1996

Impact of the Final Rule, "Health Care Services of the Indian Health Service, 42 CFR Part 36"

Support Services International, Inc.

Impact of the Final Rule, "Health Care Services of the Indian Health Service, 42 CFR Part 36"

VOLUME 2: CASE STUDY REPORTS

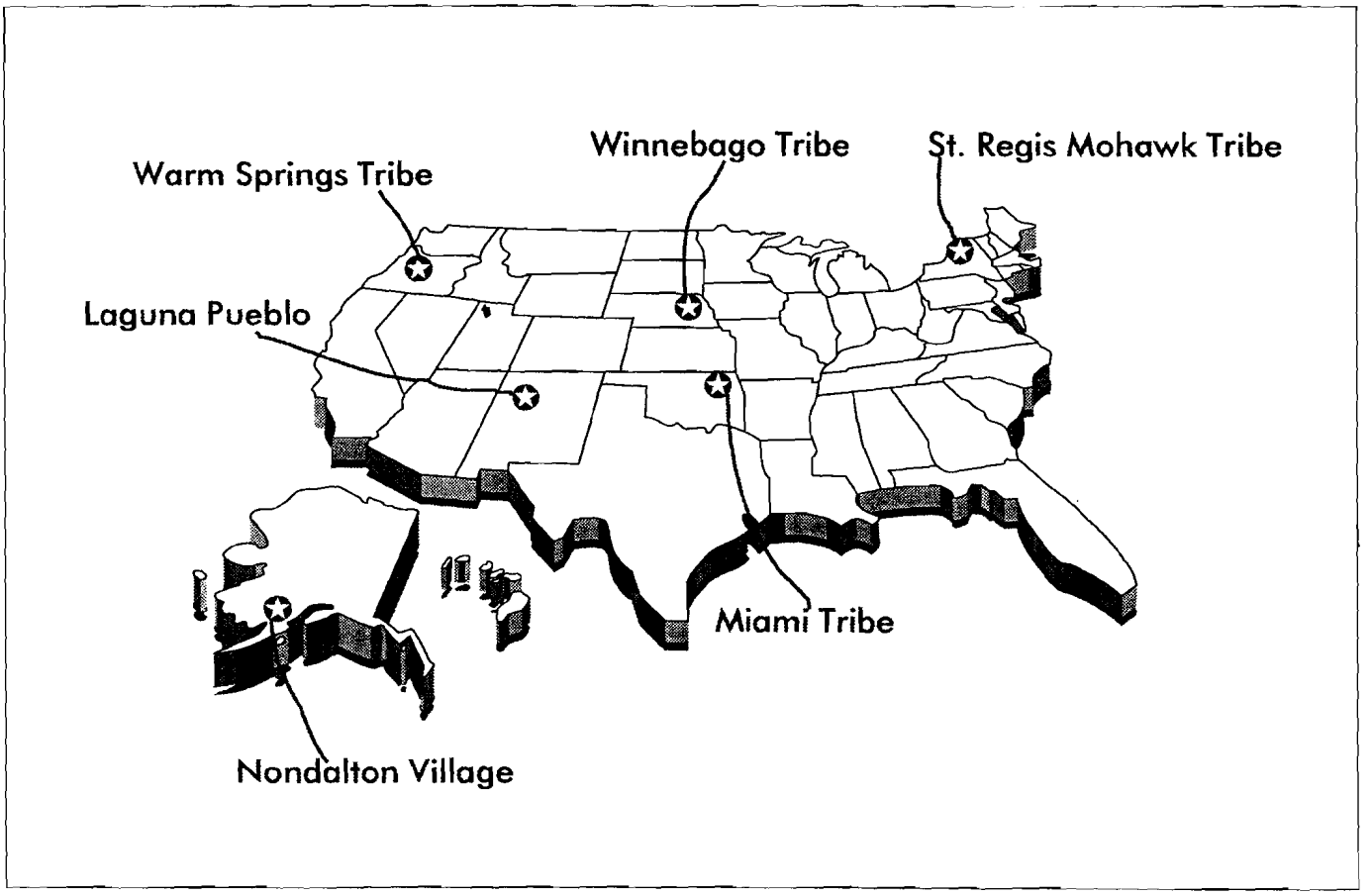

TABLE OF CONTENTS

Study to Determine the Impact of the Final Rule, "Health Care Services of the Indian Health Service, 42 CFR Part 36"

Case Study Design

The design proposed for this phase of the study is an embedded multiple case design. It involves multiple sites (six), and multiple units of analysis.

Section 719 of Public Law 100-713, the Final Rule (42 CFR Part 36), and the Scope of Work for this study specify certain parameters for the case study design. Among them are:

- Six geographic areas are designated as case study sites (northwest, northern plains, southwest, Oklahoma, Alaska, and the east)
- The case studies are to address the impact of the Final Rule on the economic, social, cultural and health status of Indian reservations and urban Indian populations.

A. Study Questions

The case studies will assess the social, economic, cultural and health status impact of the Final Rule within the six designated tribal communities and the case study findings will be synthesized with the results of the national survey of users of IHS facilities.

The study questions are defined by Section 719 of Public Law 100-713. They are:

1. How will the Final Rule impact the economic, social, cultural, and health status of reservations and urban Indian populations?
2. What alternative services and programs, if any, will be available to those Indians who will be ineligible for IHS health care services under the Final Rule?
3. What is the number of Indians currently eligible for IHS health services in the tribe/ community?
4. Under the Final Rule, what will be the number of Indians eligible for IHS health care services in the tribe/community?
5. What are program changes IHS would be required to make if the Final Rule is implemented?

B. Propositions

In addressing the study questions, certain assumptions direct the collection of data to define and ascertain the impact of the Final Rule on the six tribal communities.

1. Those Indians/Alaska Natives ineligible for IHS health care services under the Final Rule will experience adverse economic effects. Conversely, Indians who gain eligibility for CHS services under the Final Rule will experience positive economic effects.

2. Those Indians/Alaska Natives ineligible for IHS health services under the Final Rule, and who have no alternative form of health care, will experience a negative impact on overall health status. Conversely, those Indians who gain eligibility for CHS services under the Final Rule will experience a positive impact on overall health status.

3. Indian tribes/communities with large numbers of persons who lose eligibility under the Final Rule will experience adverse cultural impact (e.g., loss of tribal identity, involvement, autonomy). Conversely, many Indians will lose eligibility for health care services provided by IHS under the Final Rule.

4. Many Indians/Alaska Natives will gain eligibility for contract health services under the Final Rule.

5. Tribal enrollment procedures may change as a result of the Final Rule. These and other changes may have significant impact on the tribe's budget and economy.

6. IHS will have to make programmatic changes to accommodate the increase in CHS eligibles.

C. Basic Unit of Analysis

The basic unit of analysis will be a tribe or urban Indian community. Restricted time and resources prohibit study of more than one tribe in each of the designated geographic areas.

Criteria for selection of tribes/communities include:

- Location in one of the six geographic areas
- Desire to participate in the case study
- Level of membership-related problems (low, medium, high)

    - **Low**: A tribe with a well organized membership system. For example, automated, on-line system, can quickly respond to inquiries concerning tribal membership, and has few problems associated with membership or enrollment.

- **Medium**. A tribe with a fairly well organized membership system. For example, automated, but no on-line—not set up for quick inquiry, and/or has some problems associated with membership or enrollment.

- **High**. A tribe with problematic membership system. For example, tribe's system not automated, procedures for membership not fully standardized, many unresolved membership inquiries or disputes, recent changes in membership requirements.

- Urban Indian communities will not be included in these categories.

D. Data to be Collected

The data to be collected is defined by the study questions and propositions. The major categories of data to review include:

- Documentation: Resolutions, letters, memoranda, minutes, written reports of events (i.e., tribal council meetings), internal documents, formal studies and evaluations, etc.

- Archival records:
  - Enrollment systems
  - Inpatient/outpatient data
  - CHS utilization data
  - IHS Service population/Area
  - IHS User population/Area
  - Demographic data
  - Social Services system
  - Medicare/Medicaid services
  - State/County health care programs/services
  - Other federal health care facilities/services
  - Private health care facilities

- Interviews/Discussions with Key Informants.
  - Key informants: Tribal chairmen, tribal health directors, tribal administrators, heads of economic, social services, and education divisions, SUDs, AO staff (director, CHSO, etc).

- Direct Observation.
  - Available health care facilities
  - Available transportation

E. Data Analysis

The data for each case study site will be analyzed independently. In addition, comparisons among and trends across the six sites will be assessed.

1. Key Informant and Direct Observation Data

These case study data will be qualitative reflecting the opinions, judgments and expectations of the key informants expressed in unstructured interviews. Therefore, few quantitative statistical analysis will be conducted on the case study data; rather, the views, judgments and expectations expressed by the key informants will be elicited and organized to address the study questions and propositions.

2. Archival Data

It is anticipated that both the tribes and associated IHS components (e.g., clinics, hospital, service units, area offices) will provide statistical and other information that can be compiled, analyzed or reanalyzed. These analyses will include, when feasible and appropriate:

- Descriptive statistics such as measures of central tendency (means, medians), dispersion (range, standard deviation), and frequency distributions. Appropriate graphs and figures will be prepared.

- Measures of association (Chi square, correlation) and trend (runs test, least squares estimates).

F. Case Study Report

Portions of the case study report can be drafted before the relevant data is collected and analyzed. This will reduce the possibility of a return visit to the case study sites of collection of additional data. The outline for the case study report will include the following sections:

I. Introduction

- Purpose and objectives of study

II. Statement of Problem

- Background
- Statement of problem
- Study questions

III. Methodology

- Key informants
- Archival data collection

IV. Findings

- Individual case findings
- Cross-case findings
- Cultural impact
- Social impact
- Health status impact
- Number of persons losing eligibility for IHS services
- Number of persons gaining eligibility for CHS services
- Alternate sources of health care available

V. Discussion/Conclusion

Study to Determine the Impact of the Final Rule, "Health Care Services of the Indian Health Service, 42 CFR Part 36"

Case Study Procedures

I. Select sites

- Recommendations received from TAC, area health boards (OK and east)
- Six primary sites and six alternate sites selected
- Six primary sites contacted by phone
- Obtain name of primary contact for each tribe
- Letters of agreement/consent written to tribes
- Letters of agreement/consent received from tribes

II. Select Data Collection Team

- Training
  - Purpose of study
  - Key informant interviews
  - Archival data collection
  - Develop case study database
- Designate team leader(s)

III. Develop Data Collection Guide

- Unstructured guide for discussions with key informants
- Archival data review guide

IV. Initial Scheduling of Field Visit

- Contact appropriate IHS Area staff
  - Area Director
  - Area OTA Director
  - CHSO
- Contact appropriate tribal staff
  - Tribal Leader
  - Health Director
  - Heads of departments (Social service, education, etc).

V. Identify and Obtain Archival Data for Each Tribe

- Demographic data
- Health care data
  - user population
  - service population
  - Direct care data
  - contract health care data
- Previous relevant studies done by or for the tribe
- Resolutions, reports, documents prepared by tribe related to Final Rule
- Alternate sources of health care for tribe
  - State
  - County
  - City
  - Tribal
  - Federal (VA, Medicare)

VI. Finalize Schedule for Site Visit

- Make travel arrangements
  - Airline
  - Hotel
  - Car rental
  - Per diem

VII. Conduct Site Visit

Site Visit Guide

IHS Area: _____
Area Director: _____ Date Contacted: _____
Phone: _____
OTA Director: _____
Phone: _____ Date contacted: _____

Name of Tribe: _____
Contact Person: _____
Address: _____
Phone: _____
Dates for site visit: _____

Arrival time: _____
Departure time: _____
Name of Hotel: _____
Phone: _____

Data Collection Schedule

I. Primary Data

Key Informant	Interview Time	Location of Interview
1. Tribal Chairman/governor	_____	_____
2. Tribal Administrator	_____	_____
3. Tribal health director	_____	_____
4. Tribal education director	_____	_____
5. Director of social Serv.	_____	_____
6. Tribal Membership/Enroll.	_____	_____
7. Economic Dev. Director	_____	_____
8. IHS Staff (AO, SU, CHSO)	_____	_____
9. _____	_____	_____
10. _____	_____	_____

II. Archival Data

1. Enrollment/Membership system/data
2. Health care statistics
    - user population
    - service population
    - direct services (inpatient/outpatient)
    - CHS services

3. Demographics
4. State health services/programs
5. County health services/programs
6. City health services

Study to Determine the Impact of the Final Rule, "Health Care Services of the Indian Health Service, 42 CFR Part 36"

Winnebago Tribe

Information Collection Guide for Case Studies

This document is not a questionnaire or data collection instrument, and therefore, is not subject to the OMB review clearance process. The purpose of this document is to assist SSI staff when they conduct on-site case studies. Congress and the IHS would like to know what impact the Final Rule will have on the Winnebago Tribe in Nebraska in the following four areas: economic, social, cultural, and health status.

Name of Key Informant: _____

Position of Key Informant: _____

Membership procedures

- Requirements for membership _____

  _____

  _____

- Changes in membership procedures/criteria over the past few years _____

  _____

  _____

- Impact of Final Rule on Membership procedures _____

  _____

- Measures underway to increase membership in tribe _____

  _____

- Options for becoming eligible for health care services under the Final Rule

  __Relocate (to a HSDA)
  __Become Member of tribe
  __Other _____

- Percentage of Indian/Alaska Natives in tribe/community who are:

  __Members of Winnebago Tribe
  __Eligible for membership in Winnebago Tribe
  __Members of other tribes
  __Eligible for membership in tribe

- Knowledge/Familiarity of Final Rule

  - Level of understanding/knowledge of Final Rule by Winnebago members and those eligible for membership in Winnebago Tribe _____

    _____

  - General reaction by Winnebago members to Final Rule _____

    _____

  - General reaction by non-members of Winnebago to Final Rule _____

    _____

  - Efforts by Winnebago leadership to educate members/non members on Final Rule _____

    _____

- Health Service Delivery Area

  - How boundaries are determined _____

  - Percent of Winnebago members who live outside the HSDA _____

  - Effect of Final Rule on Winnebago members living outside HSDA _____

    _____

  - Measures to be taken by Winnebago leadership to alter boundaries of HSDA under the Final Rule _____

    _____

A. ECONOMIC IMPACT

- Impact of Final Rule on Winnebago Tribe
  - Employment _____
  - Hiring practices _____

    _____
  - Possible effects of increased membership _____

    _____
  - Ability of members to pay for own health care services _____

    _____
  - Tribal leadership payment for health care services to Indian people who are not members of tribe _____
  - Ability of Indian non-members to obtain health care services _____
- Greater demand for Winnebago services _____

  _____
- Impact of Final Rule on other federal programs in the tribe/community (HUD, BIA, etc.) _____
- Problems associated with seeking health care from non-IHS facility _____

  _____

B. SOCIAL IMPACT

- Impact of Final Rule on Community

  __Division between eligibles and non-eligibles
  __No health care services for some Indian people
  __Many people will lose eligibility for health care services
  __Lack of culturally sensitive health care providers

- Impact of Final Rule on families

  __Loss of eligibility for some family members
  __Division in family over eligibility
  __Gain in CHS eligibility for CHS services

- Reaction of tribe/community to those persons who become ineligible for health care services under the Final Rule _____

_____

- Reaction of tribe/community to those persons who become eligible for CHS services under the Final Rule _____

_____

- Impact of Final Rule on community problems such as alcohol, substance abuse, domestic violence, etc. _____

_____

- Impact of Final Rule on special populations
  - Children _____
  - Unemployed _____
  - Disabled _____
  - Elders _____

C. CULTURAL IMPACT

- Impact of Final Rule on tribal identify

  __Loss of tribal identify
  __Gain in tribal identify

- What would prevent persons from becoming members of tribe?

  __Blood quantum
  __Tribal politics
  __Not residing on/near reservation
  __Lack of transportation to tribal headquarters
  __Unaware of Final Rule
  __Intertribal marriages
  __Marriage to non-Indian

- Impact of Final Rule on tribal elections _____

_____

D. HEALTH IMPACT

- Health status of Winnebago Tribe _____

_____

- Impact of Final Rule on health status of Winnebago Tribe _____

_____

- Health resources of tribe _____

_____

- Types of health care services available for Winnebago Tribe

__IHS hospital/clinic
__Tribal health clinic
__Urban Indian health clinic
__County hospital/clinic
__City hospital/clinic
__Veterans Hospital
__Other_____

- Impact of Final Rule on health care services available to Winnebago Tribe _____

_____

- Health services provided by Winnebago Tribe

  - Kinds of services available _____

    _____

  - Eligibility for services_____

    _____

  - Impact of Final rule on tribal health services_____

    _____

  - User population _____

- Alternatives for tribal members who are not eligible for IHS health care services

  _____

- Problems associated with obtaining health care from non-IHS sources _____

  _____

- On-going health problems (diabetes, high blood pressure, etc.)

  __Types of problems _____
  __Prevalence
  __Impact of Final Rule on long-term problems

- Increase in CHS eligibles under Final Rule_____

  _____

- Impact of the Final Rule on Contract Health Service _____

  _____

CONFEDERATED TRIBES OF WARM SPRINGS CASE STUDY REPORT

I. Background

Under contract with the Indian Health Service (IHS), Office of Planning, Evaluation, and Legislation (OPEL), Support Services International, Inc. (SSI) conducted a study to determine the impact of the Final Rule (42 CFR Part 36) governing who may receive health care services from the IHS. The purpose of the study was to examine the economic, social, cultural, and health status impact of the Final Rule on reservation and urban Indian populations. In meeting the objectives of the study, data were collected through 1) tribal consultation,[1] 2) survey of the IHS user population, and 3) case studies tribes/reservations in six geographic areas within the United States. The designated geographic areas are the 1) northwest, 2) southwest, 3) northern plains, 4) east, 5) Oklahoma, and 6) Alaska. The Statement of Work (SOW) for this study specified that a single tribe/reservation was to be selected from each of the six geographic areas for study.

The case studies were designed to provide indepth information about a single group or community. It is important to note that while no single reservation or community is representative of others in any IHS Area, the results of the six case studies should be of value in determining the impact of the Final Rule on a disparate set of communities.

The Confederated Tribes of Warm Springs (hereafter referred to as the "Warm Springs Tribe") was selected as the case study site for the northwest area. This report is a summary of the findings from the Warm Springs site visit conducted in October 1992.

II. Profile of Warm Springs Tribe

The Warm Springs Reservation was formed by the Treaty of 1855 and became the home to Wascos and Sahaptin speaking bands of the Upper and Lower Deschutes. Later, Paiute prisoners of war and their families moved to the Reservation. The Reservation is currently home to the Warm Springs,

[1]Tribal consultation efforts constituted informal data collection which permitted determination of concerns about the study and positions related to the Final Rule expressed by participating tribal leaders and representatives.

Wasco, and Paiute Tribes. They are collectively referred to as the Confederated Tribes of Warm Springs.

Located in central Oregon, the Reservation covers an area of over 600,000 acres bound on the east by the Deschutes River and on the west by the Cascade Mountains. Figure 1 presents a map of the Reservation.

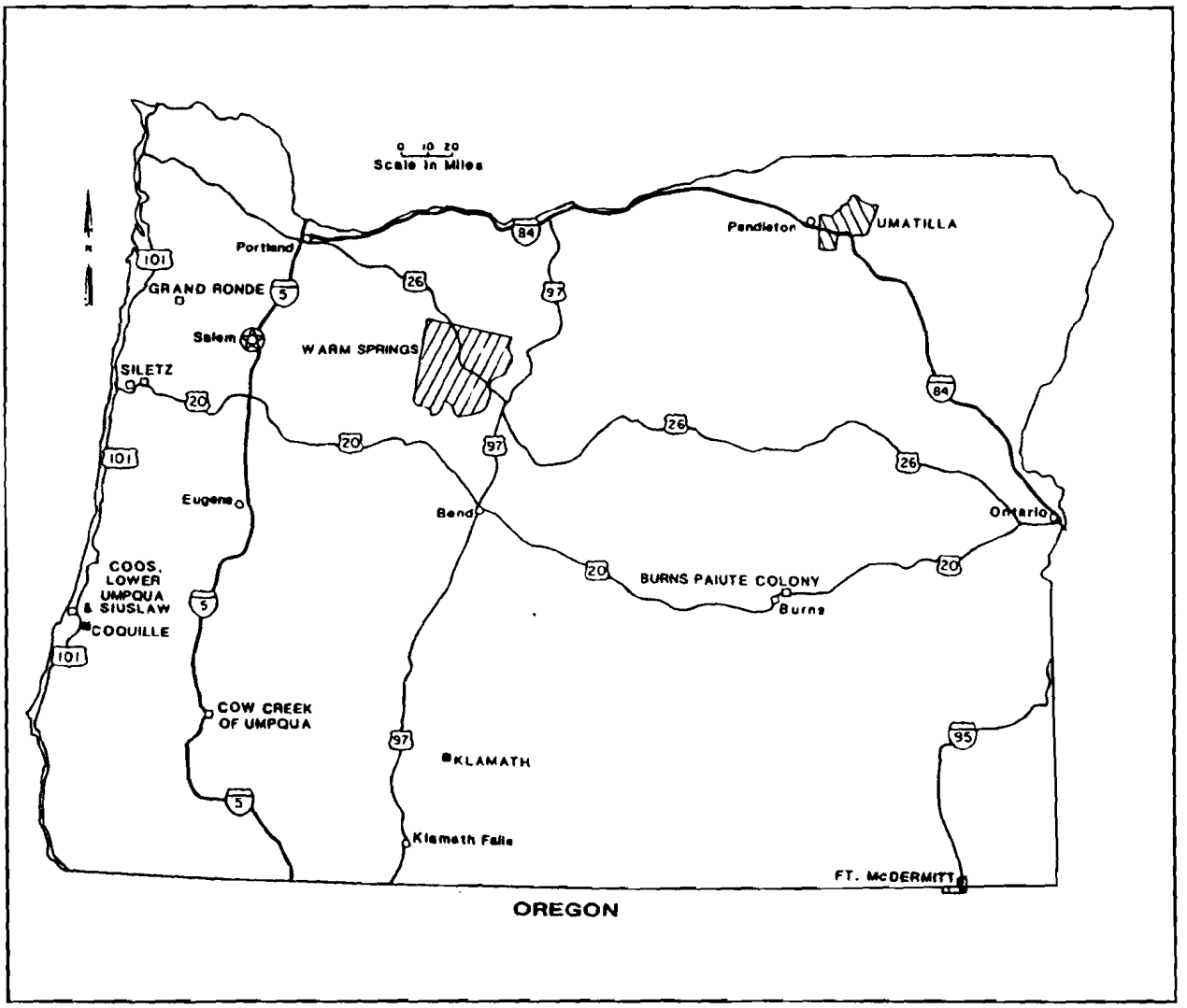

Figure 1. Location of the Warm Springs Reservation

A. Government

In 1938 the Reservation was politically organized and chartered under the Indian Reorganization Act of 1934. The tribes operate under a constitution and corporate charter, adopted by the membership at that time, which vests broad governing powers with the Tribal Council. The Tribal Council

consists of eight elected members; the three Chiefs are elected for life (one from each of the three districts), and the remaining eight council members are elected by popular vote from the three districts (three from Agency, three from Simnasho, and two from Seeksequa). Once the council is in place, the Chairman, Vice Chairman, and Second Vice Chairman are appointed. The Tribal Council also appoints the Chief Executive Officer who is responsible for the daily operation of the Confederated Tribes. Figure 2 presents an organizational chart for the Reservation.

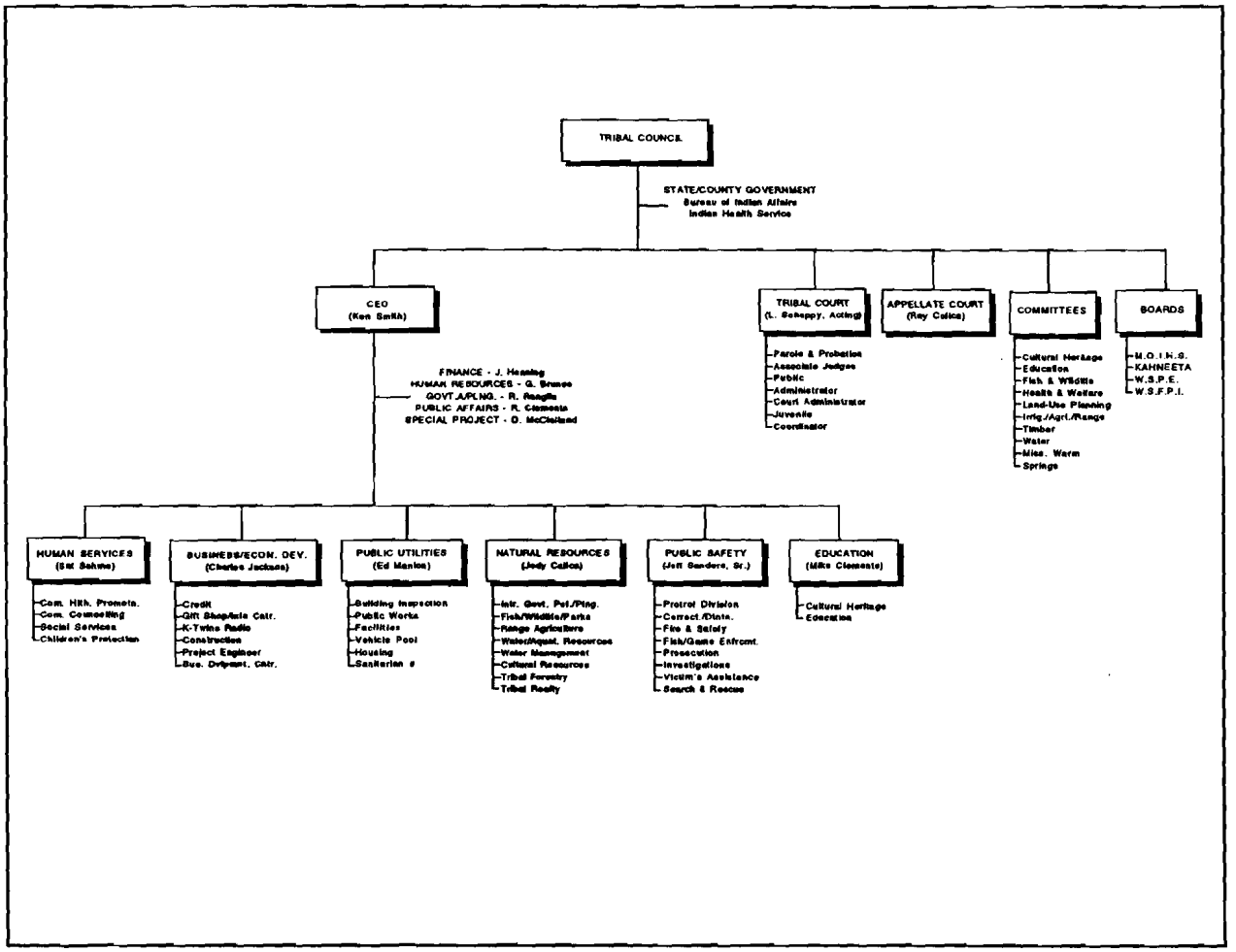

Figure 2. Tribal Organizational Chart

The Warm Springs Tribe has a strong governmental structure; each division of the government has its own clearly defined roles and responsibilities. The Health Service Delivery Area (HSDA) and the Contract Health Service Delivery Area (CHSDA) are the same and include the Reservation and the five adjacent counties of Wasco, Jefferson, Deschutes, Clackamas, and Marion.

B. Membership Criteria

The requirements for membership in the Warm Springs Tribe are as follows:

1. A person must be born to a member of the Warm Springs Tribe who is residing on the Reservation at the time of birth and be at least ¼ Warm Springs blood quantum.

2. If a person is born off the Reservation, but meets the blood quantum requirement (¼ Warm Springs), he/she must establish residency prior to applying for membership. Residency is established through living on the Reservation at least three years.

3. A person may be adopted by the Tribe. To qualify for adoption a person must meet the following requirements:

   - ❒ 1/8 degree Indian blood quantum
   - ❒ descendent of an enrolled member of the Warm Springs Tribe
   - ❒ reside on the Reservation three years prior to applying for membership
   - ❒ The Tribal Council holds a special election approximately every five years to vote in new members. To be adopted by the Tribe, a person must be on the ballot when at least 50% of the eligible voters vote. If less than 50% of the eligible voters vote, the election is considered invalid. A person may re-apply and have his name added to the ballot for the next special election. The Warm Springs Tribe currently maintains an "adoption pool" of about 105 people. Adopted members are eligible for all benefits and privileges provided to other tribal members. Informants indicated that there is a lot of friction between the enrolled members and the adoptees. The last special election was in 1987; at that time 78 names were on the ballot. The election was declared valid and 20 individuals were adopted into the Tribe.

There are 3,384 individuals enrolled in the Warm Springs Tribe, most (approximately 80-85%) of whom live on the Reservation. This is primarily attributable to their membership requirements and the economic incentives for remaining on the Reservation.

The majority of informants at Warm Springs indicated that there were no measures underway to increase tribal membership—if anything the Tribe would become more restrictive. Perhaps the

major reasoning behind limiting or restricting membership is that there are many advantages to membership in the Tribe.

C. Economy

Informants indicated that the Warm Springs Tribe has always been economically self-sufficient. Compared to the rampant unemployment that many tribes experience, the unemployment rate at Warm Springs is only about 14 percent. The Tribe presently operates many enterprises and governmental services employing in excess of 1,200 people on a year-around basis. They have several industries including the logging and forestry products industry, Ka-Nee-Tah (an exclusive tourist resort), and a hydroelectric plant. The Tribe issues monthly per capita payments to each of its members, plus a bonus check at Christmas. Tribal members under the age of 18 are given a monthly allowance of $75, and the balance is put into an Individual Indian Money (IIM) account which they receive when they reach 18 years of age. These measures are strong economic incentives for members to remain on the Reservation.

D. Health Status

The primary health problems experienced by the Warm Springs Tribes are diabetes, infant mortality, alcohol-related problems, and heart disease.

In 1988, the Confederated Tribes of Warm Springs began a strategic planning effort to improve the health of the Warm Springs community. This effort was carried out with the support of an IHS Tribal Management Grant. Through this grant, the Tribe developed a "health status information profile" which provided three categories of information: 1) the current health status of the Warm Springs community, 2) present resource investments in Warm Springs health services, and 3) present efforts to plan for and promote improved health in the community. Review of an initial profile of the Warm Springs Tribe indicated that the health status of the community was much worse when compared to other communities.[2]

In addition, the Tribe established a goal of becoming the healthiest Indian community by the year 2000. This goal includes not only the absence of disease, but improvement of living conditions, promotion of healthy, well-adjusted individuals and families, and encouragement of quality life experiences for the community.

---

[2] *Interim Community Health Report*, The Confederated Tribes of Warm Springs Reservation of Oregon, March 1992.

Health Care Resources. The Warm Springs Tribe has been providing a wide range of health and social services since the late 1960s and early 1970s. The Tribal Health Department currently administers the following programs under a 638 contract: Alcohol and Drug, Mental Health, Health Eduction, Environmental Health, Maternal & Child Health, and Community Health Representative (CHR). In addition, the Tribal Health and Social Services Department receives several state contracts all of which are in compliance and are certified as providing quality service.

IHS provides approximately 60 percent of the funding for the health care services provided to the Warm Springs Tribe. The Tribe realizes that IHS does not have adequate resources to fully meet its responsibilities to provide an adequate level of health care. Therefore, the Tribe has devoted a significant portion of its own resources to the health care effort. Over 30 percent of the health resources of the community come from tribal funding. Of this amount, approximately 9 percent is through insurance for tribal employees, and an additional 21 percent is through direct funding by the Tribe. The Tribe is gradually moving in the direction that will permit development of its capacity and capability to address the larger and broader spectrum of health care.

Twelve percent of the health care budget comes from other programs such as Medicaid and Medicare, state programs, and other third party sources.

Currently the Tribe is constructing a new 37,000 square foot health facility. The plan is to provide it lease free to the IHS under terms of Public law 101-512, Joint Venture Demonstration Project. There are currently no IHS hospitals available to the Warm Springs Tribe. IHS health care is provided through contract health services.

III. Method

The case studies were arranged through the Office of Tribal Activities (OTA) within the designated IHS Areas. The following steps were followed in arranging case study site visits:

- ❒ Project staff contacted the OTA Director within the designated IHS Area Office

- ❒ The OTA Director contacted the appropriate tribal representative(s) to discuss participation as a case study site. In three of the Areas (Alaska, the east, and Oklahoma) tribal organizations were contacted to facilitate selection of a case study site. The areas and respective organizations are
  - Alaska: the Alaska Native Health Board (ANHB)
  - East: the United South and Eastern Tribes (USET)

- Oklahoma: the Oklahoma City Intertribal Health Board.

- ❒ Project staff contacted the representatives of the selected tribe to confirm the tribe's interest in participating in the study.

- ❒ Project staff sent a packet of materials to the designated tribal contact (usually the Tribal Health Planner or the Tribal Administrator). This packet of materials included the letter from the Director of IHS, the Project Synopsis, an outline of the case study approach, a list of the types of individuals to serve as key informants as well as a list of desired secondary data sources, a draft Letter of Agreement, and a copy of the data collection guide for conducting the case studies.

- ❒ Once the Letter of Agreement was signed by the appropriate tribal official(s), a schedule of interviews was developed for the site visit.

Data were collected through 1) unstructured interviews with key informants from the tribe, and 2) review of secondary data sources. A discussion of each area is presented below.

A. Unstructured Interviews of Key informants

Unstructured interviews were conducted with the following key informants:

- ❒ Sal Sahme, Human Services General Manager
- ❒ Julie Quaid, Director, Early Childhood Education Center
- ❒ Madeline Queahpama, Supervisor, Vital Statistics
- ❒ Gayle Rodgers, Director, Social Services
- ❒ Henry Walden, Health Educator, Human Services
- ❒ Bob Jackson, Director, BIA Social Services
- ❒ Russell E. Alger, Service Unit Director, Warm Springs
- ❒ Roberta Queahpama, CHS Administrator.

The interviews, ranging from 45-60 minutes in duration, were conducted over a two-day period on October 12-13, 1992. Each informant was interviewed separately. After the interviews were completed, the interviewer prepared a summary of the information collected. At the site visit exit interview, this summary was presented to the key informants to obtain their feedback regarding any errors or omissions. No objections were raised by the informants at the exit interview. Finally, the draft of this Case Study Report was submitted to the Public Health Educator for review and feedback. This document reflects the feedback obtained from the tribal reviewers.

B. Secondary Data

The following tribal documents were collected and reviewed:

- ❒ Interim Community Health Report
- ❒ General Information on Tribe
- ❒ Data from the Service Unit

Information from these documents is included in earlier tribal profile sections and in the Findings section that follows.

IV. Findings

A. General Findings

1. Lack of information on the Final Rule. All informants indicated that most of the Warm Springs residents were probably unaware of the Final Rule. Very little information has been made available to them. The IHS has provided information to the Human Services Division and to the Tribal Council.

2. Reaction to Final Rule. Some of the informants who were familiar with the Final Rule expressed concern that implementation of the Final Rule would definitely have a negative impact on those individuals who are ineligible for membership, particularly in the area of health.

B. Tribal Membership Issues

There will likely be no effort made to increase tribal membership. If anything, the Tribe would likely become more restrictive in membership issues. There are members of the Warm Springs community who are not members of the Tribe, but are recipients of the health care services provided.

C. Health Impact

The Tribe does not have a hospital (there are no IHS Hospitals in the Portland Area), so they must rely on CHS funds for all their inpatient care. The Tribe does have its own optional self-insurance policy which became fully vested in 1989. Eighty-six percent of all eligible tribal employees are on the tribal insurance program. In the past, the Service Unit has not always followed through on third

party reimbursements; however, efforts are being made to change this. The Service Unit has an agreement with the Tribe that they will not collect on the Tribe's insurance policy.

The informants indicated that if the Final Rule is implemented, more individuals would likely be eligible for CHS. Some informants expressed a concern that current CHS funding level may be insufficient to meet the needs of the Tribe. If the number of individuals eligible for CHS increases under the Final Rule, become an even more serious problem would be created. The Northwest Portland Indian Health Board conducted their own study concerning the possible impact of the Final Rule. Their estimates indicated an increase in CHS eligibles for the Portland Area.

D. Economic Impact

Most informants indicated that the Final Rule would have a slightly negative impact on the economy. If community members currently using IHS health care services are no longer eligible under the Final Rule, additional tribal resources will be expended to provide health care services for these individuals.

E. Social Impact

Alcohol-related problems are a major health issue for the Tribe. An area of possible adverse impact of the Final Rule concerns eligibility for alcohol treatment programs involving the family. If some family members are not eligible for the treatment programs under the Final Rule, conflict would likely occur within the family. Generally, however, informants anticipated little adverse impact from the implementation of the Final Rule.

F. Cultural Impact

Informants indicated that the Final Rule would have little impact on the cultural status of the Tribe. This is attributable in part to the degree of on-going rivalry and factionalism occurring (the three tribes, status of membership, etc.) at Warm Springs.

V. Conclusions

1. There is little knowledge of, or familiarity with, the Final Rule among tribal and community members.

2. For those members who are familiar with the Final Rule, there is a sense of having to accept "another Federal policy."

3. Implementation of the Final Rule would likely result in an increase in CHS eligibles. There is concern among informants that there may be insufficient CHS funds to meet the current CHS needs of the Tribe.

4. The Tribe will likely have to expend additional funds for health care services for community members who are not members of the Warm Springs Tribe.

INDEX

LAGUNA PUEBLO CASE STUDY REPORT

I. Background

Under contract with the Indian Health Service (IHS), Office of Planning, Evaluation, and Legislation (OPEL), Support Services International, Inc. (SSI) conducted a study to determine the impact of the Final Rule (42 CFR Part 36) governing who may receive health care services from the IHS. The purpose of the study was to examine the economic, social, cultural, and health status impact of the Final Rule on reservation and urban Indian populations. In meeting the objectives of the study, data were collected through 1) tribal consultation,[1] 2) a survey of the IHS user population, and 3) case studies of tribes/reservations in six geographic areas within the United States. The designated geographic areas were the 1) northwest, 2) southwest, 3) northern plains, 4) east, 5) Oklahoma, and 6) Alaska. The Statement of Work (SOW) for this study specified that a single tribe/reservation be selected from each of the six geographic areas.

The case studies were designed to provide in-depth information about a single group or community. It is important to note that while no single reservation or community is representative of others in any IHS Area, the results of the six case studies should be of value in determining the impact of the Final Rule on a disparate set of communities.

The Laguna Pueblo was selected as the case study site for the southwest area. This report is a summary of the findings from the Laguna site visit conducted in July 1992.

II. Profile of Laguna Pueblo

The Laguna Pueblo is located approximately 45 miles west of Albuquerque, New Mexico. It is one of 19 pueblos in the area, and is bordered by the pueblos of Acoma, Isleta, and Canoncito. The Laguna Pueblo is comprised of Old Laguna and six outlying villages within a 12 mile radius. These villages include Paguate, Encinal, Paraje, Seama, Mesita, and New Laguna. Population growth and the resulting shortage of farm land at Old Laguna led to the establishment of these outlying villages (see Figure 1) beginning about 1871.

[1]Tribal consultation efforts constituted informal data collection which permitted determination of concerns about the study and positions related to the Final Rule expressed by participating tribal leaders and representatives.

Laguna was founded between 1697 and 1699 by people from Acoma, Zuni, Zia, Oraibi (Hopi), San Felipe, Sandia, and Jemez. There is much speculation about the original population; it is thought not to be from any unified tribal group, and is presumed to be most closely related to the neighboring Acoma Tribe.

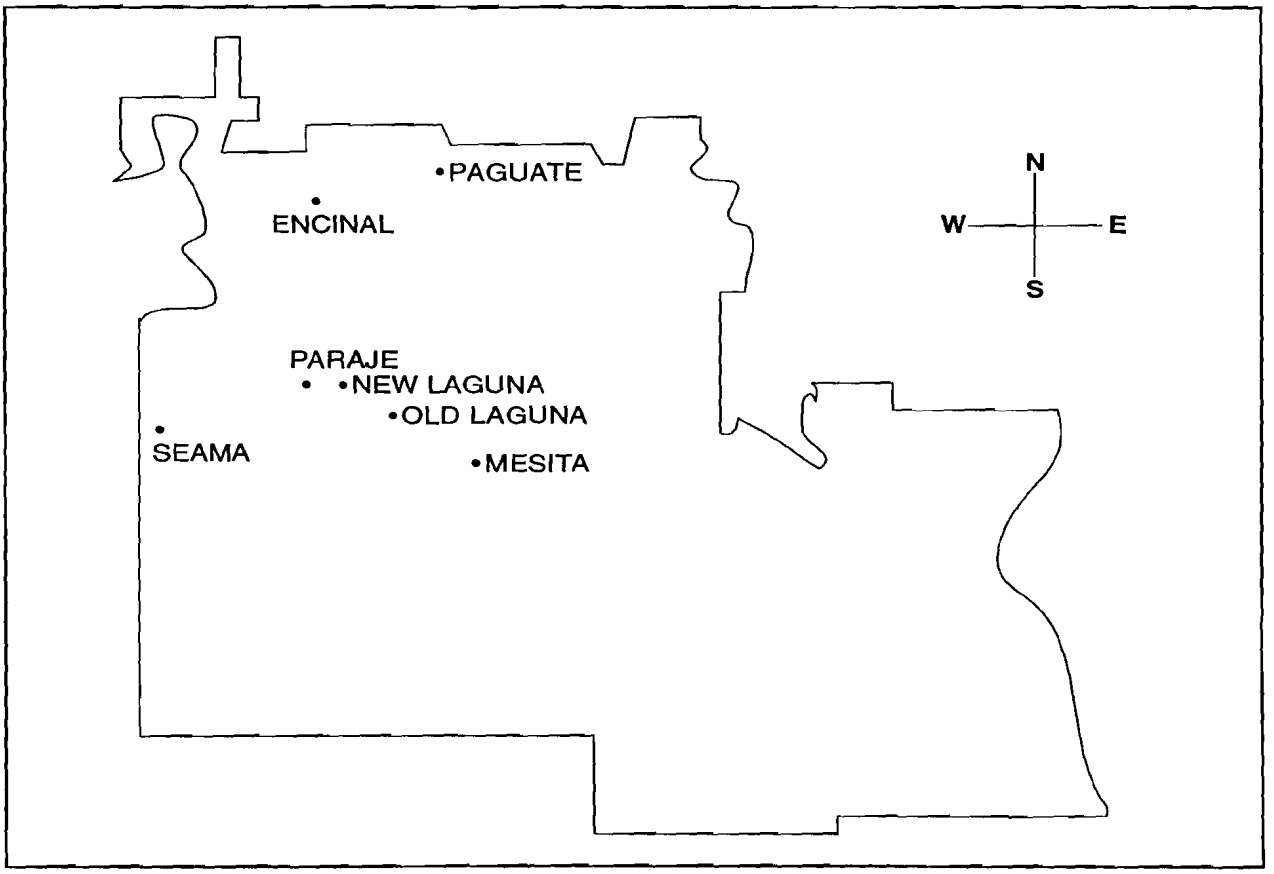

Figure 1. Laguna Tribal Reservation

The original Spanish land grant to the Lagunas consisted of 17,361 acres. Since then, and prior to the American occupation of New Mexico, the Lagunas acquired several large land areas by purchase from Spanish or Mexican landholders. In addition, twice Presidents of the United States granted the Lagunas use and occupancy of additional tracts of land. The Laguna Reservation currently consists of approximately 465,000 acres.

As of March 1992, there were 6,998 tribal members, 3,488 of whom currently reside on or near the Pueblo. Approximately 97 percent of the reservation population are tribal members.

A. Government

In 1863, Abraham Lincoln, President of the Unites States, recognized and confirmed the right of the Pueblo of Laguna to govern itself. In 1908, the Pueblo adopted its first written constitution. In 1949, the Secretary of Interior approved a new constitution adopted under the provisions of the "Indian Reorganization Act of 1934." In 1958, the Lagunas adopted a new constitution which was ratified again in 1984. This constitution specifies the qualifications for membership in the Laguna Pueblo, establishes a Pueblo Council, the Governor, and other tribal officials. Figure 2 presents the organizational structure of the Laguna tribal government.

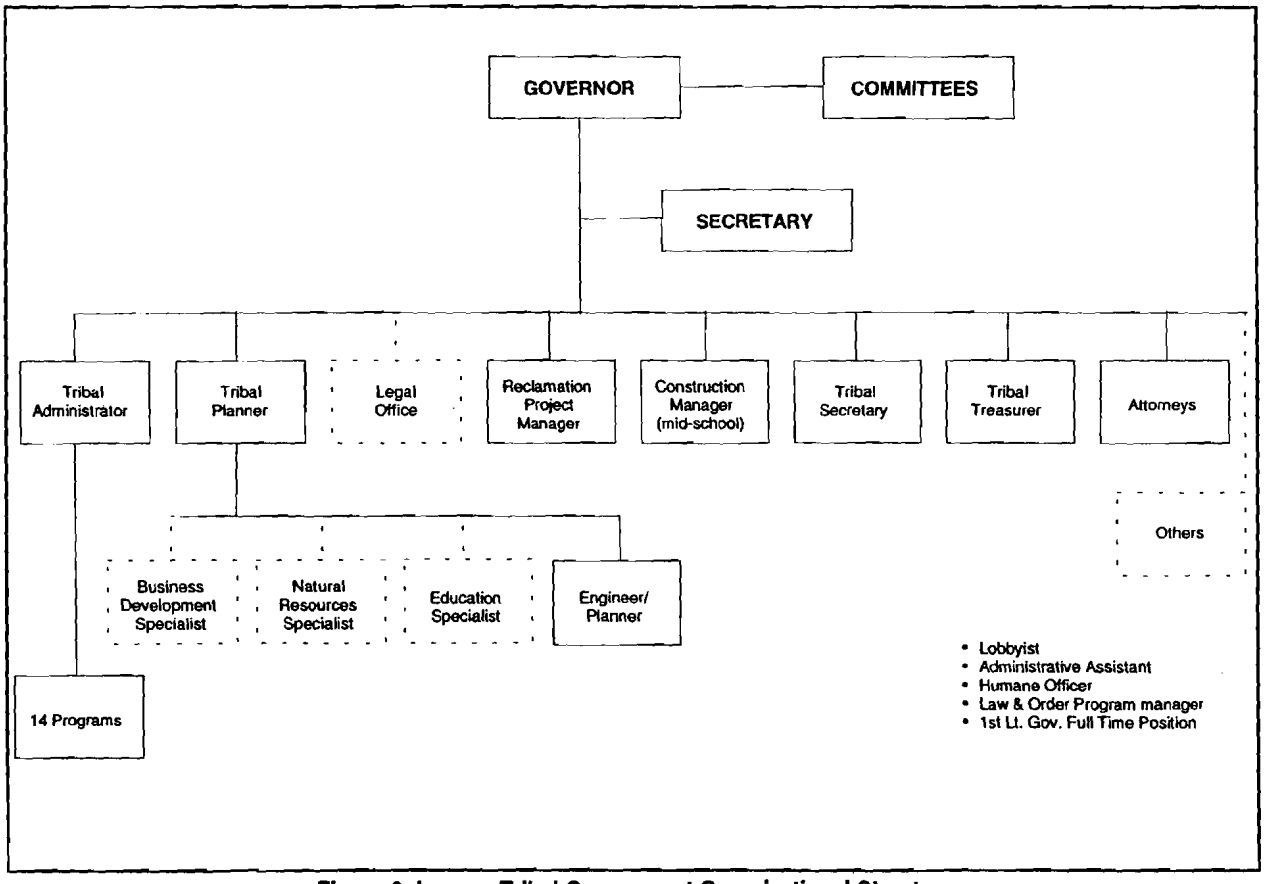

Figure 2. Laguna Tribal Government Organizational Structure

B. Membership Criteria

The Laguna Pueblo maintains a formal enrollment system which is manually operated and in good order. A person may be either a regularly enrolled or a naturalized member of the Pueblo. In order to be enrolled, a person must 1) have 1/4 degree Laguna blood quantum, and 2) be enrolled by two

years of age. Regardless of blood quantum, a person not enrolled by two years of age cannot become enrolled. In recent years the Pueblo has made per capita payments to enrolled members. These payments represent a strong incentive for Laguna parents to enroll their children in the Pueblo. The prenatal screening process at the Pueblo involves determination of eligibility for enrollment.

To become a naturalized member of the Pueblo, a person must meet four criteria; the person must 1) have at least 1/8 degree Laguna blood quantum, 2) have at least 1/4 degree Indian blood quantum, 3) reside on the Laguna Reservation, and 4) have "good standing" in the Pueblo (e.g., participate in Pueblo activities such as the maintenance of the community irrigation canals). Naturalized Lagunas enjoy all the rights and privileges as enrolled members except that they do not receive per capita distributions from the tribal treasury and cannot serve as the tribal governor. The processing of an application for naturalization sometimes requires several years for completion.

Table 1 shows the population of the Laguna Reservation by village, and by membership category.

Table 1: Population of Laguna Pueblo by Village

VILLAGE	POPULATION	ON RESERVATION	OFF RESERVATION
CASA BLANCA	315	158	157
ENCINAL	415	217	198
MESITA	962	657	305
PAGUATE	1504	658	846
PARAJE	795	363	432
SEAMA	962	356	606
LAGUNA	1882	998	884
Naturalized	127	69	58
Pending Naturalization	36	12	24
TOTAL	6,998	3,488	3,510

C. Economy

The principal economic activities of the Pueblo include services, construction, agriculture, range, and forestry. According to statistics compiled by the Bureau of Indian Affairs (BIA), there are 865 Lagunas employed. Additional tribal members would be seeking employment if child care facilities were available. Approximately 50 percent of the Lagunas living on the Reservation are unemployed due to the lack of reservation-based employment opportunities. BIA statistics also indicate that there is an unemployment rate of 23 percent of those persons actively seeking employment.

The lack of urbanization and industrialization in the area surrounding the Reservation has caused many young and highly educated Laguna members to leave the area to seek employment. Nearby cities providing employment to Lagunas are Gallup, Grants, and Albuquerque. The people of Laguna would prefer to work on or near the Pueblo so that they can participate in Laguna cultural activities. Traditions, religious beliefs, and cultural values are important and are reflected in the lifestyle and activities of the Pueblo.

Roughly 10 percent of the Laguna on-reservation population is in the age category of 65 years and older, a rate higher than the national average for all populations. This large population of elderly has resulted in the greater need for all types of services for the aging in the Laguna Pueblo. This number is likely to increase as Lagunas of retirement age return to the Pueblo to live.

The major employers on the reservation include the following:

Laguna Industries, Inc. (LII). LII was created by the Pueblo of Laguna on July 1984, and was certified by the Small Business Administration (SBA) as an 8(a) firm in the same year. This 8(a) certification is valid through 1994. LII is primarily a defense-oriented business and currently employs 240 members of the Laguna Pueblo.

Laguna Rainbow Corporation (LRC) and Laguna Elderly Care Center. The Laguna Rainbow Corporation (LRC) is a non-profit corporation chartered in 1979, and functions under the direct authority of the Laguna Pueblo Tribal Council. The LRC was established to provide a comprehensive, coordinated program of services for older tribal members living on the Laguna Reservation. The LRC is housed in a complex of buildings called the Laguna Rainbow Elderly Care Center. Among the services provided are a 25-bed residential nursing care facility, a HUD congregate housing unit (40 apartments), the Senior Companion Program, information and referral services, the Elder Day Care Program, transportation services, the Meals-on-Wheels Program, Title VI Nutritional & Social Services Program, and a few other entitlement programs.

The facility has been operating since 1982 and remains at or near 100 percent occupancy. This facility is currently the only long term care facility in New Mexico owned and operated for Indians. There is a staff of 43 persons working at the Laguna Nursing Home and Elderly Center.

Casa Blanca Market Plaza. The Laguna Commercial Enterprise, established in 1984, currently operates under the title of Casa Blanca Market Plaza (or Commercial Center). This operation consists of a major supermarket and a gas station which are both managed by the Enterprise. The Market Plaza also has five smaller shops which are leased out to other local businesses by the Enterprise. The supermarket and gas station currently employ 43 tribal members (93 percent of the workforce of the Enterprise).

Bureau of Indian Affairs. Elementary schools, road and building construction funded in part by the BIA provide jobs at Laguna.

Indian Health Service. Tribal members work at the Acoma-Canoncito-Laguna (ACL) Service Unit, in the Community Health Representative (CHR) Program, and other health related programs.

The location of the Laguna Reservation in central New Mexico, the availability of utilities, rail transportation, interstate highway I-40, good climate conditions, and "pro development" attitudes of the Tribal Council and tribal members provide a foundation for economic development. Potential areas for economic growth and development include:

- ❒ Development of a commercial park
- ❒ Tourism
- ❒ Agriculture (associated with construction of the proposed Seama Reservoir), and
- ❒ Mineral resources development.

There are, however, obstacles to economic development at Laguna. Constraints include the need for quality water, improvement of roads and development of a transportation system, housing, and the improvement of utilities. Industrial and commercial sites need to be developed. Currently the lack of capital prohibits this development.

D. Health Status

The Laguna Pueblo is served by the ACL IHS Service Unit located in San Fidel, New Mexico, approximately 15 miles from the main Pueblo village. The ACL Service Unit serves three groups: 1) the Laguna Pueblo; 2) Acoma Pueblo; and 3) the Canoncito Navajos. The ACL Service Unit consists of the ACL Hospital in Acomita, and health centers at Laguna and Canoncito. The hospital

provides general medical, pediatric, and obstetric inpatient care with 25 beds. The ACL SU also houses a dialysis unit and the New Sunrise Regional Treatment Center, a residential program for adolescents. The hospital offers a full range of outpatient and dental services as well as several specialty clinics, utilizing a combination of direct and contract services. Full diagnostic and treatment facilities support outpatient care. Well-baby, diabetic, prenatal and general medical clinics are scheduled weekly.

The health centers at Laguna and Canoncito provide a program that includes health education, public health nursing, social services, nutrition, school health program, environmental health, and alcohol and substance abuse services.

Lagunas needing medical services unavailable at the ACL Service Unit are generally referred to the IHS Indian Hospital in Albuquerque and/or private providers through the IHS contract health service (CHS) program.

The IHS regularly reports health status data for each Area, and some data are available at the Service Unit level; however, the IHS does not regularly prepare health status reports for specific tribes. While the raw data needed for such reports are available from IHS, the analyses needed to determine the health status of the Laguna Pueblo were beyond the scope of this study. Based on reports for the IHS Albuquerque Area, the major health problems confronting the Lagunas include diseases of the heart, cancer, adverse effects of accidents, diabetes, and chronic liver disease and cirrhosis.

III. Method

The case studies were arranged through the Office of Tribal Activities (OTA) within the designated IHS Area Offices: Albuquerque in this case. The following steps were followed in arranging case study site visits:

- ❒ Project staff contacted the OTA Director within the designated IHS Area Office
- ❒ The OTA Director contacted the appropriate tribal representative(s) to discuss participation as a case study site. In three of the areas (Alaska, the east, and Oklahoma) tribal organizations were contacted to facilitate selection of a case study tribe. The areas and respective organizations are:
    - Alaska: the Alaska Native Health Board (ANHB)
    - East: the United South and Eastern Tribes (USET)

- Oklahoma: the Oklahoma City Intertribal Health Board.

- ❒ Project staff contacted the representatives of the selected tribe to confirm the tribe's interest in participating in the study.

- ❒ Project staff sent a packet of materials to the designated tribal contact (usually the Tribal Health Planner or the Tribal Administrator). This packet of materials included the letter from the Director of IHS, the Project Synopsis, an outline of the case study approach, a list of the types of individuals to serve as key informants as well as a list of desired secondary data sources, a draft Letter of Agreement, and a copy of the data collection guide for conducting the case studies.

- ❒ Once the Letter of Agreement was signed by the appropriate tribal official(s), a schedule of interviews was developed for the site visit.

Data were collected through 1) unstructured interviews with key informants from the tribe, and 2) review of secondary data sources. The two data sources are described below.

A. Unstructured Interviews of Key informants

Unstructured interviews were conducted with the following key informants:

- ❒ Ramona Carillo, Head, Social Service Program
- ❒ Robert Comer, Head, Mental Health Program
- ❒ Harry D. Early, Governor
- ❒ Ramona Homer, Head, Community Health Representative Program
- ❒ Bernard Kayate, Tribal Administrator
- ❒ Jose Lucero, Enrollment Clerk
- ❒ Catherine Lopez, RN, Head, Rainbow Elderly Center
- ❒ Richard Luarkie, Tribal Planner
- ❒ E. Anne Ray, Head, Head Start Program
- ❒ Timothy Sarracino, Head, Adult Education Program
- ❒ James Toya, IHS ACL Service Unit Director.

The interviews, which ranged from 45-60 minutes in duration, were conducted over a two-day period in July 1992 at the Pueblo administration building. Each informant was interviewed separately. After the interviews were completed, the interviewers prepared a summary of the information collected. At the site visit exit interview, this summary was presented to the key informants to obtain

their feedback regarding any errors or omissions. No objections were raised by the informants at the exit interview. Finally, the draft of this Case Study Report was submitted to the Tribal Administrator for review and feedback.

B. Secondary Data

The following documents were collected and reviewed:

- ❒ Constitution of the Laguna Pueblo
- ❒ Map of Laguna Reservation
- ❒ Laguna Pueblo Overall Economic Development Plan
- ❒ ACL Service Unit Data
- ❒ IHS Patient Registration System Eligibility Data.

Information from these documents is included in earlier tribal profile sections and in the Findings section that follows.

IV. Findings

A. General Findings

1. Lack of Information on the Final Rule. While several informants had heard of the Final Rule, none were familiar with its provisions. Consequently, the Pueblo had not developed a detailed position on the Final Rule. Furthermore, the tribal officials generally lacked data needed to determine or accurately estimate the cultural, social, economic, and health status impact of the Final Rule on the Pueblo. The lack of familiarity with the Final Rule is associated, in part, with changes in the administration of the Pueblo. For example, the Pueblo Governor stands for election each year. None of the informants were in their present positions when the Final Rule was promulgated (1986). The fact that implementation of the Final Rule was twice delayed by mandates from Congress seems to have added to the confusion and misunderstanding.

2. Repudiation of the Final Rule. No informant embraced the Final Rule; rather, it was greeted with suspicion. One informant stated that the Final Rule looks "like another 'termination' effort." Governor Early stated that "this sounds like a gimmick to curtail services or to contain costs." Most informants asked why the current eligibility rules could not be retained, indicating that they saw little wrong with the current rules.

B. Tribal Membership Issues

The informants indicated that during the 1930s-1950s, the Federal government forced Laguna parents to send their children away from the Pueblo to boarding schools operated by the BIA. This separation was associated with marriages and pairings between Lagunas and members of other tribes or with non-Indians. Consequently, many children were born who had only ½ degree Laguna blood quantum. In subsequent generations, this blood quantum was often further reduced. This process was (and is) exacerbated when a child's mother was not married to the father. In such cases, the father's blood quantum is not recognized in the child's enrollment. For example, a child might be a full-blooded Indian. His mother might have 4/4 degree Indian blood as follows: ¼ Laguna, ¼ Acoma, ¼ Navajo, and ¼ Sioux. The father might be 4/4 Laguna. If the parents were unmarried (and the father's paternity was not identified), the father's Laguna blood quantum would not be recognized in the child. Consequently, the child would be recognized as ⅛ Laguna and, therefore, ineligible for enrollment in the Laguna Pueblo because he lacked the requisite ¼ Laguna blood quantum.

The informants stated that strong social pressures often operate against identification of the father—for example, the father may be married to a woman other than the child's mother, and identification of his paternity would cause hurt and social strife within the Pueblo. Such strife is contrary to the "Laguna Way." Because the child in this example would be recognized as having both the requisite ⅛ Laguna blood quantum and the requisite ¼ Indian blood quantum, the child would be eligible to become a naturalized Laguna—so long as he/she was living on the Reservation and remained in good standing with the Pueblo.

No data were available on the number of Indians residing on the Pueblo who were either ineligible for membership in the Laguna Pueblo or in some other federally recognized tribe (i.e., persons who would become ineligible under the Final Rule). Estimates of the number of Pueblo residents who would lose eligibility under the Final Rule ranged from 10 percent to 30 percent. Regardless of the number of people involved, the informants unanimously stated that it would be unfair to deny health services to Indian people who cannot demonstrate, for whatever reason, membership in a particular federally recognized tribe. The Governor and Tribal Administrator stated that the United States has a treaty obligation to provide health care to Indian people. Governor Early stated that the provision of health care was "not a promise but a treaty agreement."

Each informant was asked if the Pueblo would consider changing its requirements for membership so that Indians of Laguna descent who are currently ineligible for membership in the Pueblo could retain eligibility for IHS services under the Final Rule. Each informant indicated that the Pueblo Council would probably consider changing the membership requirements; however, such a change

was viewed as a multidimensional, complex issue likely to provoke divisive conflict among various groups in the Pueblo.

Two informants pointed out that there is great variation in the requirements for membership across federally recognized tribes. Since the Final Rule defines eligibility in terms of tribal membership, descendants of tribes with "conservative" membership requirements (e.g., requiring a high degree of blood quantum) will be treated differently from descendants of tribes with "liberal" membership requirements. The informants argued that such differences would be unfair.

C. Health Impact

All of the informants agreed that enrolled and naturalized Lagunas would be unaffected by or would benefit from the Final Rule. Conversely, all informants stated that Laguna descendants and other Indians who do not meet the requirements for regular or naturalized membership in the Laguna Pueblo (or other tribe) will be unfairly denied IHS health care services under the Final Rule. The following vignettes were provided by the informants to illustrate the expected negative impact of the Final Rule on the health status of the community.

1. Vulnerable Children. Several respondents observed that children are especially vulnerable from birth to 5 years of age. During this vulnerable time, the child cannot postpone needed health care for the clarification of eligibility issues. Several respondents estimated that 15-30 percent of the 5,000 Indians living on or near the Reservation would be denied services under the Final Rule requirement of being a member of a federally-recognized tribe. This problem would get worse with each generation. Governor Early stated that "it's wrong not to serve Indian kids—there's a need for some method of providing for Indian children who are not members."

One informant stated that it is not uncommon for grandparents to be raising the offspring of their unmarried children (i.e., grandchildren). These children are the ones most likely to 1) not be enrolled Lagunas, and 2) have health problems (e.g., as a result of poor prenatal care of the mother)—these children will be ineligible for health care services under the Final Rule.

2. Families with both Eligible and Ineligible Members. The Director of the Mental Health program observed that often a family or household is the focus of treatment. Examples given included treatment of head lice, family violence, and substance abuse. It is not uncommon for a household to include one or more Indians who are not members of the Laguna Pueblo or another tribe. Under the Final Rule, such persons (if 19 years old or older) would be ineligible for IHS care. In such circumstances, the treatment provided to the family would be vitiated. For example, if a substance abuser or a perpetrator of family violence were ineligible for IHS services, treatment of the problem

would be ineffective for the IHS eligible members of the household. Similar problems were predicted by the informants in the treatment of communicable diseases such as hepatitis and tuberculosis.

3. Alternative Health Resources for Indians Ineligible Under the Final Rule. The alternative health care facility nearest to the Laguna Pueblo is a hospital located in Grants, New Mexico, approximately 50 miles to the west. The informants stated that many Pueblo residents lack reliable transportation needed to travel to Grants. Moreover, with an average annual household income of less than $10,500, most Pueblo residents cannot afford to purchase health care even if they could travel to the available resources.

Several informants stated that while Medicare and Medicaid programs help supplement the health care provided by IHS, two barriers make these programs unavailable to Lagunas: 1) the lack of reliable transportation to the certifying agencies, and 2) cultural and language barriers separating Pueblo residents from the certifying agencies and providers. The same barriers generally pertain to Indians ineligible for membership in the Pueblo.

D. Economic Impact

The informants were asked to consider the likely economic impact of the Final Rule. Several respondents stated that, in accordance with Laguna values, families would be strongly motivated to help family members ineligible for IHS health care under the Final Rule to obtain and pay for needed health care. Given the low level of average annual Laguna household income (less than $10,500), attempts to pay for health care would be made at the expense of other necessities like food and shelter. A likely result would be to "drag down" the entire family.

Absent reliable information on the number of Laguna residents who will become ineligible under the Final Rule and, without knowledge of their employment status, the informants indicated that they could not make reasonable estimates of the economic impact of the Final Rule on the Pueblo. Nevertheless, there was a consensus that to the extent that residents lost their eligibility for IHS services, there would be a negative impact on the Pueblo economy.

The Pueblo is planning to assume greater control over its health program in the future. The Tribal Planner indicated that the Pueblo plans to obtain a "638" contract to manage its own health care. The implications of the Final Rule for these plans were unclear to the informants when the data were collected.

E. Social Impact

Discussions of the social impact of the Final Rule focused on the family. Several informants said that families will try to provide the funds needed to obtain medical care for family members who become ineligible under the Final Rule. As indicated above, these efforts are likely to bankrupt such families. One informant stated that the family will be placed in an impossible position—family members will feel duty bound to provide the needed funds but will be unable to do so.

It was noted that the Final Rule will tend to create unnatural divisions in the Laguna family and community. For example, when a mother is enrolled but her child is not, the child will become ineligible on attaining the age of 19. One informant observed that the mother does not "stop being a mother when her child has his 19th birthday. When such a child becomes ill, the mother and the family will be torn apart."

F. Cultural Impact

As with the other dimensions of the impact of the Final Rule, the informants found it difficult to assess the impact of the Final Rule on Laguna culture. Nevertheless, several values were mentioned in the interviews. Two informants mentioned the importance of protecting future generations of the Laguna. There is a clear responsibility, felt by all Lagunas, to think and act in ways that will benefit and protect future generations. The informants expressed concern that the impact of the Final Rule on future generations was unclear; however, there was a sense that the Final Rule would somehow be harmful to future generations.

V. Conclusions

1. The key informants are generally unaware of the details of the Final Rule, and lack information needed to estimate the impact of the Final Rule on the Laguna Pueblo.

2. The key informants universally oppose the implementation of the Final Rule, view it with suspicion, and prefer the current eligibility regulations.

VI. Recommendations

A. Recommendations of Key Informants

Each informant was asked for ideas on ways to change the Final Rule to compensate for its apparent problems. The following suggestions were made:

1. Build in flexibility. Allow for special cases, especially for Indian people who are not members of a particular tribe, but who have parents and grandparents who are members of such tribes.

2. IHS to pay deductible for private insurance. Often tribal members have private insurance. For example, tribal employees are provided private medical insurance. IHS should pay the deductible for service received by eligible individuals who have such insurance.

3. Personalize letters to tribal officials. Governors and tribal chairmen and other officials receive great quantities of mail yet lack sufficient administrative support systems. Consequently, important communications from Federal agencies sometimes do not get the attention they merit. If the individual's name is included in the address, the correspondence will have a greater chance of getting to the right person.

B. Contractor's Recommendations

1. Approach the issue of eligibility at the Service Unit level. Make each Service Unit Director responsible for working with the tribes served on the eligibility issue. Develop a consensus with the tribes working from the bottom (i.e., local level) up.

2. Frankly discuss with the tribes the costs and benefits associated with different eligibility requirements.

3. Do not implement the Final Rule until a reasonable degree of consensus is achieved with the tribes on the best way to deal with eligibility. Such an approach is coincident with the principle of self-determination.

INDEX

MIAMI TRIBE OF OKLAHOMA
CASE STUDY REPORT

I. Background

Under contract with the Indian Health Service (IHS), Office of Planning, Evaluation, and Legislation (OPEL), Support Services International, Inc. (SSI) conducted a study to determine the impact of the Final Rule (42 CFR Part 36) governing who may receive health care services from the IHS. The purpose of the study was to examine the economic, social, cultural, and health status impact of the Final Rule on reservation and urban Indian populations. In meeting the objectives of the study, data were collected through 1) tribal consultation,[1] 2) a survey of the IHS user population, and 3) case studies of tribes/reservations in six geographic areas within the United States. The designated geographic areas were the 1) northwest, 2) southwest, 3) northern plains, 4) east, 5) Oklahoma, and 6) Alaska. The Statement of Work (SOW) for this study specified that a single tribe/reservation was to be selected from each of the six geographic areas for study.

The case studies were designed to provide in-depth information about a single group or community. It is important to note that while no single reservation or community is representative of others in any IHS Area, the results of the six case studies should be of value in determining the impact of the Final Rule on a disparate set of communities.

The Miami Tribe was selected as the case study site for the Oklahoma area. This report is a summary of the findings from the site visit to the Miami Tribe conducted in early December 1992.

II. Profile of the Miami Tribe

The Miami Tribe of Oklahoma is located in the northeast corner of the state. The Miamis are part of a consortium (The Inter-Tribal Council, Inc.—ITCI) with five other tribes in the area which include 1) Modoc, 2) Ottawa, 3) Seneca-Cayuga, 4) Eastern Shawnee, and 5) Peoria. These six

[1]Tribal consultation efforts constituted informal data collection which permitted determination of concerns about the study and positions related to the Final Rule expressed by participating tribal leaders and representatives.

tribes are served by the IHS Miami Indian Health Center and the Claremore Service Unit. Although not a part of the ITCI, the Quapaw and Wyandotte are served by the Health Center also.

The ITCI administers a variety of programs available to the six member tribes. Among the programs are: the Job Training Partnership Act (JTPA); Adult Education; Food Distribution; Women, Infant, and Children (WIC); and substance abuse. At the time of the site visit, the Chief of the Miami Tribe was also the Chairman of the ITCI.

According to *The Miami Tribe of Oklahoma: Past, Present, and Future*, an unpublished document written by the tribal librarian, Karen Alexander, the first written mention of the Tribe was in 1658 by Gabriel Druillettes.[2] Druillettes referred to the Miami by the Chippewa term "Oumamik" which means "the peninsula dwellers." In their own language, the Miami called themselves "Twa-h-twa-h" which means the "cry of the crane."

The Tribe's aboriginal area was near the present day Green Bay, Wisconsin. At the beginning of the eighteenth century, the Tribe migrated to areas now known as southern Indiana and southwestern Ohio. The Miamis became allies with the French and, subsequently, with the English. Resenting the confiscation of their land, the Miamis fought the United States, and were defeated by General Anthony Wayne at the Battle of Fallen Timbers. In 1795, peace was established between the Miamis and the United States by the *Treaty of Greenville.*

In 1840 the Miamis signed a treaty with the United States that called for a move to what is now Miami County, Kansas. Part of the Tribe was granted permission to remain in Indiana; these persons (and their descendants) are known as the "Eastern Miamis." The bulk of the Tribe moved to Kansas over a six year period, and are known as the "Western Miamis." The Treaty of 1867 called for the Tribe to relocate from Kansas to what is now their current home in Ottawa County, Oklahoma. In the early days of the division, there was a great deal of interaction between the Eastern and Western Miamis. Consequently, many descendants of the Eastern Miamis relocated to Oklahoma with the Western Miamis. The Miamis who moved to Oklahoma became the federally recognized tribe that is the subject of this case study. The Eastern Miamis who remained in Indiana are currently seeking federal recognition.

In 1934, the *Oklahoma Welfare Act* permitted Indian tribes to form federal corporations with constitutions and bylaws. Five years later, under the leadership of Chief Harley Palmer, the constitution of the Miami Tribe of Oklahoma was ratified by the Tribe. The Tribe received its corporate charter on April 15, 1940. The current constitution and bylaws were amended and approved on May 28, 1987.

---

[2]The bulk of this tribal profile is adapted from Ms. Alexander's document.

The current tribal enrollment is 1,475 with approximately 350 members residing in Ottawa County or adjacent counties (including counties in the states of Kansas, Missouri, and Arkansas). Figure 1 shows the location of the Miami Tribe in the northeastern corner of Oklahoma.

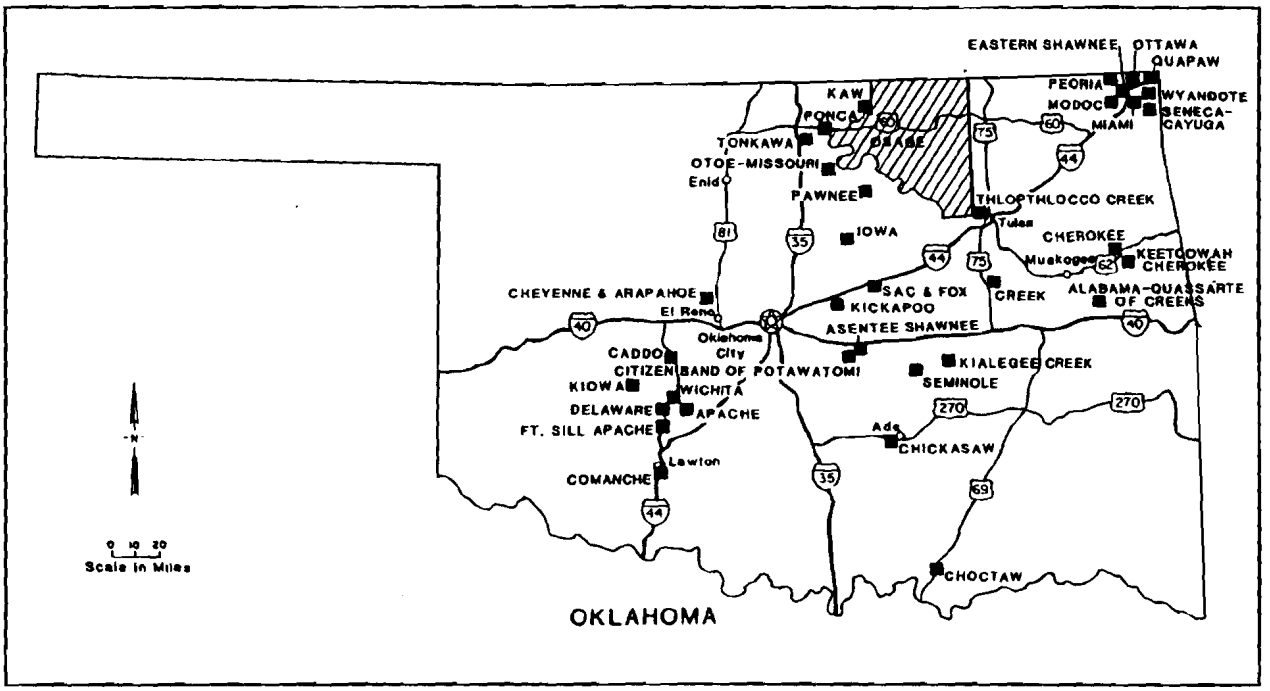

Figure 1. Location of the Miami Tribe in Oklahoma

A. Government

According to the tribal constitution, the supreme governing body of the Miami Tribe is the "Miami Council." This Council consists of all Miamis 18 years old and older. The Miami Tribe is represented by a Chief, a Second Chief, a Secretary-Treasurer, and two Councilmen, all elected by a majority vote of the Tribal Council. These elected officials constitute the Tribe's Business Committee which is empowered under the constitution to appoint subordinate committees and representatives to transact business and otherwise speak for the Tribe. The tribal members also elect three persons to serve on a Grievance Committee. Members of the Business Committee are barred from serving on the Grievance Committee. The term of office for all tribal officials is three years. Elections are held on the first Tuesday in September.

The current Chief has served since 1989 and had previously served as Chief from 1974 to 1982. He acts as Chairman of the Business Committee, and is the Head of the Executive Branch of the Tribe. In the absence of the Chief, the Second Chief performs the official duties. The Secretary-Treasurer

is responsible for the maintenance of all tribal records, including the tribal membership list, and for the disbursement and accounting of all tribal funds.

The Tribe employs 11 persons, primarily directors of programs such as education, tribal membership, and social services. Figure 2 presents the tribal organizational chart.

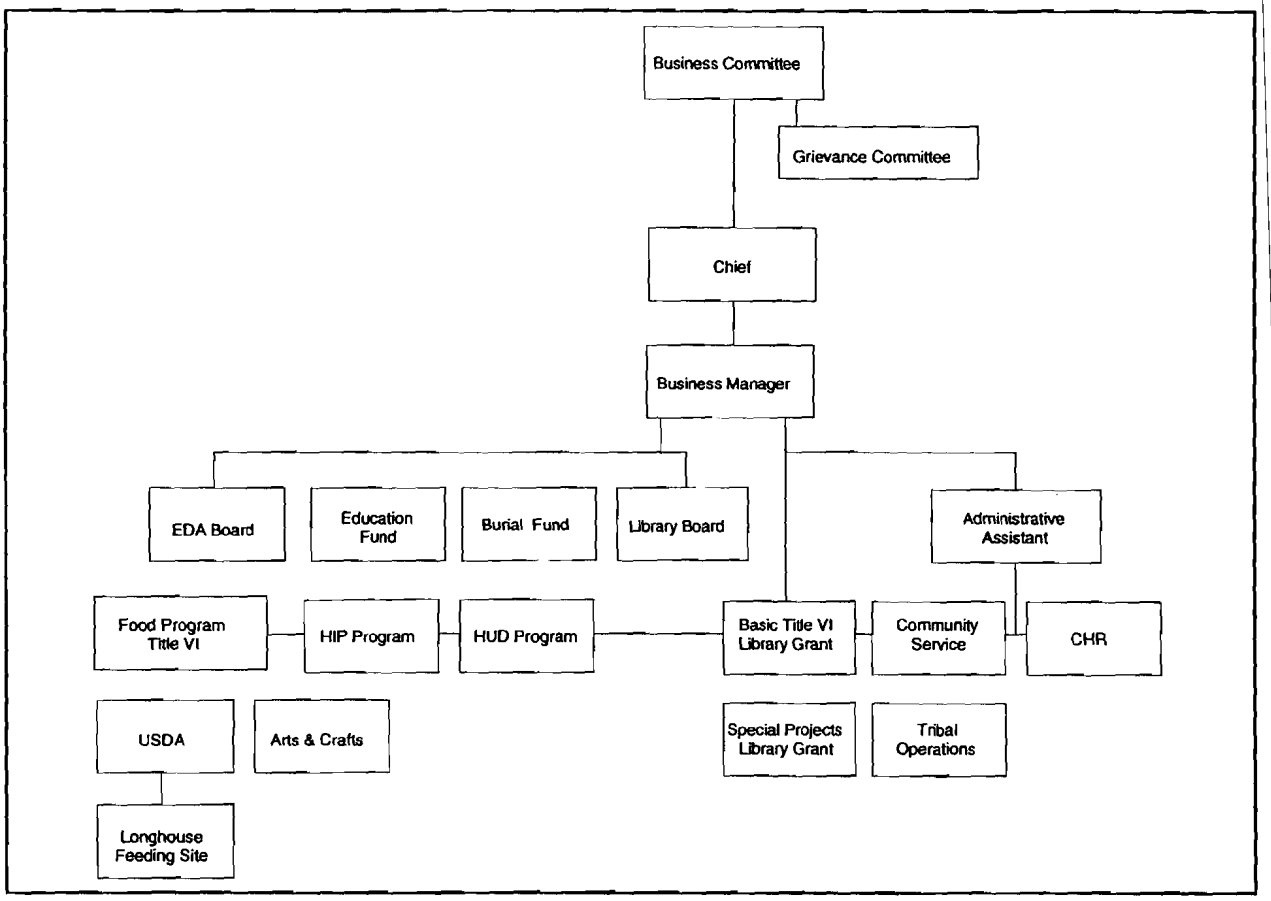

Figure 2. Miami Tribe of Oklahoma Organizational Chart

B. Membership Criteria

To be a member of the Miami Tribe, a person must demonstrate lineage/descent from a member of the 1937 tribal census; this descent must be direct and uninterrupted. Specifically, to be enrolled in the Tribe, a person must meet one of the following four conditions:

1. Be listed on the tribal roll of 1937;
2. Be a child of two parents listed on the tribal roll;

3. Be a child born of marriage between a member of the Miami Tribe and a member of any other Indian tribe;
4. Be a child born of a marriage between a member of the Miami Tribe and another person, if such child is approved for membership by the Tribal Council.

Each year at the annual meeting in September, the Tribe acts on applications for enrollment from persons in Category 4 above.

Blood quantum is not a criterion for membership, and few members have a blood quantum of one-fourth or more Miami. The head of the tribal enrollment, Janis Poque, estimated that 50-100 persons have applied for membership but cannot be enrolled because they cannot meet the requirements. The Tribe is currently considering modifying its enrollment criteria to include adoption into the Tribe.

C. Economy

The Miamis own majority interest in a short-haul petroleum trucking firm, Fritz Freight, Headquartered in Oklahoma City. In addition, the Tribe operates a gift shop at the tribal headquarters. Some tribal members are employed in the local economy in low skill and low paying jobs such as restaurant workers, and gasoline station workers. According to statistics compiled by the Bureau of Indian Affairs (BIA), the unemployment rate for the Miamis living "on or near the 'Reservation'" is 75 percent. Accordingly, unemployment and poverty are distressingly high for the Tribe.

D. Health Status

The Miamis are served by the Miami Indian Health Center. This clinic, shared with the other five tribes of the ITCI and the Quapaw and Wyandot Tribes, has seven screening rooms, and provides general medical, X-ray, laboratory, pharmacy, optometry, and dental services. The medical staff is composed of three physicians (MDs), a physician's assistant (PA), a public health nurse (PHN), two registered nurses (RNs), two licensed practical nurses (LPNs), and a nursing assistant. When the Health Center is unable to meet the medical needs of tribal members, referrals are generally made to the PHS Claremore Indian Hospital (over a one-hour drive from the Miami tribal headquarters) or to the Miami Baptist Regional Health Center (about five miles from the tribal headquarters) using IHS contract health service (CHS) funds.

The Tribe lacks the resources to compile information about the health status of its members, and the IHS reports data by Area rather than by tribe. Therefore, there is no readily available information about the health status of the Tribe. The Miami Indian Health Center provided 32,318, 36,736, and

39,714 outpatient visits in the years 1990, 1991, and 1992 respectively; however, these patient visits include all six tribes in the ITCI and the neighboring tribes of Quapaw and Wyandot. Interviews with staff at the Health Center indicated that the primary health problems of the Miamis include diseases of the heart, accident-related injuries, cancer, and diabetes.

III. Method

The case studies were arranged through the Office of Tribal Activities (OTA) within the designated IHS Area Offices. The following steps were followed in arranging case study site visits:

- ❒ Project staff contacted the OTA Director within the designated IHS Area Office.

- ❒ The OTA Director contacted the appropriate tribal representative(s) to discuss participation as a case study site. In three of the Areas (Alaska, east, and Oklahoma) area tribal organizations were contacted prior to contacting the individual tribe. The areas and respective organizations are

    - Alaska: the Alaska Native Health Board (ANHB)
    - East: the United South and Eastern Tribes (USET)
    - Oklahoma: the Oklahoma City Area Intertribal Health Board

Project staff worked with the President of the Oklahoma City Area Intertribal Health Board in selecting a tribe for participation as a case study site.

- ❒ Project staff contacted representatives of the selected tribe to confirm the tribe's interest in participating in the study.

- ❒ Project staff sent a packet of materials to the designated tribal contact (usually the Tribal Health Planner or the Tribal Administrator). This packet included a letter from the Director of IHS, the Project Synopsis, an outline of the case study approach, a list of the types of individuals to serve as key informants, a list of desired secondary data sources, a draft Letter of Agreement, and a copy of the data collection guide for conducting the case studies.

- ❒ Once the Letter of Agreement was signed by the appropriate tribal official(s), a schedule of interviews was developed for the site visit.

Data were collected through 1) unstructured interviews with key informants from the Tribe, and 2) review of secondary data sources. A discussion of each area is presented below.

A. Unstructured Interviews of Key informants

Unstructured interviews were conducted with the following key informants:

- ❒ Floyd Leonard, Chief
- ❒ David Olds, Second Chief
- ❒ Jim Estes, Tribal Administrator/Head, Economic Development Division
- ❒ Virginia Fanning, Tribal Health Director
- ❒ Karen Alexander, Tribal Education Director
- ❒ Janis Poque, Tribal Membership
- ❒ John Ballard, Director, Social Services Division
- ❒ Sharon Dawes, Business Officer, IHS Miami Service Unit
- ❒ Bill Follis, Chief, Modoc Tribe (at Chief Leonard's invitation).

The interviews, ranging from 50-90 minutes in duration, were conducted over a two-day period in December 1992 at the tribal headquarters. Each informant was interviewed separately. After the interviews were completed, the interviewer prepared a summary of the information collected. At the site visit exit interview, this summary was presented to the key informants to obtain their feedback regarding any errors or omissions. No objections were raised by the informants at the exit interview. Finally, the draft of this Case Study Report was submitted to the Tribal Chief for review and feedback. This document reflects the feedback obtained from the tribal reviewers.

B. Secondary Data

The following documents were collected and reviewed:

- ❒ Constitution of the Miami Tribe
- ❒ Map of "reservation" of the Miami Tribe
- ❒ Overall Economic Development Plan of the Miami Tribe
- ❒ *From Our Wigwam to Yours*, a community resource booklet
- ❒ BIA Unemployment Data
- ❒ *Miami Tribe of Oklahoma: Past, Present, and Future* a document authored by Karen Alexander, the tribal librarian

Information from these documents is included in the tribal profile section and in the Findings section.

IV. Findings

A. General Findings

1. Lack of Information on the Final Rule. While several informants had heard of the Final Rule and had reviewed relevant documents prior to the site visit, they indicated they did not fully understand all of the implications of the Final Rule. Consequently, the Tribe had not developed a formal position on the Final Rule. Furthermore, tribal officials generally lacked data needed to determine or accurately estimate the cultural, social, economic, and health status impact of the Final Rule on the Tribe. The fact that implementation of the Final Rule was twice delayed by Congressional mandates seems to have added to the confusion and misunderstanding about the Final Rule.

2. Expectation that the Final Rule would have little impact on the Tribe. The informants expressed a number of concerns about the availability of health care and the health care status of the Miami Tribe, but the proposed IHS eligibility regulations were not viewed as a major concern.

B. Tribal Membership Issues

The informants were unanimous in the view that the Final Rule would have little or no impact on the tribal membership system. The Tribal Health Director pointed out that the Final Rule is likely to pose a problem for other tribes—tribes with membership criteria that include blood quantum requirements. Often changes in membership rules require changes in tribal constitutions—changes which cannot be accomplished easily or quickly. Such constitutional changes often take at least three years to accomplish. Furthermore, the time required to secure formal enrollment or membership often exceeds nine months. The Tribal Health Director concluded that many Indian people in other tribes are likely to lose IHS services under the Final Rule.

C. Health Impact

As indicated in the general findings, the informants expect that the Final Rule will have little impact on the health status of the Tribe.

One informant observed that the Final Rule is unfair. He pointed out that tribes such as the Miami and Cherokee have many members with a relatively low degree of Indian blood quantum (membership rules for these tribes have no blood quantum requirement) who will be eligible for IHS care under the Final Rule; however, some "full blood" Indians who are not tribal members, for whatever reason, will be denied IHS care under the Final Rule. Still, this informant was of the opinion that the Final Rule would have little effect on the Miamis or on the other tribes in the ITCI. He added that using tribal membership as the focus of eligibility was a good idea.

One of the major concerns expressed by the informants was that many tribal members reside in Kansas, Arkansas, and Missouri; these Miamis are just outside the boundaries of the IHS service delivery area and, consequently, receive neither direct care nor CHS from the IHS. The Tribe's fundamental concern was the unfairness of eligibility based on area or residence location; eligibility based on tribal membership was acceptable.

Another major concern expressed was that health care is available to Miamis only in the hours 8:30 a.m. to 4:30 p.m. Monday through Friday when the IHS Clinic is open. Should a Miami need health care when the Miami Clinic is closed, he must travel to the Claremore Indian Hospital which is more than one hour away by automobile. Such a trip is especially difficult for tribal elders who are unable to drive or who may not have an automobile. The informants were familiar with the Pawnee Benefit Package, and they liked the flexibility associated with that system.

The Assistant Director of the Miami Health Clinic indicated that the clinic was currently operating at full capacity. For example, there is no more space for patient charts, and clinic staff often work until 7:00 p.m. (the clinic closes at 4:30 p.m.) completing the day's work. Often "overflow" patients are referred to Claremore. Therefore, planning for the impact of the Final Rule should include analysis of capacity and workload. In the case of the clinic serving the Miami Tribe, the informant anticipated no significant change in workload associated with the Final Rule.

D. Economic Impact

The informants were asked to consider the likely economic impact of the Final Rule. The clear consensus was that no economic impact was anticipated.

E. Social Impact

The informants stated that they expected the Final Rule to have no impact on the social relations among the Miamis.

F. Cultural Impact

As with the other dimensions of the impact of the Final Rule, the informants found it difficult to assess the impact of the Final Rule on Miami culture. Nevertheless, the consensus among the informants was that the Final Rule would have little impact on Miami culture.

V. Conclusions

1. The key informants are generally unaware of the details of the Final Rule, and lack information needed to make confident estimates of the impact of the Final Rule on the Miami Tribe.

2. The key informants anticipated that the Final Rule would have little or no impact on the health status, economy, social components, or culture of the Miami Tribe.

3. The focus of the Final Rule on tribal membership was welcomed by the informants.

4. Several informants stated that they believed that the Final Rule would result in the unfair denial of IHS care to Indian people of other tribes, primarily as a function of these tribes' blood quantum requirements for membership.

VI. Recommendations

Each informant was asked for ideas on ways to improve the Final Rule. The following suggestions were made:

1. Build in flexibility in eligibility determinations. Allow for special cases, especially for Indian people who are not members of a particular tribe, but who have parents and grandparents who are members of such tribes.

2. Expand the IHS service area so that tribal members living near the Miami lands in the states of Missouri, Kansas, and Arkansas are eligible for both IHS direct and contract care.

3. Expand managed care solutions like the Pawnee Benefit Package which allow tribal members to access the local medical resources.

INDEX

Nondalton Village Case Study Report

I. Background

Under contract to the Indian Health Service (IHS), Office of Planning, Evaluation, and Legislation (OPEL), Support Services International, Inc. (SSI) conducted a study to determine the impact of the Final Rule (42 CFR Part 36) governing who may receive health care services from the IHS. The purpose of the study was to examine the economic, social, cultural, and health status impact of the Final Rule on reservation and urban Indian populations. In meeting the objectives of the study, data were collected through 1) tribal information briefings, 2) a survey of the IHS user population, and 3) case studies of tribes/reservations in six geographic areas within the United States. The designated geographic areas were the 1) northwest, 2) southwest, 3) northern plains, 4) east, 5) Oklahoma, and 6) Alaska. The Statement of Work (SOW) for this study specified that a single tribe/reservation be selected from each of the six geographic areas as a case study site.

The case studies were designed to provide in-depth information about a *single* group or community. It is important to note that while no single reservation or community is representative of others in any IHS Area, the results of the six case studies should be of value in assessing the impact of the Final Rule on a disparate set of communities.

In consultation with the Alaska Native Health Board (ANHB), the Nondalton Village was selected as the case study site for the Alaska area. This report presents the findings from the Nondalton case study conducted in May 1993..

II. Profile of Nondalton Village

The Nondalton Village is located in the Illiamna Lake Subregion of the Bristol Bay Region in southwestern Alaska (see Figure 1). The Bristol Bay Region is about 40,000 square miles in size and is located 150 miles southwest of Anchorage. Nondalton is one of 29 Alaska Native villages in the Bristol Bay Region. The Nondalton Village is located on the northern bank of Six Mile Lake below Lake Clark approximately 20 miles northeast of Illiamna Village .

The Nondalton people are Athabaskan Indians; they refer to themselves as the Dena'ina. The Nondalton Village has approximately 260 residents.

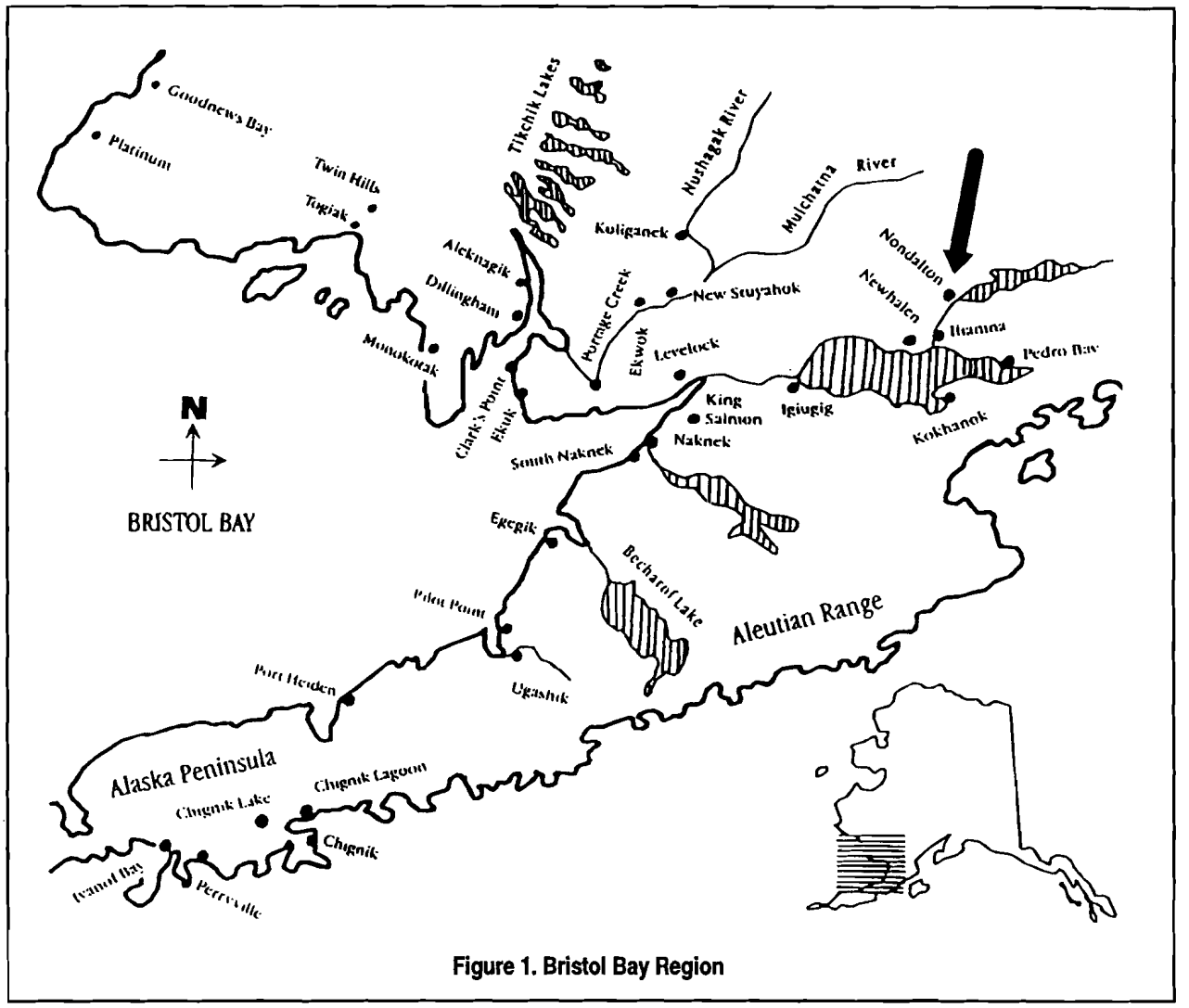

Figure 1. Bristol Bay Region

A. Government

The political environment of the Nondalton Village is complex. The Nondalton Village is a "second class city" governed by an elected mayor and community council.[1] The Native population constitutes over 90 percent of the Village residents. The Native population of the Village who are enrolled in the tribe are represented by the "Nondalton Tribal Council." Natives and others often use the term "Nondalton Village" to refer to: 1) the physical site of the Village, 2) all of the Village inhabitants, or 3) to the members of the Nondalton Village tribe. In the remainder of this report, the term "*Nondalton Tribal Village*" (*NTV*) will be used to refer to the persons enrolled in the tribe.

[1]The State of Alaska classifies cities by size and authority granted by the State. A "second class" city is accorded regulatory but not taxing authority.

Most Village residents are enrolled members of the NTV. Less than 10 non-Native persons reside in the Village including school teachers and the manager of a local store. There are a few (also less than 10) residents of the Village who are Alaska Natives but who are not members of the NTV. Approximately 80 persons enrolled in the NTV reside elsewhere.

The members of the NTV adopted the *Constitution of the Tribal Village of Nondalton* in 1991. The constitution refers both to "members of the tribal village" and "members of the tribe." In accordance with the constitution, the NTV is governed by a seven member Tribal Council. The Tribal Council selects officers including a President, Vice President, Secretary, and Treasurer. Figure 2 presents the organizational structure of the NTV government.

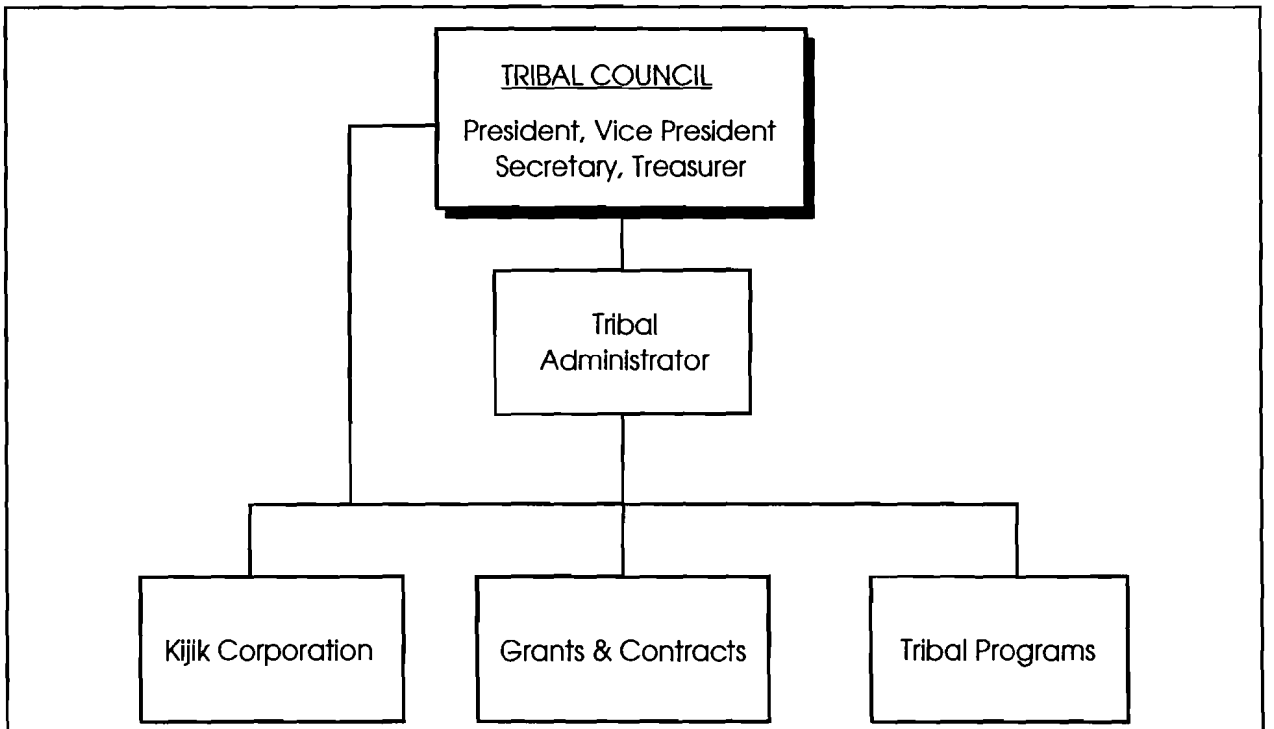

Figure 2. Nondalton Tribal Government Organizational Structure

B. Membership Criteria

The NTV maintains a formal enrollment system. While this system is not automated, it is in good order. According to its constitution, The NTV recognizes three classes of membership:

1. Base Membership: All persons listed on the "base roll of the Native Village."

2. New Members.

a) Children: All children of one-sixteenth or more Dena'ina Athabascan blood quantum born or adopted to tribal members residing in the Village.

b) Adopted Members: Any person of one-sixteenth or more Alaska Native blood quantum not otherwise eligible for membership, but with family or other significant ties to the Village may be admitted to membership at the discretion of the Village Council.

3. Honorary Members: Persons not eligible for membership may be designated honorary members by the Village Council. Honorary members may not hold elective office, do not have the right to vote, and do not become eligible for tribal benefits by reason of their honorary membership.

The NTV Constitution prohibits dual membership—no person may be a member of the NTV and be "an enrolled member of another Federally-recognized Alaska Native Village or Indian Tribe." Furthermore, the NTV Council may revoke a person's membership "for just cause upon due process of Village law."

C. Economy

Nondalton is an economically depressed village with only a small percentage of the population involved in commercial fishing or in fire fighting for the Bureau of Land Management (BLM). There are few employment opportunities available in the area other than commercial fishing. Subsistence fishing and hunting are important to the Dena'ina lifestyle and cultural heritage as well as a means of obtaining food.

The Village economy is strongly impacted by geography and climate. Because of its remote location and the lack of transportation, the cost of everything produced outside the Village (e.g., building materials, food, equipment) is relatively high. There are no roads or highways connecting the Village to other locations.[2] The primary means of transportation are by air (e.g., air freight) and water (e.g., boat). The Village has a 3,500 foot gravel runway primarily used by charter flights which transport mail, passengers, and air freight. Freight can be barged to Nondalton from Bristol Bay by means of the Kvichak River, to and across Lake Iliamna; the freight must be off-loaded from the barge and transported by road to Alexi Creek. The freight continues upriver by barge to the Village at Six Mile Lake.

The economy of the Village is impacted by three major institutions--commercial fishing, the Kijik Corporation, and Bristol Bay Native Corporation. Each of these institutions is discussed below.

1. Commercial Fishing. The principal economic activities of the Village are associated with commercial fishing. The price of salmon and other fish strongly impacts the economy of the region. A good or bad fishing season affects most facets of life in the region. Many villagers live a subsistence life style supplemented by income derived from fishing. The Bristol Bay Region is one of the richest salmon fisheries

[2]During the winter, temperatures generally range from 6 to -30 degrees Fahrenheit, and the average snowfall is 64 inches. During the winter, the Village becomes accessible by surface transportation (e.g., snowmobile, 4-wheel drive vehicles, or sled dogs).

in the world. The state of Alaska tightly controls commercial fishing in Bristol Bay (and other costal waters) requiring and selling "limited entry permits" for commercial salmon fishing. In 1993, Nondalton had 4 drift permits and 13 setnets. The state has issued no new permits since 1972. Even with a permit, the state allows commercial salmon fishing only on specified days and hours in Bristol Bay depending on the estimated size of the "run."

While new limited entry commercial fishing permits have not been issued by the state since 1972, the owner of a permit can sell or transfer it to another person. The price of permits for commercial salmon fishing have sharply escalated over the last decade. Currently, a permit may sell for more than $200,000.

2. The Bristol Bay Native Corporation (BBNC). The Alaska Native Claims Settlement Act (ANCSA) required the organization of 13 regional Native corporations to manage the assets awarded to Alaska Natives. The BBNC is one of the 13 regional corporations organized pursuant to ANCSA. BBNC is a member of the Alaska Federation of Natives (AFN), a statewide Native organization that represents the interests of Alaska Natives at the state and Federal levels. BBNC has significant land and natural resource holdings (subsurface rights to over 3 million acres in the Bristol Bay Region), and operates the Anchorage Hilton. In 1992, BBNC's total operating revenue was $35,152,000 and its net earnings were $4,821,000.

BBNC's Articles of Incorporation provide for the "issuance of 100 shares of common stock to each Alaska Native enrolled in the Bristol Bay Region." Many of the members of the Nondalton Village are shareholders in the BBNC. In 1992, BBNC's dividends per share were $4.06.

3. Kijik Corporation (KC). The ANCSA permitted the 225 recognized Native Villages in Alaska to form corporations (profit or non-profit) to manage the assets provided by the Act. The KC is the ANCSA corporation for the Nondalton Village. KC's principal offices are in Anchorage, and its principal business activities include real estate development and business support services. Each member of the Village was issued 100 shares of common KC stock. In 1991, KC paid off a $6.8 million loan several years ahead of schedule.

D. Health Status

The Nondalton Village is served by the Bristol Bay Area Health Corporation (BBAHC). The BBAHC is a "638" contractor that operates the 16-bed Kanakanak Hospital located in Dillingham, and provides health care (inpatient, outpatient, and emergency services) to 29 villages in the Bristol Bay Region of Alaska; however, members of several of the 29 Native Villages (including Nondalton) generally receive inpatient and other hospital care at the Alaska Native Medical Center (ANMC) in Anchorage. Either hospital is generally accessible to Nondalton Villagers only by air, and the costs of air charter to ANMC in Anchorage ($195 one way) are significantly less than to Kanakanak in Dillingham ($600 one way). BBAHC provides a Health Aide (similar to a Physician's Assistant) who resides in Nondalton, and provides outpatient services at a clinic in the Village. BBAHC also funds the services of a Community Health Representative (CHR) and an Alcoholism Prevention Counselor in Nondalton.

The IHS regularly reports health status data for each Area, and some data are available at the Service Unit level; however, the IHS does not regularly prepare health status reports for specific tribes or villages. While the raw data needed for such reports are available from IHS and/or BBAHC, the analyses needed to determine the health status of the NTV were beyond the scope of this case study. Based on reports for the IHS Alaska Area and data collected by BBAHC, the major health problems confronting the NTV include problems associated with unintentional injuries, heart disease, cancer, and diseases associated with alcohol abuse.

Unintentional injuries are the leading cause of death for Alaska Natives, and accidents are the leading cause of death in the Bristol Bay Service Unit. The cancer mortality rates for Alaska Natives exceed those for all other IHS Areas. Cancer is the leading cause of death for Alaska Native women, with lung cancer the most common form of the disease. Tobacco usage is common in Alaska (about 60 percent of the adult Native population are tobacco users), and it is estimated that about one-third of the lung cancer deaths are tobacco-related.

III. Method

The case studies were arranged in cooperation with the Office of Tribal Activities (OTA) within the designated IHS Area Offices. The following steps were followed in arranging case study site visits:

- SSI staff contacted the OTA Director within the designated IHS Area Office.

- The OTA Director contacted the appropriate tribal representative(s) to discuss participation as a case study site. In three of the geographic areas (Alaska, the east, and Oklahoma) tribal organizations were contacted to facilitate selection of a tribe/village. The Areas and respective organizations are:
  - Alaska: the Alaska Native Health Board (ANHB)
  - East: the United South and Eastern Tribes (USET)
  - Oklahoma: the Oklahoma City Intertribal Health Board.

- Representatives of the selected tribe were contacted to confirm the tribe's willingness to participate in the study

- The designated tribal contact (usually the Tribal Health Planner or the Tribal Administrator) was sent a packet of materials including 1) the letter from the Director of IHS, 2) the Project Synopsis, 3) an outline of the case study approach, 4) a list of the types of individuals to serve as key informants as well as a list of desired secondary data sources, 5) a draft letter of agreement for participating in the study, and 6) a copy of the data collection guide for conducting the case studies.

- ❒ Once the Letter of Agreement was signed by the appropriate tribal official(s), the interviews were scheduled and the site visit was conducted.

The ANHB expressed intense and continuing interest in and concern about the case study in Alaska. This concern was first expressed at a briefing about the study conducted in April 1992. At this briefing, the ANHB argued that a single case study conducted in Alaska could not possibly represent the complexity and diversity of the 225 Federally recognized tribes and Alaska Native Villages in the state. ANHB strongly urged that the case study be expanded to include at least three sites in Alaska.

The ANHB pointed out that tribes and Native Villages in Alaska are unique in many respects. For example, the ANCSA pertains exclusively to Alaska Indians and Natives. Furthermore, both climate and distances make Alaska unique. For example, the distance between the state capitol, Juneau and Dutch Harbor (a town near the *middle* of the Aleutian Islands) is greater than the distance between Washington, D.C. and San Francisco, California.

Concerns about the limitations of the case study approach, and repudiation of the case study design were expressed by ANHB in meetings (e.g., the Tribal/IHS Consultation Conferences in Sacramento and Denver in 1991 and 1992 respectively, and a meeting with the SSI Project Director and IHS Project Officer in Juneau in February 1993) and in writing (see Appendix A). ANHB representatives stated that the readers of this report, despite any cautions to the contrary, would tend to generalize the results to all or most of the 225 tribes and villages in the state.

Both the SSI Project Director and the IHS Project Officer met with ANHB to discuss the concerns about the study methodology and scope. The SSI Project Director explained that the overall study consisted of two basic components--1) a survey of the IHS user population, and 2) a case study with six replications. The survey of IHS users involves a complex multistage design and associated weighting of responses to achieve a sample of users that is representative of the entire IHS user population. The case study is designed to obtain in-depth qualitative information about the expected impact of the Final Rule from a disparate set of six tribes and Native villages. The case study data will neither be subjected to statistical analysis nor be viewed as representative of a larger group. Rather the case study data will be used to provide a frame of reference against which the survey statistics can be evaluated. The IHS Project Officer also pointed out that virtually any research project can be enhanced by increasing the scope of data collection; nevertheless, the addition of more case study sites in the Alaska Area (or in other IHS Areas) was not critical to the objective of the case study, and could not be justified against competing needs (e.g., patient care).

The ANHB's concerns about the scope and design of the case study were never satisfied. Despite the Board's misgivings and concerns, it cooperated and provided valuable assistance in coordinating the site visit.

During the site visit, data were collected through 1) unstructured interviews with key informants from the NTV and other groups, and 2) review of secondary data sources. The two data sources are described below.

A. Unstructured Interviews of Key informants

Because of the unique situation of American Indians and Alaska Natives (AIs/ANs) in Alaska, during the site visit, discussions were held with individuals or small groups from four categories of informants:

1. Bristol Bay Area Health Corporation (BBAHC), Dillingham, AK

- ❒ Sandy Alvarez, Board Member
- ❒ Gerald Anelon, Board President
- ❒ Robert Clark, Chief Executive Officer
- ❒ Janice McCantner, Patient Accounts Manager
- ❒ Gisela Oeffen, Director of Health Information Management
- ❒ Kathy Siebert, Coordinator CHAT Program
- ❒ Clara Trefon, Board Member.

The BBAHC is a "638" contractor that operates the 16-bed Kanakanak Hospital, and provides health care (inpatient, outpatient, and emergency services) to 29 villages in the Bristol Bay Region of Alaska. As noted in an earlier section, Nondalton Natives receive most of their hospital-based care from ANMC rather than Kanakanak Hospital. In addition to the seven key informants cited above, a meeting was held with the Executive Committee of the BBAHC Board, both during the site visit and at the Tribal/IHS Consultation Conference (*Denver 93*).

2. Bristol Bay Native Association (BBNA), Dillingham, AK

- ❒ Bruce Balter, Attorney
- ❒ Zack Brink, Board Member
- ❒ Terry Haferly, Executive Director.

The BBNA is a non-profit corporation that provides education, social services, economic development, vocational rehabilitation, and other services to the Native people in the Bristol Bay Region of Alaska, including the Nondalton Tribe.

3. Bristol Bay Native Corporation (BBNC), Anchorage, AK

- ❒ Trefon Angasan, Jr., Vice President of Corporate Affairs
- ❒ Tom Hawkins, Senior Vice President and Chief Operating Officer.

The BBNC is one of the 13 regional for-profit corporations established pursuant to the ANCSA. The original BBNC shareholders were Native people living in the Bristol Bay Region of Alaska which includes the Nondalton Village. BBNC is a member of the Alaska Federation of Natives (AFN), a statewide Native organization that represents the interests of Alaska Natives at the state and Federal levels.

4. Nondalton Tribal Village, Nondalton, AK

- ❒ Claudine Greene, Community Health Aide (CHA)
- ❒ Paulene Hobson, Tribal Council Member

- Karen Stickman, Alcohol Counselor
- Alice Trefon, Community Health Representative (CHR)
- Dennis Trefon, Tribal Administrator
- William Trefon, Sr., Tribal Chief.

In addition to the six key informants cited above, a meeting was held with the NTV Council. The NTV has approximately 320 members, of which 260 currently reside in the Village. The Village was the principal case study site.

The interviews, which were generally 60 minutes in duration, were conducted over a five-day period in May 1993. The interviews were conducted jointly by the SSI Project Director and the IHS Project Officer. Each informant was interviewed separately. A summary of the information collected was prepared and presented to the Tribal Administrator after the interviews were completed. The draft of this Case Study Report was submitted to the Nondalton Tribal Administrator, representatives from BBAHC, BBNA, BBNC, and ANHB for review and feedback.

B. Secondary Data

The following documents were collected and reviewed as part of the case study:

- Constitution of the Nondalton Village
- Maps of the Bristol Bay region
- Nondalton Village grant applications
- Narrative material and data describing the BBNA
- IHS Patient Registration System Eligibility Data
- Narrative material and data describing the BBAHC
- Narrative material and data describing the BBNC.

Information from the secondary data source documents is included throughout this report.

IV. Findings

A. General Findings

1. Lack of detailed information about the Final Rule. Most of the informants in this case study were aware of the Final Rule. The Nondalton Tribal Administrator had developed a detailed briefing for the Tribal Council regarding the purpose of the overall study and of the site visit. The Tribal Administrator and Council recognized the importance of the study, and expressed the view that the Final Rule could have a major impact on Indians and Alaska Natives. Nevertheless, few of the informants had much information about or knowledge of the complex details of the Final Rule.

2. Repudiation of the Final Rule. No informant embraced the Final Rule; rather, it was greeted with almost universal suspicion. Most informants asked why the current eligibility rules could not be retained, indicating that they saw little wrong with the current rules.

Definition of tribal membership. Repudiation of the Final Rule was centered on concern about the definition of "tribal membership." The informants almost universally indicated that almost no one in "the lower 48" (including the IHS and Bureau of Indian Affairs [BIA]) understands the current situation and historical circumstances of Indian tribes and Alaska Natives.

The BBNC informants provided a broad perspective on the impact of the Final Rule. They observed prior to the ANCSA, many American Indian/Alaska Native (AI/AN) groups were nomadic, and that entire villages were mistakenly omitted from ANCSA. The areas occupied by such nomadic groups and villages were appropriated by the state or Federal Governments leaving large numbers of AI/ANs without title to lands and/or Federal recognition. These individuals and their descendants are likely to lose access to IHS services and facilities under the Final Rule. According to the BBNC informants, the consequences of denial of access to IHS services to these AI/ANs would be catastrophic.

The informants stated that three factors make it likely that many Alaska Natives born after December 18, 1971 (after-borns) cannot substantiate membership in a tribe or village:

1. The parents (original shareholders) have moved away from their Native village.
2. The Native village does not have a formal membership or enrollment system.
3. The after-borns are not shareholders in one of the 13 Regional Native Corporations.

The BBNC informants estimated that there are approximately 40,000 AIs/ANs living in or near the city of Anchorage, and that up to 50 percent (i.e., 20,000) of these individuals cannot substantiate membership in a particular Native village or tribe. Many of these 20,000 AI/ANs are original shareholders in one of the 13 Regional Native Corporations created pursuant to ANCSA; however, many of the children (known as "after-borns") of these shareholders are not now (and may not become) shareholders. The BBNC informants

concluded that being of AI/AN descent and a shareholder in one of the 13 Regional Native Corporations should satisfy the tribal membership requirement of the Final Rule.

In a Memorandum of Joint Concerns (*Memorandum of Joint Concerns of the Alaska Area Native Health Service and the Juneau Area Bureau of Indian Affairs Related to Indian Health Service Eligibility Regulations Published September 16, 1987*), the IHS Alaska Area described a number of problems unique to AIs/ANs in Alaska. The Memorandum (see Appendix B) listed nine sets of problems and concerns including:

1. The ANCSA roll is not a tribal membership roll.

2. The ANCSA roll does not include a) AI/ANs who did not apply for or complete enrollment procedures, b) AI/ANs with less than 1/4 degree blood quantum, and c) any AI/AN born after December 18, 1971.

3. The ANCSA Village and Regional corporations are not Federally recognized tribal governments.

4. Only 21 of the (then) 197 Federally-recognized tribes have some type of formal enrollment system under development or in place.

The Memorandum recommends solutions to each of the problems discussed including according eligibility for IHS health care services to all AI/ANs on the ANCSA roll and their descendants.

The BBNC informants argued that fairness requires some means of recognizing or according "tribal membership" (for purposes of the Final Rule) to AIs/ANs who 1) lack membership in a tribal or village, and 2) are not shareholders in one of the 13 Regional Native Corporations established pursuant to ANCSA.

The BBNA informants stressed strong repudiation of the 1990 *"Memorandum of Understanding Between the Bureau of Indian Affairs (BIA), Juneau Area, and IHS, Alaska Area for Certification of Tribal Enrollment Systems"* (*MOU*). This MOU calls for 1) the BIA to review and approve the membership systems of the 225 tribes and Native villages in Alaska, and 2) the IHS to use the BIA determinations as the basis for eligibility for IHS services. BBNA staff stated that the BIA has insufficient staff to effectively review the membership systems of the 225 Native villages and Indian Tribes in Alaska. Moreover, the BBNA informants viewed the MOU as contrary to the principles of Indian self-determination.

In the context of the MOU, the IHS Final Rule is viewed with considerable suspicion. Nevertheless, absent the MOU, the BBNA informants had little problem with the Final Rule so long as an Alaska Native who 1) is an original shareholder in one of the 13 Regional Native Corporations, or 2) is the descendent of an original shareholder is deemed to be eligible under the Final Rule.

Several informants observed that there is considerable variation among the 29 villages in the Bristol Bay Region with respect to the development of enrollment systems. Some villages (e.g., Nondalton) have well developed enrollment systems and procedures. Other villages are just starting to develop enrollment systems

and procedures, and many villages lack the resources and skills needed to develop and manage enrollment systems.

B. Health Impact

The BBAHC provides a broad range of health care to the 29 villages in the Bristol Bay Region. In addition, it is not unusual for members of tribes in "the lower 48" to request and receive care (inpatient, outpatient or emergency) from BBAHC when working or visiting the Bristol Bay region. In contrast, members of the Bristol Bay (and other) Native villages, often report that they are unable to receive health care when away from Alaska. For example, AN/AIs from Alaska often travel or move to locations in the IHS Portland or California Areas (e.g., Seattle, WA, San Francisco, CA). Under the current IHS eligibility rules, AN/AIs from Alaska cannot obtain direct care in either the Portland or California Areas since there are no IHS hospitals in either of these two Areas. Furthermore, under the current eligibility regulations, AI/AN individuals are ineligible for contract health services (CHS) when outside their "home" Area. The BBAHC informants welcomed the increased access to CHS that would become available to AIs/ANs from Alaska under the Final Rule.

In general, the NTV informants anticipated that the Final Rule would directly impact few members of the Village. The informants stated that relatively few members were living away from the Village, and implied that migration from the Village is not encouraged. Therefore, the increased access to CHS services for Village members residing away from Alaska was generally viewed to be relatively unimportant. Conversely, since NTV membership is well defined, the Final Rule was generally viewed as having little impact (adverse or positive) on the Village. On the other hand, the Nondalton informants generally agreed with other informants that many AI/ANs in Alaska would be unable to demonstrate or establish tribal membership, and, consequently, would become ineligible for IHS care under the Final Rule.

Several members of NTV have married and are living with Alaska Natives from other villages. It was believed that one of these persons was actually enrolled in another village; however, the membership status of one or two other Natives was unknown to the informants. The informants described the following scenario as an example of how an AI/AN might lack formal membership in a Federally-recognized tribe or Native village. Because of medical complications, the AN might be born at the ANMC in Anchorage. The child's parents are from different Native villages (a common occurrence), and neither village has a well- organized system for tracking membership. The AN grows up living part of the time in her father's and her mother's villages, and attended the BIA boarding school in Mt. Edgecumbe (further attenuating her relationship with her parents villages).[3] Now an adult, the AN marries a member of the NTV. Her husband and children are enrolled in NTV and are eligible for IHS health care services under the Final Rule; however, the AN herself is ineligible under the Final Rule as she cannot substantiate membership in her Native village(s).

[3] The BIA no longer operates any schools in the State of Alaska; however, from 1947 to 1983 the BIA operated a boarding school for grades 9 through 12 in Mt. Edgecumbe.

Given the lack of employment and subsistence life style in most Native villages, if the AN in the example becomes ill, her family will lack the resources needed to pay for her health care. The remote location of Nondalton (and almost all other Native villages) coupled with the great difficulty of AI/ANs living in such villages have in obtaining Medicaid and/or Medicare, means that the AN woman, wife, and mother may not obtain the needed health care. Lacking the needed health care, she may become disabled and/or die. The informants suggested that such a scenario is likely to occur thousands of times under the Final Rule.

3. Alternative Health Resources for AIs/ANs Ineligible Under the Final Rule. As discussed earlier in this report, there is no health care facility (IHS or other) staffed with a physician readily accessible to the Nondalton Village. The principal access to such a facility is by means of charter flight or air ambulance to Anchorage (about a 45 minute flight). At Anchorage there is an IHS-funded hospital, ANMC and several public and private hospitals.

Several informants stated that while Medicare and Medicaid programs help supplement the health care provided by IHS. However, two barriers make these programs unavailable to members of the NTV: 1) the lack of reliable transportation to the certifying agencies, and 2) cultural and language barriers separating NTV residents from the certifying agencies and providers. The same barriers generally pertain to AI/ANs living in the Village but ineligible for membership in the NTV.

C. Economic Impact

The AI/ANs living in villages like Nondalton are resourceful and independent. Nevertheless, a complex and delicate set of relationships connects the 260 Nondalton residents. The costs (including opportunity costs) of illness, disability, and death of one individual out of a population of 260 residents seem to be far greater in these remote Native villages than in a non-Native community of, say, 15,000 in the "lower 48." In the scenario described in the previous section (Section B), the potential death or disability of one AN woman, wife, and mother (denied IHS services under the Final Rule) could have catastrophic impact on the economic status of her family. The economic impact on the community might be subtle and difficult to measure, but the informants indicated that the fragile nature of the Native villages gives the death and/or disability of each resident major impact of the village.

D. Social Impact

The informants suggested that the social impact of the Final Rule would likely parallel the economic impact. Again, virtually all the members of the NTV are duly enrolled in the tribe and, consequently, will be eligible for IHS services under the Final Rule. Persons likely to be ineligible under the Final Rule are present and future spouses of members of the NTV—spouses who, for whatever reason, cannot substantiate membership in a recognized Native village or tribe. In the case of the disability and/or death of a such a spouse, the social impact would be hard to predict or measure. Nevertheless, the informants suggested that such disabilities and deaths represent the types of costs and pressures that contribute to social problems like alcohol abuse, suicide, and anti-social behavior in Native communities.

E. Cultural Impact

As with the other dimensions of the impact of the Final Rule, the informants found it difficult to assess the impact of the Final Rule on Nondalton culture. Several respondents suggested that the Final Rule would result in the denial of IHS services to AI/ANs who cannot substantiate membership in their Native village. This denial of services would result in higher levels of morbidity and mortality which, in turn, would contribute to the burden faced by Native villages. This burden, in the context of the lack of economic and other resources, would contribute to the pessimism and despair that has often afflicted the Native communities since the arrival of Europeans in Alaska.

V. Conclusions

1. The key informants were generally unaware of the details of the Final Rule, and lacked the information needed to estimate the impact of the Final Rule on the Nondalton Village. Since the key informants lacked detailed information about the Final Rule, it seems likely that the general Village population has less information about and understanding of the Final Rule.

2. The key informants universally oppose the implementation of the Final Rule, view it with suspicion, and prefer the current eligibility regulations.

3. Because the NTV has a well organized enrollment system, the Final Rule was expected to have relatively little direct impact of the members of the NTV. Any expected impact on the NTV was based on denial of services to AI/ANs who marry members of the village.

4. Large numbers of Native villages in Alaska lack formal membership systems, and large numbers of AI/ANs in Alaska (10,00-20,000) cannot substantiate "tribal membership" as required in the Final Rule. Consequently, large numbers of AI/ANs in Alaska will become ineligible for IHS care under the Final Rule. The denial of IHS services to these AI/ANs would be catastrophic to their families and to the Native villages.

VI. Recommendations

A. Recommendations of Key Informants

Each informant was asked for ideas on ways to change the Final Rule to compensate for its apparent problems. The following suggestions were made:

1. For purposes of the Final Rule, accord the equivalent of tribal membership to any AI/AN who 1) is an original shareholder in one of the 13 ANCSA Regional Native Corporations, or 2) is a descendent of a shareholder in one of the 13 Regional Native Corporations (i.e., an "after-born").

2. Build in flexibility. Allow for special cases, especially for AI/ANs who 1) are members of tribes or villages that lack or recently lacked formal membership systems, or 2) were adopted at birth by persons who were not members of the child's village or tribe.

INDEX