1979

An Evaluation of the Albuquerque Area Indian Health Service Optometric Services Provided to 19 Pueblo Indian Communities

All Indian Pueblo Council, Inc., New Mexico Inter-tribal Health Authority, Eye Care Evaluation Project.

JL. Toya

KL. Reid

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FINAL REPORT

EVALUATION OF THE ALBUQUERQUE AREA
INDIAN HEALTH SERVICE OPTOMETRIC SERVICES
PROVIDED TO 19 PUEBLO INDIAN
COMMUNITIES

ALL INDIAN PUEBLO COUNCIL, INC.
1015 Indian School Rd. N.W.
P.O. Box 6507
Albuquerque, New Mexico 87107
FINAL REPORT

EVALUATION OF THE ALBUQUERQUE AREA
INDIAN HEALTH SERVICE OPTOMETRIC SERVICES
PROVIDED TO 19 PUEBLO INDIAN
COMMUNITIES

Prepared by the
All Indian Pueblo Council, Inc.,
New Mexico Intertribal Health Authority
Eye Care Evaluation Project
1015 Indian School Road, N.W.
Albuquerque, New Mexico 87197

James L. Toya, Executive Director, N.M.I.H.A.
Ken L. Reid, Project Director

Consultant/Project Staff:

Joseph Duffy, O.D.
Jerome Bettman, O.D.P.
Irma Woody
Sara Taylor

February 6, 1979
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ACKNOWLEDGEMENTS

This final report is the end product of a consumer evaluation of Eye Care Services provided to the Pueblo people of New Mexico by the Indian Health Service (IHS). It was a joint effort by tribal members, health staff and tribal leaders. Without this cooperation, the review and consequent analysis and recommendations, would not be genuine.

Contributors of time, advise and patience are:

Pueblo Health Departments
IHS Optometric Clinic Staff - Albuquerque Area
IHS Headquarters - Optometric Health Service Branch:
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   Siu Wong, O.D.
American Optometric Association:
   Alice Martin
University of New Mexico School of Medicine
IHS Area Statistics and Planning Branch

Finally, we the project staff wish to acknowledge the Pueblo Governors and Councils for the continuous interest in the development of improved and expanded health services for our people.

All Indian Pueblo Council, Inc.
New Mexico Intertribal Health Authority

This Project was carried out under Contract 242-77-C-0524, U.S. Department of Health, Education, and Welfare, Public Health Service Indian Health Service, Albuquerque Area
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Practitioners and Research Optometrists who have examined large numbers of American Indian people, often report that a surprisingly large number of Native Americans overwhelmingly have a larger visual acuity problem than Caucasian people. In an article by the University of Houston for example, the statement was made that American Indians show a high incidence of various ocular abnormalities. Trachoma, retinoblastoma, phakomorphic angle-closer glaucoma, and iridocyclitis associated with the active pulmonary tuberculosis occur more frequently in Indians than in the general population. In as much as such reports tend to almost always involve selected patients, there is a need for controlled comprehensive study involving the consumers as key research evaluators. Although this evaluation project was not designed to assess the epidemiological effects of our Pueblo people, it has warranted the effects of services as perceived by the consumers.

Peer review has been the trend in evaluation of health service programs. However, a different echelon of evaluation utilizing the recipients of services, was utilized in this project. Uniquely, the review also included assessments of the optometrists with the IHS system. This methodology allowed the project staff to analyze the information within the context of the Indian Health Service system as specifically serving a defined population.

During the month of January 1978, the New Mexico Intertribal Health Authority, a Division of Health of the All Indian Pueblo Council, began the evaluation of the eye care services under a contract from the Indian Health Service. This was the beginning of a six-phase evaluation project designed to assess and delineate the level of optometric health care provided, and define ways to improve the eye care status of our Pueblo people within realistic funding constraints. The six-phase objectives of study were:
1 - 2 Months: Planning - Orientation Phase

Assemble Evaluation Team
Review purpose and objectives
Establish procedures and communications
Orientate tribal leaders and associated staff
Make professional contracts

3 - 4 Months: Development Phase

Develop strategy for meeting objectives
Establish work assignments
Coordinate consultant services
Schedule study site visits
Design alternate service evaluation models
Coordinate plan with tribal leaders

5 - 6 Months: Implementation Phase

Collect service delivery information
Literature search
On-site assessment
Compile demographic and optometric statistics
Report to tribal leaders

7 - 9 Months: Study and Analysis Phase

Review and analyze information
Collate and review literature
Biostatistical analysis of service data
Develop alternate service delivery models
Develop recommendations
Identify priorities

The tradition and culture of Pueblo Indians has remained strong. This was taken into close consideration during all phases of the evaluation. Particularly, when operations of optometry clinics conflict with tribal activities. This will be identified in later sections. The Albuquerque Area Indian Health Service also serves a non-Pueblo population. These Indian populations are located within the boundaries of the State of New Mexico/Colorado with the same optometric problems within their communities. The tradition and cultural ties of these communities, in relations to the provision of health care, is unknown to our project staff, and not within
the scope/intent of our contract. Further, the IHS is allocated resources to serve all Indians within the Area. Pueblo specific data was not readily available and was recomputed from Area wide statistics.

The Eye Care Evaluation Project staff, while conducting a comprehensive assessment of Indian Health Service Optometry Programs, coordinated the study with each community, their tribal council and governor (Pueblo Specific).

The general level of optometric health services is of a primary concern in the evaluation, as well as any trends in the eye care level of the Pueblo Indian population. It is also important to make comparisons of the level to that of the remainder of the New Mexico and U.S. population. However, some data and comparative information was available.

The optometric profession has become acutely aware of an ever increasing demand for its services throughout the nineteen Pueblo Indian communities. This demand has been created by substantial Indian population increases, coupled with emerging public information and recognition of optometric services as an important health measure.

The level of studies, surveys and research projects conducted within the field of optometry and relative medical/surgical services, have been limited in scope and intent towards the American Indian populations. The major objectives of this project focused on the provision of quality, comprehensive optometric care. Primary to the development of comprehensive services as provided to general American Public, which embraces conditions beyond the eye health (general and ocular disease), the refraction status (for clearness) and adequate functioning for comfort, (single binocular vision), and includes such conditions as low vision, aniseikonia, etc.
I. OVERVIEW: Eye Care, The Results of a Consumer Orientated Evaluation

The era of self-determination policy has facilitated the initiatives of the Pueblo Tribes to review and assess the health services provided by the Federal Government. Designated and designed as a consumer evaluation, this project to "Evaluate Albuquerque Area Indian Health Service Optometric Services provided to the Nineteen (19) Pueblo Tribes," highlights the common problems and barriers to eye care services, outlines consumer needs and wants; and, recommends alternative solutions.

Participation by Pueblo people as consumers of eye care services; including tribal leaders, community service providers and non-participants in the IHS service programs, provided community perceptions of eye care services provided and desired.

Participation by IHS Optometric staff and related professional organizations, as providers of eye care services, provided extent and content of services provided as well as the availability of alternate resources.

Indian tribes throughout the nation today are subject to Medical/Health Services as provided by the Public Health Service, Indian Health Service. This agency as the primary provider of health care, is in turn subject to resource allocations made by Congress. In view of this fact, the field of optometric health care is considered as a secondary life threatening service, as opposed to the primary medical delivery component such as treatment of disease, surgery, general medical services and others. Although eye care has not been recognized as a routinely life saving service, it is still considered to be essential for cognitive achievements, cultural preservation, general learning abilities, and well-being of our people.
More importantly, it would include visual functions and conditions that affect learning, (conception, preschool, school-age and beyond), earning (after school age), and cultural, social or traditional avocation and recreation. Further, it includes detection of conditions which signal beginning or developing eye and vision problems, and provision of regimens of care to protect them. It includes the development and enhancement of visual abilities for the purpose of improving patients' visual information processing. It includes the recognition, compliance and respect towards the Indian populations, with their definition and interwoven levels of cultural medicine.

Because it is difficult for these objectives and goals to become a reality within our Indian populations, only strategies for assessment and planning were carefully prepared. The evaluation format, timing, and design was developed to focus on several key levels. These levels have been based on the nationally recognized incremental optometric program. This program places specific interest and management guides in systematically controlling a comprehensive operation of health care.

A. Management  E. Disease Occurrence Rates
B. Planning      F. Patient Responsiveness
C. Patient Utilization Rates   G. Effectiveness
D. Accessibility     H. Efficiency

The following section, address the end-results of the evaluation project.
II. BACKGROUND

A. General Information of the Tribes

The Nineteen (19) Pueblo Indian communities exist as sovereign entities within the State of New Mexico. Pueblo tribes are recognized as autonomous governments with separate councils, administrations and leaders. Since the European inquisition, in the years 1100-1200 A.D., the Pueblo people have been living in peaceful, settled communities. They continue in existence today in much the same manner. Their society and rights of individuals are protected by an organized system of government.

The native language is still spoken with five distinctive dialects. The Pueblo tribes separated by these language dialects are as follows:

Taos
Picuris .................................. Tiwa Dialect

Nambe                         Santa Clara
Pojoaque                       Tesuque ...................... Tewa Dialect
San Ildefonso                  San Juan

The Southern Pueblos are the following:

Jemez .................................... Towa Dialect

Cochiti                        Zia
San Felipe                     Santa Ana ............... Keresan Dialect
Santo Domingo                 

Sandia
Isleta .................................. Tiwa Dialect

Acoma
Laguna .................................. Western Keresan Dialect

Zuni .................................... Zunian Dialect

Many of the Pueblos are living in the same place where the Spaniards found them in the 16th Century. The Spaniards attempted to convert the Indians to Roman Catholicism. The Pueblos held true to their traditional
beliefs; and, thoughts of their religion being taken away, brought fear upon them. They took their religion underground around the year 1692. Cultural medicine was strong, and practiced daily with the traditional way of life. This harmonized the true feeling of well-being through interactions with mother nature.

However, sudden bursts of illness and disease were spread throughout the Indian country, this provoked cultural medicine and healing practices. Diseases known as smallpox, chickenpox, measles, and others, were introduced by Spanish settlers, and exploration parties. Time progressed with increasing morbidity and mortality rates, the result of contagious diseases and increased warfare with non-Pueblo tribes.

As a basic protection for soldiers, health services for American Indians began in the early 1800's when Army physicians took steps to curb smallpox and other contagious diseases. Tribes living near military posts and camps were of the primary concern. Treaties committing the federal government to provide health services were introduced in 1832 when a group of Winnebagos in the Midwest were promised medical care as partial payment for rights and property ceded to the government. Of almost 400 treaties negotiated with Indian tribes from 1778 to 1871, about two dozen provided for some kind of medical service. Although most treaties imposed time limits of 5 to 20 years for provision of care, the federal government adopted a policy of continuing services after the original benefit period expired.

Today, congressional measures are still initiated to limit the magnitude and extent of medical services to Indian people. The new Contract Health Care Regulations of 1978, places a geographical boundary on all Indian people for determination of eligibility for contract (private resources under contract
to the IHS) medical services. Medical care is provided to Urban Indians only in emergency cases. Optometric health services which is severely underfunded, less recognized, and minimally supported is another variable which affects the "comprehensiveness" of health care available.

B. The Optometric Program

In this modern technological society it is imperative that every child and adult have good vision and ocular health. A child's visual system and ocular health must be adequate to develop his/her potential learning capabilities; the adult requires good visual health to be productive and successful in his/her work and life, and the elderly require good vision and ocular health to overcome barriers associated with old age and changing lifestyle.

The Optometry Program within the Albuquerque Area Indian Health Service, is a fairly new service within the delivery system. Optometric services were established in 1967. Since then, services have expanded in direct proportion to resources allocated to the program. The present goal of the program is "the state where no vision or eye condition exists which adversely affects the academic, vocational, professional, physiological well-being of a person." This goal is to be achieved through the following objectives:

1). To provide quality, comprehensive care on a regular basis. This care should be geographically and economically be available to all recipients;

2). To detect and prevent vision anomalies as early as possible in life;

3). To provide maintenance professional vision services to all people who desire it;

4). To encourage the assistance of the Indian people to develop an optometric program to meet their needs;
5). To encourage active participation and understanding of the vision care provided by the optometry staff, vision health education will be promoted; and,

6). To assure that no person is denied care due to the inability to pay.

Activities to achieve these objectives are implemented, through a coordinated approach by the Albuquerque Area Optometric and tribal communities. These activities are:

a). Preschool: Examination of children (0-4 years) prior to entering school. Problems such as amblyopia or other ocular anomalies could be readily treated if identified early. The program should be coordinated with appropriate personnel.

b). Headstart and kindergarten students: There should be an annual screening of all children and referral to the optometrist if further treatment is warranted. The parent should be with the child for the examination, as parental understanding of the child's problem is important for patient compliance. These students, along with the preschool age children will have first priority in receiving optometric care. Follow-up progress exams will be scheduled whenever possible.

c). Other students: The importance of eye care at this age stresses the need for both preventive and maintenance optometric care to enhance the learning process. Failure in this area will seriously affect the learning process of the child if this visual and ocular systems are not functioning properly.

(Near the beginning of school year, all students are to be screened under the direction of the staff optometrist. The screening may be performed by the optometrist, PHN, School Nurse, teacher, CHR or other qualified person. Direct optometrist participation, utilizing the Modified Clinical Technique (MCT) is the recommended screening method. Those requiring further evaluation should be scheduled at the optometry clinic. Every parent should accompany his child to his/her appointment. Throughout the year, the optometrist is available and encourages consultation with any of the school system staff regarding special problems and priorities. The optometrist will participate in the educational problems with the students and school staff whenever possible).
d). Adults: While the optometry program emphasizes provision of care to children, the visual needs of the adult population must be neglected. Gainful employment and the spirit of self-determination may be seriously hindered by an inefficient visual system. Adults under 40 years of age are encouraged to have a routine eye examination every 2 years and those over 40 years, annually.

e). Eye Disease: Whenever an eye disease is suspected, the optometry clinic should be contacted immediately. Depending on the nature of the disease, these patients will generally be seen on a same day basis. Routine referrals for any tests of short duration, such as intra-ocular pressure measurement, etc., will be done on a walk-in basis. The optometrist will be available on an on-call basis during other normal clinic hours for consultation of eye disease or injuries. When the diagnosis or treatment of the eye disease requires the more specialized care, patients will be referred to an ophthalmologist.

f). Eye Safety: The optometrist will act as eye safety consultant for the service unit and the community as needed. Periodic review of the hospital eye safety program will be conducted. The OSHA standards will be utilized. Industrial and home eye safety will be stressed.

g). Diabetic Eye Clinic: In coordination with other health professionals, the optometrist will conduct an eye screening of all diabetic patients on a regular schedule.

h). Trachoma: In coordination with other health professionals, the optometrist will conduct a trachoma screening program on a periodic basis.

i). Contact Lenses: Contact lenses will be fitted if they are the most practical means of ophthalmic correction or when they are medically indicated. Patients who wish to wear glasses for cosmetic reasons will be scheduled as time permits. Patients presently wearing contact lenses will be examined on a routine appointment basis.

j). Health Board: The optometrist will maintain communication with the health boards and other representatives of community health services.

Spectacles

a). Students: Glasses for children are provided at no charge. The frame selected must be from the contracted optical frame selection. Lenses must be clear. When a frame other than the contracted company is selected
or when tinted lenses are desired, the normal prescription cost of the item must be paid as in the adult program.

b). Adults: They have the option of receiving a prescription to take an optical store of their choice or of selecting from one of the IHS sample frames and ordering from the company direct. Adults pay for their glasses.

c). Spectacles will not be denied to any individual because of the inability to pay. If this problem is uncovered, the matter will be referred to the Social Work Service. Upon their determination, payment will be accomplished through the Medicaid/Medicare or New Eyes for the Needy Program.

The previous activities are designed to crosscut a full spectrum of services which are suggested for a comprehensive Eye Care Program. However, the determination as to whether these performances are accomplished, and to what extent, has been undetermined. An important factor which is influential towards this determination is manpower. The professional optometric teams of the Albuquerque Area Indian Health Service are servicing a large multi-tribal and cultural Indian population of 26 tribes (excluding Urban Indians). According to the Indian Health Service population statistics, the following demographic data of professional manpower vs. service population is presented.

<table>
<thead>
<tr>
<th>SERVICE UNIT</th>
<th>% TIME</th>
<th>MANPOWER</th>
<th>POPULATION SERVING*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuquerque</td>
<td>100%</td>
<td>1 Optometrist</td>
<td>20,878</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Optician</td>
<td></td>
</tr>
<tr>
<td>Acoma, Canoncito,</td>
<td>10%</td>
<td>1 Contract Part-Time Optometrist</td>
<td>6,280</td>
</tr>
<tr>
<td>Laguna</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mescalero</td>
<td>10%</td>
<td>1 Contract Part-Time Optometrist</td>
<td>1,916</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Tentatively</td>
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<td></td>
<td></td>
<td></td>
<td>effective</td>
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<td></td>
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<td>April 1979)</td>
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(Continued)......

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<thead>
<tr>
<th>SERVICE UNIT</th>
<th>% TIME</th>
<th>MANPOWER</th>
<th>POPULATION SERVING*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Fe</td>
<td>10%</td>
<td>1 Contract (Taos Only)</td>
<td>14,381</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>2 Full-time Optometrists</td>
<td></td>
</tr>
<tr>
<td>Zuni</td>
<td>100%</td>
<td>1 Optometrist</td>
<td>7,517</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Optometric Assistant</td>
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* Albuquerque Area Population Indian Health Service - FY'1978
  Office of Program Planning & Evaluation

Background information presented provides the general scheme of the present level and conditions of optometric services provided to Pueblo Indians by the IHS. Subsequent sections further identify, define and delineate levels of services, barriers to service, unmet needs and alternative approaches to improved eye care services.
III. STUDY APPROACH

A. Planning and Orientation

The Eye Care Evaluation Project of the New Mexico Intertribal Health Authority was initiated by the Pueblo people. Its purpose, a review and analysis of the Indian Health Service Optometry Program. The NMIHA was charged with the responsibility for developing the study approach to be utilized in the evaluation of the delivery of optometric care to the Nineteen (19) Pueblos of New Mexico.

It is important to note that methodology must be considerate of the rules of the governing bodies of each Pueblo community. The Evaluation Project staff contacted key tribal officials to discuss tribal specific reviews. Pueblo governors were notified when and what staff were active in the Pueblo villages.

During this phase, an effort was made to orientate all appropriate individuals to the procedures of our study approach. This orientation and involvement facilitated composite justification in those recommendations derived from the evaluation efforts.

Effective communication networks between the tribal leaders, people, IHS staff and evaluation team, were key factors in developing the study approach. Pueblo governors and tribal health boards were continually appraised of the course and progress of the project. This enabled corrective actions on issues which were not previously considered or discussed. The spirit of cooperation was emphasized and a positive approach coupled with suggested solutions to defined problems, was the overall attitude of the review.

This study approach was considerate of the factors and methods of service delivery, inherent in the IHS system. The information derived
in this phase was utilized to establish criteria for the analysis of all data received during the course of the study. As unusual as the project seems, the final report itself represents the pioneering efforts on the part of the Pueblo people to establish evaluative mechanisms for the services that are provided to them from the federal agencies. Within this content, it is our understanding that this feedback from a consumer perspective will be utilized to increase resources and improve the delivery of health care services, and that this optimism be shared by all study participants, including I.H.S.

B. Development Phase

This phase emphasized the development of a logical, valid, and relevant approach to apply towards assessing the Optometry Programs from the consumers point of view.

The procedure for developing this approach: data gathering methodology and analysis was completed through tribal officials, leaders, representatives, by the Eye Care Evaluation Research Team. The criteria developed for assessment of optometric services of each Pueblo community provides a basis for the understanding and analysis of compiled data.

The criteria was designed as follows:

a. Clinic Environment

1. Patient's mental impression of IHS Optometry staff/program.
2. Physical-clinic environment.
4. Organizational structure of optometry program.

b. Types of services provided by the IHS Optometry

1. Direct optometric health care delivery.
2. "In-direct" optometric health care.
c. The End-Results of Services and Activities

1. Outcome - "Magnitude and Extent of Optometric Health Care"

2. Single, systematic or stratified levels of services.

d. Recommendations

1. Design alternate service delivery models if needed.
   a. Facility operating hours.
   b. Stratified time-chart for direct health delivery/ Pueblo or Pueblos.

2. Design a cross-cultural mechanism in which the implications would be sensitized and relevant for understanding and support of the optometric health care providers.

The standardized mechanism required for statistical analysis and community assessment, in addition to recommendations, was designed according to a stratified method. This stratified method was defined by stating that different levels of programs, tribal leaders, and concerned individuals are, such as: 1) Service Unit Health Boards, 2) Community Health Representatives, 3) Governors/Tribal Officials, 4) Patients, 5) Patients who do not go to clinic etc. Therefore, in order to initiate a relevant and sufficient data gathering effort, only specific questions, concerns, and issues were compiled into a chronological order by Research Staff and supporting tribal health workers/officials. In addition to this approach, constraints and limitations were defined, in respect to traditional values and survey form (Evaluation Instrument), which influences the development of valid alternatives.

1. Evaluation Team

Evaluation information is dependent on the collection methods, data compilation, and the amount of time which it takes to obtain this
information. Therefore, the key staff with the project have to be trained and become aware of details involved within the evaluation collection process, and at the same time, respectful and considerate to our Pueblo people, and their traditional values. In essence, the evaluation team must be sound in judgement and credibility.

The Evaluation Team is listed accordingly:

Project Director
Researcher
Part-time Researcher
Optometrist Consultant
Ophthalmologist Consultant
Program Secretory

2. Period of Performance

Project staff coordinated all activities according to specific ongoing activities with tribal health programs, Service Unit Health Boards, Indian Health Service Personnel, and Tribal Leaders/Officials.

Research staff were primarily responsible for working closely with the consumers of the nineteen Pueblos, while professional consultant staff were specifically assigned in the evaluation and review of the optometry clinics. Depending on the information compiled, two days were spent at each Pueblo to gather data and observe clinical and community needs. However, before implementing the on-site assessments, a one day training and orientation meeting was held between staff, tribal health workers, service unit health boards, tribal officials and Indian Health Service staff to review and finalize the criteria and standards to be utilized in the evaluation.

3. Evaluation Instruments

The process of developing and finalizing the evaluation instruments for the community assessments included several community based phases
established for maximal support and relevancy of material and/or information to be gathered.

No formal survey form was utilized. Pueblo communities have been subjected to many and varied surveys. It was not the purpose of this study to initiate another study, rather to document the needs as expressed by the Pueblo people through community service workers, tribal leaders, IHS staff and tribal health boards. These needs have not changed since the inception of IHS services, but have increased with increased tribal knowledge of visual illness and problems and the availability of connective action. Objective reviews and in-depth sessions were conducted in all areas of community consumer and provider concerns, such as:

1) Service Unit Health Boards/Committees
2) Community Health Representatives
3) Tribal Leaders/Councils
4) Students
5) Non-Patients
6) Patients
7) Indian Health Service Personnel
8) State and other local program staff
9) Others - Identified during course of study

Biostatistics, although minimal were available through the Albuquerque Area Office of Program Planning and Evaluation. Therefore, no survey forms were developed.

4. Evaluation Size

This phase emphasized collection of data on several levels. This allowed for an objective type of evaluation, for constructive purposes, only in developing a more responsive program for the Pueblo people.

In addition to the on-site assessment of clinics, a Clinical
Evaluation form was modified from an Evaluation Form prepared by the American Optometric Association. This form was divided into three parts. They are Part I - Optometry Clinic, sent directly to the optometrist for completion and returned. Part II - Optometry Clinic Standards, sent to the Albuquerque Area Office to determine the IHS clinic standards, in relation to the clinical standards of non-IHS optometry clinics. Part III - Financial Information, cost containment analysis on financial expenditures and appropriations. The evaluation team held on-site visits with the Tribal Governors/Councils, and the Community Health Representatives. The Evaluation team also spent one to two days at each clinic and interviewed patients as they entered and exited from their examinations. After the patient interviews were completed, the Research Team conducted follow-up sessions with the patients to determine the amount of people who are actually benefitting from the optometry services, and those who are not, then why did these services not help them?

From the above procedures, specific problems in the optometric care to the Pueblo people were analyzed and recommendations made.

C. Implementation Phase

The evaluation team also conducted on-site observational assessments of the optometry clinic and staff at each health facility. It was required to involve local participation in these on-site visits. Particular to those tribes served by each Service Unit.

Concurrently, a literature search was being conducted at the University of New Mexico Medical Library. Because of the limited amount of information regarding optometric care to the Indian people the reference material was found to be limited. References producing the greatest amount of information
were; the Index Medicus, Monthly Catalog of U.S. Government Publications and the Hospital Literature Indices.

The purpose of a literature search is to collect documents, reports, studies, and general information which may be of interest and utilized as resources for determining the maintenance level of optometric health care to the public. It is utilized in this study to compare and analyze programmatic aspects.

The analysis phase lasted approximately three months. After the review and analysis of information, the conclusions and recommendations were developed. A draft report was developed and reviewed by the tribal leaders, health boards, Indian Health Service and other professional organizations before submission of the final report to Headquarters, Indian Health Service.

D. Report Development Phase:

The development of this report comprises the methods, results, discussions and recommendations of upgrading the Indian Health Service Optometry Program to a level that is acceptable and culturally relevant to the Pueblo Indian communities. The following work objectives have been listed to better visualize the results of this report.

1. Develop an alternate service delivery model with respect to tribal wants, needs and concerns based on recommendations.
2. Comulate and define recommendations.
3. Identify tribal priorities and constraints.
4. Identify IHS priorities and constraints.
5. Identify faulty areas of service delivery.
6. Identify professionally sufficient optometric programs and areas.
7. Intensive review of draft with tribal representatives and IHS Optometry staff.

E. Close-Out Phase

Allowed for the completion of the report in a logical and tribally endorsed fashion, specifying aspects of the optometric programs and services. The following work objectives have been listed as follows with the final phase:

1. Integrate recommendations
2. Finalize report
3. Review with tribal leaders
4. Evaluate project effectiveness
   a. Approach
   b. Scope
   c. Personnel
5. Other ancillary activities
   a. Planning
   b. Resource Identification
6. Close out Fiscal Processes
7. Final Report to Tribal Leaders

The next section presents the results of our evaluation efforts as implemented through the management of the Indian people. Specific concerns, positive approaches in the handling of patients, as well as financial and manpower needs are presented.
IV. RESULTS

Little has been published or documented concerning the visual profile of our Pueblo Indian people, as well as other Indian communities and tribes throughout the nation. Various pathological reports and epidemiological summaries have been published regarding specific Indian groups within finite boundaries, however, never has there been any comprehensive reports which include the consumer perspective, ideas, priorities and concern. The Pueblo Indian tribes representing four (4) language families and exhibiting a stratified range of cultural variation, have explicitly taken the initiative to perform an evaluation of a federal government health service delivery program, from the consumers point of view. This initiative provides the fundamental thrust of people and community development in respect to tribal sovereignty and cultural preservation.

This evaluation report represents the findings of a consumer designed methodology in working with the providers to enhance the understanding and development of the visual health care of our Indian people. Stratified levels of this evaluation methodology were utilized to assess every element within this delivery system, such as: appointment systems, patient education, quality assurance, patient satisfaction, refractions, and others as listed accordingly. This enormous optometric delivery system encompasses many areas of sensitivity, which requires technical variability and understanding of medical technology, bio-physics and general academic achievements in becoming an optometrist or ophthalmologist. In essence, the providers must be familiar and educated in people practice, cultural sensitivity, communications, respect, and community priorities. Being that this delivery system is working with a minority group with a conservative and progressive stronghold in maintaining their culture and self-image, this evaluation design is innovative, unique, and designed to be culturally relevant, and valid in its context. Assessments
from the various Nineteen (19) Pueblo communities have been collated to provide a comprehensive outlook in Albuquerque Area Optometric services which comprises:

1. Santa Fe Service Unit
2. Albuquerque Service Unit
3. Acoma-Canoncito-Laguna Service Unit
4. Zuni/Ramah Service Unit

The results have been accumulated and presented in the following sections which have an origin of both the Indian Health Service (providers) and the Nineteen (19) Pueblo Indian communities (consumers).

A. Optometric Services

In this era of modern medical technology and the overly abundant level of rural health care, accessibility is of a primary concern, especially to our Nineteen (19) Pueblo Indian communities. Primary, tertiary, and secondary medical services are provided through the management of the Indian Health Service for all recognizable Indians/tribes throughout the nation. However, the magnitude and extent of these services are limited in scope, accessibility, and priorities as determined according to congressional support. One segment of this delivery system being optometric health care within the Albuquerque Area according to service reports are designed to provide the following:

a. Vision Analysis (incremental program)
b. Limited Vision Screening
c. Limited Contact Lens Service

According to a working paper developed by the American Optometric Association, the realities of a fullscope optometric program of vision care services include:
- An examination of infants, especially when the parents or pediatrician suspect a vision problem.

- A professional examination, comprehensive in scope, of every child before he or she enters school.

- Annual examination during the school years.

- Biennial examinations of those aged 20-40 years of age.

- Annual examination of those over 40 years.

- Appropriate treatment services depending upon the eye vision condition diagnosed, e.g., eyeglasses for refractive errors, vision therapy for eye coordination or vision development problems, low vision aids to assist those with partial sight, or treatment for ocular disease.

- Screening programs for glaucoma and trachoma.

These supportive activities are suggested for an ideal optometric program. These functions were collectively developed to meet the national demands for full scope optometric health care, which is clearly underscored by the following statistics:

- As a child's age increases there is a steady increase in significant vision problems involving 20% of children aged 5-9, and rising to 31% of youths aged 15-19. The most significant vision problems of the 0-19 age group is vision performance (16%), followed by visual acuity (9%) and myopia (8%).

- In the 40-70 age group, as the eye lenses lose elasticity, most people will need new prescriptions for reading glasses with frequent changes during these years. Furthermore, cataract, glaucoma and degenerative eye diseases appear with increased frequency.

- There is a great increase of vision problems during the 60's with 92% of persons over 65 needing professional eye care.

In concurrence with these statistics the availability of optometric services is limited, according to type of services and its availability
to the Nineteen (19) Pueblo Indian tribes. The following service chart as developed by the Albuquerque Area Optometric Consultant, identifies the type of services provided through the existing resources.
<table>
<thead>
<tr>
<th></th>
<th>Headstart</th>
<th>Vision Analysis</th>
<th>Contact Lenses (Cosmetic)</th>
<th>Vision Training</th>
<th>Low Vision</th>
<th>Diabetic Screening Clinic(1)</th>
<th>Hypertension Screening Clinic(1)</th>
<th>Trachoma Screening Program(1)</th>
<th>Glaucoma Screening Program(1)</th>
<th>Eye Safety Program</th>
</tr>
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<tbody>
<tr>
<td>A-C-L</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Anticipated</td>
</tr>
<tr>
<td>Mescalero</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
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</tr>
<tr>
<td>Santa Fe</td>
<td>Yes</td>
<td>Yes</td>
<td>Anticipated (2)</td>
<td>Anticipated</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Anticipated</td>
</tr>
<tr>
<td>Zuni</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Anticipated</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Anticipated</td>
</tr>
</tbody>
</table>

(1) The inclusion of additional clinics/services to be provided which are routinely performed only on patients scheduled for the optometry clinic by appointment.

(2) Anticipated indicates approximately within one calendar year.
B. Appointment System

Efficient utilization of clinical time, professional services, as well as patient referrals and general counseling, have been primary factors in the determination of a cost-effectiveness/efficient delivery system.

The Albuquerque Area Indian Health Service optometric appointment scheduling system is developed according to an incremental priority for service basis. A waiting list and appointment scheduling system is primarily coordinated and implemented by the Community Health Representatives of each Indian community. However, some Pueblo tribes prefer that the patients themselves should take this initiative rather than burden this responsibility with the CHRs. The CHRs are then placed with this responsibility and due to the demand for optometric services, are left with no alternative but to rely on a waiting list for service basis. This waiting list has been estimated for first examinations of each scheduled patient within a time frame up to 2 years.

No appointment confirmation notices are sent to the scheduled patient by either the optometric staff or tribal community health workers. It is confirmed by verbal communications, and understanding between the optometric clinicians and Pueblo tribe. Influential factors for this type of system have been focused primarily on the rural accessibility from the reservations to the optometric clinical facilities, and sometimes, the unavailability of communicative network systems designed to inform the patients.

According to Senator Fannin's editorial, effective health personnel are a primary factor in the provision of quality health care, where manpower is in short supply or under utilized, the health care system is placed in serious jeopardy. Combined with shortages in manpower, the low level of patient care services provided to Indian people constitute the heart of
the crisis in Indian health care. With the present level of professional optometric personnel which totals 5½ optometrist, and the high demand for services, screening programs, referrals, and other pathological exams, the appointment system will undoubtedly play a major role in the satisfaction of services provided to our Indian people.

There are similar consistencies of appointment scheduling between the various service units, however, no community designed scheduling has yet been achieved.

The mean appointment scheduling per given day as seen by the optometrists is determined at 13 scheduled patients per day.

- Santa Fe Service Unit - 14 Scheduled Patients/Day
- Albuquerque Service Unit - 11 Scheduled Patients/Day
- Acoma-Canoncito-Laguna Service Unit - 13 Scheduled Patients/Day
- Zuni/Ramah Service Unit - 14 Scheduled Patients/Day

C. Priorities for Services

Despite the legal commitment of the Indian Health Service towards the provision of high level health care for Indian people, it is simply unable to deliver sufficient services at the present time to meet current tribal priorities, needs, concerns and demands. As a result, the treatment of acute, as well as chronic epidemiological diseases and general vision analysis cannot be adequately handled or expanded, diabetes control and prevention activities are hampered, hypertension screening and treatment is minimal, eye safety programs are non-existent, and as a result, the demand for eye care services are increasing with a restriction or development of a priority list.

The present level of optometric services are primarily designed to service the schoolage population of our Pueblo Indian communities.
analysis and attempted yearly screening with visits to the optometrist, are coordinated with the school districts and tribal headstart, kindergarten and elementary school systems. Specific activities and services are provided only if you fall within a certain age category, such as: Headstart School Age Children (primary priority), Elementary, Junior and Senior High School Age Students (second priority), adult and elderly populations (third priority).

The ideology of developing restrictions for the consumers in seeking health/medical care from the Indian Health Service decreases the moral and ethnical policy for attaining the highest possible level of health care of all Indian people. The warranted concern as expressed by the Nineteen (19) Pueblo tribes of the quality and provision of optometric services, due to the longevity of these restrictions, has sparked the initiative to redevelop priorities for these services. The Nineteen (19) Pueblo tribes have repeatedly emphasized for additional manpower, training programs for CHRs, and other health workers, as well as the provision of services designed to include the high risk groups such as Diabetics, Hypertensive Patients, Children, Elderly and others. This is an enormous task which requires cooperation, participation between the tribes and the Indian Health Service (see Appendix I). Clinic Environment and Facilities.

The optometric clinical conditions and physical appearances have some apparent factors towards the professionalism of providing medical health services. The field of optometry recognized by most Pueblo consumers to be in the incubation stage, have throughout the past several years developed into a hospital orientated provision of health care. Optometric services are presently provided (Albuquerque Area) through newly developed service unit facilities, namely (1) Santa Fe Service
Service Unit, (2) Zuni Service Unit, (3) Acoma-Canoncito-Laguna Service Unit (anticipated) - presently located in a temporary tin building, (4) Albuquerque Service Unit Field Clinic - located at SIPI School Health Facility and Dental Clinic.

However, opthalmological services are non-existent, except through contracts, poses another spacing problem. When the design for the new facilities were developed, the spacing allotment for optometric, dispensing, and opthalmological services were not considered. As a result, the present facilities, including Albuquerque Service Unit Field Clinic, are having problems. This spacing problem places a barrier on the extent and magnitude of services to be provided, namely vision analysis, and limited dispensing activities.

According to an evaluation report developed by Headquarters, James Hamilton, O.D., Chief of Optometry (see Appendix II), three of the four service units were merited for spacing problems, these being:

(1) Santa Fe Service Unit

Point Loss:

a. Clinic not commensurate with other clinics at facility in appearance and size for population ratio.

b. Size too small for adequate care of patient load requirements...old 144 sq. ft., for optometry offices; new 200 sq. ft., operative/office.

c. No administrative area

d. No lab

e. No pathology room

f. No closed storage space

(2) Albuquerque Service Unit - SIPI Optometry - Facility is inadequate with existing manpower.

(3) Acoma-Canoncito-Laguna Service Unit:

(Laguna Satellite Clinic)
Point Loss:

a. Optometry Clinic is dirty and not commensurate with other professional offices. Not located in main health facility. No toilet, no water, no dispensing area, no waiting room - patients must wait outside in all weather.

(4) Zuni Service Unit:

Point Loss:

a. Some facility shortage: In which space for assistant is needed to provide sure direct patient services such as ophthalmometry, tonometry, etc.

Community concerns have all been directed to some spacing problems which influence the limitation of adequate full scope optometric care. These concerns have been noted as:

Albuquerque Service Unit - SIPI Optometric Facility:

- The clinic environment is not tidy. The optician's work space and record keeping seems to be overcrowded. This is visible by all patients and visitors due to the sharing of receptionist space with the medical clinic staff and nurses.

- Optometrist office located in the examining room. This spacing problem infinges on the professionalism of services, as well as provides limitations in the promotion of patient's rights, and confidentiality.

- One typewriter is shared by both medical receptionist and the optician.

- Telephone disturbances, nurses conversations in the hall, babies crying and other disruptions have been noticed.

Santa Fe Service Unit:

- Facilities are still in need of improvement. The space (300 sq. ft.) used by the Optometrist and Optician is inadequate. This hampers the amount and extent of optometric services as provided to the patients and therefore, reflects on the quality of treatment as prescribed.

- Privacy on behalf of the patient is not practiced due to spacing problems.

- The new hospital environment is great, however, it appears that no plans were ever developed to include optometric/pathology and low vision training clinics.
Acoma-Canoncito-Laguna Service Unit: (Laguna Satellite Clinic)

- The clinic environment poses a health and safety hazard to patients. Insects and other pests have been seen within the waiting room and examination room.

- The Otpometric Clinic is located separately from the Laguna Health Clinic. It is physically located on top of a small hill surrounded by construction materials and weeds.

- Air conditioning during the summer time and heating during the winter is inadequate and obsolete.

- Patients usually have to wait outside the clinic due to having a small one couch waiting room.

- The examining room walls are held together with sheetrock paneling, nails and exposed conduit electrical piping.

- The flooring is solid concrete with no tile or linoleum.

- There is only one lighting fixture for the examining room.

- There are no lavatory facilities within the tin shack.

- The entire optometric facility is suitable for construction shack, but not a medical facility.

- Indian Health Service, Public Health Service need to understand the consequences that our Indian people are going through, by having to provide professional medical services from a tin shack.

- There is no dispensing room.

- There is no office for the Optometrist. It is merely a two (2) room shack with a closed up pipe for a bathroom all located in one room.

- The present plans for an Optometric Clinic within the new Acoma-Canoncito-Laguna Hospital is combined with the Audiology Department. The floor space is inadequate for an Optometric Clinic, with tentative plans in moving the clinic to a new storage building which is presently under construction.

- At the present time, the Optometric Clinic Building is shared with the Environmental Health Department and serves as their storage space for pesticides, animal cages and various equipment.
Zuni Service Unit:

The clinic is well located and does not require a long distance for the major portion of the population. It is approximately 800 sq. ft., in area and consists of an exam room/consultation room, dispensing area, laboratory and waiting room.

Dr. Schmierer's office is located in the examining room. This spacing problem infringes on the professionalism of services, as well as provider's limitations in the promotion of patient rights and confidentiality.

These consumer responses are consistent with some of the findings as addressed by Dr. Hamilton. However, a more specific and detailed identification of problems encountered by the consumers have produced a bleak picture, which our Indian people today are facing regarding facilities.

D. Prescription/Visual Examinations

Visual examinations have been a noted concern through most of the Nineteen (19) Pueblo communities. Due to the restriction for services as placed on our Indian population, the interest and concern regarding the quality of visual examinations, as well the quality of the spectacles were generated. The following data was compiled by the respective Pueblos as serviced by the underlined Service Units:

Albuquerque Service Unit - SIPI Facility:

Visual examinations in the past were noted by CHRs to be very brief 5-10 minutes/patient. However, there has been some noted and recent improvement of time taking by Optometrist for thoroughly examining patients (15-20 minutes). Frequent problems with prescriptions and the availability of frame selections is a
major problem. The adults seen by the Optometrist have been noted to complain about not being able to see through the required glasses, or their vision is worst than before. This results in patients attempting to see another optometrist (private practice), and issued another pair of glasses.

NOTE: 1. This results in patients doubling the cost for glasses.
2. Also has some impact on the professionalism and competence of the optometrist which is relayed back to the community and consumers.
3. This also results in labeling and stereotyping the Indian Health Services, and can have some negative impact on all medical health services (IHS) and relative appointment scheduled.

No visual screening is conducted within the Pueblos. Community Health Representatives and other tribal health workers have to arrange for the headstart children to be bused to SIPI. This also eliminates maximum participation of parents to get involved and acquainted with the child's visual condition and needs. There is no visual patient education or health education to be conducted, other than what the optometrist and optician explains within the clinic.

Santa Fe Service Unit:

- Glasses that are received from fabrication are sent to Eight Northern Offices instead of the Optometry Clinic. Often times the CHRs are not notified of the glasses arriving.

- There has been an increase in price for glasses. The explanation is unknown, and hard to explain to the patients who are paying for the glasses.

- IHS verbal policy relative to a maximum issuance to patients being one pair of glasses within a two year time frame, is non-realistic.

- The length of time in receiving glasses from the fabricating companies vary from Pueblo to Pueblo. The time frame has been estimated at two weeks to four months.
- Lens and frame repairs have taken up to two months before they are returned to the patient. If repairs cannot be done at the clinic, they are sent to the optical company. Optician should be able to complete all minor repairs at the clinic. Repairs and adjustments at the Optometry Clinic take at least one hour. When patients arrive at the clinic for repairs or adjustments, they have to sign in at the reception area. Medical records are pulled and sent to the Optometry Clinic and patients have to wait until the Optician receives his chart before any services are rendered.

- Visual screening is conducted at every Pueblo. The Optometrist and Optician usually coordinate this effort with every tribal CHR program.

- No low vision training is available, nor is a pathology clinic.

- A special diabetics clinic is in existence and highly favorable to most tribal members. This is one of a very few IHS Optometric Programs which actually implements a specialty clinical program for diabetics.

Acoma-Canoncito-Laguna Service Unit - Laguna Satellite Facility:

- Due to the lack of equipment, space and facilities, eye examinations are limited to refractions. Patients waiting for their examinations are required to wait in a crowded, uncomfortable, unventilated waiting room or outside in their vehicles until called in for their examination. Patients with acute eye problems are referred to the contract Ophthalmologist (Dr. Bettman) in Albuquerque. The patient's examining room is shared with the CHR and also serves as the fitting and dispensing room for glasses.

- Presently there is no optician to assist in fitting and dispensing of glasses. These duties are undertaken by the optometrist and ordering is done by the CHR. The CHR brings to the Medical Records Department, at least two days in advance, a list of the names of patients who will be seen by the optometrist. The Medical Records clerk will then pull the records and are awaiting the CHR when she arrives on the clinic is sometimes the medical records are not ready for pick-up and the CHR will have to wait for them.

- The Optometry CHR is responsible for scheduling appointments, ordering glasses, handling money orders, dispensing glasses, minor repairs and adjustments, transporting patients to the Optometry Clinic, assisting optometrist at the clinic.

- The major complaints of the community is the amount of time that is taken before glasses are received from fabrication. Waiting time is approximately one month. The waiting list is too long. Patients have been on the waiting list for a few months to have their eyes examined.
- Some of the problems encountered by the CHR in the adult program is the non-receipt of payment for their glasses. CHR has explained to them in their own native language and in English why they must pay the amount. CHR has also explained that their prescription cannot be sent to American Optical unless payment accompanies the order, but this explanation has not been too effective.

- Problems have also been encountered with Pueblo employees of the mines in regards to the issuance of safety glasses. The Optometry Clinic has a limited amount of frames the community can choose from. This not included in frame selection, frames for safety glasses. The mine administration wants the Optometry Clinic to provide the employees with the safety glasses frames. Some tribal members including the optometrist feels that the services and facilities are already limited and this request should be undertaken by the mining company. Optometrist will examine the patients and give them their prescription and they can have it filled by the company thus meeting the specifications for safety lens and frames.

Zuni Service Unit:

The findings as collected from the people being serviced by the Zuni Service Unit Optometric Clinic facility, are very pleased with the thorough examinations as provided by the Optometrist. Although the technical utilization of the equipment by the optometrist is no understandable to the patients, most of the patients feel comfortable in the competency of the optometrist and optician examinations.

There has been some noted concern, however, regarding the optometrist services, and explanation, communications with the elderly. The elderly patients have expressed feelings of uneasyness, and are at time not comfortable with the optometrist. The use of technical medical equipment for visual examination and the impatient attitude of the optometrist have been identified as influential factors.

This does not pose itself to be a major problem and can be remedied very pleased with the thorough examinations, regardless of the attitude problems.
The major concern regarding the filling of optometric prescriptions for glasses by the Fabricating Company, has been known to dampen the efforts made by the patients to remedy their visual problems. It has been estimated to receive the glass from the Fabricating Company in, at a time frame of 1-2 months (perceived by community).

E. Manpower

Effective health personnel are a primary factor in the provision of quality health care; where manpower is in short supply or underutilized, the health care system is placed in serious jeopardy. Another factor which needs to be considered is cultural priorities. The Nineteen (19) Pueblo tribes have deemed it necessary to ration and adjust to the lingering minimal level of profession optometric services. As a result, the restrictions of being able to see an optometrist for the betterment of visual health is taking its toll against our people, and culture. If the adult and elderly people are denied services or placed on a waiting list for 2 years before seeing an optometrist, the level of utilizing of cultural knowledge to teach our young will decrease. The younger population (headstart, kindergarten, elementary, junior and senior high) will not be able to gain and carry on the traditional means of cultural preservation, cultural medicine, and the Indian ways of harmony and life.

According to the Resource Allocation Criteria Document of the Indian Health Service (see Appendix III), it is determined that the optometric manpower for the Albuquerque Area Indian Health Service is 60% staffing deficient to meet the needs, in which nine (9) additional optometric personnel at an estimated cost of $198,000.00 is required to adequately serve the Indian people within the Albuquerque Area.
F. Education/Experience - Opticians

According to Dr. Hamilton's Evaluation Report and the SIPI training curriculum, opticians are not capable enough to provide the full scope provisions as required by their job descriptions. The opticians which have attended the Southwestern Indian Polytechnic Institute Optician Training Course, are not capable of performing:

1. Ophthalmometry
2. Tonometry
3. Contact Lens Delivery
4. Visual Fields
5. Vision Training

There has also been a trend in the amount of continuing education that the opticians have. Lack of participation in the most recent and actual participation in continuing education was this past year, in which the SIPI Optician was given the opportunity to attend the American Optometric Associations Annual Meeting (1978). The other opticians, continuing education are sporadic and upward mobility in their career development is not emphasized. There has been no record of in-house education or training for the opticians at the service unit facilities.

G. Optometric Delivery System

No operational policies and procedures manual is available or has been developed for use throughout the Indian Health Service Optometric Program. In general, priorities for services, contract services, quality assurance, program efficiency and program development, is dependent upon each given optometrist, service unit, and area office. Therefore, there is no consistency between any given optometric program, other than what is considered as a service unit operational plans.
There is no system in monitoring contract services, other than what is required by contractual agreement with the Indian Health Service. This includes the effectiveness of patient education, quality of services, communications, visual training, patient rights and others. However, there has been very little dissatisfaction of services provided by contract optometrists and ophthalmologists serving the Albuquerque Area populations.

The documentation of concerns and interests as perceived by the consumers, in addition to the clinical review conducted by consultant staff, and the Indian Health Service Headquarter's Optometric Review Team, provides a comprehensive approach and outlook on the entire delivery system. Noted instances regarding the appointment system, or the effectiveness of patient education may not be relevant or understandable to the consumer. However, the provider may not recognize the problem and assume that everything is understood. Therefore, no consistency in operations of the optometric facilities are coordinated to serve the Indian tribes here within the Albuquerque Area Indian Health Service. The Pueblo communities are established as unique and independent systems of tribal governments, which often requires variable levels of management and priority setting. Therefore, if any plans are initiated for the development of operational policies and procedures, a direct involvement, development, and coordination of each respective tribe should be taken.

H. Contract Health Services

Because of the limited facilities, services, and personnel of the Indian Health Service, it is impossible to provide the full range of necessary medical services needed. To solve this problem, the Indian Health Service is authorized to enter into contracts with private doctors, hospitals, and
medical/health facilities. Such contract care is generally in the form of emergency care, and the unavailability of specialized manpower, such as an ophthalmologists.

On August 4, 1978, Part II of the Federal Register carried the rules establishing contract health services delivery areas and IHS contract care eligibility for Indians and their dependents.

This is the resulting set of rules stemming from the proposed notice of rule-making, published in the Federal Register on October 22, 1976. Interested persons were given until December 21, 1976 to submit written comments, objections and recommendations. Many of our Pueblo people working in many areas and levels of health or in leadership positions at tribal levels responded.

These comments and recommendations were considered according to the August 4, 1978 Federal Register in making the final changes. However, there are still a few areas of concern to the Indian people. The new regulations will affect the referral system of patients being seen by ophthalmologists, optometrists, and other specialty services as arranged. The following section describes some of these concerns which will dampen the Optometric Delivery System of the Albuquerque Area Indian Health Service:

1) The restrictions placed on Indians moving off the reservations by necessity are unfair. Becoming ineligible for IHS Contract Health Services in the quest to earn a living is totally unacceptable. Many of our people move to jobs in the cities, jobs are not a plentiful on or near one's reservation. This is a tendency of going back to the termination era on a smaller scale.

This section places a great emphasis on reservation boundaries in relation to their location in a county(s).
2) A person leaving his reservation to work somewhere his reservation is not within the county of his place of employment, or where his reservation shares no common boundary with the county he works in, becomes ineligible for IHS Contract Health Services 180 days after leaving his reservation.

3) Clear definition of "close social and economic ties" is needed. The definition should be made at the tribal level by the governing body or at the IHS Area Office level with considerable consultation with the tribes involved.

The federal government has treaty obligations to the Indian people, it should not determine eligibility for contract health service by considering boundaries or income. The sections above need careful consideration, with local description and involvement in the definition of eligibility.
V. RECOMMENDATIONS

A. Overview:

This section addresses the final recommendations as developed by the Nineteen (19) Pueblo Indian tribes in respect and conclusion of the results. These recommendations are positively developed and consumer inclined. In a working and understanding agreement with the Indian Health Service under this specially designed evaluation contract, the following recommendations are developed to increase the effectiveness and efficiency of the available resources, and most importantly, in achieving the highest possible optometric health care of our Indian people.

The visual health needs, concerns and interests have knowingly been of a major priority by the Nineteen (19) Pueblos. Consumers have often been eliminated or excluded in many cases, with the initial planning and development of optometric services or programs. This Evaluation Project, innovative in its design, scope and intent, has contributed many hours in the collection of local data, community priorities and general assessment of the present optometric services. The previously discussed data, presented in a comprehensive outline, collectively presents the status of eye care as perceived from the consumers point of view. With this data, this section positively contributes for the promotion and progressive development of services, health and well-being for our Indian people. The Nineteen (19) Pueblo tribes in conjunction with the Indian Health Service, therefore, presents the following recommendations:

B. Optometric Services (Recommendations):

The goal of the Indian Health Service states: "Raise the health of the Indian and Alaskan Native people to the highest possible level and assist them in every way possible to achieve a better quality of life." In corre-
nation with this goal, a comprehensive full scope optometric program must be initiated in all the Service Units, namely:

1) Santa Fe Service Unit
2) Albuquerque Service Unit
3) Acoma-Canoncito-Laguna Service Unit
4) Zuni-Ramah Service Unit

Specific programs must be designed to include:

* Headstart Program
* Vision Analysis
  - Contact Lense Program
  - Vision Training
  - Low Vision
  - Diabetic Screening Clinic
  - Hypertension Screening Clinic
  - Trachoma Screening Clinic
  - Glaucoma Screening Clinic
  - Eye Safety Program
  - Community Optometric Education Program
  - Community Development Program

These programs are of a great importance in the promotion, prevention and treatment of Eye Care Services to our Pueblo people, in which 2 out of the 12 services as presently provided (*).  

C. Appointment Systems (Recommendations):

The increment-directed optometric program must be redefined and coordinated with each Pueblo community in order to maintain an effective, and efficient utilization of services. Each service unit within the Albuquerque Area is established to provide medical services to a geographical boundary of tribes. These tribes are represented on these service units with appointed tribal representatives which work in conjunction with the IHS to meet the health needs of the consumers. The present appointment system is non-responsive in meeting the needs of total population and age groups, particularly the adults and elderly.
D. Priorities for Services (Recommendations):

In order to meet the visual needs of our Indian people, restrictions for eye care services must not be placed. This dampens the conservative and progressive development of the health and well-being of our Indian people, and infringes on the self-determination effort of community and human development. In review of the conclusion section of this document, a major factor which influences these restrictions is due to manpower.

If any restrictions for services are to be placed, then the Indian tribes themselves must be involved in the final determination of establishing priorities. It is, therefore, highly recommended that consistent modification and review regarding the appointment systems be held with tribes. Community priorities must be regarded as a major determination for optometric services. Being that these medical provisions were established to service our Indian people, then, the people must be given the opportunity to make their own determinations. This will meet the self-determination effort, and community development initiative of our communities.

E. Environment/Facilities (Recommendations):

The physical and environmental conditions of the optometric clinics, are inadequate. The present conditions do not meet the spacing and environmental requirements as stated by the Resource Allocation Criteria Document. It is therefore highly recommended that appropriate steps be initiated to improve the physical conditions of the clinics specifically:

1) Laguna Optometric Satellite Clinic: which presents itself as a hazardous facility rather than a professional optometric clinic. A facility improvement plan needs to be developed in conjunction with respective tribal representatives.

The remaining service unit facilities, specifically:

1) Santa Fe Service Unit
2) Albuquerque Service Unit - SIPI Facility
3) Zuni-Rama Service Unit
Must be allotted adequate physical spacing in order to meet minimal R.A.C. requirements. This plan must be developed in conjunction with each Pueblo tribe and its respective leaders.

F. Prescriptions/Visual Examinations (Recommendations):

Thorough visual analysis and appropriate prescriptions must be offered, frequent misunderstandings between the optometrists and patients were noted, especially for adults and elderly patients. The Nineteen (19) Pueblos have expressed the inadequacies of having to choose frames that seem to be obsolete. As a result, most patients will not feel satisfied with the prescribed lenses, and stereotype all IHS Optometric Programs to be the same.

It is highly recommended that frequent orientations regarding the vision analysis process and dispensing be offered to each Pueblo community. This plan must be developed in conjunction with tribal health programs, and relative tribal administration.

G. Manpower (Recommendations):

In order to meet the needs of our Pueblo people, adequate personnel must be sought, as well as supported by congressional initiative. The Indian Health Service is the primary sponsor for Primary, Tertiary, and Secondary health services for our Indian people. These services are offered in accordance to treaty obligations, and must be adequate, effective and efficient in meeting the health needs of all recognized Indian tribes.

The Albuquerque Area Indian Health Service has identified a minimum of nine (9) additional optometric positions totaling approximate $198,000.00. In support of these positions see Appendix III. It is therefore, highly recommended that the Indian Health Service, in conjunction with the Indian tribes through congressional support, identify, recruit, and place these
positions within the Albuquerque Area Indian Health Service to meet the needs of our people.

H. Education/Experience - Opticians (Recommendations):

All optometrists, optometric assistants and optometric CHRs must be assured appropriate continuing education opportunities. This would include attending conferences, in-house and on the job training. There should also be an exchange of in-house education. For example, the optometrist would provide information to all professionals requiring an update on vision and eye care. The optometrist would also attend other seminars provided by the house staff, while the opticians are involved in constant training programs to upgrade their abilities as opticians. These training programs must be made available to all the Pueblo community health programs and interested people.

I. Optometric Delivery System (Recommendations):

Roughly, half the United States population needs some form of eye/vision care, as compared to approximately 75% of our Pueblo population, and only approximately 1/4 of those needing care are receiving it from any source. Ninety percent of patients needing such care require services that are within the scope of the present practice of the Albuquerque Area Indian Health Service. Clearly then there is a large unmet need for the present optometric services, in which the people are the victims of restricted services.

It is therefore, highly recommended that the Albuquerque Area Optometric Services, in conjunction with each Pueblo tribe, initiate a directive for this system to be community directed. The tribes themselves must be given the opportunity to develop a system and program to meet the needs of their communities, in essence, "Community Directed Optometric Program."
J. Patient's Rights/Confidentiality (Recommendations):

All efforts must be afforded in assuring the patients' rights and confidentiality of information. The present physical and environmental conditions of the optometric clinics do not meet this requirement. It is therefore highly recommended that remedial steps be taken to recognize this policy, and respect to each given patient (see Appendix IV).

K. Other Programmatic/Service Recommendations:

* Each service unit should have a suitable library. This should include journals, books, audio-visual materials for patients. This library should be useful to the optometrist, assistants, house staff, community health workers, and to other individuals who may wish to know more about vision and eye care.

* An improved contract for eyeglasses must be developed which would provide a wider selection of frame styles for all ages if funds are available.

* Patient education must be increased and be coordinated with the health educator at each service unit and respective tribal health programs. Appropriate patient literature, lectures, audio-visual material and training sessions for each optometric personnel and community workers should strengthen the optometric patient education program.

* A preceptorship program should be encouraged and developed. This usually indicates a point in the optometry program when the equipment is adequate and more than just maintenance optometric care is provided. The preceptorship program would provide additional manpower and, therefore services, though time is required to supervise the student(s). This program also introduces interns to the IHS which would assist in recruitment of optometrists for the future. The tribes, however, must be included in the development of any such programs, and, should have the final authority for approval/disapproval.
REFERENCES


APPENDIX I

PATIENT SEEN RATE/POPULATION
Zuni-Reno Service Unit
Patient Seen Rate/Population *
Record Count FY1976 and FY1977

COMUNITY

- FY1976 - Total Patients 843
- FY1977 - Total Patients 1734

* Albuquerque Area Office of Program Analysis and Statistics
Santa Fe Service Unit

Patient Seen Rate/Population

RECORD COUNT FY1976 and FY1977

Number of Patients

COMMUNITY

- FY1976 - Total Patients 2882
- FY1977 - Total Patients 2940

* Albuquerque Area Office of Program Analysis and Statistics
Albuquerque Service Unit
Patient Seen Rate/Population
Record Count FY1976 and FY1977

COMMUNITY

- FY1976 - Total Patients 3576
- FY1977 - Total Patients 3429

* Albuquerque Area Office of Program Analysis and Statistics
APPENDIX II
VISION ANOMOLIES IN THE INDIAN POPULATION
### Vision Anomalies in the Indian Population

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Population</th>
<th>Percent with Vision Anomalies</th>
<th>Number with Vision Anomalies</th>
<th>Percent Frequency of Exam Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5</td>
<td>65,260</td>
<td>36.2</td>
<td>23,624</td>
<td>1.00</td>
</tr>
<tr>
<td>5 - 9</td>
<td>75,223</td>
<td>42.3</td>
<td>31,819</td>
<td>1.00</td>
</tr>
<tr>
<td>10 - 14</td>
<td>70,740</td>
<td>57.6</td>
<td>40,746</td>
<td></td>
</tr>
<tr>
<td>15 - 19</td>
<td>56,293</td>
<td>58.1</td>
<td>32,706</td>
<td>1.00</td>
</tr>
<tr>
<td>20 - 44</td>
<td>136,000</td>
<td>68.0</td>
<td>92,480</td>
<td>0.33</td>
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<tr>
<td>45 - 64</td>
<td>64,762</td>
<td>90.0</td>
<td>58,286</td>
<td>0.50</td>
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<td>Over 65</td>
<td>29,891</td>
<td>95.0</td>
<td>28,396</td>
<td></td>
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<tr>
<td>All Ages</td>
<td>198,169</td>
<td>61.8</td>
<td>308,057</td>
<td>0.63</td>
</tr>
</tbody>
</table>

2. Based on the Lame Deer Study (4) and the Zuni-Ramah Study (5).
3. Based on percent accepting refraction (5).
4. Based on frequency of exam factor (5).
APPENDIX III
HEADQUARTERS, I.H.S. EVALUATION REPORT
CLINIC SPACING REQUIREMENTS
ATTACHMENT A-1:

POPULATION: Less than 7105 and part-time services, only.

MAJOR EQUIPMENT:
A - Ophthalmic Chair, I.A.1.
B - Ophthalmic Stand, I.A.1.
POPULATION: Less than 7105 and part-time services, only.

MAJOR EQUIPMENT:
A - Ophthalmic Chair, I.A.1.
B - Ophthalmic Stand, I.A.1.

- ALTERNATE SATELLITE EYE CARE CLINIC

192 sq. ft.

Alternate (Type-2) clinics should only be constructed where the floor plan configuration does not allow twenty foot eyelanes to be constructed.
POPULATION: Less than 7105 and a permanently-based optometrist.

MAJOR EQUIPMENT:

A - Ophthalmic Chair, I.A.1.
B - Ophthalmic Stand, I.A.1.
C - Treatment Chair, II. 14.
ATTACHMENT B-2:

POPULATION: Less than 7105 and a permanently-based optometrist

MAJOR EQUIPMENT:
A - Ophthalmic Chair, I.A.1.
B - Ophthalmic Stand, I.A.1.
C - Treatment Chair, I.A.1.

ALTERNATE ONE(1) EYE LANE EYE CARE CLINIC

440 sq. ft.

Alternate (Type-2) clinics should only be constructed where the floor plan configuration does not allow twenty foot eye lanes to be constructed.
ATTACHMENT C-1:

POPULATION: 7105 - 8380

MAJOR EQUIPMENT:
A - Ophthalmic Chair, I.A.1.
B - Ophthalmic Stand, I.A.1.
C - Treatment Chair, II. 14.

TWO (2) EYE LANE EYE CARE CLINIC
750 sq. ft.
ATTACHMENT C-2:

POPULATION: 7105 - 8880

MAJOR EQUIPMENT:
A - Ophthalmic Chair, I.A.1.
B - Ophthalmic Stand, I.A.1.
C - Treatment Chair, II. 14.

576 sq. ft.

Alternate (Type-2) clinics should only be constructed where the floor plan configuration does not allow twenty foot eye lanes to be constructed.
ATTACHMENT D-1:

POPULATION: 8881 - 17,760

MAJOR EQUIPMENT:
A - Ophthalmic Chair, I.A.1.
B - Ophthalmic Stand, I.A.1
C - Treatment Chair, II. 14.

THREE (3) EYE LANE EYE CARE CLINIC

1050 sq. ft.
POPULATION: 8881 - 17,760

MAJOR EQUIPMENT:
A - Ophthalmic Chair, I.A.I.
B - Ophthalmic Stand, I.A.I.
C - Treatment Chair, II. 14.

ALTERNATE THREE (3) EYE LANE EYE CARE CLINIC
896 sq. ft.

Alternate (Type-2) clinics should only be constructed where the floor plan configuration does not allow twenty feet eye lanes to be constructed.
POPLULATION: 17,761 and over

MAJOR EQUIPMENT:

A - Ophthalmic Chair, I.A.1.
B - Ophthalmic Stand, I.A.1.
C - Treatment Chair, II.14.

FOUR (4) EYE LANE EYE CARE CLINIC

1375 sq. ft.
POPULATION: 17,761 and over

MAJOR EQUIPMENT:
A - Ophthalmic Chair, I.A.1.
B - Ophthalmic Stand, I.A.1.
C - Treatment Chair, II. 14.

ALTERNATE FOUR (4) EYE LANE EYE CARE CLINIC
1224 sq. ft.  
(34' x 36')

Alternate (Type-2) clinics should only be constructed where the floor plan configuration does not allow twenty foot eye lanes to be constructed.
RECEPTION AND REST ROOMS

200 - 300 sq. ft.

TOTAL LENGTH FLEXIBLE, 16' to 36'
APPENDIX IV

RESOURCE ALLOCATION CRITERIA - FY 1978

OPTOMETRIC MANPOWER - ALBUQUERQUE AREA I.H.S.
### RESULTS OF THIRD APPLICATION OF RESOURCE ALLOCATION CRITERIA

**BY IHS AREA, SERVICE UNIT AND PROGRAM ELEMENT**

(FY 1978)

<table>
<thead>
<tr>
<th>SERVICE UNIT</th>
<th>PROGRAM ELEMENT: Optometry</th>
<th>Required Positions</th>
<th>Available Positions</th>
<th>Additional Need Pos.</th>
<th>$(000)</th>
<th>Staffing Deficiency (Percent Deficient)</th>
<th>TO TOTAL AREA EXP.</th>
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<tr>
<td>Albuquerque</td>
<td></td>
<td>4.5</td>
<td>2.0</td>
<td>2.5</td>
<td>55.0</td>
<td>56%</td>
<td>28%</td>
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<tr>
<td>Acopa-Canoncito-Laguna</td>
<td></td>
<td>3.0</td>
<td>--</td>
<td>3.0</td>
<td>66.0</td>
<td>100%</td>
<td>33%</td>
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<tr>
<td>Mescalero</td>
<td></td>
<td>1.5</td>
<td>--</td>
<td>1.5</td>
<td>33.0</td>
<td>100%</td>
<td>17%</td>
</tr>
<tr>
<td>Santa Fe</td>
<td></td>
<td>4.0</td>
<td>2.0</td>
<td>2.0</td>
<td>44.0</td>
<td>50%</td>
<td>22%</td>
</tr>
<tr>
<td>Zuni</td>
<td></td>
<td>2.0</td>
<td>2.0</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>15.0</strong></td>
<td><strong>6.0</strong></td>
<td><strong>9.0</strong></td>
<td><strong>198.0</strong></td>
<td></td>
<td><strong>60%</strong></td>
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### Third Application of Resource Allocation Criteria

**FY 1978**

<table>
<thead>
<tr>
<th>Personnel Category</th>
<th>Total Required Positions</th>
<th>Authorized FY 1978 Positions</th>
<th>Distribution of Urgent Personnel Need</th>
<th>Total Urgent Personnel Need</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Authorized FY 1978 Positions</td>
<td>with Existing Facilities &amp; Quarters</td>
<td>with New Facilities</td>
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<tr>
<td>Inpatient Care (Total)</td>
<td>493.2</td>
<td>341.0</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Direct Patient Care</td>
<td>346.5</td>
<td>291.0</td>
<td>25.9</td>
<td>16.7</td>
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<tr>
<td>Administration</td>
<td>151.7</td>
<td>50.0</td>
<td>50.9</td>
<td>40.8</td>
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<tr>
<td>Ambulatory Care Services (Total)</td>
<td>505.9</td>
<td>319.0</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Ambulatory Medical Care (Total)</td>
<td>336.4</td>
<td>246.0</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Direct Amb, Med Care</td>
<td>289.4</td>
<td>239.0</td>
<td>31.1</td>
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<td>Administration</td>
<td>47.0</td>
<td>7.0</td>
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<td>Out-Patient</td>
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<tr>
<td>Audiology</td>
<td>10.7</td>
<td>-</td>
<td>-</td>
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<td>Emergency Medical Services</td>
<td>68.0</td>
<td>-</td>
<td>32.0</td>
<td>36.0</td>
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<tr>
<td>Community Health Services (Total)</td>
<td>302.6</td>
<td>132.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Community Health Nursing</td>
<td>97.0</td>
<td>51.0</td>
<td>21.5</td>
<td>30.0</td>
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<td>Public Health Nursing</td>
<td>34.5</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>Environmental Health</td>
<td>49.6</td>
<td>32.0</td>
<td>8.3</td>
<td>5.3</td>
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<tr>
<td>Mental Health</td>
<td>102.0</td>
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<td>25.5</td>
<td>22.0</td>
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<tr>
<td>Social Service</td>
<td>14.0</td>
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<td>-</td>
<td>-</td>
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<tr>
<td>Health Education</td>
<td>19.5</td>
<td>12.0</td>
<td>2.5</td>
<td>2.0</td>
</tr>
<tr>
<td>TOTAL - EXCLUDING AREA OFFICE</td>
<td>1,306.7</td>
<td>792.0</td>
<td>244.1</td>
<td>177.4</td>
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<tr>
<td>Administration (Area Office)</td>
<td>191.6</td>
<td>122.0</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Contract Health Services (In $'s)</td>
<td>$9,550,625</td>
<td>$5,694,000</td>
<td>-</td>
<td>-</td>
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<td>GRAND TOTAL</td>
<td>1,498.3</td>
<td>914.0</td>
<td>244.1</td>
<td>177.4</td>
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APPENDIX V

PATIENT'S BILL OF RIGHTS
The official policy of the Indian Health Service Optometry Program for providing optometry services for Indian/Alaskan Native people is stated in the succeeding paragraphs. This policy will be followed in-so-far as the resources and capabilities of the optometric program allows.

1. The Indian/Alaskan Native patient has the right to considerate and respectful care including sensitivity on the part of the provider, to his/her culture and heritage (religious beliefs, folkways, and mores).

2. The patient, or an appropriate member of his family in the case of minors, non-English speaking patients, or patients whose condition is such that they could not understand, has the right, when it is in his best interest optometric, to get all information concerning not to be in his best interest to have the information, the patient has the right for the information to be given to another appropriate person (family member, guardian, other physician, or optometrist) acting in his behalf. He also has the right to know who the optometrist is that is responsible for his care.

3. The patient has the following rights concerning informed consent. (Approval to do certain special procedures or treatments).
   a. His optometrist must give him all the information needed for him to make a decision whether or not to agree to the procedure or treatment.
   b. The information provided should include at least an explanation of the procedures and/or treatments involved, the risks the patient may be taking and how long the patient may have to be incapacitated (out of work or restricted from normal activities) due to the procedure or treatments.
   c. The patient has the right to know whether other choices, if any, he may have other than the procedures or treatments indicated.
   d. The patient has the right to know the name and qualifications of the person(s) who will be responsible for his procedures or treatment.
   e. In emergency situations (life threatening or possibility of permanent loss of critical functions), the optometrist may not be able to provide extensive information to the patient because of lack of time. In such instances, the optometrist would not be responsible for providing extensive information because giving such information may be taking precious time and, therefore, could be more dangerous for the patient.
4. The patient has the right to refuse treatment to the extent permitted by law—but if he does, he must be informed of the risk he is taking by doing so. Example of this might be patient requesting early (premature) discharge from the hospital, or an early transfer to another hospital or nursing home.

5. The patient has the right to privacy and dignity concerning his own illness and optometric management of that illness. Case discussion, examination, and treatment shall be conducted in confidence. Optometric students and para-professional trainees will always be introduced to the patient. The patient has the right to refuse permission for their presence if they are not directly involved in his care.

6. The patient has the right to expect that all the records and other information about his care to be kept confidential.

7. The patient has the right for the following services when he requests care:
   a. Services will be provided to the patient to the extent the facility and its resources can provide the services.
   b. If the facility has such resources, it will provide:
      (1) Evaluation (diagnosis and general health condition of patient).
      (2) Service (treatment or procedures to prevent, control or cure illness).
      (3) Referral (providing additional optometrists or other appropriate individuals to provide care which may be required and is not available from the optometrist seeing the patient at the time).
   c. The patient has the right to expect that his referring optometrist or other appropriate person(s) designated, will secure up-to-date reports of his care and progress while he is receiving care in a referral, contract hospital or optometric office.
   d. When referring a patient to another facility when he can receive care not available at the local facility:
      (1) The referral must be optometrically indicated.
      (2) The patient must give his permission to be referred.
      (3) The patient has the right to know the alternatives to such a referral before he gives his permission.
      (4) The facility or optometrist to which the patient is to be referred must accept the patient before he is referred.

8. The patient has the right to know how and to what extent his local health facility is related to other non-local health facilities (private, state, county, other federal or university clinics and hospitals).
9. There are many conditions and illnesses that have no known generally accepted cures or treatments or which occur more frequently among certain population groups or in certain areas of the country. Continual efforts are being made to find such cures or to discover why these conditions occur as they do. Cures are usually discovered through research. Some patients develop these difficult or generally incurable diseases. When it is generally considered by the best optometric authorities to be untreatable by normal accepted methods, then the following choices are available to the patient and his optometrist:

a. Make the patient as comfortable as possible and let the disease run its course.

b. Suggest to the patient that he might consider treatments by new, experimental (unproven) methods. The patient has the right to know if the optometrist, referral clinic or facility plans to use unproven methods of treatment that will affect his care or treatment. The patient will be told he has the right to refuse to take part in any of these research projects.

10. The patient has the right to expect reasonable continuity of care such as:

a. To know ahead of time what appointment times are available to him.

b. To know what optometric personnel are available to him.

c. To know where the services can be obtained.

d. That an appropriate person from his health facility will keep him informed as to other things he needs to have done after he is discharged from the clinic, hospital, or facility.

11. The patient has the right to know what clinic or hospital rules and regulations apply to his conduct.

12. The patient has the right to take complaints on health services to either the Service Unit Director or Chairman of the local Indian Health Board or their designated patient advocate. The Service Unit Director shall be held accountable to hear and begin investigation on patient complaints within 48 hours. The patient should receive a reply in writing on the status of his complaint within five (5) working days following his complaint. A patient, Chairman or local Board and/or Service Unit Director may report unresolved problems to the Chairman of the New Mexico Intertribal Health Authority and/or Area Director who must take immediate action to investigate and resolve the patient's problems.

In the event the Service Unit Director and/or Chairman of local Health Board feels that a patient's allegations relate to severely substandard optometric practice, he will request the Area Director to arrange for an investigation by an independent authority who will report his findings to the Area Director and Chairman, Area Health Board.

This policy shall be reviewed periodically for making amendments and/or up-dating.