such center is located on an Indian Reservation, nor are any of these specifically designed to serve the large urban Indian population.

In fiscal 1976, Congress directed the National Institute of Mental Health to undertake a study of the mental health care available to Native

Americans and problems particular to them.

This mandate is found in Senate Report No. 94-366, dated September 10, 1975, and reads as follows:

"The Committee is most concerned with the extremely high incidence of mental health problems affecting Native Americans. The latest figures available to the Committee indicate that while the suicide rate for the Nation as a whole was 11.9 per 100,000, the rate of suicides among Indians was 19.4 per 100,000 and among Alaskan Natives was a staggering 35.0 per 100,000. The Committee urges the Institute to develop a program aimed at improving the mental health of our Native Americans."

Our subsequent experience indicates relatively little actual NIMH program change has occured with reference to Native Americans. In the State of South Dakota, there is an attempt being made to have Indian representation on the advisory board to the Community Mental Health Centers since the area catchment population has significant numbers of Indian people. There are indications that an Indian staff person may be hired in two new South Dakota Community Mental Health Centers. However, no additional progress or new programs funded by NIMH since 1975 can be ascertained. We are, however, hopeful of the intent of the Director NIMH and our efforts will continue to further develop collaborative programs.

We suggest that consideration be duly given to the establishment of such centers, staffed by and for Indian people.

H. C. Kennedy, M.D.

P.L. 94-437 Title II

Activity: Indian Children's Village Area: Albuquerque

Resources:	Fiscal Year	Position	Amount
	FY 1978	20	$360,000
	FY 1979	20	$297,000
	FY 1980	10	$360,000

A. DESCRIPTIVE PROGRAM INFORMATION, INCLUDING GOALS/OBJECTIVES

I. Background:

There is an unmet need for bringing diagnoses, therapy, education, training and follow-up for Indian children who are handicapped up to an acceptable level and insuring adequate training for those professionals and para-professionals who serve the handicapped.

The recognition of this unmet need has come about as a result of IHS long range study and planning, surveys done by Indian organizations and tribes and increased sensitivity of Indian parents to the comparative inadequacies of their children's care.

Public Laws -142 and 94-437 make feasible a significant forward step toward equity of opportunity for handicapped Indian children.

Public Law -142 mandated education and related training and care for all handicapped from age three through age twenty-one. Congressional sensitivity and HEW/INTERIOR awareness led to designation of BIA to serve in essence as a fifty-first state to insure delivery to Indians. This necessitates outreach to locate all handicapped people between the ages of three and twenty-one - by

law - and such a "child find" program is now on going.

To be effective in education and related activities there is a need for definitive diagnoses. In many instances this can only be accomplished in a residential facility.

Public Law 94-437 authorized developing just such a center in Section 201 of Title II. By implication outreach, diagnoses and evaluation, integrated curriculum and therapy, monitoring and follow-up are all integral to complete service for the handicapped.

Operational Considerations:

1. It has been determined that this national resource will be located in the Albuquerque Area.
2. Existing facilities which can be brought up to acceptable standards will be used with new construction as an alternative.
3. The Albuquerque location permits ease of liaison with the Chief of Mental Health, IHS, and the head of BIA Special Education.
4. The University of New MExico and its Medical College staff have indicated intent to support.
5. There is relative nearness to the large Indian population and Albuquerque is central to the national Indian population.
6. Expansion can include enlargement of the initial operation or replication.
7. To meet with the intent of PL-142 and PL 94-437, it appears that early operation with phased development of functions is the best course of action. Based on this concept, several steps have been taken.

8. PL 94-437 resources have been programmed for the Indian Children's Village -

	1978	1979	1980
Personnel	20	20	10
Funding	$360,000	$297,000	$396,000

These resources are above Area 437 quota.

These figures are cumulative.

9. An Indian Children's Village development team has been established using Albuquerque Area MCH and MH personnel. This team is being supported on request by Area and IHS Headquarters as needed.

10. The team has established liaison with appropriate focal points in HEW, EDA, the New Mexico State Government, and some local organizations, National organizations including civic clubs will be briefed later.

11. There will be a Board of Directors which will include:

a. Chief of Mental Health, IHS

b. Chief of Maternal & Child Health of IHS

c. Chief of Special Education of BIA

d. Chief of Pediatrics, UNM

e. Chief of Psychology, UNM

f. Chief of Psychiatry, UNM

g. A banker

h. A lawyer

i. At least eight Indian people who have demonstrated interest in health and education of the handicapped.

12. There will be a Professional Advisory Board. It will be a sounding board for the Development team initially and for an Executive Director, ultimately. The educational, technical and medical disciplines active in the center will be represented as appropriate.

13. It is assumed that IHS Headquarters will support all developmental aspects of The Indian Children's Village. These will include expediting funds and personnel, acquisition, negotiation for construction and negotiations with BIA for educational and support people (e.g. food service and yards and grounds and building maintenance) as well as surrogate parents and transportation people.

14. It is assumed that travel funds and one secretary (GS 6 or 7) will be provided to support the Development Team, IHS engineering teams and contract negotiations and consultations.

15. The phasing of operations is basically a transition from:

    a. Emphasis on field work and case find with start up of residential services

    to

    b. Field monitoring and full residential services

    to

    c. Full residential diagnoses, treatment, social service and monitoring supplemented by halfway houses, day care, special classes, occupational relying and monitored home care.

16. Duplication of resources and activities already existing in IHS or in this vicinity will be avoided. (e.g. EEG)

17. Pre-admission evaluation and testing will be done where feasible. (e.g. blood counts).

18. The referring IHS Area will assume responsibility for contract medical care costs and obtaining parental permission for diagnosis, therapy and emergency care.

19. Third party payments will be used when available and construction will meet Title 18 and 19 standards as will services.

20. HEW and BIA educational funds will be used to maximum appropriate extent. EDA and other construction resources will be explored.

21. Association with existing Indian facilities and non-Indian facilities for education and care of the handicapped will be established.

22. Affiliation with national associations for "The Village" and its staff will be an objective.

23. The University of New Mexico and other academic facilities relationship will include use of their facilities and services, on-site visits and assignment of interns and externs.

24. Data collection and analysis will be correlated and coordinated with the national IHS resources located in Albuquerque.

25. An adequate on-site library will be backed up by University, public and private resources.

26. State Crippled Children's Service eligibility will be used as a basis for joint support of Indian Children's needs.

27. Maximum structural protection will be provided through construction planning and personnel training to prevent fires, accidents and self inflicted injuries.

    Attention will be given to fencing, sidewalks, storage or toxic agents, use of protective glass, suitable railing, locks, ramps, padded furniture and walls, non-skid surfaces, etc.

28. The cottage plan for housing will permit admission isolation, crib care, special diets, protection of the emotionally disturbed and comfort for the physically limited.

29. Range of cases will ultimately be from birth to twenty-one years and will include the spectrum of the handicapped - physical, retarded, mental, emotional, congenital, acquired and multiple. This is made feasible by combining the cottage approach with individualized curricula and therapy.

30. The cottages also allow for use as respite homes and for staff contact with families on admission or discharge.

31. Case records will be handled in accord with both the Privacy Act and the laws governing access. Adequate personnel training in these areas will be provided.

32. Initial transportation to and from "The Village" will be a function of the referring Area. Local transportation will be arranged with BIA, local school systems or an assigned ambulance.

33. Communications will include an eight hour switchboard, intercoms and a night phone. There will be a duty administrative and professional O.D.

III. Personnel Notes

1. There will be an Executive Director for the Indian Children's Village who will be a physician experienced in administration and care of the handicapped. He will also serve as the executive secretary to the Board of Directors and to the Professional Advisory Board. This position will be filled within six months after appropriations have been obtained.

   The Executive Director will report to the Board of Directors. His responsibilities will include accounting for a fiscally responsible and effective operation in accord with highest professional standards, applicable governmental regulations, the parameters of Indian culture and the intent of PL 94-437.

2. The Deputy Director for Professional Services will coordinate clinical care and diagnoses with educational care and diagnosis and will insure individualized curricula integrated with rehabilitation and specific therapy as well as needed follow-up.

3. The Deputy Director for Administration will coordinate budget, acquisition of equipment and supplies, assignment of space, personnel matters and other administrative functions.

4. Social Services will have a broad function including participation in case find and monitoring teams, liaison with tribal and state social service and staff consultation.

5. Nutrition and Dietetics Service will include overall control of food service, special diets and parental guidance.

6. Nursing Service will include day to day medical care, immunizations and first aid as well as participation in case conferences and field trips.

7. The educational coordinator will integrate cottage care, the rehabilitation through education, educational diagnosis, class work, art therapy and music therapy. This will be closely coordinated with the special therapies (physical, speech, occupational and recreational).

8. Speech and hearing therapy will be conducted in accord with services already existing in the Albuquerque Area in the IHS or under contract.

9. Alcoholism* - often an additional handicap will be handled in conjunction with existing plans and policies.

10. Dental care will be by a non-assigned exam from the Albuquerque Area with contract specialists for complex problems.

*Not coordinated with Dr. Andre as yet. Other functions.

11. All therapy will be culture oriented.

12. Professional competence and Indian preference will both be stressed in acquiring personnel. When possible handicapped people will be employed.

13. A phased personnel plan based on IHS employing fifty people by 1980 follows. Personnel positions to be filled will be compatible with annual increments of 20 - 20 - 10 and with the phased increase of functions previously referenced.

RESIDENTIAL THERAPY

The core of The Village's diagnostic and treatment approach is the concept of residential diagnoses and follow-up therapy, based on the idea that every experience in the daily life of the child shall be therapeutic for him. All phases of his environment - social, educational and recreational - will be designed and controlled to meet both his emotional and his intellectual needs. Sound relationships will be carefully fostered with staff members who can help promote growth in many areas. Competition and stimulation will be strategically regulated depending upon the capacities of the child. Structure will be supplied where necessary, leniency where indicated. Each day will be planned and supervised to encourage success and achievement, to discourage frustration and failure. My personal experience confirms that the result of these efforts is a healing, restorative force which greatly enhances formal treatment and therapeutic educational programs.

CLINICAL TEAMS

Because each person is uniquely individual, each child will be considered on an individual basis, his program tailored to his own needs. This 24-hour daily program will be planned and conducted by Clinical Teams composed of professional representatives from the fields of therapeutic education, psychiatry, psychology, medicine, and social work, all cooperating to continually assure the best treatment approach for the child. This multidisciplinary teamwork, in which different viewpoints are contributed to modify or reinforce findings of others, will enable a synthesis of each child's skills, apitudes, attitudes and physical conditions to attain one objective: the highest emotional, mental, spiritual and physical development of the child.

THE HOMOGENEOUS UNIT - "THE COTTAGE CONCEPT"

The treatment program is designed for children who present a wide range of clinical categories and who represent vastly differing age groups. To achieve both treatment and academic progress, patients will be grouped homogeneously, according to program needs, diagnostic findings and chronological age. Each child resides in one of 26 geographically separate units. Independently staffed and operated under the direction of a central administration, each unit provides a warm, homelike atmosphere, with a close staff-to-child ratio, where virtually all of the child's program requirements can be met. Educational as well as home, recreational and treatment facilities are closely related and the atmosphere is conducive to participation in rewarding group activities and to the development of close personal relationships both with peers and staff members.

Upon enrollment, the child is assigned to that unit which, in the opinion of the professional staff, best suits his needs at that time. As the child progresses in his program, subsequent evaluations are made, which may indicate transfers to other units to accommodate the child's changing needs.

The goal of most enrollments is the child's return to his family and community, under the direction and guidance of his physician or the referring professional person. For those individuals whose intellectual potential is severely limited, however, the need for shelter and protection in a structured environment may continue indefinitely in another location. The same type of warm, homelike environment should be provided for these youths in small, self-contained community-like settings. Here, limitations and disabilities can be accepted and opportunities for personal achievement and self-respect assured. The community environment enables a degree of fulfillment unattainable in competitive society.

while encouraging growth socially, intellectually, and emotionally. Grouped according to age, social needs and learning aptitudes; each is offered a daily program which may include arts and crafts activities, specific tasks within the unit, or, where possible, sheltered workshop or vocational training assignments in various activity areas within the treatment centers. The aim is effective treatment for living, rather than a system of training or custodial care.

EDUCATION PROGRAMS

A full therapeutic educational environment from kindergarten through high school will be available through the Village. Instruction will be highly individualized, consisting of either private lessons or work done in very small groups. The actual curriculum will range through all of the offerings of a modern school system. For example, a high school course of study may vary from the most intensive academic roster to a general or vocational roster of any degree of intensity indicated.

Academic performance is regarded as a function of the total personality; and both competition and demand will be carefully structured and controlled according to individual emotional maturity and intellectual and physical capacities.

After transferring from the Village, some youths will experience scholastic success at grade-level. Others will experience success in the practice of a trade. Still others, with retarded or impaired intellectual function, will achieve self-support and self-confidence by acquiring skills of artisanship or other productive techniques which come within their range of capability. Whatever the range of abilities involved, the goals of personality development and reasonable challenge will be paramount in every therapeutic educational activity.

RECREATIONAL PROGRAMS

An extensive recreational, extra-curricular program will be an integral part of The Village offering. There will be encouragement to participate in culturally oriented games, sports, social and artistic pursuits, and other activities in order to develop skills in non-academic areas.

Sports activities will range from the simplest non-competitive games among more limited children, to inter-unit contests and competition. Shopping trips, visits to museums and similar cultural outings, as well as bowling, movies and various field trips will be all a part of The Village recreational program.

THE VOCATIONAL REHABILITATION PROGRAM

For those youths whose interests and abilities are essentially non-academic, there will be a flexible vocational rehabilitation program which will seek to identify individuals with aptitudes and abilities along vocational lines and develop these capacities to the full potential of the individual. The program will include a government certified sheltered workshop, as well as on-the-job training opportunities.

It is projected that some youths will perform a variety of bona fide industry operations under conttact with local firms for which they will receive a regualr paycheck. On-the-job training, for which they will be also compensated, encompasses many of the varied day-to-day functions of a residential treatment center ranging from indoor and outdoor maintenance, to food preparation and service, housekeeping work, child care, etc. The purpose of these programs is to encourage all students to know the rewards of performing a meaningful task, and to open doors to job opportunities for those who leave The Village.

The vocational program will include a modified school curriculum consisting of

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basic arithmetic skills, oral and written English and social studies. Programs will be individually prescribed according to the recommendations of the clinical and educational teams, with schedules determined according to individual needs with continued counseling and close personal supervision.

The Villages mobile teams will visit homes, schools and other programs to which children are discharged to the maximum possible extent to insure a productive monitoring.

Albuquerque Area

SAFETY - INJURY CONTROL - ACCIDENT PREVENTION

Problem:

Accidents account for 20% of all Indian deaths in FY 1976. There were over 132,118 Indian People injured in accidents (9,413 in the Albuquerque Area). Costs for treating accident victims exceeded $12 million in FY 1976. (Albuquerque Area over $500,000). 16% of all IHS Hospital beds are taken up by accident victims. Hospitalization due to accidents are exceeded in the Albuquerque Area only by hospitalization due to pregnancy and childbirth. The death rate due to accidents among American Indians is 3.7 times higher than the national average. The Albuquerque Area has an accidental injury rate of 225 per thousand population. Injury and death due to accidents are without question the principle health problem facing Indian people today.

On September 28, 1974 President Ford signed Executive Order # 11807 ordering all federal agencies to implement all aspects of the Occupational Safety and Health Act (OSHA) of 1970. HEW Safety Manuel standards implementing this order indicates requirements on staffing, inspections, reporting procedures, investigation and training of staff. Recent legal opinions on OSHA and liability of the federal government, with specific reference to safety officers' liability, has caused greater and greater emphasis to be placed on this aspect of the program. Since mandatory action is identified under these directives it has tended to place limitations upon our primary initial objective of reducing the accident problem among our Indian constituents.

Solution - Plan of Action:

Accidents can be prevented by implementing the same techniques applied to any other preventive medicine activity. The same principles of epidemiology apply. The chain of accidents can be broken by reducing or removing "unsafe acts" or "unsafe conditions" through training, inspections, motivation, surveillance and accident investigations.

Reduced highway speed limits in FY 1974 have already resulted in a drop in Indian Motor Vehicle accidents. Similar reduction due to fire and poisonings are becoming evident with the concentration on building inspections (heating and electrical), fire prevention services and training in storage of poisons and drugs, lock-top medicine bottles, more explicit instructions by pharmacists to patients etc. Similar results could be anticipated in other accident problem areas.

We have noted a statistically identifiable trend in a lowering of accidents due to falls, machinery accidents, fires and drownings in the Albuquerque Area for a three year period since we began to place emphasis on community injury control. Two thirds of the tribes with safety programs have shown either "reductions" or "no increase" in injuries for two and three year periods. Tribes without organized safety programs have shown routine increase in eleven reservations with incidental reduction in only three. It appears that even with minimal input a beneficial reduction in accident rates can be realized. Similar observation are now evident with the OSHA efforts in private industry which should also manifest itself in governmental agencies as statistics can be compiled.

1. Establish within the Occupational Health & Safety Branch three (3) professional safety officer positions to be located at (1) Santa Fe Service Unit. (2) Albuquerque Service Unit, (3) Grants Field Office. These individuals would provide the technical support to tribal groups in implementing a safety program and provide the necessary training, inspection-survey surveillance services and motivational work necessary to carry out an accident prevention program. They would be the primary support and backstop for the CHR/Safety Officers currently being established in several reservations.

2. Expand the CHR/Safety Officer program to include at least several more major reservations such as Jemez, San Juan, Jicarilla, Six Sandoval and Ignacio Ute. We presently have CHR/Safety Offiters as follows:

(1) Isleta
(2) Zuni
(3) Santa Clara
(4) San Ildefonso
(5) Laguna
(6) Taos
(7) Zia
(8) Mescalero
(9) Canoncito
(10) Alamo
(11) Acoma
(12) Santa Domingo (application pending)

4. The addition of three professional position would permit compliance with the OSHA and DHEW requirements as they pertain to periodic safety inspections of IHS facilities, fire prevention inspection, staff OSHA training, Defensive Driver Training (required by CSC), posting, investigating and reporting as mandated in the OSHA Act and providing technical assistance to Indian and non-Indian industry on tribal land regarding the intent of the Act. Special assistance is urgently required, and would be provided through these positions, to assist and advise in new areas of industrial expansions related to Mine safety (uranium and coal) as well as processing and refining of these substances.

5. Establish a permanent secretarial position in the OHS Branch to provide administrative and secretarial support to this branch.

Impact of Solution:

Through reduction of accidents considerable savings in inpatient-outpatient services could be realized. Suffering due to accidental injuries could be, substantially reduced. Property loss, particularly due to motor vehicle accidents and fire, would be reduced. With a reported 9,413 Indian injuries last year in Albuquerque the paradox appears to be that the total problem is under reported. For each accident requiring medical attention, an estimated five other occur which are untreated and consequently unreported. The problem is one of major magnitude and is also interrelated with problems of alcoholism, mental health, and socio-economic factors. It presents the greatest unmet need in the IHS today.

OCCUPATIONAL HEALTH AND SAFETY BRANCH

OBJECTIVES

This newly established Branch is very much understaffed. The growth of this Branch and activity will depend a great deal on the emphasis placed on the need for such a problem by Headquarter's and area staff.

The objective of this program is to establish awareness of the safety problem among Indian people at the community and reservation level and to comply with OSHA requirements in IHS facilities as directed by Presidential Executive Order and HEW Manuel regulations. Accidental injuries to Indian people are over three times higher than the national average and the leading cause of death in the Albuquerque Area, being almost double the second highest reported category of mortality.

The present staffing consists of one Sanitarian (CO) who is Chief of the Branch, one Staff Safety Officer (Sanitarian CO), and one temporary secretary. To continue to develop the program and in order to get the program organized and oriented at the service units and field level, the following positions are needed at this stage of development:

1. District Safety Officer, 03 or GS-7:

   Location: Santa Fe to cover northern pueblos. $ 14,000

2. District Safety Officer, 03 or GS-7:

   Location: Albuquerque to cover Pueblos in Albuquerque Service Unit and Mescalero. $ 14,000

3. District Safety Officer, 03 or GS-7:

   Location: Grants Field Office; to cover Zuni, Laguna, Acoma, Canoncito. $ 14,000

4.	Three vehicles	$ 4,800
5.	Secretary for Area Office, GS-4	$ 8,000
6.	Equipment and supplies	$ 1,500
	TOTAL - - - - - - - - -	$ 56,300

ALBUQUERQUE AREA IHS CONTRACT HEALTH SERVICES

The Indian Health Service, in addition to operating hospitals and clinics, has a Contract Health Service Program.

This program, essentially, is to contract with private hospitals, physicians and dentists to provide specialty health care to patients that the IHS does not have the facility or expertise to provide such care.

The cost of health care has increased at a rapid rate and the funds available to the Albuquerque Area Contract Health Care Program has increased almost at the rate of hospital and medical costs.

However, in this Area the Indian population has increased approximately 40% which has caused problems in the Contract Health Services Program.

Further, the advances in health care techniques are now available to local residents, such as kidney dialysis, organ transplants, treatment for cancer, and special diagnostic procedures in laboratories and radiology. These are very expensive, but do add to the longevity of the population.

This fiscal year the Congress appropriated approximately 19 million dollars to the Indian Health Service which is expected to make a big impact on the unmet surgical needs of the Indian population.

ALBUQUERQUE AREA IHS CONTRACT HEALTH SERVICES - Page 2

Two major health problems known in this Area are alcoholism and mental health, which should be addressed.

In FY-77 only a small portion of CHS funds could be utilized for these two problems: $17,600 in alcoholism detoxification and $13,000 in mental health per se.

(Use Dr. Andre's brief on alcoholism)

ALBUQUERQUE AREA

CONTRACT CARE ALLOCATIONS

FISCAL YEARS 1967 THRU 1977

Fiscal Year	Amount
1967	$1,779,900
1968	$1,192,950
1969	$1,137,000
1970	$1,382,000
1971	$1,512,000
1972	$2,251,400
1973	$2,337,400
1974	$3,074,000
1975	$3,755,000
1976	$4,527,000
1977	$5,117,300

Budget/AAO
11/3/77

MORTALITY DATA
Albuquerque Area
Indian Health Service

The category "Unknown, Ill-defined conditions" was the second leading cause of death in 1967, accounting for 32 deaths per year, a rate of 119 per 100,000 population. This decreased to 19 deaths, a rate of 52.5 per 100,000. Better acceptance of the health services offered to Indians has meant that fewer deaths have occured "Unattended".

Pneumonia and influenza death rates have decreased from 51.1 to 30.4 deaths per 100,000 population in 1974. More effective use of Ambulatory Patient Care facilities has resulted in earlier diagnosis, reduced hospitalization and mortality due to pneumonia.

Suicides numbered 12 in 1967, 9 in 1974. The suicide death rate decreased from 44 to 25 deaths per 100,000 population in this time.

Tuberculosis mortality continued a long term decline. In the charted period, 1967 showed a tuberculosis death rate of 16. This decreased to 6 deaths per 100,000 population in 1974. During this period a radical change in treatment occured with less reliance on long term hospitalization and greater stress on early detection and intensive use of tuberculosis fighting drugs.

Infant mortality has shown a gradual decrease in recent years. In 1961, 51 babies out of every 1,000 born died before they reached 1 year of age. This infant death rate was more than twice the United States(all races)rate. By 1976, the Indian residents of the Albuquerque Area had an infant death rate of 18 deaths per 1,000 live births, compared with the U. S. rate of 15. As of 1976, the Albuquerque Area Indian neonatal rate (death in the first 28 days of life) was lower than that of the U. S.

Page 2. (Suggested Narrative)

Heart disease death rates increased from 62 to 94 deaths per 100,000 population in the 1967-74 period. This probably reflects both the aging of the population and the reduction in the category "Unknown and Ill-defined conditions".

Cirrhosis of liver deaths increased at a greater rate. The 1967 rate was 49 deaths per 100,000 population and this increased to 94 in 1974, indicating an alcohol problem of major proportions. The cancer death rate increased from 44 to 75, again probably reflecting same aging of the population and the reduction in the category "Unknown, Ill-defined conditions".

Alcoholism as a cause of death increased as did cirrhosis of the liver Alcoholism increased from 13 to 56 deaths per 100,000 population.

Homicides increased in this period from 15 to 36 deaths per 100,000 population.

ALBUQUERQUE AREA -- SERVICE UNITS STAFFING

SERVICE UNIT	HOSPITAL CARE	CONTRACT CARE	ENVIRON-MENTAL HEALTH	DENTAL	PUBLIC HEALTH NURSING	HEALTH EDUCATION	FIELD MEDICAL SERVICES	MENTAL HEALTH	HOSPITAL MEDICAL OUTPATIENT	FIELD CLINIC MEDICAL OUTPATIENT	TOTALS
01 Albuquerque 1/											
Ceiling	87	3	8	29	10	4	1	6	23	31	202
On Duty, 10/23/77	86	5	8	30	10	4	1	6	23	36	209
Vacancies	1	2 over	-	1 over	-	-	-	-	-	5 over	7 over
05 Mescalero											
Ceiling	27	-	2	2	2	-	-	2	6	-	41
On Duty, 10/9/77	27	1	1	2	2	-	-	1	6	-	40
Vacancies	-	1 over	1	-	-	-	-	1	-	-	1
06 Santa Fe											
Ceiling	48 2/	1	10	11	8	3	4	9	17	35	146
On Duty, 11/9/77	59	1	10	11	6	3	-	9	17	37	153
Vacancies	11 over	-	-	-	2	-	4	-	-	2 over	7 over
07 Zuni-Ramah											
Ceiling	83	-	3	9	5	2	-	1	29	16	148
On Duty, 10/23/77	75	-	3	9	4	1	-	1	27	15	135
Vacancies	8	-	-	-	1	1	-	-	2	1	13
04 Acoma-Laguna-Canoncito											
Advanced Positions 1/	10	-	-	-	-	-	-	-	-	-	10
On Duty, 11/9/77	5	-	-	-	-	-	-	-	-	-	5
Vacancies	5	-	-	-	-	-	-	-	-	-	5
TOTAL POSITIONS	255	4	23	51	25	9	5	18	75	82	547
TOTAL ON-DUTY STAFF	252	7	22	52	22	8	1	17	73	88	542
VACANCIES	3	3 over	1	1 over	3	1	4	1	2	6 over	5

AREA-WIDE CEILING	761
TOTAL ON-DUTY STAFF	745
VACANCIES	16

1/ Includes Laguna Health Center current positions structure with the exception of the 10 advanced (new) positions.
2/ Includes five (5) advanced (new) positions.

Budget, AAO 11/9/77

ALBUQUERQUE AREA - SERVICE UNIT STAFFING

VACANT POSITIONS

ALBUQUERQUE SERVICE UNIT

PHYSICIAN ASSISTANT

MESCALERO SERVICE UNIT

FIELD ENGINEER

MENTAL HEALTH TECH.

SANTA FE SERVICE UNIT

2 CLINICAL NURSES

LPN

SOCIAL WORKER ASSOC.

ZUNI SERVICE UNIT

EQUIPMENT MECH.

GENERAL SUPPLY SPEC.

SUPPLY CLERK

2 MEDICAL DOCTORS

PHYSICIAN ASST.

2 Clinical Nurses

3 LPN's

PUBLIC HEALTH NURSE

COMM. HEALTH TECH.

The Albuquerque Area Indian Health Service Dental Program

The current dental staffing in the area provides a ratio of about one dentist per 3,438 people. It is obvious from this ratio that the dental needs of the Indian people in the area are not being met. During FY - 77 the dental program was only able to provide 17% of the services which were expected to be required during that year (see attachment 1 for further information).

It would be unreasonable to expect total utilization if all resources were available. The IHS dental Master Resource Plan (12/09/76) indicates a requirement of 19.8 dental man-years for the Albuquerque Area. The current staffing provides 13 dental man-years.

Due to the limited resources the dental program has been following a plan of priority care for children. This is an incremental dental program oriented toward head-start and school-age children.

The demand for adult dental services is increasing and the data indicate that the area dentists have been seeing more adult patients. The program, however, cannot substantially increase treatment for adults without displacing the young patients currently served.

The need for orthodontic care is large. During FY - 1977, of 197 twelve-year olds examined, 24 percent were in need of orthodontic treatment for severe malocclusions. At the current program level each orthodontic case treated would displace five to ten other children who were in need of more basic dental care to prevent tooth loss.

The community component of an oral health program is in need of much more attention in all locations of the Area. This component includes dental health education and prevention programs. Fluoridation of community water supplies is critical to any program of prevention of dental disease. This area needs a high level of effort on the part of IHS and the Indian communities to create greater awareness of the steps available to prevent dental disease. This effort should focus on the family, the schools, and the tribal governments. The dental branch intends to hire a dental health education specialist but additional positions are needed to encourage fluoridation and to provide outreach. These positions could be in the form of dental CHRs and fluoridation specialists hired by the Office of Environmental Health. The Chief, Dental Services Branch intends to focus increasing attention on the development of community awareness and participation in oral health.

Staffing

There are 17 dentists and 36 auxiliaries employed in the dental program. These positions are involved with providing direct clinical services, program management, and training.

Dentists	-	13 full-time clinical equivalent
Auxiliaries	-	17 Dental assistants
		5 Dental therapists
		7 Lab technicians

Page 2

Staffing - cont'd

Training - 3 part-time dentists
1 Dental assistant instructor
2 Laboratory Technology instructors

Clerical-Secretarial - 4

Management - 1 full-time dentist, 1 part-time dentist

Dental services are provided in 20 locations throughout the area. Direct services and training are provided in one location.

Contract dental care is provided by about 25 private practitioners. These vendors provide care in their own offices and some in IHS facilities.

The facility at Southwestern Indian Polytechnic Institute provides training for dentists, dental assistants, dental therapists, and dental laboratory technicians. This training is both long-term and short-term and the staff does the primary teaching job. Consultants may be called in as required.

The current budget for direct dental services is approximately $1.2 million. The contract budget is $252,000.

Attachment 1

	Expected Need FY - 77	Services Provided FY - 77	Percentage of Need Provided
Examinations	44,692	15,029	34
Teeth Restored	123,628	32,006	18
Teeth Extracted	55,284	8,483	15
Space Maintainers	1,073	136	13
Prosthetic Units	24,178	964	4
Periodontal Services	28,111	1,021	4
Orthodontic Services	6,167	31	1

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ALBUQUERQUE AREA
INDIAN HEALTH SERVICE

HUMAN PLAGUE CASES 1949 - 1977

YEAR	UNITED STATES	NEW MEXICO	NEW MEXICO INDIANS
1977	17	8	7
1976	16	9	1
1975	20	16	2
1974	8	7	3
1973	2	1	0
1972	1	0	0
1971	2	1	1
1970	13	9	3
1949 - 69	40	27	8
TOTALS	119	78	25

About two-third (2/3) of all human plague case since 1949 in the United States have been in New Mexico. One-third (1/3) of these cases have been Indian.

ALBUQUERQUE AREA PROGRAM PACKAGE

CONTROL OF VECTOR-BORNE DISEASES

January 29, 1976

Program: Surveillance and Control of Vector Borne Diseases and Biological Insults in the Albuquerque Area.

I. Introduction:

A program package for surveillance and control of vector-borne diseases and biological insults in the Albuquerque Area was prepared and submitted for consideration and possible funding in December of 1971 and again in April of 1975. Lack of available positions and funding has thus far resulted in nonimplementation of the program in the Albuquerque Area.

This is an up-date of these requests.

II. Background:

Encephalitis, plague, rabies, tuleremia, Rocky Mountain Spotted Fever and fly-borne intestinal diseases still represent major potential health problems among the Indian population in the Albuquerque Area.

Mosquito-borne encephalitis virus has been detected in New Mexico in each of the past ten years and the threat of a human outbreak cannot be disregarded. Current levels of control of mosquitoes and their breeding places are irregular and undependable. If effective control of mosquitoes and a reduction in the encephalitis outbreak potential is to occur, research needs to be expanded to determine effective mosquito control methods without further contamination of the environment with indiscriminate use of pesticides.

Seventy percent of all plague cases in the United States since 1949 have occured in New Mexico. Fifteen of the 20 reported human cases in the United States during 1975 were in close proximity to the Albuquerque Area. One human case of plague resulting from the bite of an infected flea could develop into the pneumonic form of plague and lead to a widespread outbreak of the disease with devastating consequences in the form of death and undue suffering. Current levels of surveillance against plague are very inadequate resulting in a "Fire fighting" type approach to the problem.

Intestinal diseases carried by flies are highly prevalent in the Indian communities. Current insanitary conditions in and around the communities of the Albuquerque Area present the likelihood of increased incidence of intestinal diseases spread by flies and other insects.

Rabies, one of the most dreaded diseases communicated from the lower animals to man is widespread among skunks, raccoons, coyotes, foxes and bats. Immunization of domestic dogs and cats and the control of stray animals, essential elements in an effective rabies control program, are not always accomplished in many of the Indian communities because of the lack of funds and personnel. Public understanding of the threat of rabies is inadequate and without an increase in efforts to control the disease an increase in the incidence of rabies can be expected. Other vector-borne diseases such as Rocky Mountain Spotted Fever and Tularemia are present within the Indian communities; however, sufficient staff has not been available to maintain surveillance levels adequate to fully understand the ecology of these diseases. Biological insults which result from contact with insects such as roaches and bedbugs are common in the Indian communities. Control of these problems are high on the priority list of the Indians themselves as the problem is visible and ever present.

III. Objective:

To establish an effective surveillance and control program in the prevention of vector-borne diseases among Indians in the Albuquerque Area.

IV. Action Steps:

1. Health education activities aimed at informing the Indian people of the causal relationship of vector-borne diseases and appropriate preventive measures to be used.

2. Locate and provide continuing surveillance of plague endemic areas and identify epizootics as they occur. This will be accomplished by utilizing the prairie dog as a sentinel animal, swabbing prairie dog burrows for fleas, trapping and bleeding small rodents and animals, bleeding domestic dogs which also serve as sentinel animals, etc. The above specimens would be submitted to the National Communicable Disease Center in Fort Collins, Colorado, for analysis to determine the presence of Yersinia Pestis organisms or antibody titers.

3. Apply appropriate control measures in populated areas where plague is found to be present. These measures would be designed to prevent plague from spilling over into the human population.

4. Surveillance of potential encephalitis problems through the utilization of sentinel chicken flocks. Antibody titers from sera

to be used to determine presence and variety of encephalitis in the area.

5. Initiation of mosquito control activities to control mosquito-borne encephalitis. Insecticides to be utilized as a last resort with primary emphasis on biological control measures - continuing research will be required in this regard.

6. Rabies immunization clinics co-ducted in all Indian communities to insure adequate immunization levels for all domestic dogs and cats. Selected wild mammal population control in areas where rabies has been demonstrated to be prevalent.

7. Promotion of animal control regulations within the Indian communities.

8. Promotion of improved sanitary conditions in and around Indian homes and communities to eliminate fly breeding areas. Control measures applied as a last resort.

9. Provide assistance concerning insect or vector-borne disease problems to any individual or Indian community upon request.

The Office of Environmental Health through its Environmental Health Services Branch is responsible for monitoring the proposed program. In order for this group to conduct an adequate and effective program, the following additional resources would be required.

V. Resources Required:

A. Contract and Agreements (Current Identified Sources)

1. Contract with Southern Ute Tribe for Biological Aide Services Covering the Southern Ute and Ute Mountain Ute Tribes. $10,000

2. Agreement with City of Albuquerque for Vector Control Services on the Isleta, Sandia, and Santa Ana Reservations. This agreement is primarily for mosquito and limited fly control activities during the summer months. $ 5,000

B. Equipment and Supplies:

Insecticide	$ 5,000
Sprayers	
(1) Back-Paks 10 at $75	$ 750
(2) Buffalo Turbine	$ 4,000
(3) Hand Sprayers 10 at $40	$ 400
Rabies Vaccine, Needles, Syringes, etc.	$ 5,000

C. Training:

Contract and OEH Staff

Training 2 days each at $25 per day $50 ea. 20 x 50	$ 1,000

D. Personnel:

Salaries and Benefits (To be Contracted for with Individual Tribes) Ten persons to carry out surveillance and control of vector-born diseases at $8,000 each.	$80,000
Benefits at 13.5% FICA, FUTA, etc.	$10,800
Transportation Travel - 10 persons at 12,000 miles per year each. 120,000 miles at 12 cents per mile	$14,400
Total Resources Requested	$136,350

VI. Evaluation:

Specific goals and needs will be established at the beginning of each fiscal year. It is anticipated that these will vary slightly each year due to accomplishments made the previous year.

Objectives and action steps established to meet the specific goals and needs will be evaluated on a continuing basis. Accomplishments will be reported on a monthly basis, with the reporting system designed to show percent of objectives met. This will allow for review and redirection of the program at any time should the need arise.

The ultimate success and evaluation of the program should be demonstrated by a marked reduction in vector-borne diseases and biological insults in the Albuquerque Area.

Laboratory Services Branch
Unmet Needs

Program Trends F.Y. 78

1. The trend in nationwide laboratory services is a steady annual increase in the total laboratory service provided. The trend in the Albuquerque Area has been consistent with this nationwide trend. From available figures the workload in the Albuquerque Area IHS has increased by approximately 72816 tests in F.Y. 77 over F.Y. 76.

   Another trend is toward increasingly complex sophisiticated laboratory testing procedures, with an increase in automated procedures, demanded by newly trained physicians coming to our Area with clinical training based on this laboratory trend, and are expecting our laboratories to comply with this trend.

2. Problems

   The most significant

   a) Lack of professional Staff Positions

   b) Lack of Major Equipment

   The Albuquerque Area with a total technical work force of 15 (12.5 full time and 2.5 temporary or intermittent) produced approximately 385224 tests in F.Y. 77. These tests represent a time value of 2,627,227 minutes per year. Based on the RAC figure of 88,612 minutes per person per year and the College of American Pathologists recommendation of no more than 13,000 tests per Technologist per year. The Albuquerque Area would require 30.0 professional laboratory staff based on this workload.

This is an additional 15 positions required for current workload.

LABORATORY STAFFING BASED ON RAC

Service Unit	Present Full Time Staff	RAC Staff Needs	Additional	Cost
Albuquerque	5.0	12.0	7.0	$86352.00
Mescalero	1.5(includes x-ray duties)	3.0	1.5	$18504.00
Santa Fe	3.0	5.0	2.0	$24672.00
Zuni	5.5(includes 2.5 temporary)	10.0	4.5	$55512.00
TOTAL	15	30.0	15.0	$185040.00

Laboratory Major Equipment Needs

ALBUQUERQUE SERVICE UNIT

Automated 5 Channel Cell Counter	$18,000.00
Blood Storage Refrigerator w/Alarm System	$ 2,000.00
	$20,000.00

MESCALERO SERVICE UNIT

Automated Blood Chemistry Analyzer(on order)	$15,000.00
Blood Gas Analyzer	$10,000.00
Blood Storage Refrigerator w/Alarm System	$ 2,000.00
Microscope	$ 2,500.00
Floor Model Centrifuge	$ 2,500.00
Kodak X-ray Processor	$ 8,000.00
Water Purity System	$ 1,200.00
Hematocrit Centrifuge	$ 350.00
	$41,550.00

SANTA FE SERVICE UNIT

New Facility	NONE

ZUNI SERVICE UNIT

Automated 5 Channel Cell Counter	$18,000.00
Automated Blood Chemistry Analyzer(on order)	$15,000.00
Water Purity System	$ 1,200.00
Hematocrit Centrifuge	$ 350.00
Dackfield Microscope Condenser	$ 250.00
X-ray Machine w/Fluoroscope (current machine continually malfunctioning)	$80,000.00
X-ray Machine, Portable (current portable x-ray unit down, unable to get repaired)	$25,000.00
TOTAL	$139,800.00
TOTAL EQUIPMENT	$201,350.00

Another major problem is the lack of staff development funds, to provide yearly staff development for each of our personnel. It is estimated that a minimum of $600.00 per technical person is required to provide one week of staff development. This would indicate a total need of approximately $9000 for laboratory staff development based on current position level of 15. RAC accessed needs of 15 additional positions would be an additional $9000 for a total staff development need of $18,000. The total budget for laboratory improvement, which must be used for Consultant Salary, Consultant travel, equipment, temporary positions, supplies, educational materials and staff development is $70,400. The amount allocated for staff development is $5000, indicating a fund deficiency of $4000 and a projected deficiency based on RAC of $13,000.

Current Year Program Budget

16336	Temporary & Intermittent Staff
18258	Area Lab Consultant Salary
5000	Staff development
2500	Area Consultant travel
2500	Consultants, speakers, in-service etc.
2000	Educational Materials
2500	Journals, Professional Study, Seminars, Workshops, Slides, Film etc.
4000	Quality Control Chemistry Continued Hematology & Coagulation to be added
15000	Equipment
2306	Emergency
70400	Total

Total Identified Unmet Needs

1. Staffing

15 current positions	$185040.00
Future 15 RAC Positions	$185040.00

2. Equipment

current needs	$201350.00
future RAC needs	Unknown

3. Staff Development

current needs	$ 9000.00
future RAC needs	$ 9000.00

4. Work Space

(based on CAP figures of 45 tests per net square foot.)

current needs	Unknown
future RAC needs	Unknown

TOTAL UNMET NEEDS	$185,040.00
	201,350.00
	13,000.00
	$399,390.00

Total Unmet Needs

Current

Staffing	$185,040.00
Equipment	201,350.00
Staff development	13,000.00
Work Space	?
	$399,390.00 Plus

Future (RAC)

Staffing	$185,040.00
Equipment	?
Staff development	9,000.00
Work Space	?
	$194,040.00 Plus

OPTOMETRIC PROGRAM - ALBUQUERQUE AREA

Priorities for Service:

1. School age population - Head Start up.
2. Adults who require correction for employment.
3. All others who require visual correction.

Need - Adults generally receive minimal service due to demands of priority No. 1.

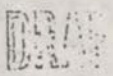
Resources:

Total required = 24 positions	$480,000
available = 6 positions	146,000
Unmet need = 18 positions	$234,000

FY '77 - 1565 glasses dispensed at $22.00 per pair (average cost).

Burial Policies

DRAFT



BIA/IHS Relationship Regarding Payment for Burials

The Bureau of Indian Affairs and Indian Health Services have revised their respective policies as it pertains to burial assistance for indigent Indians who expire in an Indian Health Service facility or a contract care facility.

Guidelines for the provision of burial assistance to indigent Indians who expire in an Indian Health Service facility or contract care facility for each agency are as follows:

1. The Bureau will be responsible for providing burial assistance for the indigent Indian who expires in an Indian Health Service facility or contract care facility on his native reservation if there is an established miscellaneous assistance program on the reservation.
2. The Bureau will be responsible for providing burial assistance to the indigent Indian who expires in an Indian Health Service facility or contract care facility away from his native reservation if the body is being returned to the deceased's reservation for burial and there is an established miscellaneous assistance on that reservation. There is no time limit of the period an Indian may have lived away from his native reservation. The agency at the reservation where the indigent Indian expires will be responsible for any preliminary cost associated with the burial subject to reimbursement from the receiving agency which will ultimately be responsible for the total cost of the burial assistance for eligible Indians whose body is brought back to their reservation for burial.

3. The Bureau will be responsible for providing the minimum necessary cost of transportation of the body back to the deceased's native reservation if there is a miscellaneous assistance program and such services has been requested by the relatives or next of kin.

4. Indian Health Service will be responsible for making the initial contact with the deceased's family or next of kin following the Indian's expiration.

5. Indian Health Service in consultation with the family or next of kin will be responsible for th notifying the local mortuary and for making preliminary arrangements for care of the deceased's body.

6. Indian Health Service will be responsible for burial assistance to indigent Indian whose native reservation does not have an established miscellaneous assistance program.

7. Indian Health Service will be responsible for referring families or next of kin to the Bureau when they express a desire for burial assistance.

8. Indian Health Service will be responsible for notifying the local authorities when the indigent Indian cannot be identified as to tribal affiliation or reservation connections.

9. In those instances where eligibility for burial assistance cannot be immediately determined, Indian Health Service x or the next of kin will be responsible for all cost associated with the burial subject to reimbursement if the indigent Indian is found to be eligible.

All other requirements prescribed in 66 IAM 3.1.12A Burials are to be met.

In effect, the significant changes in the Bureau burial policy is the extension of services to indigent Indians who expire in an Indian Health Service facility

or contract care facility away from their reservation; the elimination of time period within which a person may have lived away from his reservation and the removal of the $1CO limit for Bureau participation in the cost of transportation of the body back to the reservation.

Should you have any questions, please call or write your respective Central Office.

SUPPLEMENT B

Title 42--Public Health

CHAPTER I--DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

PART 36--INDIAN HEALTH

Subpart J--Indian Health Care Improvement Act Programs

BILLING CODE: 4110-84

Title 42--Public Health

CHAPTER I--DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

PART 36--INDIAN HEALTH

Subpart J--Indian Health Care Improvement Act Programs

AGENCY: Department of Health, Education, and Welfare

ACTION: Final rules

SUMMARY: These rules prescribe requirements for the following activities authorized by the Indian Health Care Improvement Act:

(1) Indian health professions recruitment and scholarship grant programs intended to encourage Indians to enter the health professions and insure the availability of Indian health professionals to serve Indians;

(2) Continuing education allowances for employees of the Indian Health Service;

(3) Contracts with urban Indian organizations to assist those organizations to carry out programs in urban centers to make health services more accessible to the urban Indian population; and

(4) Leasing from Indian tribes of land or facilities which the Indian Health Service would otherwise be authorized to acquire or build.

EFFECTIVE DATE: (date of publication)

FOR FURTHER INFORMATION CONTACT:

Dr. Robert C. Birch, Indian Health Service. Telephone: 301-443-1044. Address: Room 5A-55, 5600 Fishers Lane, Rockville, Maryland 20857. SUPPLEMENTARY INFORMATION: On May 23, 1977 a notice of proposed rulemaking was published in the Federal Register (42 F.R. 26306 et seq.) proposing to establish requirements for Indian health professions recruitment and scholarship grant programs, continuing education allowances for employees of the Indian Health Service, contracts with urban Indian organizations, and leases with Indian tribes authorized by sections 102, 103, 104, 106, 502 and 704 of the Indian Health Care Improvement Act, Pub. L. 94-437 (25 U.S.C. 1601 et seq.). Interested persons were given until July 7, 1977 to submit written comments, suggestions or objections.

A. Changes Made From The Proposed Rules.

After full and careful consideration of all comments received, certain provisions of the proposed rules have been revised as noted below:

1. Clarifying language has been added to the definitions of health professions schools renumbered as sections 36.302(m), (n), and (o) to indicate that the Commissioner of Education referred to in those definitions is the Commissioner of Education of the Department of Health, Education, and Welfare.

2. The definition of "school of allied health professions" renumbered as section 36.302(m) has been changed to incorporate a generic definition of educational programs in the allied health professions, and to include certificate programs. As a generic definition is by its nature quite broad and does not provide a list of specific allied health professions curricula, a requirement has been added as a new section 36.304 that the Secretary publish a list of allied health professions for consideration in the award of preparatory and Indian Health scholarships.

Several commentors suggested deletion of the requirement that the school be affiliated with a hospital. The definition with respect to affiliation has been revised so that affiliation is required when it is necessary for completion of the programs of education offered by the school. Additionally, the method of affiliation has been specified and a definition of hospital has been added at section 36.302(g) for purposes of clarity.

3. The definition of "school of nursing" renumbered as section 36.302(o) has been revised to accord more closely with accreditation requirements in the definition of school of nursing in section 853 of the Public Health Service Act. (42 U.S.C. 298b).

4. The population requirement in the definition of "urban center" renumbered as section 36.302(t) has been reduced from 50,000 to 10,000 so as not to exclude smaller cities in midwestern and other areas.

5. The definition of "urban Indian organization" renumbered as section 36.302(v) is revised to include organizations which have the provision of health programs as one of their major functions, but not necessarily the principal function, if the health programs are administered by a distinct organizational unit within the organization. This change was made so as not to exclude multipurpose organizations with major functions other than administration of health programs. Section 36.302(v)(3) has been revised to require that the board of directors be composed of urban Indians elected or appointed in accordance with the articles of incorporation and bylaws of the organization. This change was made to insure full Indian control of the organization. Language has been added to section 36.302(v)(5) to except organizations administering urban projects under contracts with the Secretary prior to October 1, 1977 from the requirements of paragraphs (v)(2) and (v)(3) of section 36.302(v) for the period of such contracts or until July 1, 1978, whichever is later.

6. Section 36.312(c)(7) has been amended for clarification to require that when the target population of a proposed recruitment project includes a particular tribe or tribes, the grant application must include an official document in such form as is prescribed by the tribal governing body of each such tribe indicating that the tribe will cooperate with the applicant.

Several comments suggested the language in 42 C.F.R. § 36.206 be substituted for section 36.312(c)(7). Section 36.206 of 42 C.F.R. applies to contracts with tribal organizations under the Indian Self-Determination Act, Pub. L. 93-638, and provides that before the IHS may enter into a contract with a tribal organization, the IHS must be requested to do so by the tribe in the form of a resolution complying with the specified requirements of that section. This requirement was not adopted as it implements a specific requirement of section 103(a) of Pub. L. 93-638 which is not applicable to recruitment grants under the Indian Health Care Improvement Act, Pub. L. 94-437, and would establish an unnecessary requirement for tribal organizations.

7. Section 36.313(b) establishing an order of priority for preference to recruitment grant applicants has been changed to place Indian tribes on a higher priority than tribal organizations.

8. Section 36.317(b) Accounting for royalties has been deleted as subpart F of 45 C.F.R. Part 74, made applicable to recruitment grants by section 36.319 of these regulations, covers accounting for royalties and makes current Public Health Service grants policy applicable.

9. Section 36.323(a) has been revised to change the amount of the monthly stipend for recipients of preparatory scholarships to $400 per month with specified adjustments to conform to the monthly stipend awarded to recipients of National Health Service Corps Scholarships under section 751(g)(1) of the Public Health Service Act (42 U.S.C. 294t(g)(1)).

10. Subdivision J-4--Indian Health Scholarship Program has been revised to reflect a change in the statutory authorization for the program. Section 104 of the Indian Health Care Improvement Act amended section 225 of the Public Health Service Act to authorize the award of Indian Health Scholarships to students in health professions schools under section 225. However section 225 was repealed effective October 1, 1977 by section 408(b) of the Health Professions Educational Assistance Act of 1976, Pub. L. 94-484. The preamble to the May 23, 1977 Notice of Proposed Rulemaking at 42 F.R. 26306 noted that regulations for the Indian Health Scholarship Program were proposed in the expectation that Congress would take corrective action before repeal became effective. Section 307(n)(1) of the Health Services Extension Act of 1977, Pub. L. 95-83, adopted on August 1, 1977, adds a new section 757 to the Public Health Service Act (42 U.S.C. 294y-1) effective October 1, 1977 authorizing the award of Indian Health Scholarships to students in health professions schools under Subpart IV of Part C of Title VII of the Public Health Service Act which authorizes the National Health Service Corps Scholarship Program.

Subdivision J-4 of these regulations has therefore been revised to make certain necessary amendments to conform to section 757 of the Public Health Service Act. References to regulations at 42 C.F.R. Part 62 have been deleted as those regulations, issued under section 225 of the Public

Health Service Act which was repealed, will not be applicable to Indian Health Scholarships. Section 36.330 has been revised to provide that Indian Health Scholarships will be awarded pursuant to Subpart IV of Part C of Title VII of the Public Health Service Act, and such implementing regulations as may be promulgated by the Secretary except for the requirements in Subdivision J-4.

Section 36.333(c)(1) has been revised to require that the service obligation in private practice be in a health manpower shortage area designated under section 332 of the Public Health Service Act (42 U.S.C. 254e). This will make the reference to "physician or other health professional shortage area" in section 757(b)(2) of the Public Health Service Act consistent with the reference to "health manpower shortage area" in section 753 of the Public Health Service Act (42 U.S.C. 294v) specifying requirements for the service obligation in private practice under the National Health Service Corps Scholarship Program. A new section 36.334 has been added requiring publication of a list of recipients of Indian Health Scholarships in the Federal Register. This is consistent with section 36.324 requiring publication of a list of recipients of preparatory scholarships.

II. Corrections in the text of section 36.350(e) have been made to conform that section to section 504(d) of the Indian Health Care Improvement Act.

12. Certain changes have been made to section 36.351 governing the application and selection process for contracts with urban Indian organizations. Section 36.351(b) has been revised for clarification to indicate that proposals will be selected which "best promote the purposes of Title V of the Act" taking into consideration the factors listed. In this regard several comments suggested that section 36.351(b) should specify that proposals meeting a maximum number of factors would be selected. This was rejected in favor of clarifying the standard with respect to which all factors would be considered.

Section 36.351(b)(1) has been revised to indicate that the extent of unmet health care needs of urban Indians should be determined on the basis of the latest available statistics on the factors listed in that section. A fifth category of "under 1000" has been added to section 36.351(b)(2). Section 36.351 (b)(4)(iii) has been deleted in response to comments objecting to its inclusion on the grounds that proximity of the applicant's facilities to other sources of health services is not a significant additional factor, in light of the other factors listed in section 36.351(b)(4), for assessing duplication with other health services projects.

Section 36.351(b)(8) specifying identification of a city as a BIA relocation site as a factor for consideration has been deleted as that factor is not applicable to the majority of cities considered urban centers under these regulations. The word "clinic" in section 36.351(b)(9) has been changed

to "program" as some existing projects have not developed to the stage where they have clinics, but nevertheless have a health program. The suggestion of one commentor that cities with urban Indian health clinics be given priority over other cities was rejected as cities with clinics are not necessarily those with the greatest need.

13. Section 36.352 on fair and uniform provision of services has been revised for purposes of clarity.

14. Certain provisions have been renumbered to accommodate the above changes.

Discussion of Miscellaneous Comments

The Secretary does not agree that the proposed rules would be improved as suggested by some commentors and has rejected the following suggestions:

1. That section 36.301(a) Policy contain a statement to the effect that it is the policy of the Secretary that the Indian Health Care Improvement Act Programs governed by these regulations are subject to contract under the Indian Self-Determination Act. Such a statement would be inappropriate as the recruitment, scholarship and urban programs established under Pub. L. 94-437 are not subject to the Indian Self-Determination Act. However, as Indian tribes and tribal organizations are preferential grantees under the recruitment program, section 36.301(a)(2) does refer to Indian self-determination and assisting tribes and tribal organizations to develop their manpower programs.

2. That section 36.301(a) Policy contain a statement that the needs of Indian tribes, tribal organizations and the Indian Health Service will be given priority consideration. A policy statement to this effect would be confusing. The needs of the Service are based on identified needs of tribes and tribal organizations.

3. That the definition of Indian be expanded to include adopted children and grandchildren of specified tribal members. Section 4(c)(1) of Pub. L. 94-437 uses the terms "descendant, in the first or second degree, of any such member" which includes only the natural child or grandchild of specified tribal members.

4. That the phrase "such as reservation health boards, national health promotion councils, etc." be added to the definition of "Indian health organization". The definition is based upon certain characteristics an organization must have to qualify. Adding a few examples of organizations which may qualify will not necessarily clarify the definition and may be misleading if not inclusive.

5. That section 36.303 requiring scholarship applicants to provide evidence of tribal membership or other evidence that they are Indian under renumbered section 36.302(h) be revised to specify what evidence will be acceptable in the case of persons of Indian blood who are not members of an Indian tribe. It is not the purpose of section 36.303 to interpret the definition of Indian in section 36.302(h) but only to establish a general rule

that scholarship applicants must submit evidence that they are Indian. It should be noted that section 36.302(h) which defines the term "Indian" for the purposes of subdivisions J-2, J-3 and J-4, includes persons considered by the Secretary of the Interior to be Indian for any purpose or determined to be Indian under regulations promulgated by the Secretary of Health, Education, and Welfare, e.g., 42 C.F.R. § 36.12.

6. That section 36.313(b) establishing an order of priority for preference to recruitment grant applicants give urban Indian organizations the same priority as tribes and tribal organizations. This would conflict with section 102(b)(1) of Pub. L. 94-437 which requires that preference be given to applications of tribes and tribal organizations.

7. That section 36.312(d)(1) be changed to indicate that aptitude or other testing done in elementary and secondary schools as part of a recruitment project be "culturally sensitive". The grant review process will require that testing procedures used be culturally sensitive.

8. That section 36.312 specify mandatory and optional activities for recruitment projects. The examples of activities listed in section 36.312 are intended to encourage innovative approaches in the design of proposed projects rather than restrict applicants to a particular list of mandatory and optional activities.

9. That payments to recruitment grantees and urban Indian organizations be required to be made in advance of incurring expenses. Sections 36.314(a) and section 36.350(c) in accordance with Department policy allow advance payment in the discretion of the Secretary.

10. That recruitment projects under subdivision J-2 be focused on elementary and junior high school students. Such students are included with respect to project activities listed in section 36.312.

11. That consideration be given in the award of recruitment grants to Indian Health Career Programs currently in operation. Prior experience will be taken into consideration under several of the factors listed for evaluation of grant proposals under section 36.313.

12. That the limitation on preparatory scholarship grants to two academic years be deleted from section 36.320. The limitation is imposed by law under section 103(b) of Pub. L. 94-437.

13. That "stay in school" programs designed to assist Indian students to remain in school be included in the preparatory scholarship program under subdivision J-3. Section 103 of Pub. L. 94-437 which authorizes the preparatory scholarship program is limited to scholarships.

14. That an applicant's professional goals be included in section 36.322(b) as a factor for consideration in the award of preparatory scholarships. An application must indicate the applicant's professional goals under section 36.322(a)(1) and such goals will be considered under the factors already listed. For example, the applicant's stated reasons for asking for the scholarship will be considered under section 36.322(b)(4) and the relative needs of the IHS and Indian health organizations for persons in particular health professions under section 36.322(b)(5) will be matched up with the professional goals of applicants.

15. That faculty recommendations be deleted as a factor under section 36.322(b) for evaluating applications for preparatory scholarships for the reason that faculty recommendations may not be available to the average student. Faculty recommendations are considered a relevant factor for determining an applicant's demonstrated capability to successfully complete courses of study in a health professions school under section 103 (a)(2) of Pub. L. 94-437. However, faculty recommendations are only one of several factors listed in section 36.322(b) of these regulations for evaluating applications.

16. That vocational and technical schools be included in the list of schools students may attend. The comments referred to the definitions of health professions schools in section 36.302, which are limited to schools for the particular health professions designated in sections 102 and 103 of Pub. L. 94-437 and section 757 of the Public Health Service Act. The accreditation and other academic requirements in those definitions are considered essential to assure the quality of education provided to students on Indian Health Scholarships.

17. That a definition of Indian preference be included in the definition section of these regulations to assure that Indians will receive priority in the award of Indian Health scholarships. Priority for Indians is provided in renumbered section 36.331 in accordance with section 757(b)(1) of the Public Health Service Act.

18. That tribal organizations and the Indian Health Service be given an equal priority with respect to the service obligation for Indian health scholarships. Renumbered section 36.332 allows fulfillment of the service obligation by service in the IHS, an urban Indian organization, or in private practice (such as with a tribal organization) which meets the requirements of that section. No distinction is made as to priority.

19. That distribution of Indian Health Scholarships among the health professions under proposed section 36.334 be tied to job availability within the IHS. Under that section, renumbered as section 36.333, the needs of the IHS are given priority consideration in the distribution of scholarships and the determination of IHS needs assumes projected availability of positions.

20. That stipends for Indian Health Scholarship recipients be determined on the basis of what is necessary to meet the recipient's needs. The amount of the stipend is fixed by law at $400 per month with specified annual percentage increases under section 751(g) of the Public Health Service Act (42 U.S.C. 294t(g)).

21. That the phrase "substantial number of Indians" in proposed section 36.333(c) stating requirements for service in private practice be defined to mean where the practice serves a majority of Indians. The suggested definition was not adopted as it would make the percentage of Indians served by the practice the determining factor regardless of whether significant numbers of Indians are served.

22. That Indian health professionals employed by the IHS be given priority over other Indians for Indian Health Scholarships. Priority is afforded to Indians as distinguished from non-Indians. There is no basis in section 757 of the Public Health Service Act to give an additional preference to Indian employees of the Service.

23. That the regulations require a list of IHS employees receiving continuing education allowances under subdivision J-5 be published in the Federal Register. This suggestion was rejected as inappropriate since such allowances are internal personnel matters and statistics on such allowances will be reported to Congress annually.

24. That nurses be eligible for continuing education allowances under subdivision J-5. Nurses are included under the phrase "other health professionals" in section 36.340.

25. That the population requirement in the definition of urban center and the priority list for specified urban Indian populations in section 36.351(b) (2) be deleted. Inclusion of population indicators is necessary to clarify program criteria.

26. That the phrase "on an optional basis" be added to section 36.351 (b)(4)(i) and (ii) after the word "utilization". As the language in that section does not imply that utilization of existing health services by urban Indians is on other than an optional basis, there is no need to add the suggested phrase for clarification.

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27. That section 36.351(b)(11), renumbered as section 36.351(b)(10), be changed to specify letters of support from either the Indian or non-Indian communities in an urban center but not from both; so that letters from the non-Indian community not be considered mandatory. Letters of support from the non-Indian community are relevant under section 36.351(b) as indicative of the potential cooperation of that community with the applicant for purposes of carrying out project activities. However, such letters are only one of many factors to be considered under section 36.351(b).

28. Comments were received requesting information on administrative procedures for programs governed by these regulations. Clarification of administrative procedures are properly the subject of program guidelines and will be addressed in the program operation plans.

Comments Beyond Scope

Several comments were received that were beyond the scope of the notice. They include suggestions:

1. That the regulations contain minimum requirements for State recognition of Indian tribes;

2. That Pub. L. 94-437 funds be distributed among the IHS Area Offices and then to the tribes.

3. That the Indian Health Service implement an extern program for high school students.

The current meeting totals for the period October 1, 1976 — June 1977:

No. of Pub. L. 94-437 meetings held throughout the U.S.	187
No. of communities in which meetings were held	72
No. of people at meetings	7,358
American Indian/Alaska people represented at meetings	800,000+
No. of communications cards processed by IHS Core Team	2,693

Part 36 of Title 42 is amended by adding the following new Subpart J.

The Department of Health, Education, and Welfare has determined that this document does not contain a major proposal requiring preparation of an Inflationary Impact Statement under Executive Order 11821 and OMB Circular A-107.

DATED: 3 NOV 1977

s/ Julius B. Richmond
Assistant Secretary for Health

APPROVED:

s/ JAL
Secretary

Subpart J—Indian Health Care Improvement Act Programs

Subdivision J-1—Provisions of General and Special Applicability

Sec:

Subdivision J-2--Health Professions Recruitment Program for Indians

Subdivision J-3—Health Professions Preparatory Scholarship Program for Indians

Subdivision J-4—Indian Health Scholarship Program

Subpart J—Indian Health Care Improvement Act Programs

AUTHORITY: Sec. 102, 103, 104, 106, 802, and 704 of P.L. 94-437 (25 U.S.C. 1612 and 1613 ~~42 U.S.C. 2001~~), 25 U.S.C. 1615, 1652, and 1674; sec. 702 of P.L. 94-437 (25 U.S.C. 1672b); Sec. 757, 91 Stat. 392-393 (42 U.S.C. 294y-1)

SUBDIVISION J-1 PROVISIONS OF GENERAL AND SPECIAL APPLICABILITY

§ 36.301 Policy and applicability.

(a) *Policy.* (1) It is the policy of the Secretary to encourage Indians to enter the health professions and to ensure the availability of Indian health professionals to serve Indians. The recruitment and scholarship programs under this subpart will contribute to this objective.

(2) The regulations of this subpart are intended to be consistent with principles of Indian self-determination and to supplement the responsibilities of the Indian Health Service for Indian health manpower planning and for assisting Indian tribes and tribal organizations in the development of Indian manpower programs.

(b) *Applicability.* The regulations of this subpart are applicable to the following activities authorized by the Indian Health Care Improvement Act:

(1) The award of health professions recruitment grants under section 102 of

the Act to recruit Indians into the health professions (Subdivision J-2);

(3) The award of preparatory scholarship grants under section 103 of the Act to Indians undertaking compensatory preprofessional education (Subdivision J-3);

(3) The award of Indian Health Scholarship grants pursuant to section 225(1)(2) of the Public Health Service Act, as added by section 104 of the Act, to Indian or other students in health professions schools (Subdivision J-4);

(4) The provision of continuing education allowances to health professionals employed by the Service under section 106 of the Act (Subdivision J-5);

(5) Contracts with urban Indian organizations under section 502 of the Act to establish programs in urban areas to make health services more accessible to the urban Indian population (Subdivision J-6); and

(6) Leases with Indian tribes under section 704 of the Act (Subdivision J-7).

§ 36.302 Definitions.

As used in this subpart: (a) **"Act"** means the Indian Health Care Improvement Act, Pub. L. 94-437 (25 U.S.C. 1601 et seq.).

(b) "Academic year" means the traditional approximately 9 month September to June annual session, except for students who attend summer session in addition to the traditional academic year during a 12 month period, for whom the academic year will be considered to be of approximately 12 months duration.

(c) "Budget period" means the interval of time into which the approved activity is divided for budgetary purposes, as specified in the grant award document.

(d) "Compensatory preprofessional education" means any preprofessional education necessary to compensate for deficiencies in an individual's prior education in order to enable that individual to qualify for enrollment in a health professions school.

(e) "Health or educational entity" means an organization, agency, or combination thereof, which has the provision of health or educational programs as one of its major functions.

(f) "Health professions school" means any of the schools defined in paragraphs ~~(g), (m), or (n)~~ (h) of this section.

~~(g)~~ "Indian" or "Indians" means, for purposes of Subdivisions J-2, ~~and~~ J-3, and J-4 of this subpart, any person who is a member of an Indian tribe, as defined in paragraph (l) of this section or any individual who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band or other organized group terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is the natural child or grandchild of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary.

(m), (n), or (o)

(h)

(g) "Hospital" means general, tuberculosis, mental, and other types of hospitals, and related facilities such as laboratories, outpatient departments, extended care facilities, facilities related to programs for home health services, self-care units, education or training facilities for health professions personnel operated as an integral part of a hospital, and central services facilities operated in connection with hospitals, but does not include any hospital providing primarily domiciliary care.

, and J-4

(i) [h] "Indian health organization" means a nonprofit corporate body composed of Indians which provides for the maximum participation of all interested Indian groups and individuals and which has the provision of health programs as its principal function.

(j) [i] "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(k) [j] "Nonprofit" as applied to any private entity means that no part of the net earnings of such entity inures or may lawfully inure to the benefit of any private shareholder or individual.

(l) [k] "Project period" means the total time for which support for a project has been approved, as specified in the grant award document.

(m) [l] "School of allied health professions" means a junior college, college, or university—

(1) Which provides, or can provide, programs or education leading to a baccalaureate or associate degree (or to the equivalent of either) or to a higher degree in medical technology, optometric technology, dental hygiene, or in any of such other of the allied health professional curricula as are specified by regulation of the Secretary;

(2) [Which is affiliated with a teaching hospital; and]

(3) Which is accredited or, assured accreditation by a recognized body or bodies approved for such purpose by the Commissioner of Education.

(n) [m] "School of medicine," "school of dentistry," "school of osteopathy," "school of pharmacy," "school of optometry," "school of podiatry," "school of veterinary medicine," and "school of public health" means a school which provides training leading, respectively, to a degree of doctor of medicine, a degree of doctor of dental surgery or an equivalent degree, a degree of doctor of osteopathy, a degree of bachelor of science in pharmacy or an equivalent degree, a degree of doctor of podiatry or an equivalent degree, and a graduate degree in public health, and including advanced training related to such training provided by any such school, and is accredited or assured accreditation by a recognized body or bodies approved for such purpose by the Commissioner of Education.

(o) [n] "School of nursing" means a collegiate, associate degree, or diploma school of nursing, as those terms are defined [in this paragraph below, which is accredited or assured accreditation by a recognized body or bodies approved for such purpose by the Commissioner of Education]:

(1) The term "collegiate school of nursing" means a department, division, or other administrative unit in a college or university which provides primarily or exclusively a program of education in professional nursing and allied

(1) Which provides, or can provide, programs of education leading to a certificate, or to an associate or baccalaureate degree (or the equivalent or either), or to a higher degree for preparing personnel with responsibilities for supporting, complementing, or supplementing the professional functions of physicians, dentists, and other health professionals in the delivery of health care to patients or assisting environmental engineers and others in environmental health control and preventive medicine activities.

(2) Which, if in a college or university which does not include a teaching hospital or in a junior college, is affiliated through a written agreement with one or more hospitals which provide the hospital component of the clinical training required for completion of such programs of education. The written agreement shall be executed by individuals authorized to act for their respective institutions and to assume on behalf of their institution the obligations imposed by such agreement. The agreement shall provide:

(i) a description of the responsibilities of the school of allied health professions, the responsibilities of the hospital, and their joint responsibilities with respect to the clinical components of such programs of education; and

(ii) a description of the procedure by which the school of allied health professions and the hospital will coordinate the academic and clinical training of students in such programs of education; and

(iii) that, with respect to the clinical component of each such program of education, the teaching plan and resources have been jointly examined and approved by the appropriate faculty of the school of allied health professions and the staff of the hospital.

of the Department of Health, Education, and Welfare.

subjects leading to the degree of bachelor of arts, bachelor of science, bachelor of nursing, or to an equivalent degree, or to a graduate degree in nursing, and including advanced training related to such programs of education provided by such schools;

(2) The term "associated degree school of nursing" means a department, division, or other administrative unit in a junior college, community college, college, or university which provides primarily or exclusively a two-year program of education in professional nursing and allied subjects leading to an associate degree in nursing or to an equivalent degree;

(3) The term "diploma school of nursing" means a school affiliated with a hospital or university, or an independent school, which provides primarily or exclusively a program of education in professional nursing and allied subjects leading to a diploma or to equivalent indicia that such program has been satisfactorily completed;

(p) ~~(o)~~ "Secretary" means the Secretary of Health, Education, and Welfare and any other officer or employee of the Department of Health, Education, and Welfare to whom the authority involved has been delegated.

(q) ~~(p)~~ "Service means the Indian Health Service.

(r) ~~(q)~~ "State or local government" means any public health or educational entity which is included within the definition of State or local government in 45 CFR 74.3 and Indian tribes or tribal organizations.

(s) ~~(r)~~ "Tribal organization" means the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities.

(t) ~~(s)~~ "Urban center" means any city with a population of ~~50,000~~ 10,000 or more as determined by the United States Census Bureau, which the Secretary determines has a sufficient urban Indian population with unmet health needs to warrant assistance under Title V of the Act.

(u) ~~(t)~~ "Urban Indian" means any individual who resides in an urban center, as defined in paragraph(s) of this section, and who meets one or more of the four criteria in paragraph ~~(1)~~ (1) through (4) of this section.

(h) (v) ~~(u)~~ "Urban Indian organization" means a nonprofit corporate body situated in an urban center which:

(1) Is composed of urban Indians;

~~(2) Has the provision of health programs as its principal function;~~

~~(3) Is governed by a board of directors elected by the members of the organization;~~

(4) Provides for the maximum participation of all interested Indian groups and individuals; and

(5) Is capable of legally cooperating with other public and private entities

, but only if such program, or such unit, college or university is accredited;

, but only if such program, or such unit, college or university is accredited;

, but only if such program, or such affiliated school or such hospital or university or such independent school is accredited.

(4) The term "accredited" as used in this subsection when applied to any program of nurse education means a program accredited or assured accreditation by a recognized body or bodies, or by a State agency, approved for such purpose by the Commissioner of Education of the Department of Health, Education, and Welfare and when applied to a hospital, school, college, or university (or a unit thereof) means a hospital, school, college, or university (or a unit thereof) which is accredited or assured accreditation by a recognized body or bodies, or by a state agency, approved for such purpose by the Commissioner of Education of the Department of Health, Education, and Welfare.

10,000

(2) Has the provision of health programs as:

(i) its principal function, or

(ii) one of its major functions and such health programs are administered by a distinct organizational unit within the organization.

(3) Is governed by a board of directors composed of urban Indians elected or appointed in accordance with the articles of incorporation and bylaws of the organization.

for the purpose of performing the activities described in § 36.350(a) of Subdivision J-6 of this subpart. Except that criteria (2) and (3) of this subsection shall not apply to an organization administering an urban Indian health project under a contract with the Secretary prior to October 1, 1977, for the period of such contract

or until July 1, 1978, whichever is later.

§ 36.303 Indians applying for scholarships.

(h)

(a) For purposes of scholarship grants under Subdivisions J-3 and J-4 of this subpart, Indian applicants must submit evidence of their tribal membership (or other evidence that the applicant is an Indian as defined in paragraph ~~(a)~~ of § 36.302 of this subdivision) satisfactory to the Secretary.

(b) Where an applicant is a member of a tribe recognized by the Secretary of the Interior, the applicant must submit evidence of his or her tribal membership, such as:

(1) Certification of tribal enrollment by the Secretary of the Interior acting through the Bureau of Indian Affairs (BIA); or

(2) In the absence of such BIA certification, documentation that the applicant meets the requirements of tribal membership as prescribed by the charter, articles of incorporation or other legal instrument of the tribe and has been officially designated a tribal member by an authorized tribal official; or

(3) Other evidence of tribal membership satisfactory to the Secretary.

(c) Where the applicant is a member of a tribe terminated since 1940 or a State recognized tribe, the applicant must submit documentation that the applicant meets the requirements of tribal membership as prescribed by the charter, articles of incorporation or other legal instrument of the tribe and has been officially designated a tribal member by an authorized tribal official; or other evidence, satisfactory to the Secretary, that the applicant is a member of the tribe. In addition, if the terminated or State recognized tribe of which the applicant is a member is not on a list of such tribes published by the Secretary in the FEDERAL REGISTER, the applicant must submit documentation as may be required by the Secretary that the tribe is a tribe terminated since 1940 or is recognized by the State in which the tribe is located in accordance with the law of that State.

(h)

(d) An applicant who is not a tribal member, but who is a natural child or grandchild of a tribal member as defined in paragraph ~~(a)~~ of § 36.302 of this subdivision must submit evidence of such fact which is satisfactory to the Secretary, in addition to evidence of his or her parent's or grandparent's tribal membership in accordance with paragraphs (b) and (c) of this section.

§ 36.305

~~§ 36.304~~ Additional conditions.

The Secretary may, with respect to any grant award under this subpart, impose additional conditions prior to or at the time of any award when in his judgment such conditions are necessary

§ 36.304 Publication of a list of allied health professions.

The Secretary, acting through the Service, shall publish from time to time in the Federal Register a list of the allied health professions for consideration for the award of preparatory and Indian Health scholarships under subdivisions J-3 and J-4 of this Subpart, based upon his determination of the relative needs of Indians for additional service in specific allied health professions. In making that determination, the needs of the Service will be given priority consideration.

to assure or protect advancement of the approved project, the interests of the public health, or the conservation of grant funds.

NOTE.—*Nondiscrimination.* (a) Grants and contracts under this subpart are exempted from the requirements of section 601 of the Civil Rights Act of 1964 (42 U.S.C. 2000d), prohibiting discrimination on the basis of race, color or national origin, by regulation at 45 CFR 80.3(d) which provides, with respect to Indian Health Services, that "An individual shall not be deemed subjected to discrimination by reason of his exclusion from the benefits of a program limited by Federal law to individuals of a particular race, color, or national origin different from his."

(b) Attention is called to the requirements of Title IX of the Education Amendments of 1972 and in particular to section 901 of such Act which provides that no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance.

(c) Attention is called to the requirements of section 504 of the Rehabilitation Act of 1973, as amended, which provides that no otherwise qualified handicapped individual in the United States shall solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

SUBDIVISION J-2—HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS

§ 36.310 Health professions recruitment grants.

Grants awarded under this subdivision, in accordance with section 102 of the Act, are for the purpose of assisting in meeting the costs of projects to:

(a) Identify Indians with a potential for education or training in the health professions and encouraging and assisting them (1) To enroll in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, nursing, or allied health professions; or (2), if they are not qualified to enroll in any such school, to undertake such post-secondary education or training as may be required to qualify them for enrollment;

(b) Publicize existing sources of financial aid available to Indians enrolled in any school referred to in paragraph (a)(1) of this section or who are undertaking training necessary to qualify them to enroll in any such school; or

(c) Establish other programs which the Secretary determines will enhance and facilitate the enrollment of Indians, and the subsequent pursuit and completion by them of courses of study, in any school referred to in paragraph (a)(1) of this section.

§ 36.311 Eligibility.

Any Indian tribe, tribal organization, urban Indian organization, Indian health organization or any public or other non-profit private health or educational entity is eligible to apply for a health professions recruitment grant under this subdivision.

§ 36.312 Application.

(a) An application for a health professions recruitment grant under this subdivision shall be submitted to the Secretary at such time and in such form and manner as the Secretary acting through the Service may prescribe.[1]

(b) The application shall be executed by an individual authorized to act for the applicant and to assume on behalf of the applicant the obligations imposed by the terms and conditions of any award, including the regulations of this subdivision.

(c) In addition to such other pertinent information as the Secretary may require, the application for a health professions recruitment grant shall contain the following:

(1) A description of the legal status and organization of the applicant;

(2) A description of the current and proposed participation of Indians ~~in the activities of the applicant (if any)~~ (if any) in the applicant's organization.

(3) A description of the target Indian population to be served by the proposed project and the relationship of the applicant to that population;

(4) A narrative description of the nature, duration, purpose, need for and scope of the proposed project and of the manner in which the applicant intends to conduct the project including:

(i) Specific measurable objectives for the proposed project;

(ii) How the described objectives are consistent with the purposes of section 102 of the Act;

(iii) The work and time schedules which will be used to accomplish each of the objectives;

(iv) A description of the administrative, managerial, and organizational arrangements and the facilities and resources to be utilized to conduct the proposed project;

(v) The name and qualifications of the project director or other individual responsible for the conduct of the project; the qualifications of the principal staff carrying out the project; and a description of the manner in which the applicant's staff is or will be organized and supervised to carry out the proposed project;

(5) An itemized budget for the entire project period for which support is sought and justification of the amount of grant funds requested;

(6) The intended financial participation, if any, of the applicant in the proposed project specifying the type of contributions such as cash or services, loans of full or part-time staff, equipment, space, materials or facilities or other contributions;

(7) When the target population of a proposed project includes a particular Indian tribe or tribes, ~~an official document in such form as is prescribed by the tribal governing body~~ an official document in such form as is prescribed by the tribal governing body of each such tribe indicating that the tribe or tribes will cooperate with the applicant.

(d) In the case of proposed projects for identification of Indians with a po-

[1] Applications and instructions may be obtained from the appropriate Indian Health Service Area or Program Office ~~or by writing the Director, Indian Health Service, Room 5A-55, 5600 Fishers Lane, Rockville, Maryland 20857.~~

tential for education or training in the health professions, applications must include a method for assessing the potential of interested Indians for undertaking necessary education or training in the health professions. Proposed projects may include, but are not limited to, the following activities:

(1) Identifying Indian elementary and secondary school students through observations, aptitude or other testing, academic performance, performance in special projects and activities, and other methods as may be designed or developed;

(2) Identifying Indians in college or university programs, related employment, upward mobility programs or other areas of activity indicative of interest and potential;

(3) Review of the upward mobility plans, skills banks etc. of organizations employing Indians to identify individuals with appropriate career orientations, expression of interest, or recognized potential;

(4) Conducting workshops, health career days, orientation projects or other activities to identify interested Indians at any age level;

(5) Performing liaison activities with Indian professional organizations, Indian education programs (including adult education), Indian school boards, Indian parent, youth recreation or community groups, or other Indian special interest or activity groups;

(6) Identifying those Indians with an interest and potential who cannot undertake compensatory education or training in the health professions because of financial need.

(c) Proposed projects designed to encourage and assist Indians to enroll in health professions schools; or, if not qualified to enroll, to undertake post-secondary education or training required to qualify them for enrollment may include, but are not limited to, the following activities:

(1) Providing technical assistance and counseling to encourage and assist Indians identified as having a potential for education or training in the health professions—

(i) To enroll in health professions schools,

(ii) To undertake any post-secondary education and training required to qualify them to enroll in health professions schools, and

(iii) To obtain financial aid to enable them to enroll in health professions schools or undertake post-secondary education or training required to qualify them to enroll in such schools;

(2) Conducting programs to (i) identify factors such as deficiencies in basic communication, research, academic subject matter (such as science, mathematics, etc.), or other skills which may prevent or discourage Indians from enrolling in health professions schools or undertaking the post-secondary education or training required to qualify them to enroll, and (ii) provide counseling and technical assistance to Indians to assist them in undertaking the neces-

sary education, training or other activities to overcome such factors.

(f) Proposed projects to publicize existing kinds of financial aid available to Indians enrolled in health professions schools or to Indians undertaking training necessary to qualify them to enroll in such schools may include, but are not limited to, the following activities:

(1) Collecting information on available sources of financial aid and disseminating such information to Indian students, Indians, recruited under programs assisted by grants under this subdivision and to Indian tribes, tribal organizations, urban Indian organizations, Indian health organizations and other interested groups and communities throughout the United States;

(2) Providing information on available sources of financial aid which can be utilized by programs and counselors assisting Indians to obtain financial aid.

(g) Proposed projects for establishment of other programs which will enhance or facilitate enrollment of Indians in health professions schools and the subsequent pursuit and completion by them of courses of study in such schools may include, but are not limited to, the following activities:

(1) Compilation and dissemination of information on—(i) Health professions education or training programs and the requirements for enrollment in such programs; and

(ii) Post-secondary education or training curricula and programs designed to qualify persons for enrollment in health professions schools;

(2) Developing and coordinating career orientation programs in local schools (including high schools) and colleges and universities;

(3) Developing programs to enable Indians to gain exposure to the health professions such as arranging for (i) visits to health care facilities and programs and meetings or seminars with health professionals, (ii) part-time summer or rotating employment in health care facilities, programs, or offices of health professionals, (iii) volunteer programs, or (iv) other means of providing such exposure;

(4) Developing programs which relate tribal culture and tradition, including native medicine, to careers in the health professions; and

(5) Developing programs to make Indians aware of projected health manpower needs, expected employment opportunities in the health professions, and other factors in order to orient and motivate Indians to pursue careers in the health professions.

§ 36.313 Evaluation and grant awards.

(a) Within the limits of funds available for such purpose, the Secretary, acting through the Service, may award health professions recruitment grants to those eligible applicants whose proposed projects will in his judgment best promote the purposes of section 102 of the Act, taking into consideration:

(1) The potential effectiveness of the proposed project in carrying out such purposes;

(2) The capability of the applicant to successfully conduct the project;

(3) The accessibility of the applicant to target Indian communities or tribes, including evidence of past or potential cooperation between the applicant and such communities or tribes;

(4) The relationship of project objectives to known or anticipated Indian health manpower deficiencies;

(5) The soundness of the fiscal plan for assuring effective utilization of grant funds;

(6) The completeness of the application.

(b) Preference shall be given to applicants in the following order of priority (1) Indian tribes and tribal organizations, (2) urban Indian organizations and other Indian health organizations, and (3) public and other nonprofit private health or educational entities.

(c) The amount of any award under this subdivision will be determined by the Secretary on the basis of his estimate of the sum necessary for all or a designated portion of the direct costs of the project plus an additional amount for indirect costs, if any, which will be calculated by the Secretary either: (1) On the basis of his estimate of the actual indirect costs reasonably related to the project, or (2) on the basis of a percentage of all or a portion of, the estimated direct costs of the project when there are reasonable assurances that the use of such percentage will not exceed the approximate actual indirect costs. Such award may include an estimated provisional amount for indirect costs or for designated direct costs (such as fringe benefit rates) subject to upward (within the limits of available funds) as well as downward adjustments to actual costs when the amount properly expended by the grantee for provisional items has been determined by the Secretary.

(d) All grant awards shall be in writing, and shall set forth the amount of funds granted and the period for which support is provided.

(e) Neither the approval of any project nor the award of any grant shall commit or obligate the United States in any way to make any additional, supplemental, continuation, or other award with respect to any approved project or portion thereof. For continuation support, grantees must make separate application at such times and in such form as the Secretary may dictate.

§ 36.314 Payment and use of funds.

(a) The Secretary acting through the Service will make payments to a grantee either by way of reimbursement for expenses incurred in the project period, or in advance for expenses to be incurred, to the extent he determines such payments are necessary to promptly initiate and conduct the approved project.

(b) Any funds granted under this subdivision shall be used solely for carrying out the approved project in accordance with section 102 of the Act, the regulations of this subdivision, and the terms and conditions of the grant award.

§ 36.315 Publication of list of grantees and projects.

The Secretary acting through the Service shall publish annually in the FEDERAL REGISTER a list of organizations receiving grants under this subdivision including for each grantee:

(a) The organization's name and address

(b) The amount of the grant

(c) A summary of the project's purposes and its geographic location.

§ 36.316 Alteration or renovation.

Grant funds used for alteration or renovation shall be subject to the condition that the grantee shall comply with the requirements of Executive Order 11246, 30 FR 12319 (Sept. 24, 1965) as amended, and with applicable rules, regulations, and procedures prescribed under that Order.

§ 36.317 Grantee accountability.

(a) *Accounting for grant award payments.* All payments made by the Secretary shall be recorded by the grantee in accounting records separate from the records of all other funds, including funds derived from other grant awards. With respect to each approved project the grantee shall account for the sum total of all amounts paid by presenting or otherwise making available evidence satisfactory to the Secretary of expenditures for costs meeting the requirements of this subpart except that when the amount awarded for indirect costs was based on a predetermined fixed percentage of estimated direct costs, the amount allowed for indirect costs shall be computed on the basis of such predetermined fixed-percentage rates applied to the total or selected elements of the reimbursable direct costs incurred.

(b) *Accounting for royalties.* Royalties received by grantees from copyrights on publications or other works developed under the grant, or from patents or inventions conceived or first actually reduced to practice in the course of or under such grant shall be accounted for as follows:

(1) *State and local governments.* Where the grantee is a State or local government royalties shall be accounted for as provided in 45 CFR 74.44.

(2) *Grantees other than State and local governments.* Where the grantee is not a State or local government as so defined, royalties shall be accounted for as follows:

(i) Patent royalties, whether received during or after the grant period, shall be governed by agreement between the Assistant Secretary for Health, Department of Health, Education, and Welfare, and the grantee pursuant to the Department's patent regulations (45 CFR Parts 6 and 8).

(ii) Copyright royalties, whether received during or after the grant period, shall first be used to reduce the Federal share of the grant to cover the costs of publishing or producing the materials, and any royalties in excess of the costs of publishing or producing the materials shall be distributed in accordance with

Chapter [illegible]

Subpart [illegible]

Sec. [illegible]

Accountability. (b)

Accountability. (1) *Date of final accounting.* A grantee shall render, with respect to each approved project, a full account, as provided herein, as of the date of the termination of grant support. The Secretary may require other special and periodic accounting.

(2) *Final settlement.* There shall be payable to the Federal Government as final settlement with respect to each approved project the total sum of (i) any amount not accounted for pursuant to paragraph (b) (1) of this section; and (ii) any other amounts due pursuant to Subparts P, M, and O of 45 CFR Part 74. Such total sum shall constitute a debt owed by the grantee to the Federal Government and shall be recovered from the grantee or its successor or assigns by set-off or other action as provided by law. delete

§ 36.318 Publications and copyright.

(a) *State and local governments.* Where the grantee is a State or local government the Department of Health, Education, and Welfare copyright requirement set forth in 45 CFR 74.160 shall apply with respect to any book or other copyrightable materials developed or resulting from a project supported by a grant under this subpart.

(b) *Grantees other than State and local governments.* Where the grantee is not a State or local government, except as may otherwise be provided under the terms and conditions of the award, the grantee may copyright without prior approval any publications, films, or similar materials developed or resulting from a project supported by a grant under this subpart, subject to a royalty-free, nonexclusive, and irrevocable license or right in the Government to reproduce, translate, publish, use, disseminate and dispose of such materials, and to authorize others to do so.

§ 36.319 Applicability of 45 CFR Part 74.

The provisions of 45 CFR Part 74, establishing uniform administrative requirements and cost principles shall apply to all grants under this subpart to State and local governments. The relevant provisions of the following subparts of Part 74 shall also apply to all other grantee organizations under this [illegible] subdivision:

SUBPART

A—General.
B—Cash Depositories.
C—Bonding and Insurance.
D—Retention and Custodial Requirements for Records.
F—Grant-Related Income.
K—Grant Payment Requirements.
L—Budget Revision Procedures.

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*The Department of Health, Education and Welfare Grants Administration Manual is available for public inspection and copying at the Department's Regional Offices. Information concerning fees is set forth in 45 CFR 5.71 and may be requested from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

M—Grant Closeout, Suspension, and Termination.
O—Property.
Q—Cost Principles.

SUBDIVISION J-2.—HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS

§ 36.320 Preparatory scholarship grants.

Scholarship grants may be awarded under this subdivision and section 103 of the Act for the period (not to exceed two academic years) necessary to complete a recipient's compensatory preprofessional education to enable the recipient to qualify for enrollment or re-enrollment in a health professions school. Examples of individuals eligible for such grants are the individual who:

(a) Has completed high school equivalency and needs compensatory preprofessional education to enroll in a health professions school;

(b) Has a baccalaureate degree and needs compensatory preprofessional education to qualify for enrollment in a health professions school; or

(c) Has been enrolled in a health professions school but is no longer so enrolled and needs preprofessional education to qualify for readmission to a health professions school.

§ 36.321 Eligibility.

To be eligible for a preparatory scholarship grant under this subdivision an applicant must:

(a) Be an Indian;

(b) Have successfully completed high school education or high school equivalency;

(c) Have demonstrated to the satisfaction of the Secretary the desire and capability to successfully complete courses of study in a health professions school;

(d) Be accepted for enrollment in or be enrolled in any compensatory preprofessional education course or curriculum meeting the criteria in § 36.320 of this subdivision;

(e) Be a citizen of the United States.

§ 36.322 Application and selection.

(a) An application for a preparatory scholarship grant under this subdivision shall be submitted in such form and at such time as the Secretary acting through the Service may prescribe.* However, an application must indicate: (1) The health profession which the applicant wishes to enter and (2) whether the applicant intends to provide health services to Indians upon completion of health professions education or training by serving as described in section 36.333 or otherwise as indicated on the application.

(b) Within the limits of funds available for the purpose, the Secretary, acting through the Service, shall make scholarship grant awards for a period not to exceed two academic years of an individual's compensatory preprofes-

* Applications and instructions may be obtained from the appropriate Indian Health Service Area or Program Office.

sional education to eligible applicants taking into consideration:

(1) Academic performance;

(2) Work experience;

(3) Faculty recommendations;

(4) Stated reasons for asking for the scholarship; and

(5) The relative needs of the Service and Indian health organizations for persons in specific health professions.

§ 36.323 Scholarship and tuition.

(a) Scholarship grant awards under this subdivision shall consist of:

~~(1) A stipend in an amount not in excess of one half the basic pay and allowances of a commissioned officer in the Public Health Service, without dependents, on active duty in pay grade O-1 with less than two years of service;~~ and

(2) An amount determined by the Secretary for transportation, tuition, fees, books, laboratory expenses and other necessary educational expenses.

(b) The portion of the scholarship for the costs of tuition and fees as indicated in the grant award will be paid directly to the school upon receipt of an invoice from the school. The stipend and remainder of the scholarship grant award will be paid monthly to the grantee under the conditions specified in the grant award.

(1) A stipend of $400 per month adjusted in accordance with paragraph (c);

(c) The amount of the monthly stipend specified in paragraph (a) (1) shall be increased by the Secretary for each academic year ending in a fiscal year beginning after September 30, 1978, by an amount (rounded to the next highest multiple of $1) equal to the amount of such stipend multiplied by the overall percentage (as set forth in the report transmitted to the Congress under section 5303 of Title 5, United States Code) of the adjustment (if such adjustment is an increase) in the rates of pay under the General Schedule made effective in the fiscal year in which such academic year ends.

§ 36.324 Publication of a list of recipients.

The Secretary, acting through the Service, will publish annually in the FEDERAL REGISTER a list of recipients of scholarship grants under this subdivision, including the name of each recipient, tribal affiliation and school.

SUBDIVISION J-4—INDIAN HEALTH SCHOLARSHIP PROGRAM

§ 36.330 Indian health scholarships.

Indian Health Scholarships will be awarded by the Secretary pursuant to ~~section 338(i)(2) of the Public Health Service Act in accordance with regulations set out in 42 CFR Part 62~~ except as set out in this subdivision for the purpose of providing scholarships to Indian and other students at health professions schools in order to obtain health professionals to serve Indians.

Subpart IV of Part C of Title VII of the Public Health Service Act, and such implementing regulations as may be promulgated by the Secretary

~~§ 36.331 Eligibility.~~

~~In lieu of an agreement to serve under § 62.3(d) of 42 CFR, an applicant must agree to serve as provided in § 36.333 of this subdivision.~~

§ 36.331

~~§ 36.332~~ Selection.

(a) The Secretary, acting through the Service, shall determine the individuals who receive Indian Health Scholarships.

(b) Priority shall be given to applicants who are Indians.

§ 36.332

~~§ 36.333~~ Service obligation.

The service obligation provided in ~~§ 62.9 of 42 CFR~~ shall be met by the recipient of an Indian Health Scholarship by service in:

Section 757(b)(2) of the Public Health Service Act

(a) The Indian Health Service,

(b) An urban Indian organization assisted under Subdivision J-6.

(c) In private practice of his or her profession if, the practice (1) is situated in a physician or other health-manpower shortage area designated under section 332 of the Public Health Service Act and (2) addresses the health care needs of a substantial number of Indians as determined by the Secretary in accordance with guidelines of the Service.

~~§ 36.331~~ Distribution of scholarships.

§ 36.333

The Secretary, acting through the Service, shall determine the distribution of Indian Health Scholarships among the health professions based upon the relative needs of Indians for additional service in specific health professions. In making that determination the needs of the Service will be given priority consideration. The following factors will also be considered:

(a) The professional goals of recipients of scholarships under section 103 of the Indian Health Care Improvement Act;

(b) The professional areas of study of Indian applicants.

§ 36.334 Publication of a list of recipients.

The Secretary, acting through the Service, will publish annually in the Federal Register a list of recipients of Indian Health Scholarships, including the name of each recipient, tribal affiliation if applicable, and school.

SUBDIVISION J-5.—CONTINUING EDUCATION ALLOWANCES

§ 36.340 Provision of continuing education allowances.

In order to encourage physicians, dentists and other health professionals to join or continue in the Service and to provide their services in the rural and remote areas where a significant portion of the Indian people reside the Secretary, acting through the Service, may provide allowances to health professionals employed in the Service in order to enable them to leave their duty stations for not to exceed 480 hours of professional consultation and refresher training courses in any one year.

SUBDIVISION J-6.—CONTRACTS WITH URBAN INDIAN ORGANIZATIONS

§ 36.350 Contracts with Urban Indian organizations.

(a) The Secretary, acting through the Service, to the extent that funds are available for the purpose, shall contract with urban Indian organizations selected under section 36.351 of this subdivision to carry out the following activities in the urban centers where such organizations are situated:

(1) Determine the population of urban Indians which are or could be recipients of health referral or care services;

(2) Identify all public and private health service resources within the urban center in which the organization is situated which are or may be available to urban Indians;

(3) Assist such resources in providing service to such urban Indians;

(4) Assist such urban Indians in becoming familiar with and utilizing such resources;

(5) Provide basic health education to such urban Indians;

(6) Establish and implement manpower training programs to accomplish the referral and education tasks set forth in clauses (3) through (5) of this subsection;

(7) Identify gaps between unmet health needs of urban Indians and the resources available to meet such needs;

(8) Make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians; and

(9) Provide or contract for health care services to urban Indians where local health delivery resources are not available, not accessible, or not acceptable to the urban Indians to be served.

(b) Contracts with urban Indian organizations pursuant to this title shall be in accordance with all Federal contracting laws and regulations except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935 as amended (The Miller Act, 40 U.S.C. 270a et seq. which is concerned with bonding requirements).

(c) Payments under contracts may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of Title V of the Act.

(d) Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract made by him with such organization pursuant to this subdivision as necessary to carry out the purposes of Title V of this Act: Provided, however, that whenever an urban Indian organization requests retrocession of the Secretary for any such contract, retrocession shall become effective upon a date specified by the Secretary not more than one hundred and twenty days from the date of the request by the organization or at such later date as may be mutually agreed to by the Secretary and the organization.

(e) In connection with any contract made pursuant to this subdivision, the Secretary may permit an urban Indian organization to utilize, in carrying out such contract, existing facilities [owned] by the Federal Government within his jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.

§ 36.351 Application and selection.

(a) Proposals for contracts under this subdivision shall be submitted in such form and manner and at such time as the Secretary acting through the Service may prescribe.

(b) The Secretary, acting through the Service shall select urban Indian organizations with which to contract under this subdivision [under this subdivision whose proposal] will in his judgment best promote the purposes of Title V of the Act taking into consideration the following factors:

(1) The extent of the unmet health care needs of the urban Indians in the urban center involved [determined on the basis of the latest available statistics on] incidence and prevalence, life expectancy, infant mortality, dental needs, housing conditions, family income, unemployment statistics etc.

(2) The urban Indian population which is to receive assistance in the following order of priority:

(i) 9,000 or more;
(ii) 4,500 to 9,000;
(iii) 3,000 to 4,500;
(iv) 1,000 to 3,000.

(3) The relative accessibility which the urban Indian population to be served has to health care services in the urban center. Factors to be considered in determining relative accessibility include:
(i) Cultural barriers;
(ii) Discrimination against Indians;
(iii) Inability to pay for health care;
(iv) Lack of facilities which provide free care to indigent persons;
(v) Lack of state or local health programs;
(vi) Technical barriers created by State and local health agencies;
(vii) Availability of transportation to health care services;
(viii) Distance between Indian residences and the nearest health care facility.

(4) The extent to which required activities under section 36.350(a) of this subdivision would duplicate any previous or current public or private health services projects in the urban center funded by another source. Factors to be considered in determining duplication include:
(i) Urban Indian utilization of existing health services funded by other sources;
(ii) Urban Indian utilization of existing health services delivered by an urban Indian organization funded by other sources;
~~(iii) How near other sources of health services are to facilities of the applicant urban Indian organization.~~

(5) The appropriateness and likely effectiveness of the activities required in § 36.350(a) of this subdivision in the urban center involved.

(6) The capability of the applicant urban Indian organization to perform satisfactorily the activities required in § 36.350(a) of this subdivision and to contract with the Secretary.

(7) The extent of existing or likely future participation in the activities required in § 36.350(a) of this subdivision by appropriate health and health related Federal, State, local, and other resource agencies.

~~(8) Whether the city is identified as a Bureau of Indian Affairs relocation city.~~

(9) Whether the city has an existing urban Indian health [program].

(8)

(10) The applicant organization's record of performance, if any, in regard to any of the activities required in § 36.350 (a) of this subpart.

(9)

~~(11) Letters demonstrating local support for the applicant organization from both the Indian and non-Indian communities in the urban center involved.~~

(10)

§ 36.352 Fair and uniform provision of services.

Contracts with urban Indian organizations under this subdivision shall incorporate the following clause:

The Contractor agrees, consistent with medical need, [and the efficient provision of medical services to make no discriminatory distinctions against Indian patients or beneficiaries of this contract which are inconsistent with the fair and uniform provision of services.]

~~to make no discriminatory distinctions against Indian patients or beneficiaries of this contract. For the purpose of this contract, discriminatory distinctions include but are not limited~~

(v) under 1,000.

to the following actions not based upon medical need:

(a) Denying a patient any service or benefit or availability of a facility;

(b) Providing any service or benefit to a patient which is different, or is provided in a different manner or at a different time from that provided to other patients under this contract; subjecting a patient to segregation or separate treatment in any manner related to the receipt of any service; restricting a patient in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service, benefit; discriminating against a patient in determining whether the patient satisfies any admission, enrollment, quota, eligibility, membership, or other requirements or conditions which individuals must meet in order to be provided any service or benefit; the assignment of times or places for the provision of services on the basis of discriminatory distinctions not based on medical needs.

§ 36.353 Reports and records.

For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract under this title, such organization shall submit to the Secretary a report including information gathered pursuant to § 36.350(a) (7) and (8) of this subdivision, information on activities conducted by the organization pursuant to the contract, an accounting of the amounts and purposes for which Federal funds were expended, and such other information as the Secretary may request. The reports and records of the urban Indian organization with respect to such contract shall be subject to audit by the Secretary and the Comptroller General of the United States.

SUBDIVISION J-7.—LEASES WITH INDIAN TRIBES

§ 36.360 Leases with Indian tribes.

(a) Any land or facilities otherwise authorized to be acquired, constructed, or leased to carry out the purposes of the Act may be leased or subleased from Indian tribes for periods not in excess of twenty years.

(b) Leases entered into pursuant to paragraph (a) shall be subject to the requirements of section 322 of the Economy Act (40 U.S.C. 278a), which limits expenditures for rent and alterations, improvements and repairs on leased buildings.

[FR Doc.77-14647 Filed 6-20-77;8:45 am]

BILLING CODE: 4110-84

Title 41—Public Contracts and Property Management

CHAPTER 3—DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PART 3-4—SPECIAL TYPES AND METHODS OF PROCUREMENT

Subpart 3-4.57—Negotiated Procurement Under the Buy Indian Act

AGENCY: Department of Health, Education, and Welfare

ACTION: Final rules

SUMMARY: These rules prescribe Department policy on preferential purchasing from Indians and Indian firms under section 303 of the Indian Health Care Improvement Act, and the negotiating authority of the Buy Indian Act.

EFFECTIVE DATE: (date of publication)

FOR FURTHER INFORMATION CONTACT:

Dr. Robert C. Birch, Indian Health Service, Telephone: 301-443-1044. Address: Room 5A-55, 5600 Fishers Lane, Rockville, Maryland 20857.

SUPPLEMENTARY INFORMATION: On May 23, 1977, a Notice of Proposed Rulemaking was published in the Federal Register (42 F.R. 26314 et seq.) proposing to amend subpart 3-4.57 of 41 CFR to accord with section 303 of the Indian Health Care Improvement Act, Pub. L. 94-437 (25 U.S.C. 1633), and for other purposes.

Under section 303(a) of Pub. L. 94-437, the Secretary may use the negotiating authority of the Buy Indian Act (25 U.S.C. 47) to give preference to Indians and Indian firms: (1) in the construction and renovation of Indian

Health Service (IHS) facilities and (2) in the construction of sanitation facilities for Indian homes and communities. The Secretary may give a preference unless he finds, pursuant to regulations and after considering certain evaluation criteria listed in section 303(a), that the project to be contracted for will not be satisfactory or cannot be properly completed or maintained under the proposed contract.

Under the proposed regulations, those findings and criteria would be made applicable to all Indian Health Service procurements under the Buy Indian Act. In addition, certain other changes in subpart 3-4.57 of 41 CFR were proposed with respect to (1) the definition of Indian firm, (2) the required degree of Indian ownership, and (3) procedures for prior notification of Indian firms. Interested persons were given until July 7, 1977 to submit written comments, suggestions or objections.

Change Made From the Proposed Rules

After full and careful consideration of all comments received, section 3-4.5705(b) has been changed to insert the words "are to be in writing and" after the word "determinations". The change is in response to a comment that the determination made under section 3-4.5705(a), that the project or function to be contracted for is likely to be satisfactorily performed and properly completed or maintained under the contract, be made in writing.

Discussion of Miscellaneous Comments

The Secretary does not agree that the proposed rules would be improved as suggested by some commentors and has rejected the following suggestions:

1. That the regulations provide that other appropriate agencies within the Department may act as agents of the IHS in advertising and awarding design and construction contracts with Indian organizations. This is not necessary as section 3-4.5700, Scope of Subpart, provides that Subpart 3-4.57 applies to procurements "made by or on behalf of the Indian Health Service".

2. That the regulations should give a preference to tribally owned or operated construction companies. As Indian tribes may request contracts under the Indian Self-Determination Act, Pub. L. 93-638, a preference for tribal companies under these regulations is not necessary.

3. That an Indian contractor be required to prove that the contractor will give employment preference to Indians and is in a position to employ Indians as a large percentage of its work force. Final regulations published on September 30, 1977 (42 F.R. 52400), as corrected on October 7, 1977

(42 F.R. 54552), have revised sections 3-4.5703(c) and (e) of the Buy Indian Act regulations to include requirements for Indian preference in training and employment and the award of subcontracts to Indian firms pursuant to section 7(b) of the Indian Self-Determination Act, Pub. L. 93-638 (25 U.S.C. 450 e(b)).

4. That evaluation criteria in section 3-4.5705 not apply to Indian firms in California. The evaluation criteria are specified in section 303(a) of Pub. L. 94-437 (25 U.S.C. 1633(a)) without exception for particular geographic areas.

5. Certain recommendations for stylistic changes not affecting substantive meaning have been rejected in favor of retaining simpler language. It was suggested that the words "provide for utilizing the Buy Indian Act" be substituted for "calls for the use of the Buy Indian Act" in the third and fourth lines of section 3-4.5701 and that the last sentence in section 3-4.5703(a) as proposed be rewritten as two sentences without substantive change.

Public Participation

Following publication of the Notice of Proposed Rulemaking (NPRM) on May 23, 1977 and during the public comment period which ended July 7, 1977, about 6,000 copies of the NPRM were distributed to American Indian and Alaska Native people, IHS staff, and other interested persons.

Meetings were held with American Indian and/or Alaska Native people, IHS staff, and others to stimulate understanding of the NPRM and to encourage public comment where interested. Examples of locations where these meetings were held include: Arizona — Sells, Tucson, Window Rock; California — Escondido, Sacramento; San Francisco; Minnesota — Bemidji, Duluth; Nevada — Reno; New Mexico — Albuquerque, Dulce, Santa Fe, Zuni; Oklahoma — Chilocco; Washington — Seattle; Wisconsin — Stockbridge-Munsee.

The current meeting totals for the period October 1, 1976 — June 1977:

No. of Pub. L. 94-437 meetings held throughout the U.S.	187
No. of communities in which meetings were held	72
No. of people at meetings	7,358
American Indian/Alaska people represented at meetings	800,000+
No. of communications cards processed by IHS Core Team	2,693

Part 3-4 of Title 41 is amended by amending subpart 3-4.57 as follows.

The Department of Health, Education, and Welfare has determined that this document does not contain a major proposal requiring preparation of an Inflationary Impact Statement under Executive Order 11821 and OMB Circular A-107.

DATED: 3 [illegible]

s/ Julius B. Richmond
Assistant Secretary for Health

APPROVED:

Secretary

Part 3-4 of Title 41 is amended by amending subpart 3-4.57 as follows:

Subpart 3-4.57—Negotiated Procurement Under the Buy Indian Act

Authority: Sec. 303 of Pub. L. 94-437 (25 U.S.C. 1633); 25 U.S.C. 47; sec. 702 of Pub. L. 94-437 (25 U.S.C. 1672)

1. Section 3-4.5700 is amended to read as follows:

§ 3-4.5700 Scope of subpart.

This subpart sets forth policy on preferential purchasing from Indians under the negotiating authority of the Buy Indian Act. Applicability of this subpart is limited to procurements made by or on behalf of the Indian Health Service, U.S. Public Health Service.

2. At the end of § 3-4.5701 add the following:

§ 3-4.5701 Policy.

* * * Section 303 of the Indian Health Care Improvement Act (P.L. 94-437) calls for the use of the Buy Indian Act in the construction and renovation of facilities pursuant to section 301 of that Act and in the construction of safe water and sanitary waste disposal facilities pursuant to section 302 of that Act.

3. Section 3-4.5702-2 is amended to read as follows:

§ 3-4.5702-2 Indian Firm.

An Indian firm means a sole enterprise, partnership, corporation, or other type of business organization owned and controlled by one or more Indians (including, for the purpose of sections 301 and 302 of Pub. L. 94-437, former or currently federally recognized Indian tribes in the State of New York) or by an Indian firm; or a non-profit firm organized for the benefit of Indians and controlled by Indians.

4. Paragraph (a) of § 3-4.5703 is amended to read as follows:

§ 3-4.5703 Requirements.

(a) *Indian ownership.* The degree of ownership that is called for by § 3-4.5702-2 shall be 100 percent during the period covered by a Buy Indian contract unless a deviation from that 100 percent requirement is approved on an individual basis by the Area or Program Office Director of the Indian Health Service responsible for the area or program with respect to which the Buy Indian contract is to be entered into. Such a deviation, which may be to not less than 51 percent, must be accompanied by an appropriate justification for such a deviation.

* * * * *

5. The following § 3-4.5705 as added to read as follows:

§ 3-4.5705 Evaluation criteria.

(a) A contract may be negotiated with, and preference given to, Indians under the Buy Indian Act only if it is first determined that the project or function to

be contracted for is likely to be satisfactorily performed under such a contract and that the project or function is likely to be properly completed or maintained under such a contract.

(b) The determination called for by paragraph (a) to be made prior to the award of a negotiated contract under the Buy Indian Act will be made by the official specified in § 3-4.5704-1(b). Such determinations are to reflect a consideration of the following criteria:

are to be in writing and

(1) Whether there is ownership of a business organization, and control of such a business organization or of a nonprofit firm, as is called for by § 3-4.5702-2.

(2) Whether the Indian firm has the equipment, buildings and facilities necessary to assure the efficient and orderly performance of the contract or whether it has reasonable access thereto for that purpose.

(3) Whether the Indian firm has established bookkeeping and accounting procedures, adequate to assure the efficient and orderly performance of the contract, including a compliance with labor requirements and a timely compliance with reporting requirements.

(4) Whether the Indian firm has substantive knowledge of the project or function to be contracted for, based either upon satisfactory performance of a similar project under a prior contract or upon demonstrated experience in managing, or being otherwise intimately involved in, a similar project.

(5) Whether the Indian firm has an adequate number of employees, or has reasonably available to it sufficient personnel, who are or will be under a reasonable on-the-job training program adequately trained to satisfactorily perform the contract.

(6) Whether the Indian firm has the experience and financial ability to adequately perform a contract of the proposed scope and magnitude, considering its present and potential commitments to other projects.

6. At the end of § 3-4.5704 add the following new paragraph (c):

§ 3-4.5704 Competition.

* * * * *

(c) Contracts proposed to be entered into by the Indian Health Service should be synopsized and publicized in the Commerce Business Daily (See § 1-1.1003-1) and copies thereof sent to the tribal office of the Indian tribal government directly concerned with the proposed procurement as well as to Indian firms and others having a legitimate interest therein. Such synopses should state that to the extent provided for pursuant to the Buy Indian Act qualified Indian firms will be given preference in the award of such contracts.

41 CFR

[FR Doc. 77-19048 Filed 6-29-77; 8:45 am]

TAB B

Public Law 94-437
94th Congress, S. 522
September 30, 1976

An Act

To implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Indian Health Care Improvement Act".

Indian Health Care Improvement Act.
25 USC 1601 note.

FINDINGS

SEC. 2. The Congress finds that— 25 USC 1601.

(a) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.

(b) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.

(c) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.

(d) Despite such services, the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States. For example, for Indians compared to all Americans in 1971, the tuberculosis death rate was over four and one-half times greater, the influenza and pneumonia death rate over one and one-half times greater, and the infant death rate approximately 20 per centum greater.

(e) All other Federal services and programs in fulfillment of the Federal responsibility to Indians are jeopardized by the low health status of the American Indian people.

(f) Further improvement in Indian health is imperiled by—

(1) inadequate, outdated, inefficient, and undermanned facilities. For example, only twenty-four of fifty-one Indian Health Service hospitals are accredited by the Joint Commission on Accreditation of Hospitals; only thirty-one meet national fire and safety codes; and fifty-two locations with Indian populations have been identified as requiring either new or replacement health centers and stations, or clinics remodeled for improved or additional service;

(2) shortage of personnel. For example, about one-half of the Service hospitals, four-fifths of the Service hospital outpatient clinics, and one-half of the Service health clinics meet only 80 per centum of staffing standards for their respective services;

(3) insufficient services in such areas as laboratory, hospital inpatient and outpatient, eye care and mental health services, and services available through contracts with private physicians, clinics, and agencies. For example, about 90 per centum of the surgical operations needed for otitis media have not been performed, over 57 per centum of required dental services remain to be provided, and about 98 per centum of hearing aid requirements are unmet;

(4) related support factors. For example, over seven hundred housing units are needed for staff at remote Service facilities;

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(5) lack of access of Indians to health services due to remote residences, undeveloped or underdeveloped communication and transportation systems, and difficult, sometimes severe, climate conditions; and

(6) lack of safe water and sanitary waste disposal services. For example, over thirty-seven thousand four hundred existing and forty-eight thousand nine hundred and sixty planned replacement and renovated Indian housing units need new or upgraded water and sanitation facilities.

(g) The Indian people's growth of confidence in Federal Indian health services is revealed by their increasingly heavy use of such services. Progress toward the goal of better Indian health is dependent on this continued growth of confidence. Both such progress and such confidence are dependent on improved Federal Indian health services.

DECLARATION OF POLICY

25 USC 1602.

SEC. 3. The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy.

DEFINITIONS

25 USC 1603.

SEC. 4. For purposes of this Act—

(a) "Secretary", unless otherwise designated, means the Secretary of Health, Education, and Welfare.

(b) "Service" means the Indian Health Service.

(c) "Indians" or "Indian", unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) hereof, except that, for the purpose of sections 102, 103, and 201(c)(5), such terms shall mean any individual who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary.

(d) "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

43 USC 1601 note.

(e) "Tribal organization" means the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities.

(f) "Urban Indian" means any individual who resides in an urban center, as defined in subsection (g) hereof, and who meets one or more

of the four criteria in subsection (c) (1) through (4) of this section.

(g) "Urban center" means any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary.

(h) "Urban Indian organization" means a nonprofit corporate body situated in an urban center, composed of urban Indians, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).

TITLE I—INDIAN HEALTH MANPOWER

PURPOSE

SEC. 101. The purpose of this title is to augment the inadequate number of health professionals serving Indians and remove the multiple barriers to the entrance of health professionals into the Service and private practice among Indians. 25 USC 1611.

HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS

SEC. 102. (a) The Secretary, acting through the Service, shall make grants to public or nonprofit private health or educational entities or Indian tribes or tribal organizations to assist such entities in meeting the costs of— Grants. 25 USC 1612.

(1) identifying Indians with a potential for education or training in the health professions and encouraging and assisting them (A) to enroll in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, nursing, or allied health professions; or (B), if they are not qualified to enroll in any such school, to undertake such post-secondary education or training as may be required to qualify them for enrollment;

(2) publicizing existing sources of financial aid available to Indians enrolled in any school referred to in clause (1)(A) of this subsection or who are undertaking training necessary to qualify them to enroll in any such school; or

(3) establishing other programs which the Secretary determines will enhance and facilitate the enrollment of Indians, and the subsequent pursuit and completion by them of courses of study, in any school referred to in clause (1)(A) of this subsection.

(b)(1) No grant may be made under this section unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe: *Provided*, That the Secretary shall give a preference to applications submitted by Indian tribes or tribal organizations. Application, submittal and approval.

(2) The amount of any grant under this section shall be determined by the Secretary. Payments pursuant to grants under this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions as the Secretary finds necessary. Amount and payment.

(c) For the purpose of making payments pursuant to grants under this section, there are authorized to be appropriated $900,000 for fiscal year 1978, $1,500,000 for fiscal year 1979, and $1,800,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984 there are authorized to be appropriated for such payments such sums as may be specifically authorized by an Act enacted after this Act. Appropriation authorization.

HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS

Scholarship grants, eligibility requirements. 25 USC 1613.

SEC. 103. (a) The Secretary, acting through the Service, shall make scholarship grants to Indians who—

(1) have successfully completed their high school education or high school equivalency; and

(2) have demonstrated the capability to successfully complete courses of study in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, nursing, or allied health professions.

Two-year limitation.

(b) Each scholarship grant made under this section shall be for a period not to exceed two academic years, which years shall be for compensatory preprofessional education of any grantee.

(c) Scholarship grants made under this section may cover costs of tuition, books, transportation, board, and other necessary related expenses.

Appropriation authorization.

(d) There are authorized to be appropriated for the purpose of this section: $800,000 for fiscal year 1978, $1,000,000 for fiscal year 1979, and $1,300,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984 there are authorized to be appropriated for the purpose of this section such sums as may be specifically authorized by an Act enacted after this Act.

HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

Appropriation authorization.

SEC. 104. Section 225(i) of the Public Health Service Act (42 U.S.C. 234(i)) is amended (1) by inserting "(1)" after "(i)", and (2) by adding at the end the following:

"(2)(A) In addition to the sums authorized to be appropriated under paragraph (1) to carry out the Program, there are authorized to be appropriated for the fiscal year ending September 30, 1978, $5,450,000; for the fiscal year ending September 30, 1979, $6,300,000; for the fiscal year ending September 30, 1980, $7,200,000; and for fiscal years 1981, 1982, 1983, and 1984 such sums as may be specifically authorized by an Act enacted after the Indian Health Care Improvement Act, to provide scholarships under the Program to provide physicians, osteopaths, dentists, veterinarians, nurses, optometrists, podiatrists, pharmacists, public health personnel, and allied health professionals to provide services to Indians. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with this section except as provided in subparagraph (B).

Distribution.

'(B)(i) The Secretary, acting through the Indian Health Service, shall determine the individuals who receive the Indian Health Scholarships, shall accord priority to applicants who are Indians, and shall determine the distribution of the scholarships on the basis of the relative needs of Indians for additional service in specific health professions.

Active duty service obligation.

"(ii) The active duty service obligation prescribed by subsection (e) shall be met by the recipient of an Indian Health Scholarship by service in the Indian Health Service, in a program assisted under title V of the Indian Health Care Improvement Act, or in the private practice of his profession if, as determined by the Secretary in accordance with guidelines promulgated by him, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

Post, p. 1410.

"Indians."

"(C) For purposes of this paragraph, the term 'Indians' has the same meaning given that term by subsection (c) of section 4 of the

Indian Health Care Improvement Act and includes individuals described in clauses (1) through (4) of that subsection.". Ante, p. 1401.

INDIAN HEALTH SERVICE EXTERN PROGRAMS

SEC. 105. (a) Any individual who receives a scholarship grant pursuant to section 104 shall be entitled to employment in the Service during any nonacademic period of the year. Periods of employment pursuant to this subsection shall not be counted in determining the fulfillment of the service obligation incurred as a condition of the scholarship grant. 25 USC 1614.

(b) Any individual enrolled in a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, nursing, or allied health professions may be employed by the Service during any nonacademic period of the year. Any such employment shall not exceed one hundred and twenty days during any calendar year.

(c) Any employment pursuant to this section shall be made without regard to any competitive personnel system or agency personnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive system. Any individual so employed shall not be counted against any employment ceiling affecting the Service or the Department of Health, Education, and Welfare.

(d) There are authorized to be appropriated for the purpose of this section: $600,000 for fiscal year 1978, $800,000 for fiscal year 1979, and $1,000,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984 there are authorized to be appropriated for the purpose of this section such sums as may be specifically authorized by an Act enacted after this Act. Appropriation authorization.

CONTINUING EDUCATION ALLOWANCES

SEC. 106. (a) In order to encourage physicians, dentists, and other health professionals to join or continue in the Service and to provide their services in the rural and remote areas where a significant portion of the Indian people resides, the Secretary, acting through the Service, may provide allowances to health professionals employed in the Service to enable them for a period of time each year prescribed by regulation of the Secretary to take leave of their duty stations for professional consultation and refresher training courses. 25 USC 1615.

(b) There are authorized to be appropriated for the purpose of this section: $100,000 for fiscal year 1978, $200,000 for fiscal year 1979, and $250,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984 there are authorized to be appropriated for the purpose of this section such sums as may be specifically authorized by an Act enacted after this Act. Appropriation authorization.

TITLE II—HEALTH SERVICES

HEALTH SERVICES

SEC. 201. (a) For the purpose of eliminating backlogs in Indian health care services and to supply known, unmet medical, surgical, 25 USC 1621.

dental, optometrical, and other Indian health needs, the Secretary is authorized to expend, through the Service, over the seven-fiscal-year period beginning after the date of the enactment of this Act the amounts authorized to be appropriated by subsection (c). Funds appropriated pursuant to this section for each fiscal year shall not be used to offset or limit the appropriations required by the Service under other Federal laws to continue to serve the health needs of Indians during and subsequent to such seven-fiscal-year period, but shall be in addition to the level of appropriations provided to the Service under this Act and such other Federal laws in the preceding fiscal year plus an amount equal to the amount required to cover pay increases and employee benefits for personnel employed under this Act and such laws and increases in the costs of serving the health needs of Indians under this Act and such laws, which increases are caused by inflation.

Employment during seven-fiscal-year period.

(b) The Secretary, acting through the Service, is authorized to employ persons to implement the provisions of this section during the seven-fiscal-year period in accordance with the schedule provided in subsection (c). Such positions authorized each fiscal year pursuant to this section shall not be considered as offsetting or limiting the personnel required by the Service to serve the health needs of Indians during and subsequent to such seven-fiscal-year period but shall be in addition to the positions authorized in the previous fiscal year.

(c) The following amounts and positions are authorized, in accordance with the provisions of subsections (a) and (b), for the specific purposes noted:

(1) Patient care (direct and indirect): sums and positions as provided in subsection (e) for fiscal year 1978, $8,500,000 and two hundred and twenty-five positions for fiscal year 1979, and $16,200,000 and three hundred positions for fiscal year 1980.

(2) Field health, excluding dental care (direct and indirect): sums and positions as provided in subsection (e) for fiscal year 1978, $3,350,000 and eighty-five positions for fiscal year 1979, and $5,550,000 and one hundred and thirteen positions for fiscal year 1980.

(3) Dental care (direct and indirect): sums and positions as provided in subsection (e) for fiscal year 1978, $1,500,000 and eighty positions for fiscal year 1979, and $1,500,000 and fifty positions for fiscal year 1980.

(4) Mental health: (A) Community mental health services: sums and positions as provided in subsection (e) for fiscal year 1978, $1,300,000 and thirty positions for fiscal year 1979, and $2,000,000 and thirty positions for fiscal year 1980.

(B) Inpatient mental health services: sums and positions as provided in subsection (e) for fiscal year 1978, $400,000 and fifteen positions for fiscal year 1979, and $600,000 and fifteen positions for fiscal year 1980.

(C) Model dormitory mental health services: sums and positions as provided in subsection (e) for fiscal year 1978, $1,250,000 and fifty positions for fiscal year 1979, and $1,875,000 and fifty positions for fiscal year 1980.

(D) Therapeutic and residential treatment centers: sums and positions as provided in subsection (e) for fiscal year 1978, $300,000 and ten positions for fiscal year 1979, and $400,000 and five positions for fiscal year 1980.

(E) Training of traditional Indian practitioners in mental health: sums as provided in subsection (e) for fiscal year 1978, $150,000 for fiscal year 1979, and $200,000 for fiscal year 1980.

(5) Treatment and control of alcoholism among Indians: $4,000,000 for fiscal year 1978, $9,000,000 for fiscal year 1979, and $9,200,000 for fiscal year 1980.

(6) Maintenance and repair (direct and indirect): sums and positions as provided in subsection (c) for fiscal year 1978, $3,000,000 and twenty positions for fiscal year 1979, and $4,000,000 and thirty positions for fiscal year 1980.

(7) For fiscal years 1981, 1982, 1983, and 1984 there are authorized to be appropriated for the items referred to in the preceding paragraphs such sums as may be specifically authorized by an Act enacted after this Act. For such fiscal years, positions are authorized for such items (other than the items referred to in paragraphs (4)(E) and (5)) as may be specified in an Act enacted after the date of the enactment of this Act. Appropriation authorization.

(d) The Secretary, acting through the Service, shall expend directly or by contract not less than 1 per centum of the funds appropriated under the authorizations in each of the clauses (1) through (5) of subsection (c) for research in each of the areas of Indian health care for which such funds are authorized to be appropriated. Research funds.

(e) For fiscal year 1978, the Secretary is authorized to apportion not to exceed a total of $10,025,000 and 425 positions for the programs enumerated in clauses (c) (1) through (4) and (c)(6) of this section. Appropriation authorization.

TITLE III—HEALTH FACILITIES

CONSTRUCTION AND RENOVATION OF SERVICE FACILITIES

SEC. 301. (a) The Secretary, acting through the Service, is authorized to expend over the seven-fiscal-year period beginning after the date of the enactment of this Act the sums authorized by subsection (b) for the construction and renovation of hospitals, health centers, health stations, and other facilities of the Service. 25 USC 1631.

(b) The following amounts are authorized to be appropriated for purposes of subsection (a): Appropriation authorization.

(1) Hospitals: $67,180,000 for fiscal year 1978, $73,256,000 for fiscal year 1979, and $49,742,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984, there are authorized to be appropriated for hospitals such sums as may be specifically authorized by an Act enacted after this Act.

(2) Health centers and health stations: $6,960,000 for fiscal year 1978, $6,226,000 for fiscal year 1979, and $3,720,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984, there are authorized to be appropriated for health centers and health stations such sums as may be specifically authorized by an Act enacted after this Act.

(3) Staff housing: $1,242,000 for fiscal year 1978, $21,725,000 for fiscal year 1979, and $4,116,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984, there are authorized to be appropriated for staff housing such sums as may be specifically authorized by an Act enacted after this Act.

(c) Prior to the expenditure of, or the making of any firm commitment to expend, any funds authorized in subsection (a), the Secretary, acting through the Service shall—

(1) consult with any Indian tribe to be significantly affected by any such expenditure for the purpose of determining and, wherever practicable, honoring tribal preferences concerning the Consultation.

size, location, type, and other characteristics of any facility on which such expenditure is to be made; and

(2) be assured that, wherever practicable, such facility, not later than one year after its construction or renovation, shall meet the standards of the Joint Committee on Accreditation of Hospitals.

CONSTRUCTION OF SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

25 USC 1632.

SEC. 302. (a) During the seven-fiscal-year period beginning after the date of the enactment of this Act, the Secretary is authorized to expend under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), the sums authorized under subsection (b) to supply unmet needs for safe water and sanitary waste disposal facilities in existing and new Indian homes and communities.

Appropriation authorization.

(b) For expenditures of the Secretary authorized by subsection (a) for facilities in existing Indian homes and communities there are authorized to be appropriated $43,000,000 for fiscal year 1978, $30,000,000 for fiscal year 1979, and $30,000,000 for fiscal year 1980. For expenditures of the Secretary authorized by subsection (a) for facilities in new Indian homes and communities there are authorized to be appropriated such sums as may be necessary for fiscal years 1978, 1979, and 1980. For fiscal years 1981, 1982, 1983, and 1984 for expenditures authorized by subsection (a) there are authorized to be appropriated such sums as may be specifically authorized in an Act enacted after this Act.

New York Indian tribes, eligibility for assistance.

(c) Former and currently federally recognized Indian tribes in the State of New York shall be eligible for assistance under this section.

PREFERENCE TO INDIANS AND INDIAN FIRMS

25 USC 1633.

SEC. 303. (a) The Secretary, acting through the Service, may utilize the negotiating authority of the Act of June 25, 1910 (25 U.S.C. 47), to give preference to any Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians including former or currently federally recognized Indian tribes in the State of New York (hereinafter referred to as an "Indian firm") in the construction and renovation of Service facilities pursuant to section 301 and in the construction of safe water and sanitary waste disposal facilities pursuant to section 302. Such preference may be accorded by the Secretary unless he finds, pursuant to rules and regulations promulgated by him, that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at his finding, shall consider whether the Indian or Indian firm will be deficient with respect to (1) ownership and control by Indians, (2) equipment, (3) bookkeeping and accounting procedures, (4) substantive knowledge of the project or function to be contracted for, (5) adequately trained personnel, or (6) other necessary components of contract performance.

Construction personnel, pay rates.

(b) For the purpose of implementing the provisions of this title, the Secretary shall assure that the rates of pay for personnel engaged in the construction or renovation of facilities constructed or renovated in whole or in part by funds made available pursuant to this title are not less than the prevailing local wage rates for similar work as determined in accordance with the Act of March 3, 1931 (40 U.S.C. 276a–276a–5, known as the Davis-Bacon Act).

40 USC 276a note.

SOBOBA SANITATION FACILITIES

SEC. 304. The Act of December 17, 1970 (84 Stat. 1465), is hereby amended by adding the following new section 9 at the end thereof:

"SEC. 9. Nothing in this Act shall preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat. 674), as amended by the Act of July 31, 1959 (73 Stat. 267).". 42 USC 2004a.

TITLE IV—ACCESS TO HEALTH SERVICES

ELIGIBILITY OF INDIAN HEALTH SERVICE FACILITIES UNDER MEDICARE PROGRAM

SEC. 401. (a) Sections 1814(c) and 1835(d) of the Social Security Act are each amended by striking out "No payment" and inserting in lieu thereof "Subject to section 1880, no payment". 42 USC 1395f, 1395n.

(b) Part C of title XVIII of such Act is amended by adding at the end thereof the following new section: 42 USC 1395x.

"INDIAN HEALTH SERVICE FACILITIES

"SEC. 1880. (a) A hospital or skilled nursing facility of the Indian Health Service, whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for payments under this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as it meets all of the conditions and requirements for such payments which are applicable generally to hospitals or skilled nursing facilities (as the case may be) under this title. Hospital or skilled nursing facility, eligibility for payments. 42 USC 1395qq.

"(b) Notwithstanding subsection (a), a hospital or skilled nursing facility of the Indian Health Service which does not meet all of the conditions and requirements of this title which are applicable generally to hospitals or skilled nursing facilities (as the case may be), but which submits to the Secretary within six months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for payments under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted. Ineligible hospital or skilled nursing facility, submittal of plan for compliance.

"(c) Notwithstanding any other provision of this title, payments to which any hospital or skilled nursing facility of the Indian Health Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the hospitals and skilled nursing facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this title. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the hospitals and skilled nursing facilities of such Service in the United States are in compliance with such conditions and requirements. Fund for improvements.

"(d) The annual report of the Secretary which is required by section 701 of the Indian Health Care Improvement Act shall include (along with the matters specified in section 403 of such Act) a detailed Post, p. 1413. Post, p. 1410.

statement of the status of the hospitals and skilled nursing facilities of the Service in terms of their compliance with the applicable conditions and requirements of this title and of the progress being made by such hospitals and facilities (under plans submitted under subsection (b) and otherwise) toward the achievement of such compliance.".

(c) Any payments received for services provided to beneficiaries hereunder shall not be considered in determining appropriations for health care and services to Indians.

Services to an Indian beneficiary. 42 USC 1395.

(d) Nothing herein authorizes the Secretary to provide services to an Indian beneficiary with coverage under title XVIII of the Social Security Act, as amended, in preference to an Indian beneficiary without such coverage.

SERVICES PROVIDED TO MEDICAID ELIGIBLE INDIANS

42 USC 1396.

SEC. 402. (a) Title XIX of the Social Security Act is amended by adding at the end thereof the following new section:

"INDIAN HEALTH SERVICE FACILITIES

Eligibility for reimbursement. 42 USC 1396j.

"SEC. 1911. (a) A facility of the Indian Health Service (including a hospital, intermediate care facility, or skilled nursing facility), whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this title.

Ante, p. 1401.

Facilities, submittal of plan for compliance.

"(b) Notwithstanding subsection (a), a facility of the Indian Health Service (including a hospital, intermediate care facility, or skilled nursing facility) which does not meet all of the conditions and requirements of this title which are applicable generally to such facility, but which submits to the Secretary within six months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first twelve months after the month in which such plan is submitted.".

42 USC 1396j note.

(b) The Secretary is authorized to enter into agreements with the appropriate State agency for the purpose of reimbursing such agency for health care and services provided in Service facilities to Indians who are eligible for medical assistance under title XIX of the Social Security Act, as amended.

42 USC 1396.

(c) Notwithstanding any other provision of law, payments to which any facility of the Indian Health Service (including a hospital, intermediate care facility, or skilled nursing facility) is entitled under a State plan approved under title XIX of the Social Security Act by reason of section 1911 of such Act shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of such title. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the health facilities of such Service in the United States are in compliance with such conditions and requirements.

Supra.

(d) Any payments received for services provided recipients hereunder shall not be considered in determining appropriations for the provision of health care and services to Indians. 42 USC 1396j note.

(e) Section 1905(b) of the Social Security Act is amended by inserting at the end thereof the following: "Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).". Federal medical assistance percentage. 42 USC 1396d. Ante, p. 1401.

REPORT

SEC. 403. The Secretary shall include in his annual report required by section 701 an accounting on the amount and use of funds made available to the Service pursuant to this title as a result of reimbursements through titles XVIII and XIX of the Social Security Act, as amended. 25 USC 1671 note. 42 USC 1395x, 1396.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

PURPOSE

SEC. 501. The purpose of this title is to encourage the establishment of programs in urban areas to make health services more accessible to the urban Indian population. 25 USC 1651.

CONTRACTS WITH URBAN INDIAN ORGANIZATIONS

SEC. 502. The Secretary, acting through the Service, shall enter into contracts with urban Indian organizations to assist such organizations to establish and administer, in the urban centers in which such organizations are situated, programs which meet the requirements set forth in sections 503 and 504. 25 USC 1652.

CONTRACT ELIGIBILITY

SEC. 503. (a) The Secretary, acting through the Service, shall place such conditions as he deems necessary to effect the purpose of this title in any contract which he makes with any urban Indian organization pursuant to this title. Such conditions shall include, but are not limited to, requirements that the organization successfully undertake the following activities: 25 USC 1653.

(1) determine the population of urban Indians which are or could be recipients of health referral or care services;

(2) identify all public and private health service resources within the urban center in which the organization is situated which are or may be available to urban Indians;

(3) assist such resources in providing service to such urban Indians;

(4) assist such urban Indians in becoming familiar with and utilizing such resources;

(5) provide basic health education to such urban Indians;

(6) establish and implement manpower training programs to accomplish the referral and education tasks set forth in clauses (3) through (5) of this subsection;

(7) identify gaps between unmet health needs of urban Indians and the resources available to meet such needs;

(8) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians; and

(9) where necessary, provide or contract for health care services to urban Indians.

Urban Indian organizations, selection criteria.

(b) The Secretary, acting through the Service, shall by regulation prescribe the criteria for selecting urban Indian organizations with which to contract pursuant to this title. Such criteria shall, among other factors, take into consideration:

(1) the extent of the unmet health care needs of urban Indians in the urban center involved;

(2) the size of the urban Indian population which is to receive assistance;

(3) the relative accessibility which such population has to health care services in such urban center;

(4) the extent, if any, to which the activities set forth in subsection (a) would duplicate any previous or current public or private health services project funded by another source in such urban center;

(5) the appropriateness and likely effectiveness of the activities set forth in subsection (a) in such urban center;

(6) the existence of an urban Indian organization capable of performing the activities set forth in subsection (a) and of entering into a contract with the Secretary pursuant to this title; and

(7) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other resource agencies.

OTHER CONTRACT REQUIREMENTS

25 USC 1654.

SEC. 504. (a) Contracts with urban Indian organizations pursuant to this title shall be in accordance with all Federal contracting laws and regulations except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935 (48 Stat. 793), as amended.

49 Stat. 793. 40 USC 270a-270d.

(b) Payments under any contracts pursuant to this title may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this title.

Contract revision or amendment.

(c) Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract made by him with such organization pursuant to this title as necessary to carry out the purposes of this title: *Provided, however*, That whenever an urban Indian organization requests retrocession of the Secretary for any contract entered into pursuant to this title, such retrocession shall become effective upon a date specified by the Secretary not more than one hundred and twenty days from the date of the request by the organization or at such later date as may be mutually agreed to by the Secretary and the organization.

Government facilities, use.

(d) In connection with any contract made pursuant to this title, the Secretary may permit an urban Indian organization to utilize, in carrying out such contract, existing facilities owned by the Federal Government within his jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.

(e) Contracts with urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban Indians of services and assistance under such contracts by such organizations.

REPORTS AND RECORDS

SEC. 505. For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract under this title, such organization shall submit to the Secretary a report including information gathered pursuant to section 503(a) (7) and (8), information on activities conducted by the organization pursuant to the contract, an accounting of the amounts and purposes for which Federal funds were expended, and such other information as the Secretary may request. The reports and records of the urban Indian organization with respect to such contract shall be subject to audit by the Secretary and the Comptroller General of the United States.

Report to Secretary of the Interior.
25 USC 1655.

Audit.

AUTHORIZATIONS

SEC. 506. There are authorized to be appropriated for the purpose of this title: $5,000,000 for fiscal year 1978, $10,000,000 for fiscal year 1979, and $15,000,000 for fiscal year 1980.

25 USC 1656.

REVIEW OF PROGRAM

SEC. 507. Within six months after the end of fiscal year 1979, the Secretary, acting through the Service and with the assistance of the urban Indian organizations which have entered into contracts pursuant to this title, shall review the program established under this title and submit to the Congress his assessment thereof and recommendations for any further legislative efforts he deems necessary to meet the purpose of this title.

Submittal to Congress.
Legislative recommendations.
25 USC 1657.

RURAL HEALTH PROJECTS

SEC. 508. Not to exceed 1 per centum of the amounts authorized by section 506 shall be available for not to exceed two pilot projects providing outreach services to eligible Indians residing in rural communities near Indian reservations.

25 USC 1658.

TITLE VI—AMERICAN INDIAN SCHOOL OF MEDICINE; FEASIBILITY STUDY

FEASIBILITY STUDY

SEC. 601. The Secretary, in consultation with Indian tribes and appropriate Indian organizations, shall conduct a study to determine the need for, and the feasibility of, establishing a school of medicine to train Indians to provide health services for Indians. Within one year of the date of the enactment of this Act the Secretary shall complete such study and shall report to the Congress findings and recommendations based on such study.

25 USC 1661.

Report to Congress.

TITLE VII—MISCELLANEOUS

REPORTS

Report to the President and Congress. 25 USC 1671.

SEC. 701. The Secretary shall report annually to the President and the Congress on progress made in effecting the purposes of this Act. Within three months after the end of fiscal year 1979, the Secretary shall review expenditures and progress made under this Act and make recommendations to the Congress concerning any additional authorizations for fiscal years 1981 through 1984 for programs authorized under this Act which he deems appropriate. In the event the Congress enacts legislation authorizing appropriations for programs under this Act for fiscal years 1981 through 1984, within three months after the end of fiscal year 1983, the Secretary shall review programs established or assisted pursuant to this Act and shall submit to the Congress his assessment and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians, and insure a health status for Indians, which are at a parity with the health services available to, and the health status, of the general population.

Program review, submittal to Congress.

REGULATIONS

Consultation. 25 USC 1672.

SEC. 702. (a)(1) Within six months from the date of enactment of this Act, the Secretary shall, to the extent practicable, consult with national and regional Indian organizations to consider and formulate appropriate rules and regulations to implement the provisions of this Act.

Publication in Federal Register.

(2) Within eight months from the date of enactment of this Act, the Secretary shall publish proposed rules and regulations in the Federal Register for the purpose of receiving comments from interested parties.

(3) Within ten months from the date of enactment of this Act, the Secretary shall promulgate rules and regulations to implement the provisions of this Act.

Rules or regulations, proposed revision or amendment; publication in Federal Register.

(b) The Secretary is authorized to revise and amend any rules or regulations promulgated pursuant to this Act: *Provided*, That, prior to any revision of or amendment to such rules or regulations, the Secretary shall, to the extent practicable, consult with appropriate national or regional Indian organizations and shall publish any proposed revision or amendment in the Federal Register not less than sixty days prior to the effective date of such revision or amendment in order to provide adequate notice to, and receive comments from, other interested parties.

PLAN OF IMPLEMENTATION

Submittal to Congress. 25 USC 1673.

SEC. 703. Within two hundred and forty days after enactment of this Act, a plan will be prepared by the Secretary and will be submitted to the Congress. The plan will explain the manner and schedule (including a schedule of appropriation requests), by title and section, by which the Secretary will implement the provisions of this Act.

LEASES WITH INDIAN TRIBES

SEC. 704. Notwithstanding any other provision of law, the Secretary is authorized, in carrying out the purposes of this Act, to enter into leases with Indian tribes for periods not in excess of twenty years. 25 USC 1674.

AVAILABILITY OF FUNDS

SEC. 705. The funds appropriated pursuant to this Act shall remain available until expended. 25 USC 1675.

Approved September 30, 1976.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 94-1026 part 1 and 94-1026 part 4 (Comm. on Interior and Insular Affairs), No. 94-1026 pt. II (Comm. on Ways and Means), and No. 94-1026 pt. III (Comm. on Interstate and Foreign Commerce) all accompanying H. R. 2525.
SENATE REPORT No. 94-133 (Comm. on Interior and Insular Affairs).
CONGRESSIONAL RECORD:
Vol. 121 (1975): May 16, considered and passed Senate.
Vol. 122 (1976): July 30, considered and passed House, amended, in lieu of H. R. 2525.
Sept. 9, Senate concurred in House amendment with an amendment.
Sept. 16, House concurred in Senate amendment.
WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS:
Vol. 12, No. 40 (1976): Oct. 1, Presidential statement.

TAB C

Public Law 95-83
95th Congress

An Act

To amend the Public Health Service Act to extend through the fiscal year ending September 30, 1978, the assistance programs for health services research; health statistics; comprehensive public health services; hypertension programs; migrant health; community health centers; medical libraries; cancer control programs; the National Cancer Institute; heart, blood vessel, lung, and blood disease prevention and control programs; the National Heart, Lung, and Blood Institute; National Research Service Awards; population research and voluntary family planning programs; sudden infant death syndrome; hemophilia; national health planning and development; and health resources development; to amend the Community Mental Health Centers Act to extend it through the fiscal year ending September 30, 1978; to extend the assistance programs for home health services; and for other purposes.

Aug. 1, 1977
[H.R. 4975]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Health services programs. Extension.

TITLE I—HEALTH PLANNING AND HEALTH SERVICES RESEARCH AND STATISTICS EXTENSION

Health Planning and Health Services Research and Statistics Extension Act of 1977. 42 USC 201 note.

SEC. 101. This title may be cited as the "Health Planning and Health Services Research and Statistics Extension Act of 1977".

42 USC 300*l*-5.

SEC. 102. (a) Section 1516(c)(1) of the Public Health Service Act (relating to authorizations for planning grants) is amended by striking out "for the fiscal year ending June 30, 1977" and inserting in lieu thereof "each for the fiscal years ending September 30, 1977, and September 30, 1978".

42 USC 300m-4.

(b) Section 1525(c) of such Act (relating to authorizations for State health planning and development agencies) is amended by striking out "for the fiscal year ending June 30, 1977" and inserting in lieu thereof "each for the fiscal years ending September 30, 1977, and September 30, 1978".

42 USC 300m-5.

(c) Section 1526(e) of such Act (relating to authorizations for grants for rate regulation) is amended by striking out "for the fiscal year ending June 30, 1977" and inserting in lieu thereof "each for the fiscal years ending September 30, 1977, and September 30, 1978".

42 USC 300n-3.

(d) Section 1531(d) of such Act (relating to authorizations for centers for health planning) is amended by striking out "for the fiscal year ending June 30, 1977" and inserting in lieu thereof "each for the fiscal years ending September 30, 1977, and September 30, 1978".

42 USC 300p-3.

SEC. 103. (a) Section 1613 of the Public Health Service Act (relating to authorizations for construction) is amended by striking out "for the fiscal year ending June 30, 1977" and inserting in lieu thereof "each for the fiscal years ending September 30, 1977, and September 30, 1978".

42 USC 300r.

(b) Section 1625(d) of such Act (relating to funds for project grants) is amended by adding at the end the following new sentence: "In addition to the amounts made available for such grants under the preceding sentence for the fiscal year ending September 30, 1978, there are authorized to be appropriated $67,500,000 for such fiscal year for such grants.".

42 USC 300t.

(c) Section 1640(d) of such Act (relating to authorizations for area health services development) is amended by striking out "for the fiscal year ending June 30, 1977" and inserting in lieu thereof "each for

* * * * * * *

cine not in a State, and, in the case of a student described in clause (i)(II), successfully completed a program described in such clause, and

"(II) successfully completed part I of the National Board of Medical Examiners' examination (or any successor to such examination).

Apportionment. The Secretary shall equitably apportion a number of positions among the schools of medicine in the States adequate to fill the needs of students identified in accordance with the preceding sentence.".

Effective date. (j) Effective October 1, 1977, section 781(d)(2)(C) of such Act
42 USC 295g-1. (relating to residency program requirement) is amended by striking out "or general internal medicine" and inserting in lieu thereof ", general internal medicine, or general pediatrics".

42 USC 295g-9. (k) Paragraph (1) of section 789(a) of such Act (relating to training in emergency medical services) is amended by striking out "and to assist in meeting the cost" and all that follows in such paragraph and inserting in lieu thereof the following: ", to assist in meeting the cost of training (including the cost of establishing programs for the training) of physicians in emergency medicine, especially training which affords clinical experience in providing medical services in emergency medical services systems receiving assistance
42 USC 300d. under title XII of this Act, and to provide financial assistance (in the form of traineeships and fellowships) to residents who plan to specialize or work in the practice of emergency medicine.".

Effective date. (l) Effective October 1, 1977, section 796(a)(4) of such Act (relat-
42 USC 295h-5. ing to project grants and contracts) is amended by striking out "of methods" and inserting in lieu thereof "or improvement of programs".

Effective date. (m) Effective October 1, 1977, section 796(c) of such Act (relating to eligibility for allied health special project grants and contracts) is amended (1) by striking out "or" at the end of paragraph (2), (2) by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; or", and (3) by adding after paragraph (3) the following new paragraph:

"(4) other public or nonprofit private entities capable, as determined by the Secretary, of carrying out projects described in subsection (a)."

Effective date. (n)(1) Effective October 1, 1977, subpart IV of part C of title VII of such Act (relating to National Health Service Corps Scholarships) is amended by adding at the end thereof the following new section:

"INDIAN HEALTH SCHOLARSHIP PROGRAM

42 USC 294y-1. "SEC. 757. (a) In addition to the sums authorized to be appropriated
42 USC 294y. under section 756(a) to carry out the Scholarship Program, there are authorized to be appropriated $5,450,000 for the fiscal year ending September 30, 1978, $6,300,000 for the fiscal year ending September 30, 1979, $7,200,000 for the fiscal year ending September 30, 1980, and for each of the succeeding four fiscal years such sums as may be specifically authorized by an Act enacted after the date of enactment of this section, to provide scholarships under the Scholarship Program to provide physicians, osteopaths, dentists, veterinarians, nurses, optometrists, podiatrists, pharmacists, public health personnel, and allied health professionals to provide services to Indians. Such scholarships shall be designated 'Indian Health Scholarships' and shall be made in accordance with this subpart, except as provided in subsection (b).

"(b)(1) The Secretary, acting through the Indian Health Service, shall determine the individuals who shall receive the Indian Health Scholarships, shall accord priority to applicants who are Indians, and shall determine the distribution of the scholarships on the basis of the relative needs of Indians for additional services by specific health professions.

"(2) The active duty service obligation prescribed in the written contract entered into under this subpart shall be met by the recipient of an Indian Health Scholarship by service in the Indian Health Service, in a program assisted under title V of the Indian Health Care Improvement Act, or in the private practice of his profession if, as determined by the Secretary in accordance with guidelines promulgated by him, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians. 25 USC 1651.

"(c) For purposes of this section, the term 'Indians' has the same meaning given that term by subsection (c) of section 4 of the Indian Health Care Improvement Act and includes individuals described in clauses (1) through (4) of that subsection.". "Indians." 25 USC 1603.

(2) Section 105(a) of the Indian Health Care Improvement Act is amended by striking out "pursuant to section 104" and inserting in lieu thereof "pursuant to section 757 of the Public Health Service Act". 25 USC 1614. *Ante*, p. 392.

(o)(1) The second sentence of section 810(a) of the Public Health Service Act (relating to computation of capitation grants for nursing schools) is amended by inserting "for each fiscal year" after "shall be computed". Nursing schools. 42 USC 296e.

(2) Paragraphs (1), (2), and (3) of such section 810(a) are each amended by striking out "such year" each place it occurs and inserting in lieu thereof "such fiscal year".

(3)(A) Section 810(c)(1)(A) of such Act (relating to requirements for nursing school capitation grants) is amended by striking out "beginning after" and inserting in lieu thereof "beginning in".

(B) Sections 810(c)(2)(A) and 810(c)(2)(B) of such Act (relating to requirements for nursing school capitation grants) are each amended by striking out "beginning after the close of" and inserting in lieu thereof "beginning in".

(4) Section 810(c)(1)(B) of such Act is amended by striking out "fiscal" each place it occurs and inserting in lieu thereof "school".

(5)(A) Section 822 of such Act (relating to nurse practitioner programs) is amended by— 42 USC 296m.

(i) inserting after "contracts for programs" in the last sentence of subsection (a)(1) the following: "for the training of nurse practitioners who will practice in health manpower shortage areas (designated under section 332) and"; 42 USC 256.

(ii) redesignating subsections (b), (c), and (d) as subsections (c), (d), and (e), respectively, and inserting after subsection (a) the following:

"(b)(1) The Secretary may make grants to and enter into contracts with schools of nursing, medicine, and public health, public or nonprofit private hospitals, and other nonprofit entities to establish and operate traineeship programs to train nurse practitioners who are residents of a health manpower shortage area (designated under section 332). Grants and contracts.

"(2) Traineeships funded under this subsection shall include 100 percent of the costs of tuition, reasonable living and moving expenses (including stipends), books, fees, and necessary transportation.

* * * * * * *

TAB D

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
ROCKVILLE, MARYLAND 20852

INDIAN HEALTH SERVICE

ASSESSMENT OF ECONOMIC AND INFLATIONARY IMPACT

The economic and inflationary impact of the attached Federal Register notice amending 41 CFR Part 3-4, Subpart 3-4.57 and 42 CFR Part 36 to implement the Indian Health Care Improvement Act, P.L. 94-437, has been carefully evaluated in accordance with OMB Circular A-107 and the Department's Inflation Impact Procedures and Criteria. I hereby certify that this amendment will have no major inflationary impact.

Date: October 18, 1977

Emery A. Johnson, M.D.
Director, Indian Health Service

TAB E

HEW NEWS

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

FOR RELEASE AT 11:00 A.M., EST
Friday, November 11, 1977

Robert N. Isquith 301-443-2065

The Department of Health, Education, and Welfare (HEW) today issued final regulations for Titles I, III, and V of the Indian Health Care Improvement Act (P.L. 94-437). This Act seeks to raise the health status of American Indians and Alaska Natives to a level equal with that of the general U.S. population by authorizing increased resources for HEW's Indian Health Service (IHS). It also authorizes new programs aimed at increasing the number of Indian health professionals serving Indians and improving urban Indians' access to health services.

Today's issuance of final regulations which go into effect immediately permit implementation of Titles I and V of the law. The regulations describe the procedures which will be followed in awarding scholarships to health professionals serving Indians under Title I, and explain the procedures for the award of grants and contracts to urban groups under Title V, which deals with urban Indians' access to health services. The regulations also modify the present procedures concerning preference given Indian-owned firms under the Buy Indian Act (25 USC 47), as called for in Title III.

New regulations are not required for Title II, which expands current IHS health service programs, Title IV, regarding Medicare and Medicaid reimbursement, and Title VI which authorizes a feasibility study for an American Indian school of medicine.

Behind the publication of these regulations is a year-long, wide-reaching effort to obtain maximum Indian and Alaska Native participation in their development. In addition to soliciting comments through publication of proposed regulations on May 23, 1977, IHS officials have held over 200 meetings throughout the country with Indian and Alaska Native leaders and other interested parties.

The final regulations are published in today's Federal Register. Copies may be obtained from the Director, Indian Health Service, Health Services Administration, Room 5A-55, 5600 Fishers Lane, Rockville, Maryland 20857.

# # #

SUPPLEMENT C

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH SERVICES ADMINISTRATION

STATEMENT BY

EMERY A. JOHNSON, M. D.

DIRECTOR, INDIAN HEALTH SERVICE

BEFORE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

COMMITTEE ON HUMAN RESOURCES

UNITED STATES SENATE

Mr. Chairman and Members of the Committee:

The Indian Health Service (IHS) provides health services to over 600,000 Indian people living on or near Federal Indian reservations, in traditional Indian country in Oklahoma and Alaska, and in certain urban areas to which limited IHS program activities are directed. Over 90,000 of these people live here in New Mexico, with about 1,800 associated with the Isleta Pueblo.

Direct health services comprise the majority of those being received by Indian citizens served by IHS. These services are delivered through an integrated system of 50 hospitals, 99 health centers including 26 school health centers and over 300 health stations. These facilities are staffed by some 9,000 IHS personnel.

The IHS goal is to elevate the health status of Indian and Alaska Natives to the highest possible level. The mission of the Service is to assure the availability of comprehensive health services to Indian and Alaska Native people and in so doing provide opportunities for Indian management and operation of health programs carried out under the auspices of the IHS.

The Congress, recognizing the need to make available the resources to fully carry out the mission of the IHS, passed P.L. 94-437, The Indian Health Care Improvement Act. This Act represents a remarkable partnership for health among the Indian people, the Executive Branch, and the Congress. The Act exists because of the recognized need to reduce the unmet health needs of Indian and Alaska Native people. The Act has established a health benefit package which defines the scope of the program and standards of quality to be attained in helping Indian people, over a seven year period, overcome these unmet health needs and related factors which have stood in the way of their quest for a health status equal to that of the general population of the United States.

Since the Act was passed, an immense national "joint effort" has been conducted, utilizing the resources of both the Indian people and the IHS, to secure the maximum possible participation of Indian people in all phases of planning the implementation of the Act. As a result, the best aspects of tribal initiative and Indian self-determination have strongly influenced development of each major step in the implementation of P.L. 94-437, such as Regulation Development Plan, the actual Rules and Regulations, the Plan of Implementation, and Operating Plans and Guidelines.

P.L. 94-437 provides new authorities for increasing Indian health manpower; it expands existing health services and facilities, including construction and renovation of safe water and sanitary waste disposal facilities. It provides eligibility for the IHS to collect reimbursements from Medicare and Medicaid to help IHS facilities achieve and maintain the conditions and requirements for Medicare and Medicaid certification and it provides new authorities for urban Indian health programs.

The support provided by President Carter's budget, and the resources made available by the Congress, have made it possible to plan during FY 1978, for substantial accomplishments in several areas important to the health of Indians such as recruiting Indian people into the health professions; providing preparatory and health professions scholarships; conducting extern and continuing education programs; expanding IHS health services and facilities for Indian people; improving the quality of IHS facilities; enhancing the working relations of IHS staff with Medicare and Medicaid staff of the Health Care Financing Administration; and expanding existing, and initiating new, urban Indian health projects.

Title I of the Act dealing with Indian Health manpower and Title V concerned with health services for urban Indians cannot be implemented until the final Rules and Regulations are promulgated. These were signed on Wednesday by Secretary Califano and are being released today in Washington. They will appear next week in the Federal Register. Of course, Title II, Health Services, and Title III, Health Facilities, are now being implemented with FY 1978 resources since additional rules and regulations weren't required for those Titles. Title IV, Access to Health Services, has been in operation since April 1, 1977.

In designing the Act the Congress recognized the difficulty of projecting beyond three years the specific health needs and actual costs of health care for the American Indian and Alaska Native people. The Act authorizes activities and resources for the FY 1978-1980 period. Therefore, in accordance with Section 701 of the Act, by December 1979, the Secretary is to review expenditures and progress of the first three years and make recommendations to the Congress concerning any additional authorizations required for the next four year period, FY 1981-1984. These recommendations will derive, in part, from plans developed by individual tribes and urban groups, reflecting the process set in motion by P.L. 93-638 and P.L. 94-437, in which these

groups will assess their own comprehensive health needs, identify actions which they believe will be effective in dealing with the needs, and make known to the executive and legislative branches of government the resources required to carry out these actions. Each Tribe and Urban group will then have a current and comprehensive health plan for their own use and which can be used by the Administration and Congress in determining resource allocation. The Indian people and Indian Health Service staff have been, and will continue, working together on this major health planning effort.

In closing, I want to emphasize that, because of the partnership between the Administration, the Congress and the Indians, those in government have a clear perception of the direction required to meet Indian health needs. The intent, concepts and authorities jointly embodied in P.L. 93-638 and P.L. 94-437, and included in the Plan of Implementation for P.L. 94-437, are inherent in this partnership as we work together to ensure the best possible results for the American Indian and Alaska Native people.

SUPPLEMENT D

SUBMITTED TO THE SENATE HEALTH SUBCOMMITTEE: INDIAN HEALTH PROBLEMS

Senator Kennedy, Ladies and Gentlement of the fact-finding committee may I introduce myself. My name is Burlinda Jaramillo and I am an employee of the United States Public Health Service, Branch of Mental Health. I am stationed in the Pueblo of Isleta as a Mental Health Coordinator. I would like to submit this written testimony as a part of the Senate fact-finding hearings regarding the health problems of the Native American, in the community of Isleta.

In my four years of service with the federal government, I have been employed as a Social Service Aide with the Bureau of Indian Affairs and also with the Public Health Service. I joined the Mental Health Branch approximately four and one-half years ago.

May I in brief, describe the goals and content of our program and the work I do. I'm sure we are all aware that psychological and social problems and life-threatening crisis situations (short-term or long-term) make up and underlie a significant portion of the overall health problems of the Indian population, much the same as non-Indian populations. I.e., unemployment, organic health problems, unstable family situations.

Since 1966 the Mental Health Branch staff has grown from one psychiatrist to a current staff of nineteen. We have six professional mental health workers who function as "consultants," and eleven paraprofessional mental health workers who function as "coordinators." The mental health professional consultants are responsible for a geographical area encompassing several distinct Indian communities or populations, while mental health

coordinators are residents within, members of, and responsible to and for a single pueblo or reservation.

Our consultants and coordinators work with Indian Health Service Hospitals, contract facilities and programs, tribal programs, other service agency programs, and other resource people in a consultative or collaborative capacity as required, or requested, and provide direct service to individuals whenever and wherever appropriate.

Depending on our job experience and in-service education, we are required to assist with individuals who have psychological or social problems or crises. The problem drinker, the elderly person depressed and failing to care for himself.

We provide local follow-up and aftercare for patients referred from other treatment facilities or care providers.

We serve as consultants with mental health professional supervisor on management or referral of difficult or complex patients, as necessary.

We assist families one of whose members has been diagnosed psychotic.

We provide and interpret cultural information to people of different backgrounds, primarily mental health professional consultants and other care providers.

We become actively involved in both IHS and other community programs in the attempt to identify psychological and social problems from the Indian community viewpoint.

We coordinate existing resources and participate in the development of new resources to provide help to individuals with psychological or social problems or crises, on case by case basis. We communicate directly with

other agencies, making referrals when necessary and appropriate. And we serve as liason between the patient, IHS, and other agencies to ensure that proper care is obtained.

We, as mental health coordinators, plan and work, in most aspects of position, with a relatively high degree of independence, reporting periodically to our supervisors on ongoing work and the more difficult or complex problems. Since we are called upon when no technical supervision is available, being geographically seperated from supervision, we are expected to accept responsibility and act according to our best judgment, using the most appropriate consultation available, to ensure obtaining r proper health care for our people.

The problems that have been identified are excessive use of drugs, including alcohol; solvent abuse; attempted and/or completed suicides, and the ever-present juvenile delinquency.

The basic cause of the problems listed above is basically the inability of some Pueblo youth to develop positive self-concepts, skills, attitudes, values, and self-discipline, enabling them to make healthy decisions and choices. Drug abuse, suicide does reflect the lack of ability to perceive alternative ways of coping as available and viable. The significant adults in their lives do not always reinforce or model healthy choices. More often, the child is further encouraged by these adults to believe he is stupid or worthless, and receives attention only when he is acting in a self-destructive way.

It is true that we have dealt with these problems in a minimal way; those we have dealt with are those that have severe problems and require

immediate attention and treatment. There are no adequate personnel to do outreach and to contact those individuals who go unnoticed and continue to abuse drugs or alcohol due to the problems that he or she may have.

With a population of approximately 3,000 (and continually growing) there are approximately 1,000 plus individuals between the ages of 9-24, the task of treatment and preventive services can become impossible, primarily because these agencies are presently overloaded.

We have formulated a checklist of overall mental health problems and the resulting statistics (those reported), and the following is shown:

1. Drug/Solvent Abuse
2. Alcoholism
3. Inadequate Recreational facilities/no community-based resources for the troubled adolescent
4. School, authority problems - lack of supervision, control, no discipline, inadequate structures within the community

ESTIMATED STATISTICS: 1973-1974

1. Suicide Attempts
   (4 males: ages 15; 18; 43; 45)
2. Completed Suicides - Gunshot
   (3 males: ages 26; 29; 39; 56)
   (1 Female: age 16)
3. Alcohol-related deaths
   (4 males: ages 26; 29; 39; 56)
   (1 female: age 37)
4. Pedestrian-Automobile Accidents
   (3 males: ages 22; 30; 26)
5. Drowing-Alcohol related
   (1 male: age 52)
6. Suspected Child Abuse
   (1 male: age 29)

7. Overdoses
   (1 male: age 22)
   (1 female: age 19)

8. Nursing Home Deaths
   (1 male: 77)
   (1 female: 88)

9. Heart-attack victims - over 60 years
   (3 males)
   (1 female)

ESTIMATED STATISTICS: 1974-1975

1. Solvent abusers
   (3 males: ages 14; 16; 23)
   (2 females: ages 15; 20)

2. Attempted Suicides & Related thoughts
   (4 males: ages 19; 22; 24)
   (3 females: ages 19; 21; 30)

3. Completed Suicides - Gunshot
   (2 males: ages 19)

4. Deaths alcohol-related
   (4 males: ages 48; 50; 52; 57)
   (1 female: age 35)

5. Assaults: stemming from family arguments
   (5 males: 16; 20; 21; 30 62)

6. Suspected Child abuse
   (2 males: ages 24; 29)

ESTIMATED STATISTICS: 1975-1976

1. Attempted Suicides - Gunshot
   (1 male: 23)

2. Attempted Suicide - overdoses
   (1 male: age 26)
   (1 female: age 48)

3. Strokes and/or Heart-attacks
   (4 males: ages 65; 66; 69)
   (2 females: ages 75; 77)

ESTIMATED STATISTICS: 1976-1977

1. Completed Suicides - Gunshot
   (2 males: ages 16; 20)

2. Undetermined causes of death
   (1 male: age 24)
   (1 female: age 89)

3. Pedestrian-Automobile deaths (alcohol-related)
   (3 males: ages 23; 24; 28)

4. Drowning (alcohol-related)
   (1 male: age 49)

5. Cancer
   (1 female: age 16)

*Estimates arrived at via: referrals from the following agencies
Bernalillo County Medical Center
Bernalillo County Mental Health Center
Albuquerque Indian Hospital
Albuquerque Area Mental Health Branch
Isleta Pueblo: Social Services & Alcoholism Program
Isleta Pueblo Court Referrals

22-796 O - 78 - 16

DRUG ABUSE. The problem of drug abuse has been seen as an influence coming from contacts with the non-Indian communities and urban areas. There is some validity to this, but it is hard to assess to what degree this is true. Mainly because more and more marijuana is being home grown on the reservation. Marijuana, solvent sprays, glues and gasolines are used by a majority of the younger population, mainly, because these are more accessible and the least costly. Among the adults there is more of a mixture in usage of alcohol with barbituates and amphetamines.

ALCOHOL ABUSE. Alcoholism is very much in competition with the drugs in both the younger age set and the older age set. The most noted difficulty about the true alcoholic and working with them is that the "individual must want to stop drinking," and not too many are which often times makes it difficult for health workers to meet goals of helping the individual in the Alcoholism/Mental Health programs.

With an increase in alcohol consumers on the reservation, we can only guess at the approximation of other compounded effects on the families and friends of these individuals, directly and indirectly.

Within the past few years, we in the health service programs, have come to rely more heavily on resources outside of our own limited communities. Because of the focus that has been placed on those "problem" people, we have to realize that we have no adequate facilities in the state of New Mexico to handle the problems that are caused by alcohol, solvent abuse. All half-way rehabilitation programs that are used are mainly located outside of the state. Our "communities problem-drinkers" have to

compete for admission with other Indians from across the country, at times, there is enough room for only one of our alcoholics. Because of out-of-state placement there is a short stay involved because of the inability to this particular person to deal with the unfamiliarity and the alien culture. It seems the problem is compounded because he must cope with strange surroundings and he would much rather go home and continue to drink than to bear the loneliness and the strangeness.

This type of problem might be alleviated with more monies for the tribe's own detox/rehab center and fully qualified personnel to aide in helping to meet their needs, while these people are near their own families and Indian medicine.

TEMPORARY SHELTER CARE. The need for foster care homes and temporary shelter homes for abused children and/or wives, is another problem. As it is group homes and some foster homes are very hard to find, especially in time of emergency, in the state of New Mexico; and when they are found there are usually long waiting lists and very few monies from the Bureau of Indian Affairs for payment. There are times that there are "situational crisis" within most families that demand a certain person be removed temporarily until things can straighten out. There are no facilities where the "problem child" can go without having to be sent to the local jail or the overcrowded juvenile detention center. If it is deemed that a child must be sent to a group home for his own "protection and well-being" there is usually a long waiting list and after the long wait, there is usually the hassle of getting contract approval from the proper agencies. Thus, the young person is given hopes and when things fall

through, a great deal of disappointment that he has to contend with.

LAWS. With the signing of the law which guarantees the rights of and the protection of the mentally ill person, there is very little that most families can do for their own protection. It is very difficult to have evaluations and/or admittance done at the Mental Health Center in Bernalillo county. Our own tribal court and law and order people have no system by which they can guarantee the safety and protection of families from their own ill family members. At times our law people are unable to do or won't do anything (whichever the case may be), until the ill person has done some physical harm to his family or himself.

LACK OF MONIES. This is another big problem in the Area offices. Since our grade and step increases are dependent upon education and training, promotions and training is limited. Also, without proper training, we in the field find ourselves handicapped and limited in just what we can do. Often times our consultations within the community is rarely taken seriously. I have found that just the term "mental health" itself, is very threatening to many people in our own community programs. Along this same line, whenever referrals are made to us from the courts or other service communities, there is a failure to understand that we "would like to try to work with a person," but unless that person wants our help, there is very little we can do. Perhaps, we make the mistake of considering every person that comes into our offices as individuals and therefore deserve the courtesy to be treated as such. The individual has the right

to choose and we cannot override this fact and force treatment or therapy on one who does not "want it." I have found that this community needs to become more aware of this attitude; and also to become more aware of their own attitudes toward the person who is having emotional or social problems and the channels that he often uses in trying to deal or work out his problems.

In conclusion, I would like to say, that the fallacy of most communities is that they view each problem of the community as if it were independent of all other problems, as if there were no inter-relatedness between people, at all.

The problems of life are not wrapped up in individual cellophane packages. The problems of youth or any age group for that matter, cannot be viewed as an isolated phenomenon. One's deterioration could very well be the deterioration of our whole Indian culture, without our realizing it.

Mental health reaches into every facet of daily living. It implies the ability to hold a job, have a family, keep out of trouble with the law, and to enjoy the usual opportunities for pleasure.

Thus, a person must have some sound mental health in order to function appropriately within a community structure and to be able to contribute constructively to himself and to his family. That each person's competence depends upon his attitude toward himself. The blending of self-acceptance and self-confidence; and in short, our whole communities' own attitude toward people with coping problems.

May I thank the members of the committee for their interest and their concern in the health matters concerning our Indian people. I hope, that

in some small way, I have been albe to give this committee an idea of the problems in field work within the community of Isleta; although I am aware that I may have failed to bring to light some other problems, perhaps I have been able to bring to light others. Thank you again.

Respectfully,

C. Burlinda Jaramillo, U.S.P.H.S.,
Division of Mental Health
Mental Health Coordinator, Isleta Pueblo

SUPPLEMENT E

Senator Edward M. Kennedy
Chairman Senate Health Sub-Committee

Mr. Chairman:

I am here today to present testimony on behalf of the Urban Indian population of Albuquerque which members approximately 17,500 people. Several matters are of great concern to us and to the tribes of New Mexico.

As a Health Planner and Educator for the Albuquerque Urban Indian Center and for the New Mexico Health Education Coalition. I would like to call your attention to #1. The delay in the Publication of the final rules and regulations for 94-437. If you will note as stated in the law Sec. 702 A-3 they are 2 months behind. This has been a problem for us as we have a proposal pending upon the release of Title V funds. We urge you to support the Albuquerque Urban Indian Health program proposal and assist in the release of funds. This proposal should it be funded would enable us to begin to coordinate available health resources in this area.

It is our understanding that Dr. Emery Johnson, Director of HEWIHS will be keenly watching the Albuquerque Area for duplication of services.

The Urban Indians must start with nothing, so duplication is not possible, the question arises how can one duplicate any services when there are no monies for out-reach programs on other services.

#2 the lack of adequate health facilities and staff for the Indian Health Clinic. Due to the Court decision on the Lewis Case, the Indian Health Services has had to redefine the eligible population for contract care. Inspite of the lack of adequate funds, space, and staff it must provide contract care to all Indians on an equal basis.

Presently, the Indian health clinic can not meet the demands it faces. The out-patient clinic saw in 1976, 32,000 patients in six small rooms with a total staff of 12 to man the clinic.

The projected peak workload was for a 10 year period which projected 20,000 out-patient visits starting in 1970 when the clinic opened for service.

The increased usage by the Urban Indians and Tribes have disrupted the staffing pattern as well as the physical space of the out-patient department and increased the waiting time from 30 minutes to 2 1/2 hours or more.

Yet only a 6% increase of personnel has been allowed to accomodate the one hundred fifty to two hundred patients seen daily. With no money to provide 24 hour coverage, the clinic operates 8:00 A.M. to 5:00 P.M. daily. Emergencies are directed to other hospitals and then are screened very carefully before being approved for pay.

The Urban Indian Center being aware of this vast problem, encourages its people to participate in the insurance programs offered by their employers. Information on Medicare, Medicaid and other resources are provided for these benefits.

How ever there are those Urban Indians who do not earn ample salaries and can not afford the high cost of insurance and must therefore rely totally on Indian Health Services for their care.

Without any more funding than has been granted the Albuquerque Area, (which has not been received as of today) Indian health services can not provide quality care for anyone in any of its departments.

The Eye Clinic has its limits, in as much as this department does not even have its own budget with which to operate, instead it is granted monies from the area allocations, it is under staffed and back logged, appointments are made on a first call first serve basis. The list is back logged for 2 to 3 months at a time. For eye examinations the waiting time for glasses range from 2 to 3 months. (see attached statistics)

The Dental Department has it's own budget to operate with but like the eye clinics is back logged for 2 and 3 months with only emergencies seen at 8:00 A.M. It also operates on a first call, first come basis. Both of these clinics are located at Southwestern Poly Technical Institute which is inaccessible to many of our Indian people due to the bus system which serves that area twice a day and because of the lack of personal transportation.

In summary, on behalf of our Indian people we recommend that you support us in acquiring a larger facility, better staffing, and adequate funds, which would permit the Indian Health Service to provide the quality care which every Indian citizen is entitled to.

Submitted By:
Mary Collado
Mary Collado
Health Educator/Planner
New Mexico Health Education Coalition
517 Fruit, N.W.
Albuquerque, New Mexico 87102

LEADING REASONS FOR OBTAINING AMBULATORY CARE
IN ALBUQUERQUE SERVICE UNIT
FY 1976

	REASON	VISITS
1.	Upper Respiratory Infection	8,617
2.	Preventative Services	6,631
3.	Skin Diseases	6,312
4.	Accidents	4,661
5.	Well Child Care	3,229
6.	Physical Exams	2,826
7.	Hypertension	2,252
8.	Pre-Natal Exam	2,218
9.	Diabetes	2,157
10.	Otitis Media	1,734
11.	Pharyngitis	1,523
12.	Gastroenteritis	874

NOTE: 5,651 visits were made for symptoms and ill defined conditions.

PRINCIPLE REASONS FOR HOSPITALIZATION
IN ALBUQUERQUE INDIAN HOSPITAL
FY 1976

	REASON	CASES	DAYS
1.	Medical & Surgical Aftercare	122	10,724
2.	Accidents & Injuries	112	834
3.	Diseases of Digestive System	94	1,127
4.	Diseases of Respiratory System	78	517
5.	Mental Disorders (Incl. Alcoholism)	74	400
6.	Diseases of Circulatory System	68	901
7.	Diseases of Skin	67	828
8.	Infective and Parasitic Diseases	60	1,121
9.	Symptoms & Ill defined conditions	30	110
10.	Complications of Pregnancy	17	78

LEADING CAUSES OF DEATH
ALBUQUERQUE SERVICE UNIT
FY 1973-1974

1.	Accidents	26
2.	Heart Disease	14
3.	Unknown, Ill defined	12
4.	Cirrhosis of Liver	8
5.	Malignant Neoplasms	8
6.	Cerebrovascular Dis.	5
7.	Homocide	4
8.	Influenza	4
9.	Diabetes	3
10.	Suicide	2

1. APC service at the Albuquerque Indian Hospital has increased by 18,886 per year from the 1972 period.

2. Much of this increase is due to increased use by Urban Indians. Residents of the City of Albuquerque received 17,064 services in F.Y. 1976, an 11,544 increase over 1972.

3. Residents of Albuquerque account for 54% of total services in 1976, 44% in 1972.

4. The second largest consumer of services in 1976 was Isleta. Isleta residents used the clinic 2,564 times. This is an increase of 1,077 services over 1972.

5. Residents of Laguna used the A.I.H. clinic 1,313 times in 1976. This is an increase of 936 over 1972.

Ambulatory Patient Care Services at Albuquerque Indian Hospital

Fiscal Year	Total Visits	Residence						
		City of Albuq.	SIPI	Canon-cito	Jemez	Zia	Isleta	Laguna
1971	3,648	1,800	-	224	266	186	557	69
1972	12,543	5,520	1,450	582	741	251	1,487	383
1973	16,708	8,125	353	915	1,088	336	2,066	684
1974	20,491	9,966	357	891	1,028	348	2,309	751
1975	24,306	12,221	915	923	1,131	450	2,274	829
1976	31,431	17,064	869	1,031	1,500	561	2,564	1,319
Increase 1972-76	18,888	11,544	-581	449	759	310	1,077	936

COMMUNITY HEALTH SERVICES
AMBULATORY PATIENT CARE SERVICES

CLINIC	1972	1973	1974	1975	1976	1977
Laguna H. C.	14,059	11,791	12,027	12,952	14,557	18,532
SIPI School H. C.	1,610	6,257	5,308	6,534	6,499	6,495
AIS School H. C.	1,798	2,022	1,892	1,374	1,910	2,331
Acomita	2,208	2,384	3,584	4,094	4,830	5,249
Alamo	854	1,423	1,606	1,509	1,646	2,011
Magdalena	736	636	494	459	712	130
Canoncito	1,685	1,107	1,310	1,770	2,093	2,255
Isleta	4,331	4,458	5,414	6,143	6,182	6,780
Jemez	4,256	5,094	4,613	4,607	5,559	5,649
Sandia	N/A	178	217	304	281	647
Santa Ana	868	1,109	966	1,280	1,429	1,205
Zia	1,643	1,692	1,198	1,584	1,642	1,843
Health Stations Sub-Totals	34,048	38,151	38629	45,610	47,340	53,126

*ASU AMBULATORY CARE WORKLOAD

F.Y.	APC Visits
1970	32,929
1971	35,407
1972	47,445
1973	55,107
1974	59,480
1975	67,124

CONTRACT HEALTH CARE

I. BACKGROUND

The Albuquerque Service Unit Contract Health Service program has been the most rapidly growing program in the Service Unit. The budget has doubled in the last five years and seems to defy attempts to contain and control it. The reasons for this growth are familiar to all: the rapidly escalating costs of hospitalization, related to the unionization of hospital employees, the medico-legal requirements that force MDs to practice "defensive" medicine and the overall inflationary pressures on the American Economy during the last decade.

The Albuquerque Service Unit has had to cope with a service unit population that has doubled in the last 2 years as a result of a court decision that redefined the eligible population. The "Lewis Decision" stated simply that in lieu of a Federal Registry a definition of the Indians determined to be eligible for contract care; all Indians should be treated equally by the Indian Health Service. The Service Unit has yet to receive any official and legal statement that defines the groups to be served and is presently treating all Indians equally in the distribution of its Contract Health resources.

The reality of funding limitations necessitates the establishment of a priority system. The order of priority for the Albuquerque Service Unit is as follows:

(A) Emergency services provided to persons of Indian blood who are members of the communities served by the Albuquerque Service Unit are paid first.

(B) The medical or surgical consultation for Service Unit community members on referral by PHS physicians.

(C) Elective procedures and operations needed by Service Unit community members who are referred by the PHS, and have had payment approved by the Service Unit Director.

II. CURRENT PROCEDURES

The Contract Health Program has instituted many new procedures in order to control expenditures with as little inconvenience to the patient as possible:

(A) There is 100% screening of all patients to determine Indian ancestry and eligibility. Form letters have been developed to assist the patient in obtaining proper documentation from their home agency. This is only necessary for non-local Indians since census records are available on local Indians.

(B) There is 100% screening and interviewing of patients for alternate resources, since the IHS is a residual resource as a third party payee. An alternate resource is sought if the interviewer feels that a patient may be eligible for some other program.

(C) Information booklets have been developed by the Service Unit Director to advise individual patients about the service unit's Contract Health Service guidelines. The Community Health Representative Directors have been informed about service unit guidelines and have been helpful in screening patients for alternate resources. The Service Unit Health Board has been informed about the CHS status on a monthly basis and individual community health boards have been informed by the Service Unit Director or Clinical Director when a community request has been made. Guidelines and policies have been published intermittently in the 19 Pueblo News.

(D) Contractors are intermittently reminded about CHS policies and guidelines.

III. ON-GOING PROGRAM

The CHS program acts as a third party payee for eligible Indian patients that have no alternate resource of payment. It serves as a supplemental payee for patients that have private insurance or Medicare, and pays for whatever balance is billed to the patient. The program does not pay for non-emergency, elective care that can be provided within the IHS Direct Care system. All emergency or elective outpatient requests for payment are reviewed by the Service Unit Director or Clinical Director to determine if the treatment falls within the scope of the CHS program. The review traditionally has not applied to the patients seen at BCMC because of the "walk in privileges" embodied in the original contract with Bernaldllo County when the Bernalillo County Indian Hospital was constructed.

Contracts are written with the major medical centers in the area: Bernalillo County Medical Center, St. Joseph's Hospital, the Presbyterian Hospital Center, Anna Kaseman Hospital, the Lovelace-Bataan Medical Center, Cibola General Hospital, and Socorro General Hospital. Individual contracts on a fee-for-service basis are written with private practitioners that can provide specialty services that are not available within the Direct Care program. Specialty clinics at the hospital, i.e., Dermatology and Podiatry, are funded on fixed fee/clinic basis and that is covered by a monthly blanket to insure continuity of the program.

IV. PROBLEMS

(A) The major problems of the program center about the lack of personnel to handle not only the sheer volume of work, but the interviewing and screening responsibilities. A temporary employee

has been funded by the Area Contract Health Service office for both the Albuquerque Hospital and Laguna Health Center. This has eliminated the usual backlog that has occurred at the end of each fiscal year preventing a realistic assessment on the Service Unit's financial status. If possible these positions should be made permanent.

(B) The other problem is the usual for all contract health programs. There never seems to be enough funding to provide for a total health program; however, most major medical problems are funded without difficulty.

V. PROGRAM EMPHASIS FOR FY 1978

(A) The major emphasis of the CHS program for FY 78 will be in the area of patient education. Most complaints from both provider and patient center about a misunderstanding of the program and its limitations. New pamphlets will be developed for patients and providers to help eliminate this misunderstanding.

(B) The CHS office will attempt to maintain its expenditures within the allocated budget by effective screening of patients and efficient utilization of the referral system. I would like to comment that this task would be much easier if a stable definition of the service area could be determined. The "On or Near" policy has been in Headquarters for over a year with no resolution in sight.

Albuquerque Service Unit Contract Health Care allocations for FY 1977

	1st. QUARTER	2nd. QUARTER	3rd. QUARTER	4th. QUARTER	TOTAL
Albuquerque	257,000.	387,000.	278,000.	352,000.	1,274,000.
Laguna	253,000.	265,000.	203,000.	164,000.	885,000.

CONTRACT HEALTH SERVICE
PROVIDERS OF HOSPITALIZATION FY 1975

HOSPITAL	CASES	DAYS
Anna Kaseman Hospital	7	16
Bernalillo County Medical Center	750	3,147
Bernalillo County Mental Health Center	18	73
Cibola General Hospital	99	316
Lovelace-Bataan Medical Center	21	85
Presbyterian Hospital Center	154	733
Socorro General Hospital	284	929
St. Joseph's Hospital	32	187

CONTRACT HEALTH SERVICE
HOSPITALIZATION CONSUMERS BY COMMUNITY
FY 1975

COMMUNITY	CASES	DAYS
Acoma	176	750
Alamo	287	941
Albuquerque Indian School	8	23
Isleta	181	782
Jemez	129	567
Laguna	248	1,190
Sandia	20	93
Santa Ana	36	125
Southwestern Indian Polytechnic Institute	43	157
Zia	36	125

PROPOSED AMBULATORY PATIENT CARE CENTER

One of the major health management problems and unmet needs is the inadequate facility serving as the Outpatient Clinic in the Albuquerque Indian Hospital.

It is an on-going program that is barely able to meet the present needs of the Indian people and is rapidly being overwhelmed by the demand for services.

Our goal, as stated by the Indian Health Service Director, Dr. Emery Johnson, and T. J. Harwood, Albuquerque Area Director, is to deliver the best possible health care to Indian people. Therefore, our objective, in order to implement this goal, is to plan, build, and develop an ambulatory patient care center for the Albuquerque Service Unit, and possibly a referral center for the other service units of the Albuquerque Area.

A new, modern and efficient Ambulatory Patient Care Center is needed to accomplish one of the primary goals of the Indian Health Service in Albuquerque. The goal is competent and compassionate medical service to the Indian people in the Albuquerque Service Unit.

The bulk of the direct patient care done by the Albuquerque Service Unit is done in the Outpatient Department of the Albuquerque Indian Hospital. The total number of Outpatient Department visits last year was 32,000. This year it will be about 36,000. Over the past 6 years there has been a mean increase of about 20% in the total number of OPD visits per year.

The following figures are the workload as experienced in the Outpatient Department of the Albuquerque Indian Hospital which acts not only as a direct primary care provider, but also as the referral center for the outlying community health clinics.

AIH-OPD

FY 1973 16,441
FY 1974 22,962
FY 1975 24,531
FY 1976 32,031

According to these figures we can conservatively estimate about a 15% annual increase in OPD visits.

FY 1977 36,000
FY 1978 41,000
FY 1979 47,000
FY 1980 52,000
FY 1981 60,000

The populations that occupy the constituent communities of the Albuquerque Service Unit have grown only slightly. This is because many of the people have moved into the City of Albuquerque to seek housing and employment. Agriculture, pottery and Indian jewelry making are not sufficient to economically sustain the local Indian communities. This,

together with other migrant Indians, has swelled the Indian urban population. The U.S. government, through Congressional legislation and court decisions, has been obligated to furnish health care to these people. Publicity concerning recent court ruling has resulted in increasing numbers of patients seeking health care.

It has been the experience of the Albuquerque Service Unit that whenever inadequate facilities were improved in the communities, projected patient load increased immediately. Therefore, it is anticipated that the projected OPD visits will become a reality.

The present OPD in the hospital is already inadequate to handle the day-to-day patient load. Not only is the space inadequate, but also there is an insufficient number of physicians, nurses and equipment. All practicing physicians average over 60 hours of work covering the hospital and the clinics.

The following personnel are needed to handle 50,000 and 80,000 OPD visits according to the Resource Allocation Criteria (RAC) document.

	50,000	80,000
Primary Care Providers	6	9
Registered Nurses	5	7
Licensed Practical Nurses	5	8
Nursing Assistants	2	3
X-Ray Personnel	1.5	2
Laboratory Personnel	5.5	9
Pharmacy Personnel	6	9
General Clerks, Personnel	3	6
Administrative Clerks	3	3
Medical Records Personnel	3.5	5
Housekeeping Personnel	2.5	4
Supply Personnel	2	3.5
Drivers	1.5	2.5
Examining Rooms	14	21

Adequate staffing and facilities may reduce the amount of hospital care through the increased availability of primary care.

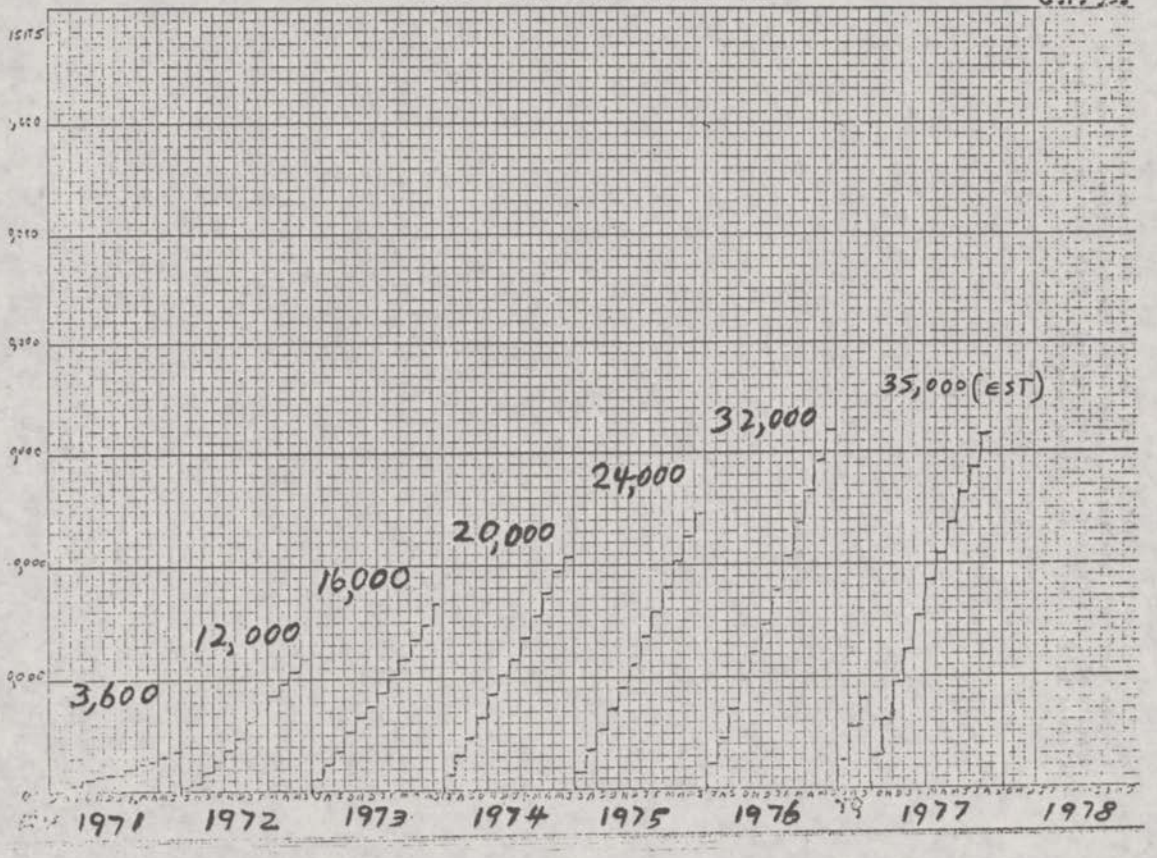
PLAN OF ACTION

In July, 1976, the service unit administrative staff, with the assistance of the Area Office Construction and Maintenance Branch, developed an initial proposal for an Albuquerque Hospital program to meet the Ambulatory Patient Care needs for about ten (10) years. This included an Ambulatory Patient Care facility, a new Medical Records Department, and a larger Supply warehouse. In February, 1977, Dr. Todd advised us that he would seek the initial $18,000. Architectural and Engineering funds for a feasibility study. In August, the funds were received and the initial stages of the plan for development was begun.

The Service Unit Health Board, as well as the Urban Indian Coalition, is very much interested in improving the Ambulatory Patient Care capacity of the Albuquerque Indian Hospital. Both parties should be involved in any additional funding requests.

A.I.H. O.P.D. ANNUAL MONTHLY CUMULATIVE VISITS

O.P.D.



SUPPLEMENT F

JICARILLA APACHE TRIBE
INDIAN HEALTH SERVICES PROPOSAL
(ABSTRACT)

The goal of the Jicarilla Apache Tribe's "Proposal for Comprehensive Community Health Center" is to raise the health status of the Jicarilla Apache people to the highest possible level. To achieve this goal, a comprehensive health services delivery system must be developed.

The responsibility for the health care of the 2,000 Jicarilla Apaches is placed on the federal government. Past and present health problems reflect major deficiencies in their health status. 45% of tribal members are presently employed. The tribal population is spread within a 15-50 miles radius of the present health center. Environmental health problems require attention and a more defined study of the problems requested.

Present health services are provided on a limited (outpatient) basis through the Public Health Services Indian Health Service Center. Inpatient care is provided through private facilities on a contract basis and through IHS Hospitals within the state. The closest hospital is located in Farmington, New Mexico which is 94 miles distant and with limited facilities.

The proposed health care delivery system has been developed to provide a comprehensive approach to the health needs of the Jicarilla Apache Tribe.

SUMMARY OF EXPENSES

Construction Costs	$6,371,750
Feasibility Study	$ 150,000
Planning and Design	$ 637,175
Equipment	$1,083,198
TOTAL:	$8,242,123

JICARILLA APACHE TRIBE

RESOLUTION OF THE
TRIBAL COUNCIL

SUPPORT TO THE HOSPITAL BOARD

Resolution No. 76-316

Whereas, request has been submitted by the Chairman of the Board, Denton Garcia, for the support of the Tribal Council for the submission of a proposal for a study on the construction of a Comprehensive Health Care Center on the Jicarilla Apache Reservation, and

WHEREAS, the Jicarilla Apache Tribal Council has for many years known that the Reservation is in need of adequate health care facilities, and they have over the years made request to the Indian Health Service and the Congressional Delegates to assist the Jicarilla Apache Tribe in obtaining adequate health care facilities, because of the remoteness of the area from hospital facilites, and now

BE IT RESOLVED, by the Jicarilla Apache Tribal Council that total support is hereby given to the Hospital Board in their efforts to seek funding for a study, which would assist the Jicarilla Apache Tribe in their efforts to obtain funding for the construction of an adequate Comprehensive Health Care Facilites, which would be most beneficial to the Residents of the Jicarilla Apache Reservation.

CERTIFICATION

The foregoing resolution was enacted upon by the Tribal Council of the Jicarilla Apache Tribe, on April 20, 1976, by a vote of 6 for, 0 against, and 0 abstaining, at a duly called meeting, at which a quorum of the Tribal Council members were present.

President

Attest:

Secretary

TRIBAL

RESOLUTION

TABLE OF CONTENTS

PROPOSAL FOR A COMPREHENSIVE COMMUNITY HEALTH CENTER TO SERVE THE JICARILLA APACHE TRIBE

Submitted to: Indian Health Service
Albuquerque Area Office
Federal Office Bldg. and U.S. Courthouse
500 Gold Avenue, S. W.
Albuquerque, N. M. 87101

Submitted by: The Jicarilla Apache Tribe
P. O. Box 507
Dulce, New Mexico 87528

March 31, 1977

THE JICARILLA APACHE TRIBE
P. O. BOX 147 • DULCE, NEW MEXICO 87528

March 23, 1977

Dr. Jack Ellis, Acting Area Director
Indian Health Service
Federal Office Building and U. S. Courthouse
500 Gold Avenue, S. W. Room 4005
Albuquerque, New Mexico 87101

Dear Dr. Ellis:

This letter presents our proposal for the development of a Comprehensive Community Health Center to serve the Jicarilla Apache Tribe.

Our particular health needs are summarized and projected within the attached narrative. Of special concern to our people is the lack of in-patient health care services available or readily accessible. Our high rate of injuries is indicated by in-patient day statistics. Associated problems such as transportation services, etc. compound this problem.

The Jicarilla Apache Tribe has identified the need for a health center which will offer in-patient services and effect a more comprehensive approach to health care delivery.

For the Jicarilla Apache Tribe, I await your earliest reply.

Sincerely,

Tribal President

Attachments

cc: Dr. Emery Johnson, Director
Indian Health Service

THE JICARILLA APACHE TRIBE
P. O. BOX 147 • DULCE, NEW MEXICO 87528

April 7, 1977

Mr. Dwight Dyer
Senate Appropriations Committee
Room 1116
New Senate Office Building
Washington, D.C. 20510

Dear Mr. Dyer:

Enclosed please find the Jicarilla Apache Tribe's Comprehensive Community Health Facility Proposal which will be used for testimony on April 20, 1977 before the Senate Appropriations Committee in conjunction with the budget hearings for the Indian Health Service FY 1978 budget.

Should you have any questions on the aforementioned proposal which our tribe will be giving testimony on, please call my office at (505) 759-3372. If I am not in my office please call Mr. Richard Tecube at (505) 759-3247. Mr. Tecube is authorized to act on my behalf during my absence.

Sincerely,

Dale Vigil
Acting President
Jicarilla Apache Tribe

DV/lc

cc: Albuquerque Area Indian Health Service

THE JICARILLA APACHE TRIBE
P. O. BOX 147 • DULCE, NEW MEXICO 87528

April 7, 1977

Mr. Fred Morhrman
House Subcommittee on Interior
Room B-308, Rayburn Building
Washington, DC 20515

Dear Mr. Morhrman:

Enclosed please find the Jicarilla Apache Tribe's Comprehensive Community Health Facility Proposal which will be used for testimony on April 18, 1977 before the Senate Appropriations Committee (House Subcommittee on Interior) in conjunction with the budget hearings for the Indian Health Service FY 1978 budget.

Should you have any questions on the aforementioned proposal which our tribe will be giving testimony on, please call my office at (505) 759-3372. If I am not in my office please call Mr. Richard Tecube at (505) 759-3247. Mr. Tecube is authorized to act on my behalf during my absence.

Sincerely,

Dale Vigil
Acting President
Jicarilla Apache Tribe

DV/lc

CC: Albuquerque Area Indian Health Service

I. BACKGROUND

The Jicarilla Tribe has recognized many deficiencies in the health status of the Indian Community. This has prompted activities to support and expand existing health services; and to define health problems, identify solutions, and locate resources. As part of this process, the following narrative has been developed.

This narrative proposes the implementation of a comprehensive health care delivery system for the Jicarilla Apache people.

TRIBAL INFORMATION:

The Jicarilla Apache Reservation is located within Rio Arriba County and northern Sandoval County. It is bounded on the West by Carson National Forest and on the east by private land and the Santa Fe National Forest (see map attached).

Approximately 90% of the Jicarilla Apaches live within 15 miles of Dulce.

Off-reservation centers within about 50 miles of Dulce are Chama, New Mexico (1,178 Pop.), Lumberton, New Mexico (300 Pop.), Pagosa Springs, Colorado (1,500 Pop.). Other smaller communities include Parkview, Canjilon, Monero, Chromo, Gobernador, and a checkerboard Navajo area to the South.

Total population to be served by the Jicarilla Indian Hospital approximates 2,000 according to Tribal Census Data.

The July 1976 estimate of "service population" of the Jicarilla Reservation is 1,657 distributed as follows:

Under 5 - 233
5 - 14 - 526
15 - 24 - 295
25 - 34 - 212
35 - 44 - 179
45 - 54 - 90
55 - 64 - 62
65 - [illegible] - 60

The entire area is one of high mountain ranges and elevated valley located along the Continental Divide between the San Juan and Rio Grande Rivers. The reservation itself consists of 742,312 acres extending southwest from the New Mexico-Colorado line for 80 miles along the western slope of the Continental Divide. Rainfall ranges from 9-14 inches in the lower and warmer southern end of the reservation. Temperature extremes are great with lows of 20° in the winter and highs of 85° - 90° in the summer. Daily variations often average over 50 degrees. Altitude of the region ranges from 6,500 to 9,000 feet.

Limited dry-land farming is possible with a growing season of only 70-80 days. Livestock raising, mining, oil, gas and timber resources are the main source of tribal income.

In 1972 the tribe received land claims settlement of $9.2 million from the Federal Government and each tribal member was given a certain share. Budget report for the Jicarilla Apache Tribe shows profit from the following resources: Lease rentals, oil & gas, bonuses, interest time certificate of deposits, agency investment, land claims income, rental income, housing, JAT Industry, court fines & fees, hunting & fishing permits, special elk fence, Dulce Community Center, livestock-grazing fees & permits, livestock sales barn, arts & crafts, newspaper, realty, firewood, Go-Gee-A-Tenda Store, and miscellaneous income.

In 1973 the following resources were added: Apache Indian Enterprises, Stone Lake Lodge, Stone Lake camping fees, game & fish token fees, accounting claims, Jicarilla Crafts CO-OP, and 69 livestock owners were accounted for both in sheep and cattle business.

The Jicarilla Apache Tribe has come a long way from being dependent on the government for their sole support. Today the Apaches are more independent in more ways and supporting themselves rather than leaning

in the government in order to survive. Today 45% of the members hold jobs to support their families.

US Highway #84 runs approximately 14 miles east of the reservation. New Mexico State Route #44 crosses the southwestern corner of the reservation while US Highway #64 crosses the northern end. New Mexico State Highway #537 traverses the reservation from north to south connecting New Mexico State Highway #44 and US Highway #64. Numerous dirt roads, poorly marked and occasionally impassable in inclement weather crisscross the region. No bus or passenger service is available to the reservation.

A paved airstrip 100 x 5,280 feet at Dulce is usable day or night and is limited to small aircraft.

The Dulce Public School, an independent school district, serves children from kindergarten through the 12th grade. An Early Childhood Education Program (Headstart and Day Care) is available to residents of the Jicarilla Apache Reservation.

Telephone service is available through the Chama, New Mexico exchange. Two-way radios are used frequently. Television service is available to parts of the region by cable. There is daily mail service to most of the region.

PRESENT HEALTH SERVICES

Dulce Public Health Service Indian Health Center: consists of an out-patient clinic with limited emergency room services. Staff includes one physician, one dentist, one community health medic, one clinic nurse, one public health nursing team, a pharmacist/laboratory/X-ray technician, a sanitarian aide, a mental health coordinator, and one mental health consultant. Regular clinic hours do not include weekends. Referral services to the hospitals previously mentioned are included. Specialty clinics are held as required. No in-patient services are offered.

Community Health Representative (CHR) Program: provides outreach services to include patient transportation (limited), health education, general medical aid, observation of patients, assistance at well-baby,

arthritis, diabetes and hypertension clinics. The present program is under staffed. CHR's assist in the clinic during normal hours, weekends, and as needed on an emergency basis.

Jicarilla Rehabilitation Program: provides alcoholism and alcohol abuse counseling, referral and treatment services. Ten staff members offer counseling and rehabilitation programs to men, women and youth. In-patient recovery services are contracted through Albuquerque Programs (ATP, Turquoise Lodge, etc.), 190 Miles; Gallup Friendship Lodge, 200 miles; Twin Lakes Recovery Center, 190 miles; and facilities in Sheridan, Wyoming; Recovered Alcoholics Patients Programs-Santa Fe, 140 miles away; Pecos Valley Treatment Center - Roswell, 320 miles distant. In addition to the in-patient recovery services available off the reservation, Half-way house treatment services are available to both men and women on-site in Dulce.

Emergency Medical Technician Services: provides emergency transportation to all residents in the area. Volunteer staff fluctuates between 9-15. A call schedule is established to provide 24-hour coverage. Patients are transported to facilities in Farminton, Santa Fe and Albuquerque. No training or equipment funds are available. Communications are coordinated with the Police Department and the local PHS clinic. Office space and work space is nonexistent.

Mental Health Training Program: A (NIMH) grant funded training program for community service workers through the University of New Mexico providing college credit leading to an Associate of Arts Degree. Students serve citizens of the Dulce Community as a part of their field training using the skills taught in class by instructors from Albuquerque and a professional social worker (tribal member) who coordinates the program.

Women, Infants and Children Program (WIC): This program provides primary assistance in food supplements, health education and assistance with new-born infants and children to 5 years of age. Since this service is only provided on a monthly basis, there are problems with follow-up, adequate facilities, and additional trained staff.

II. ANALYSIS OF NEEDS

The Jicarilla Apache Tribe has requested by resolution of the tribal council that a hospital be constructed on-reservation to provide outpatient and inpatient services to Indian residents of the area. The tribe feels that the community and surrounding area should benefit immensely from improved health care and that a new, modern hospital facility would enhance the reservation so that industries would be attracted to the community resulting in an improved standard of living.

Significant health problems and barriers to accessible comprehensive health care services are indicated by the following:

HEALTH STATUS INDICATORS

HEALTH PROBLEM	VISITS	%	VISITS	%
1. Upper Respiratory Infection	1753	13.4	1549	14.1
2. Injuries	1056	8.0	1002	9.1
3. Skin Diseases	824	6.3	681	6.2
4. Symptoms, Ill-Defined Cond.	573	4.4	760	6.9
5. Otitis Media, Acute	514	3.9	561	5.1
6. Pharyngitis	400	3.0	627	5.7
7. Asthma, Allergy	328	2.5	293	2.6
8. Prenatal Care	248	1.9	339	3.1
9. Hypertension	233	1.8	188	1.7
10. Alcoholism	137	1.0	85	0.8

Chart 1 showing principal health problems presented at Dulce Health Center in 1975 and 1976.

Infective and parasitic diseases account for a large percentage of out-patient visits and contract hospital admissions. Gastrointestinal and upper respiratory illnessess are prevalent and seasonal. Other diseases of the digestive system are responsible for a large number of outpatient visits and hospital admissions. Alcoholism and associated conditions is one of the most serious problems of the Jicarilla Apache. Accidents, both traffic and home, account for a significant workload in

the health center and contract hospitals. Prenatal and postpartum care services are deficient, demonstrating the need for increased health education emphasis in these activities. Hospitalization trends have been toward a slight decrease in pediatric cases and a large increase in the number of geriatric cases. Other diseases associated with poor general sanitation and a low level of knowledge among the Indian people about hygienic practices add to the workload. Lack of adequate nutrition among some population groups compounds the other health problems and is a definite inhibitor to health development.

Hospitalization is provided through contract facilities in Santa Fe, New Mexico (St. Vincent's Hospital - 213 beds) 140 miles distant; Farmington, New Mexico (San Juan Hospital - 106 beds) 94 miles distant; Durango, Colorado (Mercy Hospital - 95 beds) 102 miles distant; and Albuquerque, New Mexico (Bernalillo County Medical Center, Bataan Memorial Hospital and Lovelace Clinic, for highly specialized care not available in other facilities) 190 miles distant. The new U.S.P.H.S. Hospital in Santa Fe (55 Beds with surgery) scheduled for completion in late 1977 will provide needed general surgical services. The IHS hospitals in Santa Fe and Albuquerque provide very limited in-patient services.

Chart 2 showing principal reasons for hospitalization of Dulce residents. - F.Y. 1975

DIAGNOSIS	IHS HOSPITALS CASES	IHS HOSPITALS DAYS	CHS*HOSPITALS CASES	CHS*HOSPITALS DAYS	TOTAL HOSPITALS CASES	TOTAL HOSPITALS DAYS
1. Pregnancy, Childbirth	12	49	56	148	68	197
Delivery w/o compl.	3	17	22	66	25	83
Delivery w. compl.	1	2	12	48	13	50
2. Injuries	36	251	29	249	65	500
3. Dis. of Digestive Syst.	9	111	7	85	16	196
Hernia	1	4	1	53	2	57
Gallbladder	2	8	4	26	6	34
Cirrhosis	2	77	-	-	2	77
4. Symptoms, Ill-Defined	15	71	5	14	20	85
5. Dis. of Respiratory Syst.	11	52	7	41	18	93
Upper Resp. Infect.	2	15	2	10	4	25
Bronchitis	1	2	-	-	1	2
Pneumonia	7	29	3	27	10	56
6. Infective & Parasitic Dis.	14	112	1	8	15	120
Diarrheal Disease	8	55	-	-	8	55
7. Mental Psychoneurotic	14	76	1	1	15	77
Alcoholism	12	65	1	1	13	66
8. Dis. of Circulatory Syst.	6	32	1	4	7	36
Hypertension	4	15	1	4	6	14
9. Dis. of Female Genitalia	1	5	5	9		
10. Endocrin, Nutritional Dis.						
Diabetes	3	31	-	-	3	31

* Contract Health Service

Barriers associated with hospitalization for any reason, has prompted the development of a health center with inpatient care available. As indicated by the map in Exhibit A and as described in Part I of this narrative, the Jicarilla Apache population is remote and isolated from adequate hospital facilities. Distances to facilities must be traveled long distances over poor roads, often snow covered or icy.

EMERGENCY MEDICAL SERVICES

Since this program is not adequately funded, there are several unmet needs:

1. Insufficient number of trained staff
2. Lack of adequate training programs
3. No conditions or communication system with other agencies
4. Lack of facilities and equipment

Professional or para-professional medical care is limited and often over taxed. Often times there is no medical staff available to accompany patients enroute to hospital facilities or the medical staff must act as driver for the vehicle.

Good weather conditions and recreational facilities bring a large number of non-Indians and Indian visitors to the reservation during the spring and summer months. The outpatient facility and EMS programs are by law available to any person requiring emergency treatment. Therefore, during these high-risk months the facility and programs are severely taxed and over-worked.

Many Jicarilla Apache Tribal Members who need emergency room services at hospitals in surrounding communities (Farmington, Durango, etc.) are refused emergency medical treatment because they are unable to pay for the required treatment. This situation is a frequent occurrence to tribal members and no doubt the acuteness of some emergency medical treatment has resulted either in death or severe personal discomfort to the afflicted persons in need.

TRANSPORTATION

Because the accessibility to medical care is directly tied to the availability of transportation, two important parameters must be considered:

1. Emergency transportation (discussed above)
2. Transportation for regular or appointment visits to speciality clinics or inpatient facilities.

There is essentially no public transportation available on the Jicarilla reservation and consequently, almost all travel for medical attention is by private automobile. It is well documented that poor transportation adversely affects the health of rural Indians. Many families must be concerned with the availability of a car in an emergency or for appointment in one of the hospitals. Again adverse weather conditions, distance, and the scattered population all act as barriers to quality hospital services.

LACK OF HOSPITAL BASED SERVICES

Present health care on the Jicarilla reservation can be best described as primary episotic care which is more oriented to the individual than to the family and is one which is oriented more to the alleviation of a particular problem than to the comprehensive needs of the patient himself. It is the intent of this proposal to expand these services to include the provision of inpatient services and through service programs designed to include proventive health and community outreach health care.

Specialty clinics are needed to offer screening in many areas including: diabetes, hypertension, vision and hearing, anemia, skin diseases, heart diseases, cancer, mental retardation, growth and development, and chronic illness.

Community based field medical services are required to expand care in the area of nutrition, home health care, health education, family planning, and public health nursing.

A comprehensive immunization program is required for the preventive health care of this population. Also, immunization records should be established and maintained.

Clinical service to include general medicine, rehabilitation, pediatric, physical medicine, social, surgical, maternity, pathology, nursing, radiological, pharmacy, and other special services required by the Jicarilla Apache Tribe. These programs will afford optimum health care which is accessible and comprehensive.

PERSONAL HARDSHIPS

Without a local in-patient facility the Jicarilla people are faced with additional barriers to optimum health. Family members placed in hospital facilities are in essence "relocated" for health care. This applies to all age groups. Family of hospitalized children many times cannot travel to visit or attend these patients. Economic and physical barriers are evident and both affect the health of the patient as well as the family. Geriatric patient who must be separated for longer periods of time suffer from the lack of personal family support and encouragement because of the distances which separate the hospital facilities and the reservation.

Maternity patients must be regarded as emergencies because of the distances to the facilities. Every maternity patient should have the right to be admitted to clean maternity facilities where mother and infant will have the maximum opportunity for survival. Presently these patients must rely on the EMS or CHR programs for transportation. This is also dependent on workload, other emergencies, weather conditions and location of the patient within the scattered population.

III. PROJECTED WORKLOAD STATISTICS

The statistics contained in this section projects the workload expected and indicate services presently rendered.**

I. TREND IN APC SERVICES AT DULCE HEALTH CENTER

	TOTAL	PHYSICIAN*	CHM	PHARMACIST
1970	10960	N.A.	N.A.	N.A.
1971	12088	11413	--	10
1972	9939	8958	--	501
1973	12327	10321	--	1058
1974	11426	5897	1859	2010
1975	11016	4289	3643	1046
1976	13113	2598	6012	2077

*PHS AND CMS

II. TOTAL APC SERVICES FOR DULCE RESIDENTS BY PLACE OF VISIT 1975 AND 1976

	TOTAL	DULCE* H.C.	SANTA FE HOSP.	MESCALERO HOSP.	ALBUQ. HOSP.	OTHER IHS AREAS
1975	11372	10653	382	29	95	76
1976	13119	12714	293	23	33	41

*Dulce health center also served 105 for other parts of Rio Arriba County, and 12 from Taos in 1975.

CHART 3: Showing summary data for ambulatory patient care (APC) services at the Dulce Health Center and other facilities.

**NOTE: Since the Jicarilla Apaches currently do not have access to any nearby hospital, it is impossible to assemble any accurate hospital workload statistics for previous years. However, based upon hospitalization characteristics during the past three years of a similar Indian population within the Albuquerque Area (Mescalero), a hypothetical Indian Hospital workload has been derived for the Jicarilla Indian population.

The estimated hospital discharge rate per 1,000 population for Dulce is based on the Mescalero experience during the past three years since Mescalero is a similarly isolated community although not to the degree of Dulce.

Estimated average length of say for Dulce (6.5) has been based on that rate experienced in the Albuquerque Area.

INFANTS AND PRESCHOOL CHILDREN (0-4 YEARS)

Fourteen percent of the total Jicarilla Apache population is in

this age group and would account for an estimated 30% of general medical and surgical discharges and 35% of inpatient days in a hypothetical GM&S Indian Hospital in Dulce.

The most prevalent diseases in this age group are pneumonia, otitis media, gastroenteritis and upper respiratory infections. These conditions are closely related to the low level of the general economy, poor general sanitation and a basic lack of knowledge among the Jicarilla Apaches about hygenic practices. Alcoholism is also a major problem among the Indian people and indirectly contribute to the medical problems of this age group in the form of child neglect.

Social-economic conditions in this area are predicted to improve in the future. These improvements, combined with better health education and environmental sanitation, should have a positive impact on reducing the future number of infectious diseases in this group. Resultantly, it is estimated that by 1986 the discharge rate for this age group will experience a slight decrease, while the average length of stay will remain about the same.

SCHOOL AGE CHILDREN (5-14 YEARS)

The 5-14 years age group constitutes almost one-third of the total population and would account for about 9% of the estimated medical - surgical discharges and 8% of the medical surgical-inpatient days. The most common conditions experienced by those in this age group are skin infections and accidents. Gastroenteritis, pneumonia, and observation cases are experienced to lesser degrees.

To some extent the infectious diseases sould become less frequent as general environmental conditions and health education practices improve over the decade ahead. It is also the age group that has the most access to medical surveillance and preventive medical services

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through the school health program. The slight decrease in the proportion of infectious diseases, however, will be offset by case finding and screening programs as well as a continuing high incidences of accidents. It is therefore projected that by 1986 the discharge rate and average length of stay will remain unchanged in this age group.

YOUNG AND MIDDLE AGE ADULTS (15-44 YEARS)

This age group includes approximately 41% of the total population and would account for an estimated 25% of hospital discharges and 20% of inpatient days. Injuries and mental disorders (including alcoholism) are the most prominent health problems among this age group. Chronic disorders are experienced to a lesser extent.

It is projected that emphasis will be exerted on the prevention and treatment of alcoholism and other mental disorders there-by having an impact in the reduction of the incidence of accidents. However, casefinding of chronic diseases, such as diabetes mellitus and cardiovascular disorders, should more than offset the decline in injuries and mental disorders thereby causing the estimated discharge rate to increase slightly by 1986. This trend toward more chronic diseases will increase the average length of stay in this age group by approximately one day.

ADULTS (45 + YEARS)

The over 45 years age group, which represents approximately 13% of the total population, would account for an estimated 17% of total discharges and 26% of total inpatient days. The most common causes of admission are cardiovascular diseases, diabetes mellitus, pneumonia, gastroenterities, upper respiratory infections and accidents.

The planned program to increase preventive services, along with improved environmental sanitation and increased health education, should have a positive impact on the reduction of the high incidence of infectious diseases such as pneumonia, gastroenteritis, and upper respiratory infections. This decrease in hospital workload will be more than offset by the increased workload caused by the detection and treatment of more chronic diseases. A 10% increase is predicted in the discharge rate for this age group with an average length of stay increase of slightly over one day by 1986.

OBSTETRICS

About 40% of the female population is the childbearing age group (15-44 years). Obstetrical discharges would account for an estimated 18% of total discharges and 11% of total inpatient days.

Family planning services will continue to be offered to women of childbearing age, but acceptance beyond the current level will probably have to await in improvement in education, family income, and infant mortality.

WORKLOAD PROJECTIONS

A general summary of workload projection is shown below.

CHART 4

DULCE COMPREHENSIVE COMMUNITY HEALTH CENTER WORKLOAD PROJECTIONS

Projected population 1986	-	2,000
Admission Rate	-	340 / 1,000
Projected Admissions / yr.	-	680
Average Length of stay (Albuquerque Area)	-	6.5
680 Admissions / year x 6.5	-	4420 hospital days

AMBULATORY PATIENT CARE

Outpatient visits FY 1976	-	13,000
Average outpatient visits/person/year	-	8
8 opv/year x 2000 (projected population) gives projected OPV in 1986	-	16,000

BED PROJECTIONS

4420 Projected hospital days divided by 365 days/year	-	12 projected ADPL

FORMULA

$$\frac{12}{.8} + 10 = \underline{25} \text{ bed need}$$

IV. PROPOSED JICARILLA COMPREHENSIVE COMMUNITY HEALTH CENTER

The need for a health care delivery system responsive to the needs of our people can be seen by existing facilities, services, serious deficiencies in preventive health, and the basic requirements of the Jicarilla Apache Tribe for a health facility which is "Comprehensive" in nature and one which acts as the focal point for promoting optimum health.

Essential elements which will be required are:

1. A team approach to the care of the individual, in which the health professions providing services are integrated and coordinated under the leadership of the physician.
2. A spectrum of services that includes diagnosis, specific treatment, rehabilitation, education, and prevention.
3. A coordinated community and/or regional system that incorporates the full spectrum of health services and provides for coordination of care from the time of the patient's primary contact with the system through the community hospital and other health agencies.
4. Continuity among the hospital aspects of patient care, the community, the physician, and the health agencies rendering particular services.
5. Organization of the hospital care of both ambulatory and bed patients into a continuum with common or integrated services.
6. Continuing programs of evaluation and research in the quality of services provided and in their adequacy in meeting needs of the patient and the community.

Jicarilla Comprehensive Community Health Center

This proposal describes a program which will allow the planning for the facility and services which can be coordinated to provide a health care delivery system which addresses the above elements and incorporates the five primary areas of screening, prevention, curative, follow-up and evaluation. This community health center is conceived

to provide comprehensive health services to the entrie population of Dulce and emergency services to surrounding communities to assure the highest level of health attainable by Indian people residing within the area. The planning effort will incorporate the following principles:

1. Patient care of a high quality through:
   a. Provision of competent professional and technical staff and of the equipment and facilities necessary to support the facilities' patient care objectives.
   b. An organizational structure that assigns responsibility appropriately--and requires accountability--for the various functions within the institution, including those particularly related to patient care.
   c. Interaction of members of the medical staff with each other and with other members of the health team through consultations and conferences.
   d. Continuous review by appropriate persons of the adequacy of care provided by physicians, nursing staff, and paramedical technicians and of the adequacy with which patient care is supported by other facility activities.
   e. Educational activities designed to improve patient care and to keep the facilities' professional and technical staffs abreast of new medical and technological knowledge.
   f. Enforcement of standards and provision of programs for patient care that are considered desirable by the various health professions.

2. Effective community orientation through:

   a. A health board made up primarily of persons who have demonstrated concern for the community as well as leadership ability.
   h. Policies that assure availability of services as needed to all of the people in the service area.
   c. Service programs that extend into the community, and that complement and are coordinated with service programs of hospitals, mental facilities, rehabilitation centers, nursing homes, homes for the aged, community clinics, home-health services, health departments, etc.
   d. Participation of the facility in community programs to provide preventive, emergency, and casualty care, and to teach good health and health care practices to community residents.
   e. Leadership of key management personnel in the

planning and implementation of community health and health care programs.

f. A public information program that keeps the community informed about and identified with goals, objectives, and plans.

3. Economic viability through:

   a. Patient care objectives that are consistent with projected service demands and the availability of operating financing for adequate personnel and equipment required to maintain patient care of a high quality.
   b. A program to attract to the medical staff an adequate number of physicians engaged in family practice, as well as the essential medical-surgical specialists, to maintain optimum occupancy of inpatient facilities and full utilization of outpatient services.
   c. A planned program of expansion or development of facilities and services based solely on demonstrated community need, with consideration of the plans of other community health resources to avoid unnecessary duplication and to conform with health care objectives for the service area as a whole.
   d. An annual budget plan for maintaining 1) services at a high level of quality, 2) appropriate stand-by equipment and services, 3) competitive salary and wage scales and employee benefits, 4) interest and payments on mortgage and other indebtedness, and 5) depreciation funding and capital accumulation for a modernization program that will permit the facility to keep pace with modern medical and hospital practices.
   e. Community participation in the facility's programs through sponsors, contributors, auxiliaries, and volunteers.

4. Orderly, systemitized planning through:

   a. Identification of the facility's service area and determination of the area's population, socio-economic, and housing trends, travel patterns and barriers, and location of other health care resources.
   b. Establishment of short and long-range planning objectives with a table of priorities and target dates on which such objectives may be achieved.

c. Preparation of a functional program that describes the short-range objectives to be achieved and the facilities, equipment and staffing necessary to achieve them.

5. A sound architectural plan through:

a. Retention of an architect experienced in facility design and construction.
b. Selection of a site large enough to provide for parking and future expansion, and readily accessible to water and sewage lines and to population concentrations through highways, rail, rapid transit, or bus lines.
c. Determination of facility size appropriate to the projected service demands of the service area and of departmental areas large enough to provide the diagnostic and treatment services required by the medical staff on an emergency and day-to-day basis.
d. Recognition of the importance of establishing convenient traffic patterns, both within and without the facility, for movement of physicians, hospital staff, patients, and visitors, and for efficient transportation of food, laundry, drugs and other supplies.
e. An architectural design that will permit efficient use of personnel; place departments with complementary activities conveniently together; anticipate future departmental expansion; provide privacy, flexibility, and dayroom areas and adequate work space on patient units; provide interchangeability of patient rooms for clincial departments with fluctuating census; and to the greatest extent possible provide repetitive facilities in work areas.
f. Adequate attention to important concepts such as infection control, disaster planning, use of services by ambulatory inpatients as well as outpatients, intensive and extended (restorative) care units, and all other community based programs.

The planning and feasibility study will be performed by the Jicarilla Apache Tribe through its existing health board, program staff and consultant services. Assistance and support will be solicited from the Indian Health Service, the New Mexico Intertribal Health Authority, the New Mexico Health Systems Agency and other related organizations.

SERVICE DELIVERY

Indian government requires that ultimate control be in the hands of Indian people. Responsibility and authority for tribal health is charged to the tribal council and its chairman. Overall program coordination will be determined by the chairman, council and Jicarilla health board (see Exhibit B). The health services will be integrated to form a health delivery system with the Jicarilla Comprehensive Community Health Center as the base facility.

To provide inpatient services for the Indian community will be one of the main functions of the center. Data which follows projects that 25 beds with an average daily patient load of 12 will be needed to provide hospital services for the community in 1986. Major surgery will not be performed at the Dulce facility. The U.S.P.H.S. Indian Hospital at Santa Fe, New Mexico and various contract facilities in the Albuquerque Area will provide surgical services for this population. Outpatient services will be a major component of the Dulce Comprehensive Community Health Center. The facility is expected to handle 16,000 visits in 1986.

Other service areas to be expanded or developed include, but are not limited to the following:

Dental Health: The dental team will provide care including emergency services, preventative services with special emphasis on children, and therapeutic care for dental disease, which if left untreated may become acute, irreversible causes for loss of teeth.

Contract Medical Care: A program using private health facilities and providers will give needed services not available within the Indian Health program. Unusual medical and surgical diagnostic and therapeutic problems and physical rehabilitation are types of cases that would be referred to contract facilities.

Mental Health, Alcoholism, Substance Abuse: Alcoholism, substance abuse and related health problems adversely affect more aspects of Indian life than any other health problem, with most accidents, homocides, assaults, and suicide attempts being associated with drinking. Early detection, and treatment of this problem will substantially reduce the medical workload therefore, these programs will be integrated and expanded to offer a comprehensive approach to these problems.

Maternal and Child Health: The physician extender, physician and community outreach workers will educate Indian mothers on the value of prenatal, postpartum and well-baby care, develop programs for Maternal Child Health which are accessible to Indian mothers and infants which overcome transportation problems; and follow-up mothers to encourage them to receive scheduled Maternal Child Health services and integrate services provided by the WIC Program.

Otitis Media: (Disease of the middle ear) The total health team will obtain data on the extent of the disease on restorative and rehabilitative backlog; systematically screen for early detection and screening; establish educational programs for increasing awareness of the disease and the need for early treatment; and treat all cases requiring correction.

Eye Care Services: Clinic staff will provide initial screening for glaucoma and related diseases of the eye and correction of refractive error; provide for referral to specialty care; maintain an eyeglass program with the primary emphasis on school-age children.

Environmental Health: An Environmental Health Program will develop procedures for determining the tribes capabilities for operating and maintaining water and sanitation systems: and collect data to determine the amount of service needed.

Diabetes and Hypertensive Screenings and Control: The entire medical and outreach staff will make a special effort to screen, educate and control the adult population for diabetes and hypertension, placing special emphasis on the nutritional methods of controlling these problems.

Field Health Program: To include a school health program, health education, public health nursing, social services, nutrition, psychiatric, and environmental health services, will be included as part of

the comprehensive health services. The staff will be based at the center and will extend services into homes, schools, and other parts of the community.

Staffing patterns, operational quidelines, equipment lists and the formation of the Jicarilla health care delivery system will be the second major task of this proposed program.

ESTIMATED COST*

PROPOSED DULCE COMPREHENSIVE
COMMUNITY HEALTH CENTER

1. New Hospital Construction Costs
   (Based on IHS Construction Costs
   dated April 15, 1976) — $115.85/g.s.f.

2. Number of beds in facility
   (15 beds + 10 Multi-purpose beds) — 25 beds

3. Estimated Gross Square Feet/bed — 2200 g.s.f.
   NOTE: This is an estimate only, exact g.s.f./bed would be determined in development of Program of Requirements based on RAC document.

4. Total gross square feet = 25 beds x 2200 g.s.f. = 55,000 g.s.f.

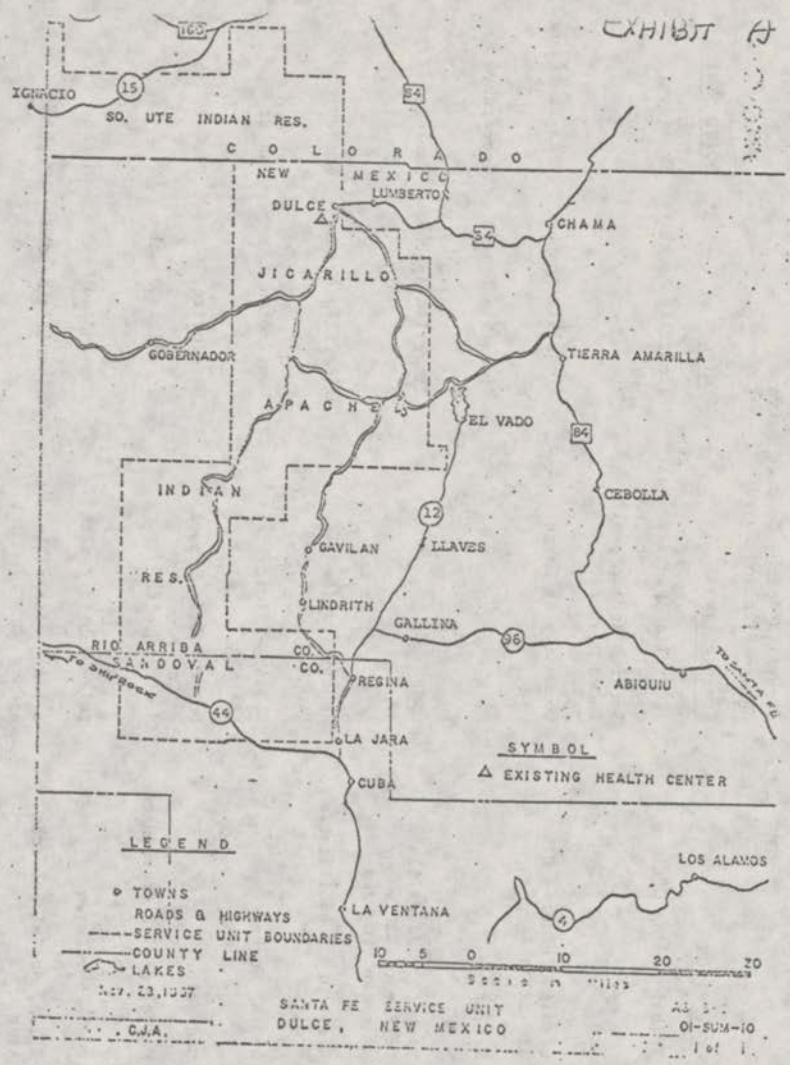
5. Estimated Cost for Facility

a.	55,000 g.s.f. x $115.85/g.s.f.	$6,371,750
b.	Feasibility Study	150,000
c.	Planning & Design (10%)	637,175
d.	Equipment Group II & III (17% of Construction Costs)	1,083,198
	TOTAL	$8,242,123

USE $8,245,000

* Prepared by Albuquerque Area IHS

EXHIBIT A


IGNACIO
SO. UTE INDIAN RES.
COLORADO
NEW MEXICO
DULCE
LUMBERTO
CHAMA
JICARILLO
GOBERNADOR
TIERRA AMARILLA
APACHE
EL VADO
INDIAN
RES.
CEBOLLA
GAVILAN
LLAVES
LINDRITH
GALLINA
RIO ARRIBA CO.
SANDOVAL CO.
REGINA
ABIQUIU
LA JARA
CUBA
SYMBOL
EXISTING HEALTH CENTER
LEGEND
TOWNS
ROADS & HIGHWAYS
SERVICE UNIT BOUNDARIES
COUNTY LINE
LAKES
LOS ALAMOS
LA VENTANA
SANTA FE SERVICE UNIT
DULCE, NEW MEXICO
C.J.A.
ATTACHMENT II

MEMb HIP: Jicarilla Apache Compreh sive Health Planning Board

NAME	OCCUPATION	REPRESENTING	TRIBE	BOARD STATUS
dward Vicenti	Tribal Zoning Officer	Jicarilla Apache-Tribal Councilman; Santa Fe Service Indian Health Board Member	Jicarilla Apache	President
ubert Velarde	Credit Officer - BIA Jicarilla Agency	Community at Large	Jicarilla Apache	Vice-President
udith Williams	Secretary	C. H. R.	Jicarilla Apache	Secretary
e Martinez Jr.	Director, Jicarilla Office of Native American Programs	ONAP	Jicarilla Apache	Member
urice Sandoval	Director, Rehabilitation Program	Rehabilitation Program	Jicarilla Apache	Member
lliam Covington	Social Worker	B.I.A. - Jicarilla Agency	Non-Indian	Member
rolyn TeCube	Counselor	Dulce Public School	Non-Indian	Member
olet Garcia	Mental Health Coordinator	Mental Health	Jicarilla Apache	Member
. Tom Holley	PHS - Physician	Dulce Public Health	Non-Indian	Member
se Vicenti	B.I.A. Social Services Aide	B.I.A. - Jicarilla Agency	Jicarilla Apache	Member

NAME	OCCUPATION	REPRESENTING	TRIBE	BOARD STATUS
Larry Panzy	Auto Mechanic	Jicarilla Apache Tribal Council	Jicarilla Apache	Alternate
Lolita Cassador	Secretary, ONAP	ONAP	Jicarilla Apache	Alternate
Juanita Tiznado	Rehabilitation Counselor	Jicarilla Apache Alcoholism Program	Pueblo	Alternate
Sam Montoya	Administrative Assistant	B.I.A. - Jicarilla Agency	Pueblo	Alternate
Tom Edmister	Elementary School Counselor	Dulce Public Schools	Non-Indian	Alternate
Isabel Callado	Mental Health Program Trainee	Mental Health Program	Navajo	Alternate
Myra Sandoval	Program Director, CHR	C. H. R.	Jicarilla Apache	Alternate
Lance Lewis	Community Health Medic	Dulce Public Clinic	Pima	Alternate
Earl Monarco	Driver, Senior Citizen, Emergency Tech.	Community at Large	Jicarilla Apache	Alternate

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
Dulce Health Center
Dulce, New Mexico 87528

Dr. Emery Johnson, Director
Indian Health Service
Department of Health Education & Welfare
Public Health Service
Health Services Administration
Rockville, Maryland 20852

Dear Dr. Johnson:

The Dulce Public Health Service Field Clinic concurs wholeheartedly with the Jicarilla Apache Tribe's proposal for a "Comprehensive Community Health Center Facility". The staff of the Dulce PHS Clinic has been involved with the Jicarilla Apache Comprehensive Health Planning Board on the planning phases for the aforementioned health facility proposal. Therefore, we have had the opportunity to review the proposal and make comments accordingly.

One of the major hindrances to adequate health care for the Jicarilla Apache Tribe is the geographical isolation of the Jicarilla Apache Reservation from major cities with hospital facilities. The proposed Comprehensive Community Health Center facility will alleviate the aforementioned problem via the on-site health center facility and its attendant staffing and health care delivery system.

Sincerely,

Lance Lewis CHM (PA)
Lance Lewis, CHM
Acting Indian Health Center Director

THE JICARILLA APACHE TRIBE
P. O. BOX 147 • DULCE, NEW MEXICO 87528

Jicarilla Rehabilitation Program
P.O. Box 145
Dulce, New Mexico 87528
March 31, 1977

TO WHOM IT MAY CONCERN:

On behalf of the Jicarilla Apache Rehabilitation Program, a grassroot down-to-earth program, that works and deals with alcoholism and Alcohol Abuse No. 1 Indian health problem in the United States, we have been trying to bring to the attention of the IHS and other federal agencies at National, Regional, State, County and various local meetings or conferences, that there is a great Need for a Comprehensive Community Health Center at Dulce, New Mexico or nearby. The people from the community of Dulce chances of survival are very slim because of the geographical isolated area and lack of facilities.

The Need for Comprehensive Community Health Center has already been brought to IHS, NIAAA, HSSD, LEAA, Senatorial and Congressional delegate's attention many times and now the Jicarilla Rehabilitation Program are grateful and happy to see a realistic proposal materialized.

Mescelero Apache Tribe, Zuni Pueblo, Acoma Laguna Pueblo, San Carlos Apache Tribe, White River Apache Tribe and many Indian tribes throughout the country have a Community Health Center in their community so there is no reason for the Jicarilla Apache Tribe being denied and deprived of a Community Health Center.

Sincerely,

Maurice E. Sandoval, Director

IN REPLY REFER TO:

United States Department of the Interior Administration
BUREAU OF INDIAN AFFAIRS
JICARILLA AGENCY
DULCE, NEW MEXICO 87528

April 12, 1977

Mr. Dale Vigil, Acting President
Jicarilla Apache Tribe
Post Office Box 147
Dulce, New Mexico 87528

Dear President Vigil:

It is my understanding that the Jicarilla Apache Tribe has organized the Jicarilla Apache Comprehensive Health Board and one of its prime objective is to have a hospital and health center constructed here on the Reservation.

This letter is to assure you of my wholehearted support in getting this project accomplished and if I can be of service in anyway please let me know.

Again, best wishes on this worthwhile endeavor.

Sincerely,

(Acting) Superintendent

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

JICARILLA APACHE TRIBE
CHR PROGRAM
DULCE NEW MEXICO 87528

April 13, 1977

Dr. Emery Johnson, Director
Indian Health Service
Dept. of Health, Education & Welfare
Public Health Service
Health Services Administration
Rockville, Maryland 20852

Dear Dr. Johnson:

The Jicarilla Apache Community Health Representative Program since its initiation in 1971 has realized the need for expansion of medical services and facilities for residents of the Jicarilla Apache Indian Reservation. Therefore, the Jicarilla Apache CHR Program renders its full support to the Jicarilla Apache Tribe's proposal for a Comprehensive Community Health Center Facility. By virtue of our program's membership on the Jicarilla Apache Comprehensive Health Planning Board, the CHR Program has had the opportunity for input and comment on the aforementioned proposal and our experience parallels the need for the proposed health center facility as cited in the proposal.

A major role of the Jicarilla Apache Community Health Representative Program has been the transportation of patients to and from various medical treatment centers. Our experience to date in this endeavor documents the fact that Dulce (the Jicarilla Apache Reservation) is extremely isolated from major cities with hospital facilities. The transportation problem (of medical patients) becomes extremely acute during the winter months when adverse weather and inclement road conditions prolongs the time required to transport patients to hospital centers. The proposed comprehensive community health center facility will alleviate the "transportation" problem somewhat and insure that residents of the Jicarilla Apache Reservation will obtain adequate health care, especially during obstetrical and emergency medical situations.

Your support of the proposed comprehensive community health center facility proposal is solicited.

Sincerely yours,

Myra Sandoval

Myra Sandoval
Director
Community Health Representative Program

MS/lc

Santa Fe Service Unit
Indian Health Board
Santa Fe PHS Indian Hospital
Field Health Building
Santa Fe, New Mexico 87501
(505) 982-1838, 1837

Representing:

Cochiti Pueblo	Santa Clara Pueblo
Nambe Pueblo	Santo Domingo Pueblo
Picuris Pueblo	Taos Pueblo
Pojoaque Pueblo	Tesuque Pueblo
San Felipe Pueblo	Jicarilla Apache Tribe
San Ildefonso Pueblo	Southern Ute Tribe
San Juan Pueblo	Ute Mountain Ute Tribe

April 1, 1977

Dr. Emery A. Johnson, M.D.
Director, Indian Health Service
Public Health Service
Rockville, Maryland 20852

Dear Dr. Johnson:

The Santa Fe Service Unit Indian Health Board is in complete agreement with the very urgent health needs of the Jicarilla Apache Tribe. The very fact that they are located in a very remote area without a good health care facility qualifies the tribe for a comprehensive health center. As you will note in their request the distance to the nearby hospital facilities is 80 miles to 190 miles which is an extreme hardship on the tribal members in times of serious illness or emergency.

Therefore, the board is in full support of the Jicarilla Apache tribe's proposal for a "Comprehensive Health Center." We realize that this is the only way to make outstanding health care available to this very remote Indian Community. We ask you to make every effort getting this proposal funded.

All positive actions taken on this important matter shall be very much appreciated.

Thank you.

Sincerely yours,

Wilfred Madrid
Chairman
Santa Fe Service Unit Indian Health Board

cc: Dr. Pintz

JICARILLA APACHE TRIBE
NATIVE AMERICAN PROGRAM

BOX 272
DULCE, NEW MEXICO 87528

TELEPHONE 505 - 759-3493

EXECUTIVE DIRECTOR
LEE MARTINEZ, JR.

April 7, 1977

Dr. Emery A. Johnson, M.D.
Director, Indian Health Services
Public Health Service
Rockville, Maryland 20852

Dear Dr. Johnson:

The Jicarilla Apache Office of Native American Programs wholeheartedly supports the Jicarilla Apache Tribe's proposal for a comprehensive community health facility (hospital). The Jicarilla Apache ONAP (formerly the Community Action Program) has assisted the Jicarilla Apache Tribe in its endeavors since 1967 to secure funding for a hospital facility and expanded medical services for residents of the Jicarilla Apache Indian Reservation. The need for the hospital facility has become more acute with the passage of time because the population of the Jicarilla Apache Tribe continues to increase yearly.

The primary hindrance to adequate quality health care has been the isolation of Dulce and the Jicarilla Apache Reservation from major cities with hospital facilities. The closest hospital is San Juan Hospital in Farmington, New Mexico which is 94 miles distant. During emergency medical situations the isolation factor to hospital centers becomes extremely acute (especially during the winter months) and many patients have died enroute to hospitals.

Your support of the Jicarilla Apache Tribe's Comprehensive Community Health Facility Proposal will be sincerely appreciated.

Respectfully,

Lee Martinez Jr.

Lee Martinez, Jr.
ONAP Executive Director

LMJ/lc

THE JICARILLA APACHE TRIBE
P. O. BOX 147 • DULCE, NEW MEXICO 87528

BY-LAWS OF THE
JICARILLA APACHE COMPREHENSIVE HEALTH
PLANNING BOARD

ARTICLE I: NAME

The board shall be called the Jicarilla Apache Comprehensive Health Planning Board.

ARTICLE II: PURPOSE

The purpose of the Jicarilla Apache Comprehensive Health Planning Board is to ascertain community health needs, plan for, and implement programs to meet said health needs as directed and delegated to the board by the Jicarilla Apache Tribal Council.

ARTICLE III: MEMBERS

Membership shall be open to any resident of the Jicarilla Apache Reservation who have evidenced a strong interest in improving the health of the Jicarilla Apache Reservation and who are approved for membership on the aforementioned board by the Jicarilla Apache Tribal Council.

The membership on the board shall consist of 1 member and 1 alternate from the following community organizations and agencies.

1. Jicarilla Apache Tribal Council
2. Jicarilla Apache Office of Native American Programs.
3. Jicarilla Apache Alcoholism Rehabilitation Programs
4. Jicarilla Agency -- Bureau of Indian Affairs
5. Indian Health Service Clinic - Dulce
6. Dulce Public Schools
7. Jicarilla Apache Mental Health Training Program
8. Jicarilla Apache Community Health Representative Program
9. Representative @ Large
10. Representative @ Large

Term of Office - The members from the following agencies shall serve two-year terms: Jicarilla Apache Tribal Council, ONAP, BIA, IHS, and the Jicarilla Apache Mental Health Training Program. The following members shall serve 4-year terms: Jicarilla Apache Alcoholism and Rehabilitation Program, Dulce Public Schools, Jicarilla Apache Community Health Representative Program, and the Representatives @ Large. Upon completion of the specified term of service, the Jicarilla Tribal Council can reappoint the members whose terms have expired, if they so desire, to unlimited successive terms.

Voting Priviledges - Each members shall be entitle to vote at each and every meeting of the board but there shall be no voting by proxy, by mail, or by absentee ballot. Only confirmed alternates (as approved by the Tribal Council) shall have voting priviledges at board meetings should the regular board member no be albe to attend the meeting. The President of the Jicarilla Apache Tribal shall serve in an Ex-officio capacity.

ARTICLE IV: QUORUM

Five voting members shall constitute a quorum.

ARTICLE V: VACANCIES

When a board position (or alternate) becomes vacant, the board shall place three names in nomination to fill the vacancy(ies). The person(s) filling the vacancy(ies) shall serve out the unexpired term of any vancancy(ies).

ARTICLE VI: OFFICERS

The officers of the board shall be a president, Vice-President, and a Secretary. The President shall conduct meetings, attest the minutes, and see that the Board carries duties as delegated by the Tribal Council.

The Vice-President shall take the place of the President in his absence of the President and Vice-President, the Secretary shall conduct all business meetings and other relevant business matters of the board.

Officers shall be elected annually at the February Meeting and shall hold office for two years - for no more than three consecutive terms.

Election of the board officers shall take place by secret ballot.

ARTICLE VII: COMMITTEES

The President shall be empowered to appoint any committee within the board deemed necessary by the Jicarilla Apache Comprehensive Health Planning Board and shall limit the tenure of the appointed committee(s) to specified tasks and/or duration.

ARTICLE VIII: MEETINGS

The board shall meet quarterly at a time and place to be specified by the board.

Special meetings may be called by any of the board's officers.

ARTICLE IX: AMENDMENTS

The Jicarilla Apache Comprehensive Health Planning Board may adopt, alter, amend, or repeal the By-Laws of the Board for the regulation of its internal affaris not in consistent with the Articles and with the proviso that any amendment(s) to the By-Laws are approved by the Jicarilla Apache Tribal Council.

INCIDENTS RELATING PERSONAL HARDSHIP CASES

Obstetrics Patient

On June 30, 1976 Judy Williams, Fern Vicenti and Nelson Lucero (Emergency Medical Technicians) were notified at 7:55 p.m. that a 23 year old female obstetrics patient needed to be transported to the Farmington, New Mexico San Juan Hospital. Mr. Lance Lewis, Community Health Medic, was also notified and he likewise attended to the call.

At 8:30 p.m. the EMT's departed for Farmington which is approximately 90 miles distant from Dulce, Shortly after de-- parting, the frequency of the patient's labor contractions be- came shorter and more frequent. The EMT's had to deliver the patient's baby enroute by Governador, New Mexico which is 40 miles distant from Dulce. The delivery was normal and they proceeded on to the San Juan Hospital in Farmington. The attending EMT's and the patient arrived at the hospital at 11:00 p.m.

It should be noted that the obstetrics patient had to be taken to the San Juan Hospital (90 miles distant) because the Dulce Indian Health Service Clinic is not adequately equipped to handle child delivery cases. This is a frequent occurrence to members of the Jicarilla Apache Tribe. During the Winter months the transportation problem for obstetrics patients be- comes more acute. The time required to transport obstetrics patients to hospitals becomes longer due to adverse weather

and road conditions. Therefore, the frequency of babies delivered enroute to hospitals (during winter months) increases accordingly.

Auto Accident Patients

Emergency Medical Technicians Judy Williams and Fern Vicenti received notification at approximately 5:00 p.m. on July 15, 1976 that an auto accident involving two males (approximate age-28) had occurred 8 miles south of Dulce on U.S. Highway 64. Dr. Tom Holley-M.D. and Lance Lewis, Community Health Medic, of the Dulce IHS Clinic were also notified of the auto accident and the need for their medical services and they responded accordingly.

Due to the inavailability of an ambulance, the Jicarilla Apache Tribal Police Department, by necessity, had to transport the two patients to the Dulce IHS Clinic in a police van. The police van arrived at the Dulce IHS Clinic at 6:00 p.m. Dr. Tom Holley and Gary Lawlwss, the Dulce IHS Clinic Pharmacist, rendered emergency medical treatment to the two male patients upon their arrival at the clinic. The auto accident patients were treated for head and facial injuries, neck injuries, body lacerations, and suspected internal injuries.

After the initial emergency medical treatment that was given at the Dulce IHS Clinic, the patients were transported in the clinic van (left at approximately 6:30 p.m.) to San Juan Hospital in Farmington, New Mexico.

It should be mentioned that on the same day an explosion occurred at the Tribe's Stone Lake Lodge Resort whereby two persons were burned with 2nd degree burns on the arms and face. The accident at the lodge diverted the resources of the Dulce IHS Clinic (likewise the services of some EMT's) to the lodge since the explosion occurred at 11:30 a.m.

The occurrence of two major accidents on the same day put a great burden on the available resources of the Dulce IHS Clinic. The occurrences of July 15, 1976 made the Dulce Community more acutely aware of the need for expanded medical facilities and services for the Jicarilla Apache Reservation and surrounding communities.

Internal Hemorrhage Patient

On December 31, 1976 Emergency Medical Technicians (Fern, Edward and Bill Vicenti) were called at 3:45 p.m. to respond to a case involving internal hemorrhage on a 49 year old female patient. The patient was transported to the Dulce IHS Clinic by the Jicarilla Apache Police Department. Dr. Tom Holley, Dulce IHS Clinic Physician, and Lance Lewis, Community Health Medic, were not available to render medical treatment to the patient. Therefore on the mentioned day the Dulce IHS Clinic did not have the services of a physician or a medic.

Since there was not a physician available to render emergency medical treatment at the time, the EMT's departed in an EMT ambulance at approximately 4:10 p.m. for the nearest clinic

with an available M.D. which happened to be La Clinica in Tierra Amarilla (40 miles distant).

Due to the severity of the internal hemorrhaging in the patient, the patient was pronounced dead on arrival at 5:00 p.m. in Tierra Amarilla by the physician at La Clinica.

The most evident point to be concerned with in this instance is the lack of a physician who could have rendered emergency medical treatment on-site in Dulce. This incident likewise made Dulce residents acutely aware of the need for expanded medical services and facilities to serve the isolated Dulce community.

Cardiac Arrest Patient

On February 19, 1977 EMT's Phyllis Velarde and Bill Vicenti were called at 5:30 p.m. to transport an elderly female patient (approximate age - 60) to the Dulce IHS Clinic for possible cardiac arrest. The patient was given emergency medical treatment at the Dulce IHS Clinic by Dr. Tom Holley, M.D.

The cardiac arrest patient was then transported to the San Juan Hospital in Farmington, New Mexico by the aforementioned EMT's in the EMT ambulance.

The cardiac arrest patient was a non-Indian who, due to the emergency medical situation, was given emergency treatment at the Dulce Indian Health Service Clinic prior to her transfer to the San Juan Hospital in Farmington. The Dulce IHS Clinic,

in accordance with Public Health Service regulations will render emergency medical treatment as needed to non-Indians.

Emergency medical services to non-Indians becomes more frequent during the summer months when tourists visit the Jicarilla Apache Indian Reservation.

Senator Kennedy,

I wish it were possible for me to talk with you. I teach 2nd Grade and am not free to attend the meeting. I probabally would not speak up anyway in front of all those people. I have always been extremely interested in the welfare of my people - especially those who are not at the meetings, and are not the ones being heard at the meetings.

One of the best things that we have is Contract Medical Care. Indians who are sick or who need Medical Care and a Doctor can go to good Doctors and to Specialists if necessary and the (PHS Indian) pays for this. Sometimes it is hard to get them to approve and to pay and you need to do a lot of running around and must be able to speak up to get it. but this is a service that is very good and worth while. When a member of our family or a friend or relative we want the best medical care available — With this Contract

Health Medical Care - This is possible. PHS Hospitals and Doctors are not the choice of people who can afford a good Doctor ~~and~~ except for minor Health services but when a person is really sick they want to have the best available and that is not PHS Indian Health. We need trained professional people. If it was easier for people to get the Contract services it would be encouraging. This service is appreciated and most beneficial to the Indian people.

I am sorry that your time is so short. I hope you can have time to read this and also that you may return some day to visit. Education is another important matter that needs attention.

Most Sincerely

Louise A. Chewiwi
Isleta Pueblo

Address
Rt 6 Box 590-A
Albuquerque - N.M.
on Highway outside of Pueblo

Senator KENNEDY. Thank you very much. [Applause.]

[Whereupon, the hearing in the above-entitled matter was adjourned.]

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