Introduction

Welcome to Indian Country!

While the information that will now come before you is intended to provide an orientation, please remember that the first rule is that there is an exception to every statement made.

Behind each statement is a tome; therefore, please consider all that you read an introduction, a tickler, a tidbit. Proceed at your own pace and dig deeper.

That being clarified, please note that through the many people that have brought you this notebook, the most important trend all expressed as the most important thing for you to know is RESPECT – patients want RESPECT for their history, their heritage, their customs, their ills. In turn, they wish to RESPECT you as a provider with whom they can form a partnership for the restoration, maintenance or achievement of good health.

> Health that involves body, mind, spirit and the land in which we dwell. Respect is a two way street and kind, nurturing words always work more effectively than quick biting tongues.
>
> Sarah Kremsner

This is Indian Nevada

Ethnic Tribes

The area presently designated as the Great Basin has been home to many people. The major tribal designations are loosely defined as Washoe, Northern Paiute, Southern Paiute and Western Shoshone. Because ancient peoples did not have borders defined by U.S. cartographers or strict immigration protocol, other tribal groups/bands traveled and camped through the area at different times.

"..........lifestyle was closely tied to the awe-inspiring land which surrounded them. They were a people of the land. Their lives were not only deeply involved in the cycles of nature, but were completely dependent on them. If one did not live in harmony with the surrounding world, nature would become hostile. If one did not know how to use what the land offered, one would not survive. The Nuwuvi knew these things. Most of all they knew that they loved and respected the earth and felt a deep kinship with all living things. They knew that *tu-weap* (the earth) would give them what they needed if they know how to take it." (Nuwuvi-A Southern Paiute History, ITCN, 1976)

"Though several historians have displayed a sensitivity for Indian life and culture, many have seen our reality from a distant vantage point. We have heard our beloved lands called "harsh", and our existence termed "savage". It is no wonder that their education has not had a positive effect on our lives. In their eyes, we have nothing in our past to be proud of."

"This history......will present the past.......from (the native) point of view. Our elders have preserved much of the past by telling and retelling the events which have shaped our lives. No history can attain complete objectivity; it can only present a point of view, a particular way to talk and think about the events of the past. All events have more than one interpretation. This is ours." (Ibid)

Political Tribes

Article I, Section 8 of the U.S. Constitution provides for a special political relationship between American Natives and the U.S. Congress. This relationship includes broad federal authority, special trust obligations and, beginning in the 1700's with treaty making as part of the historical policy of "civilizing", a pattern of funding to acculturate. The practice of providing for health services was formalized in 1921 with the Snyder Act.

Even though treaty making was abolished in 1871, treaty obligations are still in force, and though the trust responsibility to provide services is considered a moral and a legal responsibility, the commitment depends on Congressional action.

"........public understanding of their core issues comes slowly. Special Indian rights are complex and history based, emerging from the deep past rather than being ignited by the fire of the moment."

"In every instance the Indian position is fragile because it finally depends on citizens granting their scarce time to explore, to set out into unfamiliar intellectual terrain. In every instance, justice for Indian people depends on the willingness of opinion leaders in the majority society to learn about the experience of another people and how this nation has developed gradually, ..." (Charles Wilkinson. Oliver Rundell Lecture, University of Wisconsin Law School, 1990.

"(Let it be said, too, that in the making of good public policy, cooperation is an end in itself. It reduces stresses of all kinds. It heals and builds community". Ibid)

History-General

Reservation life marked the end of a traditional era and the beginning of "deep decline" The hunting/gathering societies that required vast areas of land for survival were confined to small plots of lands that could not support the subsistence/commerce ways of old.

United States policy was to create an agrarian society in the West based on European patterns of land ownership. The Allotment Act (Dawes) of 1887 resulted in 30% of Indian lands being thrown open to settlement. More land disappeared as other policies related to this policy and Act were implemented. (Not all Nevada reservations suffered allotment – they've had other experiences like loss of water.) The loss of resource base, diminution of tribal authority, and subjection to state power created devastating conditions nationwide. A congressional study, the Merriam report, chronicled the evils of the past, culminated in the Snyder Act and laid the foundation for the emergence of the Indian Reorganization Act (IRA) of 1934.

This act stated that any group of Indian people residing on federal land that held a democratic election and adopted a constitution and bylaws (approved by the government) would be granted corporate status (recognition) and from this status, a government to government relationship would flow. Not all the implications of U.S. democracy or that of corporate structure became immediately clear – in fact the last 60 years in part have been the drama of emergent understanding of IRA. However, the late 30's and early 40's were an exciting and significant time for most groups. Not all groups organized or utilized the IRA for many years. Some still do not. Some tribes are "unrecognized".

Came World War II and the siphoning and conversion of most national resources to the war effort. So much of what had been started in Indian Country was abandoned. The United States recognized itself in the Industrial Age, not the Age of Agriculture. By the 50's the national policy became that of "Termination". All reservations would be sold; proceeds divided among the members, and there would be no more Indians. "Public Law 280" gave jurisdiction to the States from which the former Indian people would receive goods and services.

The "Termination Era" was not a happy experience for all parties involved and while implemented in different ways in different areas, left deep scar tissue in a variety of sectors.

The Civil Rights Movement, the War on Poverty, The Kinder/Gentler Nation – each succeeding epoch saw national initiatives that encouraged Tribes to regain sovereignty and self-responsibility. Each has responded in their own way on their own time with varying results.

In a classic historical repeat, the Vietnam War (still officially a conflict), again siphoned the energy and resources of the Nation. The U.S.A. of the 80's and 90's saw a dramatic shift from community to corporation, from emphasis on neighborhood wealth to individual wealth.

"It was the best of times; it was the worst of times". It still is.

And you are now part of the story.

History - Health Care

Before the Intruders

Medical knowledge has always been part of traditional Indian society. Medicine men were born with special powers and acquired knowledge concerning medicinal uses of local herbs and human processes over a lifetime of prayer and practice. Other tribal members became healers with knowledge about plants and herbs.

Cultivation of one's body, maintenance of a balance between oneself and the earth, balance of individuality within family/band/tribal context was the basis of self responsibility for each tribal member. Practices that seemed abhorrent to Europeans such as the elderly crawling off to die when they could no longer contribute to their unit or suckling only one twin at birth were rooted in survival arts.

Many of the Indian Service personnel, particularly doctors, were suspicious of Indian medicine practices and believed them harmful to people. They actively discouraged their use which contributed to the decline of active traditional medicine being practiced; however many people used a combination of traditional medicine and western medicine, relying on white man's medicine for diagnostic technique and traditional medicine for cure.

Over the years, both practices have come closer to each other. Western medicine now acknowledges and incorporates the concept of holistic health and herbal practice; traditional practitioners recognize that many "modern" diseases, accidents and situations are based on things that were not present in the ancient world. Both continue to grapple with culture clash and concepts of spirituality versus technology.

Other practices that have come closer or blended. The Native American Church unites Indian belief with rituals/customs that symbolize both Indian and Christian spiritual beings. Powwows are particularly reflective of the blend of music, dress, and expression, not only Tribe to Tribe, but Indian to non-Indian.

Indian Service

The federal government has acknowledged varying amounts of responsibility for the provision of medical care to Indian people since the early treaties of the 1700's. Medical care became a formal part of the Army's program in the 1830's on posts where officers dealt with smallpox and other contagious diseases for which the Indian population had no natural immunities. Treaty making began to trade medical care by doctors in return for rights and property ceded to the government.

After the Army Cavalry era, the responsibility of health care passed through various government branches. Most "Indian Services" became consolidated under the Bureau of Indian Affairs (BIA), which had been transferred from the Department of War to the Department of the Interior in 1868. Indian Agents and other personnel no longer hold Army commissions. The Indian Service formally created a Medical Division in 1926.

Primary objectives of the health care program were the prevention and cure of illness, particularly diseases of infancy and childhood, trachoma and tuberculosis. Program expansions included dental services made available through hospitals, sanitariums, dispensaries and schools.

Indian Health Service

The Indian Service officially became Indian Health Service (IHS) when it was transferred to the Public Health Service (whose origins were in the Navy) but became part of the newly created HEW (Health Education and Welfare) under the first Secretary, Nelson Rockefeller. Commissioned officers within IHS enjoy military status.

The IHS mission is to "elevate the health status of the American Indians and Alaska Natives to the highest possible level."

First campaigns centered on those infectious and communicable diseases/syndromes resulting from lack of sanitation and clean water facilities. Diarrhea/dehydration, tuberculosis and trachoma were rampant. In 1955, tuberculosis struck about eight of every 1000 Indians; life expectancy was 51.0 years.

Reflective of the American care system, Indian Health Service became a hospital based system with the emphasis on crisis care delivery. Because there was no emphasis on preventative medicine, and the traditional practitioner network had been destroyed, most Indian people saw hospitals as a place to go to die. As a result, many patients avoided seeking health care at the early stages of a problem and only presented themselves for care when a condition was truly catastrophic.

Be advised that IHS, like any bureaucracy, is a culture unto itself, complete with its own language, customs and social order.

Owyhee Hospital

The Duck Valley Reservation served as the seat of the Western Shoshone Indian Agency, headquarters for Bureau of Indian Affairs personnel serving the reservations of northeastern Nevada for many years. The first full time physician assigned to Duck Valley was in July of 1882. In June of 1891, Dr. Carlos Montezuma, an Apache from the White River reservation who would become nationally prominent in his time, arrived in Duck Valley. He wrote to Washington of the need for a hospital and in December of 1916 work began to convert a former school facility to a five bed hospital. A new 12-bed hospital was constructed in 1936, followed by construction of a brand new 15 bed facility in 1976.

Responding to trends and in its long history of self-determination, the DVSPT compacted the hospital on October 1, 1995.

The mission of the Shoshone-Paiute Tribes of the Duck Valley Health System is "to provide, to the people of the service delivery area, the highest quality health care and services to improve and maintain health status, respecting cultural values and tribal sovereignty".

Schurz Hospital

Located on the Walker River Reservation, one of the original "Big Three" reservations established in Nevada in the 1800's, the Schurz Hospital was built in 1936 and served as the nexus for health care in Western Nevada until its closing in 1986.

Historical note:
Carl Schurz was born at Liblar, near Cologne, Germany in 1829. He was educated at the collegiate institution at Cologne and the University of Bonn.

Carl was editor of a paper identified with the unsuccessful revolution of 1848, and took part in the defense of Rastadt. Known as the one of the 48'ers, he fled from Germany, taking refuge in Switzerland, subsequently residing in Paris and London, where he was a teacher and newspaper correspondent for three years. He then emigrated to the U.S.A. in 1852.

His commanding abilities soon recognized, he was made a delegate to the national Republican convention of 1861. On the accession of President Lincoln, Schurz was appointed Minister to Spain, which he soon resigned, was appointed a Brigadier-General of volunteers, and took an active part in the second battle of Bull Run, also the battles of Chancellorsville, Gettysburg, and Chattanooga. After the war, he held numerous public positions and became connected with the press of New York, Detroit, and St. Louis. He was a delegate to the National Republican Convention of 1868 and the following year was elected a member of the United States Senate from Missouri..

Subsequently he was appointed Secretary of the Interior by Rutherford B. Hayes and served from 1877-1881. In books and articles on the German heritage in and contribution to the United States, he is praised for his strong efforts to protect the native American population. The picture is entirely different when looking at titles such as Bury My Heart at Wounded Knee, Native American Testimony,etc. Here, Schurz is accused of being ignorant, indifferent, callous and guilty of destroying the independence of Indian families and tribes by endorsing allotment. Schurz died in 1906.)

Phoenix Indian Medical Center

This 163-bed general medicine and surgical referral hospital was originally constructed as the "medical nerve center" for the Phoenix Area. It was to be the hub of medical practice for the four state region. Outlying hospitals were to send their patients to PIMC for high quality secondary and teritiary care.

Sheer distance, travel expense, distance from family, follow-up of complications made this concept cumbersome for outlying Tribes. A system of "contract care" emerged under which Service Units could/would purchase care from more localized and private sector providers.

Contract care has always been controversial in Nevada. Issues of acceptability of care have lessened as non-Indian institutions have become more accommodating of diversified patients and principles of patient rights.

Financial issues continue to plague this system. Historically underfunded, the Nevada Service Units always run out of money before the end of the fiscal year, necessitating a priority of care protocol not pleasing to patients or providers.

"Slow pay"/sloppy reimbursement causes poor relationships with providers and causes much patient stress. Because of the wonderful job IHS did in its first two decades, chronic and degenerative diseases are taking over. Indian people are living longer and "enjoying" more complicated, expensive and long lasting syndromes. This adds to the pressure of contract care budgets on a local level.

On a global level, all health care costs have skyrocketed. PIMC maintains that its cost per unit for the myriad of quality specialty and elective procedures is less and therefore all tribal providers should utilize PIMC, particularly those from Nevada where health care costs are among the highest in the Nation. This discussion provides a dynamic severely impacting the continuum of health care throughout the region.

Phoenix Area Office

The PAO is the regional administrative unit of Indian Health Service. Over 45 tribal groups representing approximately 105,000 Indian people in the states of Arizona, Nevada and Utah coordinate efforts through this office. (California became its own area in 198x)

From the primary provider to the primary partner, the evolution of roles of the Area Office from Inception, through Indian Self-Determination, through Self-Governance, to Compacting has taken a journey more difficult than any vision quest.

As each Tribe has its own unique health resources, needs, philosophy of care and goals, each Tribe is in a different stage as a health care provider. The PAO must be all things to all peoples.

Tribal Clinics

Evolution

The Indian Education and Self Determination Act (1975, PL 93-638) originally proposed that Indian Tribes be permitted to contract any function of any government agency and be allowed to redesign it to meet the unique needs of their constituency. It's passage and implementation, however, became embroiled in the Watergate era and by the time the Act was ready to be signed off on by the various secretaries, the President who initiated it as well as most his Cabinet were gone. Both the BIA and IHS signed off on "638" and immediately developed separate policies, application, and monitoring systems. One of the first programs tribes began to contract were the Community Health Representatives (CHR). A little success, a little dreaming and tribes began to think bigger................

Indian Health Care Improvement Act (1976) (amended 1980) provided significant financial resources for the expansion of health care services, resulting in new medical facilities, modernization of existing facilities and the promotion of health professional development among native peoples. This act issued in the era of move from hospital crisis mode to preventative medicine protocols, and the encouragement of "accessible, affordable, and acceptable" health care delivered through neighborhood community centers.

Tribal Specific Health Plans (TSHP) were part of the long term (ten year) effort of the Indian Health Care Improvement Act. Tribes contracted to assess their health status against performance and quality standards suggested by HIS and other major medical providers. This gave the Tribes an opportunity to dream even more and consider other medical models that emphasized prevention and self responsibility.

To complete your Tribal Specific orientation, you should obtain a copy of your sponsoring Tribe's Tribal Specific Health Plan and chart the changes over the last two decades.

Structure

Tribes have several options in developing and maintaining health clinics and related programs.

Tribes may elect to have their local facility completely run by Indian Health Service. In this situation, all employees are employees of the federal government and subject to the administration of the Phoenix Area Office for all facets of the operation.

"638" Contracts - under this mechanism, the Tribe may contract with the feds to run a particular program. "638" Contracts may be returned "retroceeded" to the Government should the Council choose not to continue administering the program/ service.

Self Governance and Compacting are a contracting mechanisms that further removes federal control and oversight, however they are transfers of federal money and all the regulations appurtenant thereto.

Relation to tribal government

In most instances, tribal councils are the contracting/grant recipient for health services. Many have appointed Health Advisory Councils, Health Committees, or some such body to oversee the operation of their clinic. Delegated duties may not be specifically articulated or defined, often leading to controversy and/or misunderstanding.

Tribes do have (IRA) authority to charter subordinate organizations such as 501(c)(3) non-profits, operating foundations or for-profit entities, but most have not explored or exploited this route. Some groups have encouraged such incorporation under state law, but this ultimately erodes the government to government relationship of Tribe to state and federal governments in the contracting and negotiating forums.

Directory of Nevada Tribal Clinics

Eastern Nevada

Walden Townsend, Administrator
Duck Valley Shoshone Tribe
P. O. Box 219
Owyhee, Nevada 89832
(702) 757-2415
(702) 757-2412 (fax)

Mary Lou Millett, Health Director
Duckwater Shoshone Tribe
P. O. Box 140066
Duckwater, Nevada 89314
(702) 863-0222
(702) 863-0301 (fax)

Ernie Woodson, Health Director
Te-Moak Tribe of Western Shoshone
525 Sunset Street
Elko, Nevada 89801
(702) 738-9251
(702) 738-2435 (fax)

G. Williams, Health Director
Goshute Tribe
P. O. Box 6104
Ibapah, Utah 84034
(801) 234-1136
(801) 234-1163 (fax)

Gracie Begay
Wells Community
(702) 752-2226

Norman Cavanaugh, SUD
Southern Bands Health Center
515 Shoshone Circle
Elko, Nevada 89801
(702) 738-2252
(702) 738-2252 (fax)

Vicky Urenda, Health Director
Battle Mountain Band
35 Mountain View Drive #205-1
Battle Mountain, Nevada 89820
(702) 635-8200
(702) 635-8016 (fax)

Peter Ford, Health Director
Ely Shoshone Tribe
16 Shoshone Circle
Ely, Nevada 89301
(702) 289-4133
(702) 289-3156 (fax)

Health Director
Elko Band
P. O. Box 748
Elko, Nevada 89801
(702) 738-8889
(702) 753-5439 (fax)

Western Nevada

Kathy Curley, Health Director
Fallon Paiute/Shoshone Tribe
P. O. Box 1980
Fallon, Nevada 89407
(702) 423-3634
(702 423-1453 (fax)

Kathy Millet
Yomba Shoshone
P. O. Box 1980
Yomba, Nevada 89310
(702) 964-2463
(702) 964-2443 (fax)

Kenneth Richardson, Health Director
Walker River Paiute Tribe
P. O. Drawer "C"
Schurz, Nevada 89427
(702) 773-2005
(702) 773-2576 (fax)

Richard Skelskey, M.D., Health Director
Moapa Band of Paiutes
One Paiute Drive
Las Vegas, Nevada 89025
(702) 865-2700
(702) 865-2821 (fax)

Linda Sheldon
Yerington Paiute Tribe
171 Campbell Lane
Yerington, Nevada 89447
(702) 463-3335
(702) 463-3390 (fax)
(702) 883-6848 (toll free)

John Ketcher, Health Director
Washoe Tribe of Nevada and California
950 Highway 395 South
Gardnerville, Nevada 89410
(702) 883-4137
(702) 265-3429 (fax)

Bill Elliott, Health Director
Pyramid Lake Paiute Tribe
P. O. Box 227
Nixon, Nevada 89424
(702) 574-1018
(702) 574-1028 (fax)

Rodney Burroughs
Fort McDermitt Tribe
P. O. Box 457
McDermitt, Nevada 89421
(702) 532-8522
(702) 532-8024 (fax)

Lovelock Paiute Tribe
P. O. Box 878
Lovelock, Nevada 89419
(702) 273-2861
(702) 273-7861 (fax)

Reno Sparks Health Center
34 Reservation Road
Reno, Nevada 89502
(702) 329-5162
(702) 329-4129

Andrew McAuliffe, P.O.
Fallon IHS Community Health Service
P. O. Box 1889
Fallon, Nevada 89407
(702) 423-2877
(702) 423-2881
(702) 423-5585 (fax)

Elvin Willie, SUD
Schurz Service Unit
P. O. Drawer "A"
Schurz, Nevada 89427
(702) 773-2345
(800) 843-5790 x 119
(702) 773-2345 x 24 (fax)