



*The Big Sky Country*

MONTANA SENATE HOUSE OF REPRESENTATIVES

APPROPRIATIONS COMMITTEE  
SPECIAL SESSION  
NOVEMBER 16, 1981

The meeting of the House Appropriations Committee was called to order at 1:45 p.m. on Monday, November 16, 1981, with Chairman Gene Donaldson presiding. All members were present.

The purpose of this meeting was to receive reports from subcommittees I & II and also allow for further testimony on relating issues. Also on the agenda was consideration of the feed bill HB 1.

HOUSE BILL 1

Chairman Donaldson, chief sponsor of HB 1, turned the meeting over to Vice-Chairman Jack Moore. Representative Moore recognized Representative Bobby Spilker.

Representative Spilker reviewed the budget proposal for the feed bill and referred to EXHIBIT 1 which is attached to the minutes. Representative Spilker said that there may be a question regarding why the balance of the appropriation for the regular session was not used for the special session. She stated that most of the money left in the regular session budget has been committed for other things such as insurance premiums, setting up for the regular session and repair of the Senate voting machines etc. Representative Spilker said that both the House and the Senate are operating with approximately one-half the staff used for the regular session. She also explained that the print shop is now being operated under the Department of Administration instead of by the Legislative Council as in the past. The \$25,000 under contracted services (see EX 1) is an approximation of what the bill will be. Representative Spilker said that the cost for printing 500 sheets of paper is \$20 more under the new management and this is something that the legislature may want to consider in the 1983 session.

Representative Bardanouve moved a DO PASS on House Bill 1. Question being called a vote was taken and passed unanimously.

Chairman Donaldson resumed the chair.

REPORT FROM SUBCOMMITTEE

Representative Moore moved that the committee adopt the subcommittee amendments as incorporated into the gray bill contained in the report to the house appropriations committee by the joint subcommittees I, II, and III. He stated that this will provide a base for all people who would like to submit amendments and help insure all amendments are submitted uniformly.

A vote was taken on the motion and passed unanimously.

REPORT FROM SUBCOMMITTEE I

Representative Moore, chairman of subcommittee I, gave an introduction of the members of the subcommittee as well as the legal staff and fiscal analysts that worked with the committee. These names are listed in the front of the report. A copy is attached.

Representative Moore began his report with the budget recommendations for the Office of Public Instruction. Reference can be made to page E-1 of the joint subcommittee report. (All page references refer to the Joint Subcommittee report to the Appropriations Committee.) Representative Moore said that the committee dealt with three areas in the OPI budget. The subcommittee recommendation result is an increase in general fund authority of \$112,138, a reduction of federal spending authority of \$598,387, and a reduction of 9.65 FTEs. The third change raises student tuition to replace lost federal funds in the vo-tech centers.

Change 1: Block Grant Administration

The subcommittee recommends \$52,214 to offset reduction in federal funds. Representative Moore explained that the committee's original action was to recommend \$214,368 general fund assistance to support continuing administrative functions in the OPI. The additional general fund will be used along with anticipated block grant funds of \$487,754 and carry-over funds of \$157,887 to finance administrative and support functions in the office of public instruction. The recommended level of funding reflects reductions in federally funded programs.

Change 2: Vo-Ed Administration

The subcommittee recommends \$59,924 to replace federal vocational education funds for the OPI. Again the original

committee action was to request \$111,018 general fund assistance. After further research and discussion, he stated the committee decided to reconsider their action and recommend that the schools raise their tuition to cover the loss in federal money.

Change 3: Increased Student Tuitions

The subcommittee recommends replacing an anticipated shortfall in federal funds in fiscal 1983 of \$464,318 with increased student tuition charges. Representative Moore said that the committee looked at the tuitions of other vocational schools in neighboring states. South Dakota is in a situation similar to Montana's and their tuition is \$280 per quarter. Based on the committee's findings, he stated we recommend that the schools consider raising their tuition from \$120 to \$180 per quarter in order to raise the needed funds.

School for the Deaf and Blind: Refer to --E3-- The school for the deaf and blind has three changes to their budget. The subcommittee recommends funding the changes with savings from an eliminated position and Title 1 carry-over funds. The subcommittee recommendations result in a net general fund reversion of \$19,322 and a reduction in federal spending authority of \$72,587.

Change 1: Career Education

The committee recommends \$35,000 for the biennium general fund support for career education programs. This program provides counseling and work-study opportunities to approximately 20-30 students at the school. The program was previously funded by the Comprehensive Employment Training Act (CETA).

Change 2: The subcommittee recommends general fund support of \$31,766 in Fiscal '83 for the special needs vocational education program.

Change 3: Title 1

The subcommittee recommends that Title I carry-over funds of \$23,618 and \$8,912 of general fund authority be used to offset reductions in Title I funding.

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Chairman Donaldson : opened the meeting to questions from the committee and other Representatives and Senators to be addressed to this portion of Representative Moore's report.

Rep. Bardanouve: Are we replacing lost revenue dollars with general fund money?

Rep. Moore: That is correct.

Bardanouve: Will we have Title I in FY '83?

Moore: Yes.

Bardanouve: Wouldn't this be part of the general fund budget next session?

Moore: Yes.

Sen. Regan: If you will refer to page 198 of the LFA's report (book 1) you will see that they also have \$154, 720 in the Interest and Income account (I&I). Why are we not using these funds to support the program and allowing the general fund money to revert?

Moore: During the last session we appropriated over \$300,000 of their I & I money. We decided, by committee action, that we would not use any of the I & I money at this time and we would have a base for the money to be used next session.

Regan: It seems to me we are not following the "Boilerplate language" which is very clear in stating that we spend money from all other available sources before general fund monies. I think the whole committee should address this.

Moore: The committee did address this.

Bardanouve: The "Boilerplate Language" has not been amended. In the university area we require that they use the I & I money before general funds. Why do we make an exception in this one agency?

Moore: We had already appropriated over \$300,000 of their I & I money and the committee decided not to use the I & I monies "period".

QUESTIONS BY THE COMMITTEE (cont.)

Representative Eudaily asked for clarification on the reconsidered action of the committee concerning the OPI budget (Vo-Ed).

Moore: The committee originally went along with the departments request for \$111,018. We later reduced the amount to \$59,924. We found that some funds that had been utilized in the past and do not require match money could be used. (He referred to sections 120, 130, 140, 150,) The funding is there if they choose to use it.

Eudaily: The committee also reduced general fund assistance for administration of OPI from their original recommendation of \$214,368 to \$52,214. Could you explain this.

Moore: Their spending authority and carry-over funds are remaining the same. There were three scenarios submitted to us by the superintendent of public instructions office. One was the Senate scenario which was the worst scenario, one was the House scenario which was the middle one and one was the authorization in the Omnibus Reconciliation Act which was the best scenario. Originally we used the worst one and by subtracting that from the carry-over in their authorized spending authority we came up with a difference of \$214,368. We reconsidered the action using the middle scenario and came up with \$52,214.

Rep. Bengtson: In reply to Representative Eudaily's question I would like to point out that we did not have testimony from the OPI when we reconsidered our action and I would like to move that we do get some input from that agency before we take executive action.

Moore: There were none of the OPI people available that day. It was a State holiday. I did announce that they would have the opportunity to bring any disagreements before the whole committee this week.

Bardanouve: In the area of Vo-ed, how would \$180 tuition compare with the university systems?

Moore: I don't have that information but I do not see any correlation between the two.

Rep. Conroy: I have information that the university tuition will be \$159 per quarter in 1982.

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QUESTIONS (cont.)

Bardanoue: I think there is a correlation. Generally the university is considered to be a more costly education and one that will result in higher income. Many of the vo-tech students are from lower income families and they can not afford this.

Moore: In many instances vo-tech students with the short term subjects are able to get jobs more easily and get better pay than college graduates.

Further discussion was held on this issue and is on tape available through the Legislative Fiscal Analyst's office.

DEPARTMENT OF INSTITUTIONS

-Alcohol & Drug Abuse Division-

Representative Moore gave an overview of the committee action on this issue. Refer to -D1- for committee recommendations.

-Management Services Division-

Refer to page -D2- for committee action on this issue.

-Mental Health-

Refer to page -D3- for committee recommendation. Refer to -D4- for language recommended by the committee to be put into HB 500 to allow the department of institutions flexibility in allocation of the mental health portion of the mental health and alcohol and drug abuse block grant.

-Women's Correctional Facility-

Refer to -D5- for committee action on this issue.

-ESEA Title I-

The committee removed spending authority as explained on -D8- through -D13- of the subcommittee's report.

Chairman Donaldson opened the meeting to question on this section of the report.

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Rep. Quilici: In regard to the planning evaluation on -D3-, how was this audit being done prior to giving the institution more FTE's?

Moore: These people were already on board but Mr. South wants to use them within a new bureau. The audit was not previously performed, at least not to the extent that Mr. South wants to do it.

Quilici: My concern is that we have been looking at the numerous cuts and trying to cut back on general funds and yet we are approving two more FTE's.

Moore: This a a block grant and 10% can be used for administration.

Following questions from the committee, Chairman Donaldson said that the committee would break for about ten minutes and then hear testimony from anyone wanting to address these issues. The committee recessed from 3:15 to 3:25.

Chairman Donaldson called on people to testify in the area of OPI administration area.

Ed Argenbright, Superintendent of Public Instruction, stated that approximately a quarter of a million dollars has already been cut by the department. A further reduction of \$325,000 is anticipated. Reducing below that level for basic office support will affect both the services of the schools and the ability to perform statutory responsibilities. He said that he did not play the game of asking for more and expecting less. The bottom line figure for OPI is \$677,560. He stated that they were anticipating revenue from the block grant in the amount of \$325,000 and that leaves a \$351,000 request. However that is funded, through carry-over or appropriation, he stated, it is needed.

Mr. Argenbright also commented on the needs for vocational education stating that the bottom line figure for this is \$695,298. They are estimating revenues of \$584,280 which calls for a \$111,000 appropriation for support of the secondary and post-secondary vocational education administration funds. He stated that if programs such as CETA change, unneeded funding in that area will revert.

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In the area of vo-tech funding Mr. Argenbright said that while the funding was recognized by the subcommittee as unnecessary it calls for his office to make an increase in tuition. The current tuition is \$100 per quarter and will go to \$120 per quarter with the existing projections. If they do not get the requested funding in the amount of \$464,318 the tuition will probably go to about \$180 per quarter. These students, he stated, are the least able to pay.

David Sexton, Montana Education Assoc., made general comments about the education portions of the recommendations. The association feels that the burden of these cuts should not fall on the shoulders of the taxpayers or the students. In many cases, he stated, the local districts will not be able to make up the differences to offset the cutbacks. The real victims will be the students "nutritionally and mentally deprived youngsters". Mr. Sexton said that the association believes that the state has an obligation to subsidize both vocational and technical education.

Robert VanDerVere representing himself, testified as a concerned citizen on the education cutbacks. He was opposed to any raise in tuitions.

Walt Laird, school district #2 Billings -food service director, stated that dist. #2 will experience a loss of \$245,000 through the paid student lunch program in the '81-'82 school year based on estimated participation. A further loss will be experienced through free and reduced lunches. He said that the Billings school board has taken the position that the lunch program should be self supporting except for the indirect cost of providing utilities, etc. As a result of the federal funding cutbacks and the position of the board all of the cost increase must be borne by the paying child. He stated that prices have increased this year from seventy and seventy-five cents to ninety and ninety-five cents for the paying child. The price for the reduced child has doubled from twenty cents to forty cents. With the expectation of continuing inflation the price is expected to increase in 1983. Mr. Laird said that participation in the program has been steadily declining due to cost increases.

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John Deeney, school district #2, Billings, commented briefly on vo-tech funding. He stated that the schools are in need of additional funding. The vo-tech center in Billings, he stated, is \$301,000 short at this time. If they do get the replacement money they would still be \$219,000 short. This money will have to be made up by either the school board kicking in money or by cutbacks in the programs. The school board is reluctant to kick in more money since it is a state vo-tech.

Carroll South, Director of the Department of Institutions, stated that the department is in support of the subcommittee recommendation and he feels that the programs they administer will be adequately funded for the next two years. He stated that his department had more federal funds than they anticipated. In the area of mental health centers they had a surplus of federal money. Their proposal which the subcommittee agreed to is to carry those funds over into FY '83 so the department will be able to maintain current level services in that area. The department is also proposing to carry over funds in the Alcohol & Drug Abuse Program because of the uncertainty of federal funds for FY '83 & '84. In regard to the women's prison, he stated, we are fine tuning that proposal and Representative Moore will present that proposal to the committee in executive action later today.

Representative Bardanouve asked Mr. South if there was any possibility that the federal government would reduce the funding for the next fiscal year because the department has carry-over funds.

Mr. South said that this is always a possibility but he has no indication that this will happen.

This concluded the presentation of Committee I.

REPORT FROM SUBCOMMITTEE II

Representative Burt Hurwitz, Chairman of subcommittee II, gave an overview of the committee action as stated in the Report of the Subcommittees I, II, & III.

LEGISLATIVE, JUDICIAL, & ADMINISTRATIVE

-Governor's Office-

Refer to -A1- for committee action on this issue

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-Department of Justice-

Refer to -A2- for committee recommendations.

-Board of Crime Control-

Refer to -A4- for committee recommendations.

-Department of Highways-

Refer to page -A6- for committee recommendations.

-Department of Administration-

Refer to -A7- for committee recommendations.

Under Department of Administration-Change 5: The committee recommended reducing the merit system council's spending authority due to the pending decentralization of the operation. The Merit System Council after taking testimony at the public hearing on November 4, 1981, has unanimously voted to disallow the proposal to decentralize the Montana Merit System. The council submitted an alternative proposal to the committee. A copy of this proposal is attached and is EXHIBIT 2 of these minutes.

Chairman Donaldson announced at this time that there would be a meeting with the Merit System Council to discuss this proposal at 8:30 this evening in room 108.

HUMAN SERVICES

-Department of Health-

Refer to -B1- through -B6- for committee recommendations.

Chairman Donaldson opened the meeting to questions on this portion of Representative Hurwitz' presentation.

Rep. Ernst: Under EMC, is the department willing to take these cuts.

Hurwitz: There are excess dollars because EMC is funded in a different way. They will now receive their categorical grant for '81 and also the block grant for '82.

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Moore: Up to now the solid waste program has been 100% general fund. Can you tell me how much is general fund money for FY '82 & '83?

Hurwitz: About \$65,000 to \$70,000 each year.

Moore: During the regular session we questioned whether or not to keep the program at current level services unless federal funds were available. Now with federal funds being reduced they are still at the 100% level.

Hurwitz: The committee did not feel they had much choice because of the mandate in the state law.

Representative Moore also questioned the committee's action to give the Air Quality Division \$30,000 general fund money to continue monitoring of air quality in Scobey since the last legislature provided \$35,512 general fund for FY '82.

Sen. Keating stated that the division explained that it was cheaper to leave the equipment there and have it operating than it would be to move it somewhere else and have to set it up again as well as retrain the people to monitor it. Also the division is still under some contracted services that cannot be cancelled.

NATURAL RESOURCES & BUSINESS REGULATION

-Department of Agriculture-

The department of agriculture had three changes to its budget. These changes added general fund totalling \$22,722 in fiscal 1982 and \$150,185 in fiscal 1983. Other spending authority was reduced \$214,886 in fiscal 1982 and \$218,592 in fiscal 1983. These changes resulted in an FTE reduction of 2.25 in fiscal 1982 and 2.76 in fiscal 1983.

Refer to -C1- for committee recommendations relating to these changes.

-Department of Commerce-

Refer to -C4- through -C6- for committee recommendations.

-Department of Fish, Wildlife, and Parks-

Refer to -C8- for committee recommendations.

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-Department of Livestock-

Refer to -C9- for committee report.

-Department of Natural Resources-

Refer to -C10- through -C12- for committee recommendations.

Change 4 (Cooney Dam Priority) was discussed by committee II and referred to committee III.

Chairman Donaldson opened the meeting for questions on this portion.

Representative Bardanouve said that he would like to bring out that when subcommittee I reviewed the Cooney Dam issue the committee finally agreed that the department would put some of the money up from the water resource funds. Now it appears that it is all fish and game money. Representative Bardanouve was concerned that if they reprioritized and placed Cooney Dam project at the top of the list a couple other important projects would not be funded. Representative Bardanouve said that the money should be probated in order to keep all of the money from going to the Cooney Dam project.

Representative Moore stated that when the issue comes before the committee in work session they should ask Mr. Barry from the department to address this issue.

Chairman Donaldson opened the meeting to others wishing to testify on these issues.

Gordon Mc Omer, Director of Department of Agriculture, said that he felt the department had been represented very well by Representative Hurwitz. He commented on the concern of Representative Conroy in regard to the \$40,000 spending authority for SB 363. He said that this money is a result of fees charged for inspection of leafcutter bee larvae for disease. The legislature neglected to put an appropriation for these funds in SB 363.

Mike Welsh, Montana United Indian Assoc. (MUIA), appeared in behalf of the assoc. and urged the committee to maintain health services provisions to the urban Indians of Montana. A copy of his testimony, EXHIBIT 3, delineating the history

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of the Montana United Indian Assoc., the health services currently provided by the MUIA's clinic alliances, the funding proposal made to the State Department of Health, three distinct budget proposals, a health services fact sheet, letters of support from consumers and providers of medical care, letters from the Montana Congressional Delegation, materials prepared for the Appropriations Subcommittee, copies of newspaper articles, a transcript of pertinent testimony from the Subcommittee and a transcript of an interview aired on KTVG Newslines 12, is attached to these minutes.

Representative Donaldson asked Mr. Welsh if this proposal was revised.

Mr. Welsh said that it is a revised proposal from what was presented to the subcommittee.

Testifying in support of continued adequate funding for the Family Planning program and in opposition to cuts in that program were: Rosalind Kotz, Kathy Van Hook and Scot Felderman. A copy of their testimony is attached and is EXHIBIT 4 of the minutes.

Dr. John Drynan, Dir. Department of Health, said that he supports the subcommittee recommendations within the department however, he stated, he would like to see the Family Planning program and the Consumer Safety remain in the department.

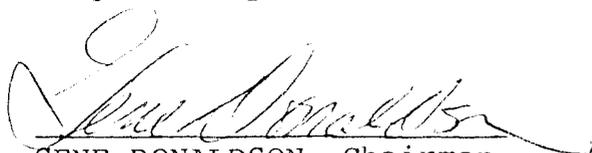
Vernon E. Sloulin, Chief of Food & Consumer Safety Bureau, testified in opposition to removal of this program. A copy of his prepared testimony is attached and is EXHIBIT 5 of these minutes.

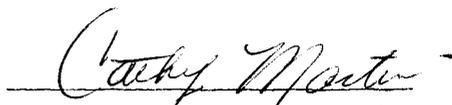
Representative Toni Bergene stated that she supports funding of the Family Planning program.

Chairman Donaldson said that the committee would reconvene at 9:30 a.m. on November 17, 1981 to continue the presentation from the committees.

Meeting adjourned at 6:20 p.m.

Respectfully Submitted:

  
GENE DONALDSON, Chairman

  
Cathy Martin, Secretary

1981 SPECIAL SESSION  
FEED BILL  
November 16, 1981

	<u>House</u>	<u>Senate</u>	<u>Legislative Council</u>	<u>Total</u>
<u>Personal Services</u>				
Salaries	\$ 89,490	\$ 65,864		\$155,354
Benefits	5,843	3,949		9,792
Per Diem	<u>45,000</u>	<u>22,500</u>	<u>          </u>	<u>67,500</u>
Total Pers. Serv.	140,333	92,313	-0-	232,646
<u>Operating Expense</u>				
Contracted Serv.	500	500	25,000	26,000
Supplies & Materials	1,700	1,000		2,700
Communications	10,109	7,082		17,191
Travel	86,159	46,411		132,570
Rent	1,500	4,000		5,500
Repair & Maint.	-0-	-0-		-0-
Other	<u>1,699</u>	<u>1,694</u>	<u>          </u>	<u>3,393</u>
Total Oper. Exp.	101,667	60,687	25,000	187,354
<u>Capital Expense</u>	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>
TOTAL	<u>\$242,000</u>	<u>\$153,000</u>	<u>\$ 25,000</u>	<u>\$420,000</u>

DEPARTMENT OF ADMINISTRATION  
PERSONNEL DIVISION

TED SCHWINDEN, GOVERNOR

MITCHELL BUILDING

STATE OF MONTANA

(406) 449-2064

HELENA, MONTANA 59620

November 13, 1981

The Honorable Gene Donaldson  
Appropriations Committee Chairman  
Capitol Station  
Helena, Montana 59620

Dear Representative Donaldson:

The Merit System Council after taking testimony at a public hearing on November 4, 1981, has unanimously voted to disallow the proposal to decentralize the Montana Merit System. The Council is firmly committed to the Merit principle which provides equality of opportunity for all persons wishing to enter public employment. The decentralization proposal not only fails to protect that principle but it further fails to provide for valid testing procedures, administrative oversight, or assure that those added or separated from the Merit System will be dealt with in a fair, impartial manner.

We would like you to know that the Merit System has operated in this state since 1940. It is a personnel system which is required in order to receive federal dollars. While we realize that those federal dollars are being substantially curtailed, it is our understanding that some monies will still be available and thus the requirement for impartial personnel administration remains.

Moreover, it is our belief that in times of economic retrenchment we should be especially certain that we do not sacrifice the right of every Montanan to open competition for available state positions.

Please be assured that the Merit System Council recognizes the need to cut state government and we are willing to take substantial cuts so long as we are satisfied that the merit principle may be continued. To that end, we have prepared a compromise proposal and are willing to adopt commensurate rule changes which would cut our staff by seventy percent, more specifically from 11.5 to 3.5 positions. Under this proposal the Job Service and the agencies would take over much of the recruitment and selection responsibility, but the all important test validation training, and oversight function would remain in the Department of Administration under the guidance of the Personnel Division and the Merit System Council. We are particularly concerned about test development and validation because it is our only objective guide for deciding who to hire for the limited number of state jobs available. As you are well aware, the competition for these few jobs is very keen.

The administration is aware of this compromise and we are asking you to consider it also. We must tell you however, that if the scaled-down merit system outlined cannot be maintained, future federal funds for social services may be jeopardized and difficulties may arise in regard to the employee appeal process. That is,

employees appealing lay-offs, or for that matter, selection procedures, may be able to allege violations of agency compliance with Merit System rules.

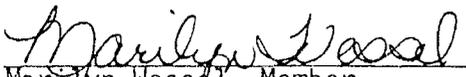
We have attached the compromise proposal with an indication of what each agency would need in order to keep the essence of the state merit system alive.

We recognize the enormity of the budget problem that confronts you, but as a citizen council, we urge you not to adopt a plan for short-run savings that could create long-term problems for Montana.

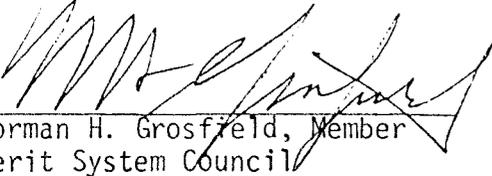
Sincerely,



Charles (Si) Seifert, Chairman  
Merit System Council



Marilyn Wessel, Member  
Merit System Council



Norman H. Grosfeld, Member  
Merit System Council

MW:lsc

PROPOSED

## MERIT SYSTEM BUDGET

( Jan 82 - Jun 82 )

## PERSONAL SERVICES

Grade	Title	Amount
14	Test Development Specialist	9,456
13	Personnel Specialist II	10,614
12	Personnel Specialist I	8,327
8	Secretary II (.5)	2,937
		<hr/>
		31,334

## Other Compensation

Council Meetings	375
Employee Benefits	7,590

## OPERATING EXPENSES

Contracted Services	
Payroll charges	75
Data processing services	935
Legal Services	1,000
	<hr/>
	2,010
Supplies and Materials	
Office	300
Photo and reproduction	750
Printing	800
	<hr/>
	1,850
Communication	
Telephone	935
Postage and mailing	1,200
Messenger services	200
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	2,335
Travel (in-state)	133
Rent (office space)	1,060
Repairs and maintenance	568

Other Expenses

Subscriptions	80
Registration fees	130

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210

TOTAL: 47,465

ALLOCATION OF TOTAL ESTIMATED EXPENDITURES  
TO PARTICIPATING STATE AGENCIES

( Jan 82 - Jun 82 )

<u>Agency</u>	<u>Positions</u> <u>( July 1, 1981 )</u>	<u>Percent</u>	<u>Total Charges</u>
SRS	1,049	51.62	24,500.92
Labor & Ind.	644	31.69	15,041.34
DHE	271	13.34	6,332.70
ADA	24.5	1.21	574.31
MH	11	.54	256.31
DES	14	.69	327.50
CC	18.5	.91	431.92
	<hr/> 2,032	<hr/> 100.00	<hr/> 47,465.00

MERIT SYSTEM BUDGET

FY 83

( July 82 thru June 83 )

PERSONNEL SERVICES

Grade	Title	Amount
14	Test Development Specialist	\$20,736
13	Personnel Specialist II	24,246
12	Personnel Specialist I	18,530
8	Secretary II (.5)	6,709
		<u>\$70,221</u>

Other Compensation

Council Meetings (3 members, 10 meetings)	\$ 750
Employee Benefits	13,320

Operating Expenses

Contracted Services	\$ 400
Payroll charges	\$ 150
Data processing	2,000
Legal services	2,000
	<u>\$ 4,150</u>

Supplies and Materials	
Office	\$ 650
Photo and reproduction	800
Printing	1,000
	<u>\$ 2,450</u>

Communication	
Telephone	\$ 1,750
Postage and mailing	1,300
Messenger service	200
	<u>\$ 3,250</u>

Travel (in-state)	\$ 144
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Rent (office space)	\$ 1,895
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Repairs and maintenance	\$ 392
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Other Expenses

Subscriptions	\$ 500
Registration fees	350
	<u>\$ 850</u>

ALLOCATION OF TOTAL ESTIMATED EXPENDITURES

TO PARTICIPATING STATE AGENCIES

( July 82 - Jun 83 )

<u>Agency</u>	<u>Positions</u>	<u>Percent</u>	<u>Total Charges</u>
SRS	1,000	52.04	50,698.41
Labor & Ind.	604	31.43	30,619.73
DHE	205	13.01	12,674.60
ADA	24.5	1.28	1,247.00
MH	11	.57	555.31
DES	14	.73	711.18
CC	18	.94	915.77
	<hr/>	<hr/>	<hr/>
	1,921.5	100.00	97,422.00

## MERIT SYSTEM STAFFING

### Test Development Specialist

The State needs this position to develop and/or validate selection devices such as employment tests, applicant screening procedures, and structured oral interviews. The requirement for the use of valid job related selection devices is found in Title 7 of the U.S. Civil Rights Act of 1964 and the interpretative Uniform Selection Guidelines of the EEOC. The Montana Human Rights Act and Code of Fair Practices also impose a similar requirement for job related selection devices. Individuals qualified for performing test development functions must usually have an advanced degree in psychology with an emphasis on tests and measurement.

### Personnel Specialist II

This position will perform a support function to the test development specialist in constructing selection devices. Technical assistance in the area of personnel selection will be provided to agencies by this position. The qualifications required for this position are a college degree in psychology, personnel administration or related field.

### Personnel Specialist I

This position will provide technical assistance to agencies in the area of Merit System Council rules, policy and procedures, and will monitor compliance with Merit System standards.

### Secretary - ½ Time

This position will provide clerical support to the professional staff of the Merit System and serve as secretary to the Merit System Council.

# Montana United Indian Association



43-5350

846 Front Street  
Helena, Montana  
59601

M U I A

## ADDRESS TO THE HOUSE APPROPRIATIONS COMMITTEE

MR. CHAIRMAN, MR. VICE-CHAIRMAN AND MEMBERS OF THE COMMITTEE:  
MONTANA UNITED INDIAN ASSOCIATION (MUIA) IS GRATEFUL FOR THIS OPPORTUNITY TO ADDRESS YOU THIS AFTERNOON:

THE MUIA IS HEREBY SUBMITTING A REVISED REQUEST FOR FUNDING TO MAINTAIN HEALTH SERVICES PROVISION TO THE URBAN INDIANS OF MONTANA. THE MUIA RECOGNIZES THAT THIS LEGISLATURE IS HEAVILY BURDENED WITH REQUESTS FROM VARIOUS SOURCES ATTEMPTING TO OFFSET THE WIDESPREAD HUMAN SERVICES BUDGET CUTS PROMULGATED BY THE DIRECTOR OF THE OFFICE OF MANAGEMENT AND BUDGET, DAVID STOCKMAN. HOWEVER, THE MUIA WISHES TO POINT OUT THAT THERE ARE SEVERAL REASONS THAT MAKE THE CLINIC FUNDING REQUEST NOT ONLY VALID, BUT ESSENTIAL:

1) IT HAS BEEN AMPLY DEMONSTRATED BY THE MUIA'S EXPERIENCE, THE CONGRESS OF THE UNITED STATES, THE MONTANA SUPREME COURT, BY TESTIMONY GIVEN AT THE BLOCK GRANT HEARINGS ON OCTOBER 28TH AND 29TH AND AT THE HEARINGS OF SUB-COMMITTEE #2 ON NOVEMBER 9TH, 10TH AND 11TH OF THIS YEAR THAT PROVISION OF HEALTH CARE SERVICES TO NATIVE AMERICANS IN MONTANA HAS NOT ACHIEVED PARITY WITH THE MAJORITY OF THE STATE'S POPULATION;

-----MUIA IS AN EQUAL OPPORTUNITY EMPLOYER-----

INDIAN AMERICAN INDIAN COUNCIL  
HELENA, MONTANA

HELENA INDIAN ALLIANCE  
HELENA, MONTANA

NORTH AMERICAN INDIAN LEAGUE  
HELENA, MONTANA

NORTH AMERICAN INDIAN ALLIANCE  
HELENA, MONTANA

MISSOULA INDIAN QUI CORE CORPORATION  
MISSOULA, MONTANA

ANACONDA INDIAN ALLIANCE  
ANACONDA, MONTANA

GREAT FALLS INDIAN EDUCATION CENTER  
GREAT FALLS, MONTANA

BILLINGS INDIAN ALLIANCE  
BILLINGS, MONTANA

NATIONAL ASSOCIATION OF  
BLACKFEET INDIANS

2) WHEN URBAN INDIANS ARE ALLOWED ACCESS TO HEALTH CARE, THE COST OF THAT CARE IS FAR BEYOND THE MEANS OF THE MAJORITY TO PAY DUE TO THE LOW INCIDENCE OF EMPLOYMENT AND THE RESULTANT LACK OF INSURANCE COVERAGE BY THIRD PARTY PAYORS. THE APPROXIMATE ONE-WAY DISTANCES FROM THE NEAREST RESERVATION TO EACH OF THE URBAN HEALTH CENTERS IS DETAILED BELOW:

GREAT FALLS TO ROCKY BOYS' = 87 MILES

HELENA TO FLATHEAD = 173 MILES

MISSOULA TO FLATHEAD = 61 MILES

IT IS IMPORTANT TO NOTE THAT VERY FEW MONTANAS WOULD DRIVE 174, 346 OR 122 MILES IN THE SUMMER TO RECEIVE PRIMARY HEALTH CARE, EVEN IF THEY COULD AFFORD THE GASOLINE, TO SAY NOTHING OF MAKING THE SAME TRIP IN THE WINTER.

EQUALLY IMPORTANT IS THE FACT THAT APPOINTMENTS HAVE TO BE MADE FOR THE SERVICE DELIVERY WHICH MANY TIMES INVOLVE PLANNING WEEKS AHEAD. IN ADDITION, IF URBAN INDIANS HAD THE MONEY FOR THE GASOLINE TO TRAVEL THOSE DISTANCES, THEY COULD PAY FOR LOCAL NON-INDIAN PRIMARY CARE.

3) THE INDIAN HEALTH SERVICE (IHS) HAS TWO PERTINENT FUNDING REGULATIONS WHICH ARE DIFFICULT TO INTERPRET DUE TO THE NUMBER OF SIGNIFICANT EXCEPTIONS POSSIBLE AND THE VARIABILITY WITH WHICH THE SEVEN RESERVATIONS IN THE STATE TREAT EACH REGULATION, TO WIT:

A) THE SO-CALLED "ON OR NEAR" POLICY BASICALLY STATES THAT INDIAN PEOPLE RESIDING ON OR NEAR A RESERVATION ARE ENTITLED TO IHS CONTRACT CARE. THE OPERATIVE CLAUSES OF THIS POLICY STATE THAT ELIGIBILITY FOR CONTRACT CARE ON A SPECIFIC RESERVATION DEPENDS, IN PART, UPON AN OTHERWISE ELIGIBLE

INDIVIDUAL'S PLACE OF RESIDENCE. IF AN ENROLLED MEMBER OF A TRIBE OTHERWISE ELIGIBLE TO RECEIVE CONTRACT CARE RESIDES IN A COUNTY ADJOINING AN INDIAN RESERVATION OR IN A COUNTY INTO WHICH THE BOUNDARY OF AN INDIAN RESERVATION PROTRUDES, THAT INDIVIDUAL MAY RECEIVE CONTRACT CARE, EVEN IF HE OR SHE DOESN'T RESIDE UPON THE RESERVATION PROPER.

THE NUMBER OF INDIAN PEOPLE QUALIFYING FOR "NEAR" RESIDENCY IS SO MINIMAL THAT THEY ARE NOT COUNTED IN MUIA'S URBAN POPULATION DATA BECAUSE IN FACT, THESE PEOPLE ARE, UNDER THE RULES, RESERVATION RESIDENTS.

B) THE "ONE HUNDRED-EIGHTY DAY" RULE STATES THAT IF AN INDIVIDUAL WHO IS OTHERWISE ELIGIBLE FOR CONTRACT CARE SERVICES HAS LIVED OFF (NOT "NEAR") THE RESERVATION FOR MORE THAN 180 DAYS, THAT PERSON MAY BE DENIED CONTRACT CARE UNLESS HE OR SHE RE-ESTABLISHES RESIDENCY PRIOR TO PROVISION OF CARE.

BOTH OF THE ABOVE REGULATIONS ARE SUBJECT TO INTERPRETATION BY THE TRIBE PROVIDING THE HEALTH SERVICE. FOR EXAMPLE, SOME TRIBES ALLOW ENROLLED TRIBAL MEMBERS LIVING OFF-RESERVATION (BEYOND THE LIMIT PROSCRIBED BY THE ON OR NEAR POLICY) TO ENJOY CONTRACT CARE SERVICES IF THEY ARE WORKING FOR THE TRIBE IN A CAPACITY THAT NECESSITATES LIVING IN A PLACE BEYOND THE ON OR NEAR POLICY'S PURVIEW. SECONDLY, MOST RESERVATIONS WILL PROVIDE PRIMARY CARE OR FIRST AID AS NECESSARY FOR EMERGENCY CASES AND WILL PROVIDE REFERRAL TO HEALTH CARE PROVIDERS AND FACILITIES OUTSIDE THE RESERVATION, BUT IN THESE CASES WILL NOT PAY FOR THOSE SERVICES NOR REIMBURSE EITHER THE VICTIM OR THE PROVIDER WHO RENDERED THE SERVICE.

4) THE COST OF HEALTH CARE PROVISION NATIONWIDE HAS BALLOONED IN EXCESS OF 19% IN THE LAST FISCAL YEAR, IN MONTANA, THIS COST HAS RISEN BY 11% DURING THE SAME PERIOD. THE URBAN INDIAN HEALTH PROGRAMS THAT ARE ADMINISTERED BY THE MUIA HAVE OPERATED EFFICIENTLY AND EFFECTIVELY (CONFIRMED BY A NATIONALLY RECOGNIZED MANAGEMENT CONSULTANT FIRM) ON A CONGRESSIONAL APPROPRIATION THAT HAS NOT CHANGED FOR TWO FISCAL YEARS, NAMELY AN AVERAGE OF \$217,073.17 FOR EACH OF 41 URBAN INDIAN HEALTH PROJECTS ACROSS THE UNITED STATES. A MEASURE OF THE EFFECTIVENESS OF MUIA'S PROGRAMS CAN BE SEEN IN THE FACT THAT WE PRODUCED A CARRYOVER SURPLUS IN FISCAL 1980 WHICH WAS APPLIED TO THE PAST FISCAL YEAR'S PROGRAM NEEDS. DUE TO A CHANGE IN CONTRACTING PROCEDURES FOR FISCAL 1981, CARRY-OVERS NOW REVERT TO THE U.S. TREASURY IF NOT UTILIZED OR ENCUMBERED DURING THAT CONTRACT YEAR.

5) THE STARK REALITY OF THE FEDERAL HUMAN SERVICES BUDGET CUTS IS THAT THERE ARE MORE HOLES IN THE "SAFETY NET" THAN THERE IS "NET." THE SAFETY NET CONCEPT WILL ULTIMATELY DEVOLVE UPON MONTANA'S 56 COUNTIES WHO WILL BE FOOTING THE BILL FOR SHARP INCREASES IN THE PAYMENT FOR ACUTE EPISODIC AND EMERGENCY ROOM CARE THAT WILL INEVITABLY OCCUR IF THE URBAN INDIAN HEALTH PROGRAMS ARE NOT FUNDED. IN ADDITION TO ASSUMING FINANCIAL RESPONSIBILITY FOR THE DRASTIC CUTS IN OTHER SERVICES, MONTANA'S COUNTIES WILL BE HARD PRESSED TO PAY FOR EMERGENT URBAN INDIAN HEALTH CARE BECAUSE THE URBAN INDIAN POPULATION WILL NOT SEEK PREVENTIVE HEALTH FROM NON-INDIAN CLINICS DUE TO THE HISTORICAL HUMILIATION, DEPRIVATION AND DISCRIMINATION SUFFERED AT THE HANDS OF MANY MEDICAL PROVIDERS. THE LAW OF THE LAND STATES THAT THIS SHOULD NOT HAPPEN;

HOWEVER, IT IS WELL KNOWN THAT FIRMLY ROOTED ATTITUDES AND PRE-  
JUDICES CANNOT BE LEGISLATED OUT OF EXISTENCE.

6) THE MONTANA SUPREME COURT, INTERPRETING THE LAW OF OUR  
LAND, POINTEDLY DEMANDED LAST THURSDAY (NOVEMBER 12, 1981) "A  
GREATER INSULATION OF INDIAN VALUES FROM WHITE INFLUENCES AND  
AUTHORITY..." AND THE COURT SAID "THE ACT (INDIAN CHILD WELFARE  
ACT OF 1978) WAS PASSED BY CONGRESS IN RESPONSE TO A SIGNIFICANT  
THREAT TO THE INTEGRITY OF INDIAN CULTURES IN THIS COUNTRY."  
THE SUPREME COURT ALSO STATED, "INDIAN PEOPLE, whether residing  
on a reservation or not, ARE IMMERSD IN AN ENVIRONMENT WHICH  
IS IN MOST RESPECTS ANTITHETICAL TO THEIR TRADITIONS." (EMPHASIS  
ADDED.) IN ADDITION, THE COURT NOTED THAT "...CULTURAL DIVERSITY  
AMONG INDIAN TRIBES IS PROFOUND BUT NOT FULLY APPRECIATED OR PRO-  
TECTED IN WHITE SOCIETY, BUT THE MONTANA CONSTITUTION RECOGNIZES  
THE NEED TO PRESERVE THE UNIQUE CULTURAL HERITAGE OF INDIANS."  
FINALLY, THE COURT DECLARED, "IN APPLYING OUR STATE LAW...WE ARE  
COGNIZANT OF OUR RESPONSIBILITY TO PROMOTE AND PROTECT THE UNIQUE  
INDIAN CULTURES OF OUR STATE FOR ALL FUTURE GENERATIONS OF MONTANANS."

IT MUST BE NOTED THAT ALL FOUR MEMBERS OF MONTANA'S CONGRES-  
SIONAL DELEGATION FULLY SUPPORT THE MUIA'S HEALTH PROGRAMS AND  
HAVE SENT US LETTERS STATING THEIR POSITION ON THIS ISSUE. MUIA  
REPRESENTATIVES HAVE MET WITH EACH DELEGATE PERSONALLY REGARDING  
THE NECESSITY FOR CONTINUING OPERATION OF THE CLINICS. THE DELE-  
GATION WAS HIGHLY VISIBLE IN ITS SUPPORT OF INCLUSION OF THE URBAN  
INDIAN HEALTH PROGRAMS IN THE INTERIOR BILL WHICH RECENTLY EMERGED  
FROM THE SENATE/HOUSE CONFERENCE COMMITTEE.

7) AS CAN BE CLEARLY SEEN BY THE ATTACHED TESTIMONY AND

BUDGETS PREPARED AT THE INVITATION OF SUB-COMMITTEE #2, THE MUIA HAS REALISTICALLY TRIMMED THE AMOUNTS NECESSARY TO OPERATE AND STAFF THE CLINICS FOR FISCAL YEAR 1982. HOWEVER, IN THE INTEREST OF PRESENTING A REQUEST TO A LEGISLATURE WHICH FINDS ITSELF SEVERELY LIMITED BY FEDERAL BLOCK GRANTS, THE MUIA PROPOSES THREE MODEL FUNDING BUDGETS (ATTACHED) TWO OF WHICH REFLECT SERVICE DELIVERY ONLY; I.E., NO ADMINISTRATION, OFFICE MATERIALS AND SUPPLIES, RENT OR OTHER DIRECT COST. THE RATIONALE BEHIND THIS APPROACH EMINATES FROM LIMITED ENCOURAGEMENT FROM PRIVATE FOUNDATIONS AND OTHER CHARITABLE INSTITUTIONS WHO HAVE INDICATED AN INTEREST IN CONTINUING THE CLINICS BUT, LIKE THE STATE, CANNOT SUPPORT THE ENTIRE COST OF MAINTAINING THEM. SINCE THE MUIA BROUGHT THE ISSUE BEFORE SUB-COMMITTEE #2, CASH AND PLEDGES TOTALING NEARLY \$35,000.00 HAVE BEEN RECEIVED.

IN SUMMARY, YOU HAVE BEFORE YOU A COMPLETE PACKET DELINEATING THE HISTORY OF THE MONTANA UNITED INDIAN ASSOCIATION, THE HEALTH SERVICES CURRENTLY PROVIDED BY THE MUIA'S CLINIC ALLIANCES, THE FUNDING PROPOSAL MADE TO THE STATE DEPARTMENT OF HEALTH, THREE DISTINCT BUDGET PROPOSALS, A HEALTH SERVICES FACT SHEET, LETTERS OF SUPPORT FROM CONSUMERS AND PROVIDERS OF MEDICAL CARE, LETTERS FROM THE MONTANA CONGRESSIONAL DELEGATION, MATERIALS PREPARED FOR THE APPROPRIATIONS SUB-COMMITTEE, COPIES OF NEWSPAPER ARTICLES, A TRANSCRIPT OF PERTINENT TESTIMONY FROM THE SUB-COMMITTEE AND A TRANSCRIPT OF AN INTERVIEW AIRED ON KTVG NEWSLINE 12. THE DELIBERATIONS AND RECOMMENDATIONS OF YOUR COMMITTEE WILL HAVE A SIGNIFICANT IMPACT ON THE HEALTH STATUS OF NOT ONLY THE MORE THAN 16,000 URBAN INDIAN PEOPLE IN THE STATE, BUT ON THE NON-INDIAN POPULATION AS WELL.

THE MONTANA UNITED INDIAN ASSOCIATION WISHES TO THANK THE  
CHAIRMAN, VICE-CHAIRMAN AND MEMBERS OF THE APPROPRIATIONS COMMITTEE  
FOR THIS OPPORTUNITY TO TESTIFY IN THE INTEREST OF THE CONTINUING  
PROVISION OF QUALITY HEALTH CARE TO MONTANA'S URBAN INDIAN PEOPLE.

# Montana United Indian Association <sup>3</sup>



846 Front Street  
Helena, Montana  
59601

November 2, 1981

Mr. John Bartlett, Deputy Director  
Department of Health and Environmental  
Sciences  
Cogswell Building  
Room A107  
Helena, Montana 59601

Dear Mr. Bartlett:

Attached please find a Program and Budget Summary of the Montana United Indian Association's (MUIA) health proposal for Fiscal Year 1982.

We feel that this proposal represents the bare minimum under which our health programs can successfully operate during FY 82. The proposed budget represents a 38.3% reduction over this year's appropriation request to the Indian Health Service.

As we discussed with you on October 29 and 30th, the MUIA can provide statistical data on hypertension, otitis media, heart disease, diabetes, infectious skin disease, sudden infant death syndrome (SIDS), premature death, and other problems apparently indigenous to Indian people in Montana's urban areas. The MUIA health department has determined that defunding of the alliances' subcontracts represents an immediate increase of emergency medical usage, hospital costs, and medicare and medicaid payments which will dramatically increase the Montana taxpayer's burden. In addition, funding decreases in Social and Rehabilitative Services' programs will significantly increase the usage of the alliances' outpatient clinics.

The health programs stimulate the growth of the local economics they serve. Cases in point include medical supplies and suppliers, providers of health care services, banking institutions, and employment (a minimum of thirty people statewide will be unemployed if the health care services are defunded).

In the past few years, urban Indian health programs have been able to generate one dollar of in-kind and volunteer services for every federal dollar granted. Our health personnel have helped to bridge cultural barriers, reduce discrimination, educate school children, and provided awareness of

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BILLINGS AMERICAN INDIAN COUNCIL  
BILLINGS MONTANA

NORTH AMERICAN INDIAN ALLIANCE  
HELENA MONTANA

GREAT FALLS INDIAN EDUCATION CENTER  
GREAT FALLS MONTANA

HELENA INDIAN ALLIANCE  
HELENA MONTANA

MISSOULA OJA QUE CORPORATION  
MISSOULA MONTANA

HELENA INDIAN ALLIANCE  
HELENA MONTANA

NORTH AMERICAN INDIAN LEAGUE  
DEER LODGE MONTANA

ANACONDA INDIAN ALLIANCE  
ANACONDA MONTANA

NATIONAL ASSOCIATION OF  
BLACKFEET INDIANS

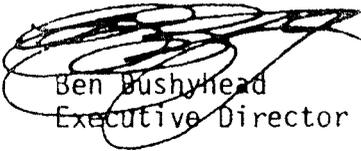
Letter to Mr. Bartlett  
Page 2. (continued)

Indian culture and customs. They have actively involved themselves in local government and provided input at community meetings.

The MUIA health staff, in conjunction with local alliances, have brainstormed innovative approaches to health care delivery and possible research programs to determine why the incidence and prevalence of specific degenerative disease afflict urban Indian populations.

We are anxiously anticipating a cooperative working agreement with the State of Montana, which would include funding, to continue our necessary health programs and to improve the deplorable health status of Montana's urban Indians.

Sincerely,



Ben Bushyhead  
Executive Director

cc: Governor Schwinden  
Individual members of the Select Committee on Indian Affairs

## PROGRAM NARRATIVE AND BUDGET REQUEST

The Montana United Indian Association (MUIA) was incorporated in 1971 as a non-profit organization representing urban Indians throughout the state of Montana. Eight local Indian alliances and the MUIA joined forces to create a consortium to provide needed services in their respective communities. Those alliances were: Anaconda, Billings, Butte, Great Falls, Havre, Helena, Miles City and Missoula.

Seven alliances currently offer services to the urban Indian population which include health care, housing, job placement assistance, educational opportunities, outreach, transportation, mental health counseling and other supportive services.

The MUIA central office, located in Helena, is responsible for the administration of state and federal programs. MUIA provides technical assistance, guidance, counseling and advocacy for the consortium and the estimated 16,000 urban Indians of Montana. A major responsibility of the MUIA is to procure funding to continue existing programs and to expand services to the urban Indian population of Montana.

In the past the MUIA has successfully obtained health funding from the Indian Health Service as a result of Public Law 94-437, "The Indian Health Improvement Act." As a result of this legislation passed in 1976, the alliances were enabled to provide the following services:

- \* A data needs assessment
- \* Establishment and provision of direct medical care on site
- \* Removal of the multiple barriers accessing health care
- \* Provision of preventive health care education

Public law 94-437, Title V, Section 501, The Indian Health Care Improvement Act, reads "The purpose of this title is to encourage the establishment of programs in urban areas to make health services more accessible to the urban Indian population;" the Congress of the United States, recognizing the severity of the urban Indian Health status, passed the public law to ensure health services provision.

Since reauthorizing Public Law 94-437 in 1980, the Congress has been exhorted to indiscriminately cut social service programs regardless of need or their accomplishment. The Office of Management and Budget (OMB) has issued several misstatements of fact about urban Indian health organization, namely "Urban Health projects largely provide referral, rather than medical, services; (they) are not required by treaty obligation; and (they) are over and above services available to the general population." In the detailed Health Proposal for fiscal year 1982, we successfully address these "artificial" issues. The documentation that follows is a skeleton outline of the needs and accomplishments of Urban Indian Health Centers.

You should be acutely aware of the life and death ramifications of immediate access to quality health care. Urban Indians face deprivation of urgently needed health care services every day. The efforts of urban Indian health care professionals will be for naught if projected cuts of one hundred percent elimination in Fiscal Year 1982 are enacted.

The Health Advisory Committee of the Montana United Indian Association has prepared the following data summary for your personal attention: Indian programs will suffer a disproportionate share of the proposed budget cuts. Indian programs, which account for only .4% of the total federal budget, would absorb nearly 3% of the national budget cut.

It cannot be disputed that American Indian people are the neediest of Montana's poor. In this, the most affluent country in the world, Indian people rank at the bottom of every social and economic statistical indicator:

- \* lowest per capita income
- \* highest unemployment rate
- \* lowest level of education
- \* shortest lives
- \* worst health conditions
- \* poorest housing
- \* highest suicide rate
- \* family poverty 300% greater than national average

Contrary to OMB justifications, Block Grants to states will not guarantee provision of Urban Indian Health Care Services to our population. All of the truly remarkable accomplishments achieved by Urban Indian health care programs in the past five years will be utterly negated - clinics will cease to exist, trained Native American health care personnel will not be able to fulfill their commitment to Indian people and, worst of all, another successful Urban Indian program will be eliminated precisely at the moment of fruition.

We can no longer look to the Federal Government to meet all our financial needs. Proposed budget cuts from the Reagan Administration will zero out urban Indian health care in Fiscal Year 82. We are requesting financial support from the State of Montana so that the MUIA may continue its commitment to all urban Indians in the State of Montana.

## THE EFFECTIVENESS OF UTILIZATION OF URBAN INDIAN HEALTH CENTERS

Urban Indian Health Care Centers are a vital key to meeting the health needs of urban and rural non-reservation Indians. In meeting those needs, Montana's urban Indian health centers have demonstrated an ability to be:

- \* cost effective and well utilized.
- \* developing and/or maintaining a quality assurance program
- \* improving the health status of American Indians
- \* developing linkages with other providers

### I. Cost Effective

In a study on several health centers, it was shown that:

- \* per patient costs are lower than national norms
- \* \$19.50 was the average cost of a patient encounter
- \* health care centers can deliver quality care at reasonable costs. Last year's average administrative costs was 19.74%, below the 20% criteria
- \* for every dollar of Title V funds, a dollar or more was matched by other sources of revenue
- \* financial audits have indicated strong financial management
- \* productivity rates are in keeping with standard norms. An average 2.6 patient encounters per hour was maintained by several of the health centers

### II. Utilization

Urban Indian Health centers have shown a marked increase in medical and dental encounters over the years and are leveling off at full productivity. Since 1979, the health care centers have had an average 55 percent overall increase in services provided. This remarked increase is attributed to:

- \* institution of more comprehensive health services where none existed before. More health centers have moved from Phase II to Phase III, increasing the level of health care.
- \* Changing patterns of utilization of expensive episodic health care (emergency rooms, hospitalization, for preventive diseases) to prevention and early intervention primary care.

### III. Quality Assurance

Initiative has been taken by the health centers to improve and maintain a high degree of professional training and responsibility. This is being achieved by:

- \* peer review
- \* on-going continuing education
- \* implementing of services, where careful review has shown a need
- \* patient evaluation of centers
- \* treatment compliance review process

### IV. Improving the Health Status of American Indians

In the past American Indians have been the victim of non-existent or poor medical-dental services. Consequently Indians suffered from a higher death rate, higher infant death rate, and higher preventable death rate.

- \* statistics have shown that the death rate of Indians is 841.4 deaths per 100,000, this in contrast to the overall USA population which is 606.1 per 100,000.

\* this is nearly a 1.4 death ratio for American Indians

Today Urban Indian Health centers are working towards improving the health status of American Indians. A study has shown that through pre-natal, WIC and post-partum care the level of infant deaths has decreased. Some centers have been able to demonstrate a lowered rate of 26.4% to 14% per 1000 births.

This decrease can be attributed to women receiving care during their first trimester rather than at the time of delivery.

In addition children are now achieving a higher than average compliance in immunizations. Other vital medical services that health care centers provide are:

- \* immunizations
- \* family planning counseling
- \* hypertension screening
- \* anemia testing
- \* dental care
- \* nutritional counseling
- \* mental health services
- \* home visits for medical and/or social services
- \* alcohol counseling and treatment
- \* para-professional health training
- \* diabetes screening and education
- \* primary and secondary specialty care
- \* health education

#### V. Linkages

Comprehensive care is being provided by health centers by developing network contacts with other health and social service agencies. Effective use of these networks have been shown, and have augmented the health center programs.

Instead of duplicating services, Urban Indian Health Centers have become integral parts of the health structure and have provided access where none existed.

BUDGET OUTLINE  
Fiscal Year 1982

Alternative I. Clinic and non-clinic alliances

Clinics in Great Falls, Helena and Missoula @ \$75,000 = \$225,000

MUIA (Administration, technical assistance, planning and fundraising)  
@ \$45,000

Transportation and referral alliances in Anaconda, Butte and Miles City  
@\$25,000 = \$75,000

Grand Total = \$345,000.00 per annum

Alternative II. Clinic Alliances only

Clinics in Great Falls, Helena and Missoula @ \$80,000 = \$240,000

MUIA (Administration, technical assistance, planning and fundraising)  
@\$45,000 or 15.7% administrative cost which is 4.3% below the 20%  
Federal administrative percentage guideline

Grand Total = \$285,000 per annum

NOTE: A detailed, line-item budget for both alternatives will be  
submitted upon request.

The MUIA clinics have realistically projected self-sufficiency by  
Calendar Year 1984. At that time, fees paid by private insurance,  
Medicaid, Medicare and funds from private foundations will enable the  
clinics to operate independently of State or Federal funds.

In the past few years, urban Indian health programs have been able to  
generate one dollar of in-kind and volunteer services for every federal  
dollar granted. Our health personnel have helped to bridge cultural barriers,  
reduce discrimination, educate school children, and provided awareness of

Indian culture and customs. They have actively involved themselves in  
local government and provided input at community meetings.

The MUIA health staff, in conjunction with local alliances, have brainstormed  
innovative approaches to health care delivery and possible research programs  
to determine why the incidence and prevalence of specific degenerative  
disease afflict urban Indian populations.

REDUCED MODEL BUDGET #1  
MONTANA UNITED INDIAN ASSOCIATION  
HEALTH CLINICS  
FOR EACH OF THREE CLINICS  
(GREAT FALLS, HELENA AND MISSOULA)

1.	<u>DIRECT LABOR</u>		
	Registered Nurse	2080 hours x 7.70	\$16,016.00
2.	<u>FRINGE</u>		
	17.5%		<u>\$ 2,803.00</u>
		DIRECT LABOR/FRINGE TOTAL	\$18,819.00
3.	<u>CLINIC SUPPLIES</u>		
	Expendable clinic supplies	\$165 mo. x 12 mo.	\$ 1,980.00
4.	<u>CONTRACT PHYSICIANS AND CARE</u>		
	A. Physicians	\$50 hr. x 7 hr./wk x 52 wks	\$18,200.00
	B. Contracted Care Services		
	1. Pharmacy	\$150.00 mo. x 12 mo.	\$ 1,800.00
	2. Dental	\$150.00 mo. x 12 mo.	\$ 1,800.00
	3. X-ray/Lab	\$150.00 mo. x 12 mo.	<u>\$ 1,800.00</u>
		CONTRACT PHYSICIANS AND CARE TOTAL	\$23,600.00
		SINGLE CLINIC TOTAL	\$44,399.00
		GREAT FALLS, HELENA AND MISSOULA GRANT TOTAL	\$133,197.00

NOTE: This budget represents a sub-subsistence level - it excludes optical care and eliminates two full time equivalents and one part time position. No provision is made for rent, office supplies, xerox, telephone or training. The assumption is that funding for the above will be found through private sources.

REDUCED MODEL BUDGET #2  
MONTANA UNITED INDIAN ASSOCIATION  
HEALTH CLINICS  
FOR EACH OF THREE CLINICS  
(GREAT FALLS, HELENA AND MISSOULA)

1. <u>DIRECT LABOR</u>		
Registered Nurse	2080 hours x 7.70	\$16,016.00
2. <u>FRINGE</u>		
17.5%		<u>\$ 2,803.00</u>
	DIRECT LABOR/FRINGE TOTAL	\$18,819.00
3. <u>CLINIC SUPPLIES</u>		
Expendable clinic supplies	\$100 mo. x 12 mo.	\$ 1,200.00
4. <u>CONTRACT PHYSICIANS</u>		
Physicians	\$50 hr. x 5 hr./wk. x 52 wks.	<u>\$13,000.00</u>
	SINGLE CLINIC TOTAL	\$33,019.00
	GREAT FALLS, HELENA AND MISSOULA GRAND TOTAL	\$99,057.00

NOTE: This budget represents the absolute minimum of direct service provision only - it eliminates optical care, pharmacy, dental, x-ray/lab, two FTEs and one part time position. As in Budget Number One, no provision is made for rent, office supplies, xerox, telephone or training. The assumption that private funding will offset these costs is again made.

MODEL BUDGET REQUEST #3  
MONTANA UNITED INDIAN ASSOCIATION  
HEALTH CLINIC  
(ONE STATEWIDE LOCATION)

1.	<u>DIRECT LABOR</u>		
	Executive Director	20%	\$ 3,600.00
	Clinic Health Director	100%	\$15,750.00
	Registered Nurse	2080 x 7.69	\$15,995.00
	Clinic Receptionist	2080 x 4.62	\$ 9,610.00
2.	<u>FRINGE</u>		
	17.5%		<u>\$ 7,850.00</u>
		DIRECT LABOR/FRINGE TOTAL	\$52,805.00
3.	<u>MATERIALS AND SUPPLIES</u>		
	A. Expendable clinic supplies	\$166.67 x 12 mo.	\$ 2,000.00
	B. Office supplies	\$100.00 x 12 mo.	<u>\$ 1,200.00</u>
		MATERIALS SUPPLIES TOTAL	\$ 3,200.00
4.	<u>CONTRACT PHYSICIANS AND CARE</u>		
	A. Physicians	\$50.00 hr. x 5 hr./wk x 52 wks.	\$13,000.00
	B. Contracted Care Services		
	1. Pharmacy	\$150.00 mo. x 12 mo.	\$ 1,800.00
	2. Dental	\$150.00 mo. x 12 mo.	\$ 1,800.00
	3. X-Ray/Lab	\$150.00 mo. x 12 mo.	<u>\$ 1,800.00</u>
		CONTRACT PHYSICIANS AND CARE TOTAL	\$18,400.00
5.	<u>EQUIPMENT/RENTAL</u>		
	A. Rent of Office Space	\$150.00 mo. x 12 mo.	<u>\$ 1,800.00</u>
		EQUIPMENT/RENTAL TOTAL	\$ 1,800.00
6.	<u>OTHER DIRECT COST</u>		
	A. Xerox	\$100.00 mo. x 12 mo.	\$ 1,200.00
	B. Telephone	\$175.00 mo. x 12 mo.	\$ 2,100.00
	C. Training	Continuing Medical Education - R.N.	<u>\$ 495.00</u>
		OTHER DIRECT COST TOTAL	\$ 3,795.00
		GRAND TOTAL	<u>\$80,000.00</u>

NOTE: This budget represents a subsistence level - it excludes optical care and provides minimal contract physician's services.

GREAT FALLS

HELENA

MISSOULA

11,651

7,291

1,785

SERVICES PROVIDED \*

(4) contracting physicians  
 Hypertension Screening  
 Urinary Screening  
 Physical Exams  
 Diet Counseling  
 Diabetic Counseling  
 Nutrition Counseling  
 Transportation  
 Prescriptions  
 Referral

10,191 Services Provided:  
 Outreach  
 Transportation  
 (2) Contracting Physicians  
 Nutrition Counseling  
 Physical Exams  
 Hypertension Screening  
 Referral  
 Elderly Nutrition  
 Prescriptions  
 Contracting Dentists  
 Urinary Screening

Outreach  
 (2) Contracting Physicians  
 Prescription Services  
 Dental Exams  
 Optometric Exams  
 Nutrition Services  
 Preventative Outpatient  
 Care

\* Total number of services provided during FY 81 is 21,327

HEALTH EMPLOYEES

Health Director  
 Registered Nurse  
 Medical Assistant

Health Director  
 Registered Nurse  
 Receptionist

Health Director  
 Health Outreach Worker  
 Clinic Receptionist (9  
 month period only)

PERCENT OF ELDERLY

3%

25%

17% Average = 14.25%

COST PER ENCOUNTER

\$7.13\*\*

\$19.50

\$17.60

\*\* Represents the average of all services provided; the cost per patient for the three clinics averages \$18.08

WRITTEN TESTIMONY  
~~WITNESS STATEMENT~~

NAME SUE SCHIELD BILL No. —

ADDRESS 508 TOOLE STREET MISSOULA DATE 11-9-81

WHOM DO YOU REPRESENT QUA QUI CORPORATION - MONTANA UNITED INDIAN ASSOC.

SUPPORT  OPPOSE  AMEND

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

TESTIMONY

SUBMITTED BY QUA QUI CORPORATION

NOVEMBER 5, 1981

Qua Qui Corporation has fought long and hard (since the inception of Public Law 94-437 in 1977) to reach our ultimate goal of providing direct, outpatient services to the Indians of Missoula.

October 1, 1980, Qua Qui Corporation's Urban Indian Clinic officially began providing those services seen for so long needed by our Indian population. Preventative health care, provided at Qua Qui's Clinic has taken precedence over last minute emergency room visits which our clients needlessly over used. Patients now regard our clinic physicians as helpful, family Dr.'s and a feeling of confidence is instilled to continually seek required health care.

Emergency room costs are triple of that charged by our clinic physicians for office visits. Our contracted pharmacist has greatly attributed to the efforts of cost efficiency by prescribing generic drugs whenever possible. Lab and X-ray expenses are contracted through low-cost facilities. Dental and Optometric services are provided at discounts to Qua Qui referred patients. These cooperative agreements have resulted in the best means of providing cost efficient, quality assured health care.

Qua Qui's data for FY 1980-81 reflects that cost per patient encounter is \$17.61. Please see the service data below for further reference. Also, please refer to the letter of support submitted by one of Qua Qui's physicians in regards to cooperative, cost efficient services.

---

SERVICES PROVIDED BY QUA QUI CORPORATION'S CLINIC  
OCTOBER 1 to SEPTEMBER 30  
FY 1980-81

POPULATION SERVED

Qua Qui Corporation has documented (monthly unduplicated count of patients per month) to have served 1,785 patients during Fiscal Year 1980-81. This number of unduplicated patients receiving health related services is

only two (2) full-time positions funded by Indian Health Service. The positions being (1) Health Program Director and (1) Health Program Outreach Worker. A Clinic Receptionist was funded for a nine month period of time. Qua Qui was able to acquire much supportive medical staff by way of community volunteers. All nursing manpower was donated by community registered nurses and faculty and student nurses from the University of Montana. During FY 80-81, Qua Qui benefited from the expertise and dedication of fourteen (14) nurses.

SERVICES PROVIDED  
(FY80-81)

A documented number of 11,467 health related services were provided by Qua Qui Corporation's Health Program. Categorical services included; (1) referrals by outreach, (2) contracted physician outpatient visits and affiliated lab and x-ray services, (3) prescription services, (4) dental exams and preventative services, (5) contracted optometric exams and supplemental payments for glasses, (6) elderly nutrition services, (7) and preventative outpatient care provided by clinic nurses.

Total FY 80-81 I.H.S. funding allocated to Qua Qui for the above direct and contracted health care provisions was \$31,425.00. The proof of cost-efficient health care services provided by Qua Qui Corporation's Health Program is displayed in the equation below:

Total contracted dollars (FY 80-81)		\$31,425.00		
Total patients served (FY 80-81)	÷		by	1785
Patient cost per encounter (FY 80-81)	=	\$17.60	=	

This amount of \$17.60 is something to be proud of in view of the fact that before Qua Qui's clinic was established, the Native Americans of Missoula were accustomed to paying triple this amount for health care by resorting to hospital emergency rooms.

The elderly Native American population of Missoula has always been viewed as a special target group of the Health Department. Fortunately

to the elderly seven days a week; both congregate and delivered. The elderly and health programs of Qua Qui work hand in hand to ensure that the cultural, social, economic and health needs of our seniors are met and continually followed-up on. Qua Qui has provided nutrition counseling and hot meals, nursing home visits, hypertension clinics and outreach transportation to approximately twenty-five (25) elderly per month. This constitutes 17% of total Indian population served in Missoula during FY 80-81.

To summarize, it is hoped that this report will address to you that Qua Qui Corporation has been able to provide the most cost efficient outpatient clinic services possible. We are requesting the chance to further fulfill our obligation to the Indians of Missoula by being able to continually provide life-sustaining, quality health care in Fiscal Year 81-82.

FAMILY PRACTICE MISSOULA

601 W. Spruce  
Missoula, Montana 59801  
Telephone: 721-1850

LARRY R. HARPER, M.D.  
DONALD R. NEVIN, M.D.  
WILLIAM A. GROMKO, M.D.



Diplomates, American  
Board of Family Practice

September 22, 1981

Ms. Sue Schield  
Health Program Director  
QuaQui Corporation  
Missoula Indian Center  
401 West Railroad  
Missoula, Mt. 59801

Dear Sue:

In followup to our meeting today, I just wanted to write and let you know of our satisfaction of the program for the past six months. We are pleased at the close cooperation between our office and QuaQui. We have also been pleased with the proven cost-effectiveness of the program. We are hopeful that funding will be continued, as I think it is a very valuable addition to the health care of the urban Indian community. Also, in this time of close scrutiny to finances, I think it is very difficult to beat the cost-effectiveness of our program, which we have been participating in for the past six months.

If I can be of further help, please do not hesitate to contact me.

Sincerely,

A handwritten signature in cursive script, appearing to read "Larry R. Harper".

Larry R. Harper, M.D.

LRH/h1

WRITTEN TESTIMONY

NAME Carol Owens BILL-NO. \_\_\_\_\_  
ADDRESS P.O. Box 2612 DATE 11/9/81  
WHOM DO YOU REPRESENT Nation American Center  
SUPPORT  OPPOSE \_\_\_\_\_ AMEND \_\_\_\_\_

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

The new Administration has proposed lumping many or all of the Federal conglomerate of grants into approximately five or six categories of block grants to the states; in education, one each in social services, energy Assistance, and Health Services. It seems to me what's going to happen is the Administration is going to create six bureaucratic monsters in each one of our states. If this is true, just how much money will be poured into administration to administer the programs. What assurance do we have that there will be community participation, who will be accountable for programs and is there some kind of guarantee that the services proposed will reach the poor and the people with special needs. If our Governor is going to be responsible for distribution of the block grant funds will he take into consideration the unmet needs of Montana's largest minority population? The Native Americans in Great Falls have found that most of our local community development block grant funds have gone mainly to brick and mortar type projects for the City of Great Falls and very little goes to human services and suffering.

In Great Falls we have 1,998 registered Urban Indians in our clinic, over 2/3 have no medical coverage, over half of those people's income is from \$0-100 per month. Our people are very poor. Through our Urban Indian Clinic, clients find help to alleviate illnesses through the competent care of our contracting physicians and our health staff. Our health staff provides numerous hours of preventative health education on a one to one basis and through group meetings and we make every effort to provide prompt medical attention so minor illnesses do not grow into chronic health problems. We have had incidences where an elderly diabetic was using her insulin needles more than once for injections because she didn't have money to buy needles, we have had a client with high blood pressure who only took his medicine every other day because he couldn't afford to buy all he needed. That is just a sample of what happens when our clients have no resources. Our Urban Indian Centers offer an island of hope in a sea of turmoil, poverty and hopelessness.

Ed. K. ...

WITNESS STATEMENT

NAME Yvonne Blackburn BILL. No. \_\_\_\_\_  
 ADDRESS 3675 Meadowlark Dr. DATE 11/17/81  
 WHOM DO YOU REPRESENT Urban Indian population  
 SUPPORT  OPPOSE \_\_\_\_\_ AMEND \_\_\_\_\_

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

As an Indian and a service provider, I am in strong support of the Urban Indian health clinics. I am a firm believer in the "holistic" approach to health care whereby we try to see that all health needs are met. We usually see our people in an emergency situation where immediate help is needed. Indian people have dignity and pride. We try to maintain that pride and dignity and help them in their time of need. In an emergency situation it seems no one wants to give their dollars to provide for these people. For example, a middle aged male comes to our clinic with a fever and cough, welfare is called for assistance; they tell me try for assistance from the reservation if he is enrolled. The reservation says he's been off the reservation too long to be eligible. I call welfare back; they state they will pay for a physician visit only if I try to find an M.D. to examine him and of course you again go through the derogation of who is going to pay for it as well as trying to find transportation to that health facility. I call back and say the man needs an X-ray.

We then have to call we have for approval. In the course of all this, this very ill man has waited 5 hours to receive the services he should have been able get immediately, not to mention the time spent obtaining the dollars to pay for the service, not to mention the whole reason the probably developed the fever and lung congestion in the first place was because he had been in a place without adequate heat. Another point I would like to bring out is the man was given a prescription. I then had to go through the whole process again to find funds ~~to pay~~ for the prescription.

This is but one example of the types of patients we see. We see non-Indians in ~~our~~ Clinic as well. They are treated with the dignity and respect they deserve and are assisted with all their needs.

Gyonne Blackburn R.N.  
Lee Pocha Memorial Clinic  
Helena Indian Alliance  
Helena, Montana

NAME Jenifer Soposh BILL No. \_\_\_\_\_  
ADDRESS 1385 Van Buren St Helena, MT DATE Nov. 9-81  
WHOM DO YOU REPRESENT Helena Indian Alliance  
Leo Pocha Clinic  
SUPPORT XXX OPPOSE \_\_\_\_\_ AMEND \_\_\_\_\_

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

Dear Chairman Hurity and Committee Members:

I'm Jenifer Soposh Clinic Director of the Leo Pocha Clinic Helena, Montana. I support funding for Urban Indian Health programs.

I realize this program is new to many of the committee members here today. I would like to make the distinction of urban Indian programs is reservation. Fifty (50%) percent of Indians living in Montana live in urban areas and do not qualify for reservation services after leaving a 180 days. Historically, the reservations have received their funding from the federal government. Urban Indian health programs have had to work so hard to assure funding through law PL 94-437. A Reagan administration has proposed zero (0) funding for urban Indian Health Care programs for FY 82. Our organization has been told that the block grant were the solution to our problems. We would only appreciate your support for our clinic

WITNESS STATEMENT

NAME Shirley Sheets BILL No. \_\_\_\_\_  
ADDRESS 508 5th Ave DATE 11-9-81  
WHOM DO YOU REPRESENT St. Paul's United Meth. Ch.  
SUPPORT Urban Indian OPPOSE \_\_\_\_\_ AMEND \_\_\_\_\_  
Health Care

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

Please support Urban Indian Health  
care, as urban Indian's health needs  
will not be met under any other funding  
allocations.

NAME Sharon Lwofeeth BILL No. \_\_\_\_\_  
ADDRESS 2141 York Rd DATE \_\_\_\_\_  
WHOM DO YOU REPRESENT Leo Pocha Clinic  
SUPPORT  OPPOSE \_\_\_\_\_ AMEND \_\_\_\_\_

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments: I work at The Helena Indian Alliance as the receptionist for the Alliance and the clinic I have seen a lot of people go through our Clinic People who were in need of Medical attention But could not afford to go another clinic. Because they didn't have the money to pay for the office calls. For example I know of a young man who is a diabetic he went to the doctor's office and they told him he couldn't see a doctor because he couldn't afford to pay. at that time we were opening our doors for the clinic so he came here. And been using the clinic service ever since then. Now what will happen to him and many others who have used our services. If we don't have the funds to operate on, they will probably never receive good medical attention again if any at all.

NAME Benilde Sarrico BILL No. \_\_\_\_\_  
ADDRESS 703 1/2 N. Rodney Street DATE \_\_\_\_\_  
WHOM DO YOU REPRESENT Leo Pacha Memorial Clinic  
SUPPORT  OPPOSE \_\_\_\_\_ AMEND \_\_\_\_\_

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

My name is Benilde Sarrico. To me, justice means that medical attention is available to all people. But since it is necessary to have a hearing today to present testimony, I would guess that means my view isn't shared by everyone.

I do some of the lab work for the Leo Pacha Memorial Clinic in Helena. I was a lab tech for about 6 years, and then quit for awhile to work in another area. One of the major reasons I quit was because I was beginning to feel like the medical profession was a big ripoff. At the last clinic I worked at, one doctor would see 20-28 patients in a 4 hour period. I was told ~~so many~~ <sup>he saw</sup> so many because he had some pretty steep alimony payments.

People are dissatisfied with the present medical system and are trying to come up with new

+ A.E.V. HARRIS + + A.E.V. HARRIS + + A.E.V. HARRIS +

alternatives. Socialized medicine has been discussed. But having worked in England for 30 years, I saw that their system was also not very satisfactory.

A clinic like the Leo Poche Memorial Clinic however, offers a satisfactory means of providing medical care to everyone. No one is ever turned away. If you have money, you pay. If you have insurance it pays. And if you are broke, the clinic pays.

The goal of this clinic is to be self-sufficient. We are asking for your help so that we can achieve this goal.

I hope that if your eyes cannot see the need, and your heart cannot justify it's elimination automatically - that you will at least be able to support this clinic for what it is - the beginning of a solution to the problem of expensive + impersonal medical care.

I am grateful to be able to work in a place that I can believe in.

WITNESS STATEMENT

NAME Edward Kennedy BILL. No. \_\_\_\_\_  
ADDRESS 436 N. Jackson Helena, Montana DATE November 6, 1981  
WHOM DO YOU REPRESENT Helena Indian Alliance  
SUPPORT XX OPPOSE \_\_\_\_\_ AMEND \_\_\_\_\_

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

SEE ATTACHMENT:

# Helena Indian Alliance

436 North Jackson  
Helena, Montana 59601  
(406) 442-9334



EDWARD KENNEDY  
Executive Director

## TESTIMONY

### HELENA INDIAN ALLIANCE

I have been hearing the concerns of Urban Indian people who are not only from Helena but from other cities with significant Indian populations. What I am hearing is evidence Urban Indians are indeed among the "Truly Needy." Indians fall at the bottom of every social & economic statistical indicator. We have the shortest life expectancy; we have the highest suicide rate; our poverty is 300% of the national average; we have the highest unemployment rate; we have the poorest housing; and we have the worst health conditions and health care. It is little wonder there is an acute need for health care for Native Americans in urban areas.

In response to the need for health care, the Indian Health Service provided funding to open our clinic and three (3) others in Montana recently. After these have been providing an invaluable services for only a short time, the new federal administration and the U.S. Senate are recommending cessation of funding. Examples of the services provided by our clinic are attached to this statement with minimum funding level budget.

Our clinic is not duplicating services provided by other resources. This is evidenced by the fact that our County C&Y Project and County Welfare Department submitted letters of support for funding of our clinic by Indian Health Services. It should also be noted that we have documentation of local health providers refusing service to Native Americans because of their inability to pay for services. The fact of the matter is that our people generally see a physician only in a crisis or life threatening situation rather than engaging in preventative medicine. Because of our clients trust of us, they were beginning to utilize our clinic regularly and engage in preventative medicine.

If our clinic and others like it are not funded, the immediate impact will be:

1. Increased deaths from heart attacks.
2. Undiagnosed & untreated diabetes.
3. Increased hearing loss from untreated otitis media
4. Increased incidence of untreated strep throat.
5. Increased incidence of untreated intestinal infectious diseases.
6. Undiagnosed and untreated dental & visual problems.

These are but a few of the problems which will be generated by the closure of our clinic. These alone will cost us the lives of many of our elderly and seriously impair the ability of our youth to succeed in life. This would rob us of the wisdom of our elders and the promise of our youth for the future.

Only through the support of the State of Montana can we continue to operate our Urban Indian Health Clinic. Only through continued operation of this clinic and similar clinics can we have a chance of fulfilling our Vision for the future.

We Have A Vision Of:

1. A life expectancy of 75 rather than 55!
2. Substantial reduction of the suicide rate!
3. Raising our people above the poverty stricken level!
4. Substantially raising our per capita income!
5. Substantially lowering our unemployment rate!
6. Raising the level of education of our people!
7. Providing higher quality housing to our people!
8. Assuring that all Urban Native Americans have quality health conditions and health care.

Our Vision is for a step toward a better future!!

We have a Vision of a day when being Indian and poor in Montana will not be hazardous to our health.

DAVID JORDAN, M.D.  
Internal Medicine  
1111 N. Rodney  
Helena, Montana 59601  
443 3457

Sirs:

I have been seeing patients at the Leo Pocha Clinic approximately one afternoon per week, since the Clinic's inception last February. During this time I have cared for many patients who, I believe, would not have received health care had it not been for the Clinic. Reasons for this are both financial and cultural, with financial problems predominating. To date, for example, fewer than 1/3 of our patients have had any kind of health insurance. This is in stark contrast to the 85% of the non-military population nationwide with some form of health insurance. Even those who do have insurance are unlikely to have coverage for visits to a doctor's office; only 20% of our "insured" patients have such coverage. Needless to say, many of these individuals are living on a very limited income. Under such circumstances, the health care which most of us take for granted, becomes "optional" and is usually neglected. An illness which might be minor if treated early, may be allowed to progress until it becomes devastating. A simple strep throat, may lead to a serious ear infection, or even worse to rheumatic fever, which is still seen among Native Americans in Montana while practically unheard of in the white population.

A more subtle problem than the lack of financial resources, is the uneasiness which an American Indian may feel in a conventional doctor's office. Memories of previous racial slurs or hassles about finances may make the waiting room an unpleasant place, while the emphasis on carefully and closely scheduled appointments runs counter to his upbringing. Even the doctor's scientific theories on the causation of disease are quite different from what the Native American has been taught. While we still try to practice modern medicine at the Pocha Clinic, it is our belief that many of our patients feel more at ease in the familiar surroundings of the Helena Indian Alliance building, with individuals of their own background providing the clerical and nursing help.

For these reasons, I believe that the Pocha Clinic has been providing a unique and valuable service to the community, which cannot be duplicated by other existing facilities. I hope that a way can be found to provide continued financial support for this very deserving endeavor.

David Jordan, M.D.

David Jordan, MD

Katherine E. Dawson, M.D., F.A.A.P.  
1537 Broadway  
Helena, Montana 59601  
Telephone 442-8181

TESTIMONY ON MONTANA URBAN INDIAN HEALTH CARE

I have been associated with the Leo Pocha Memorial Clinic since it's planning over a year ago. The planning done by the staff of the Helena Indian Alliance was excellent. Every consideration was given to the best possible service for the least amount of money.

Contributions of equipment, carpentry done by staff and as time went on, volunteer workers giving time freely all helped to make the clinic more and more the needed service for Indians that it has become.

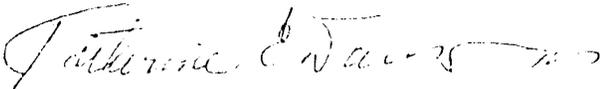
The understanding of problems and attitudes of Indian patients by Indian staff can not be over estimated. More time is available to individual patients to discover the problems and explain the illness and treatment than is possible in the average busy office. The staff does outreach in following patients where necessary; even to being present in Labor and delivery rooms with a non-english speaking patients.

The biggest impact of the Clinic is with the low income worker whose health care is not covered by a government or private insurance. One of the answers, of course, is to stop working and accept Welfare and Medicaid. But this attitude does nothing to promote self reliance of proud people.

The Leo Pocha Memorial Clinic does a great deal to keep individuals and families off Welfare roles and earning productively.

I cannot over stress how impressed I am with the goals of the Clinic and the efforts of the Staff to carry them out.

Sincerely,



Katherine E. Dawson  
M.D., F.A.A.P.

4

MONTANA BLOCK GRANT HEARING, OCT. 29, 1981 - HELENA, MT.

In our planning we must constantly separate Reservation and Urban Native Americans. Landless Native Americans like the Little Shell Band of Chippewa Cree, and hundreds of others who have not been associated with Reservations for perhaps two or three generations, receive no federal assistance.

Here in the Helena area a large number of Native Americans are constantly overlooked because the federal and state spotlight never picks them out as a part of the Native American situation.

Through the Helena Indian Alliance they have forged an instrument for making themselves visible and for working together on problems of mutual need.

Here the landless Native American Community faces 30 to 50 percent unemployment, with a great percentage of those who are employed having only part-time and low paying jobs. And now, with inflation and recession hitting them harder than probably any other group in the Helena community, the little assistance they have had is being seriously cut. Medical aid is being cut; food stamp and other aid for the working poor is being curtailed; and the working poor people of Helena, Native Americans included, simply cannot afford medical care.

No jobs, or poor jobs, mean poverty. Poverty means health problems. No basic health care means less ability to function, to find work, to hold a job. It's a vicious cycle.

One practical, common sense place to break the cycle a little bit is at the point of making health care available for Native Americans who simply cannot afford visits to white clinics and hospitals, or who are so unfamiliar with the process that they are afraid to try to get into the white medical system, or who have faced discrimination in subtle or not-so-subtle ways in years past.

The Native American community pin-pointed this need, moved ahead to establish the Leo Pocha Memorial Medical Clinic. It operates in the Helena Indian Alliance Building. It is serving the community in a wonderful fashion, already reaching many people with aid they would never be getting. And just as it seems the whole enterprise will get on its feet, federal and state cuts in assistance are killing it.

Our St. Paul's United Methodist Church has decided that we will give some financial support, but the total amount we will be able to provide cannot be a main source of funding for the Clinic.

We earnestly hope that Montana will recognize this legitimate need and this pioneering effort on the part of Helena's non-reservation Native American community. We ask that their request for funding be answered with an affirmative.

As white American members of the local and state community, the United Methodist Churches of Montana will continue to be closely associated with this political process that affects so basically the life of us and our friends.

Rev. George Harper  
St. Paul's United Methodist Church

*George Harper*

NAME William J. ... BILL No. ...  
 ADDRESS 146 ... St. ... DATE 10.1.71  
 WHOM DO YOU REPRESENT ... ASSOCIATION  
 SUPPORT ... OPPOSE ... AMEND ...

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

TESTIMONY OF THE MONTANA UNITED INDIAN ASSOCIATION  
TO COMMITTEE II

Mr. Chairman, Committee Members and distinguished guests:

The Montana United Indian Association is extremely grateful to have this opportunity to address you today on the vital issue of Health Services provision to the Urban Native American. I wish to stress that we are dealing with Urban Indian people who do not receive primary health services from reservations or tribal organizations.

The following constitutes our statistical and historical testimony; Mr. Edward Kennedy will follow me with testimony on the impact of Budget Cuts on our programs.

The Montana United Indian Association (MUIA) was incorporated in 1971 as a non-profit organization representing urban Indians throughout the state of Montana. Eight local Indian alliances and the MUIA joined forces to create a consortium to provide needed services in their respective communities. Those alliances were: Anaconda, Billings, Butte, Great Falls, Havre, Helena, Miles City and Missoula.

Seven alliances currently offer services to the urban Indian population which include health care, housing, job placement assistance, educational opportunities, outreach, transportation, mental health counseling and other supportive services.

The MUIA central office, located in Helena, is responsible for the administration of state and federal programs. MUIA provides technical assistance, guidance, counseling and advocacy for the consortium and the estimated 16,000 urban Indians of Montana. A major responsibility of the MUIA is to procure funding to continue existing programs and to expand services to the urban Indian population of Montana.

In the past the MUIA has successfully obtained health funding from the Indian Health Service as a result of Public Law 94-437, "The Indian Health Improvement Act." As a result of this legislation passed in 1976, the alliances were enabled to provide the following services:

- \* A data needs assessment
- \* Establishment and provision of direct medical care on site
- \* Removal of the multiple barriers accessing health care
- \* Provision of preventive health care education

Public law 94-437, Title V, Section 501, The Indian Health Care Improvement Act, reads "The purpose of this title is to encourage the establishment of programs in urban areas to make health services more accessible to the urban Indian population;" the Congress of the United States, recognizing the severity of the urban Indian Health status, passed the public law to ensure health services provision.

Since reauthorizing Public Law 94-437 in 1980, the Congress has been exhorted to indiscriminately cut social service programs regardless of need or their accomplishment. The Office of Management and Budget (OMB) has issued several misstatements of fact about urban Indian health organization, namely "Urban Health projects largely provide referral, rather than medical, services; (they) are not required by treaty obligation; and (they) are over and above services available to the general population." In the detailed Health Proposal for fiscal year 1982, we successfully address these "artificial" issues. The documentation that follows is a skeleton outline of the needs and accomplishments of Urban Indian Health Centers.

You should be acutely aware of the life and death ramifications of immediate access to quality health care. Urban Indians face deprivation of urgently needed health care services every day. The efforts of urban Indian health care professionals will be for naught if projected cuts of one hundred percent elimination in Fiscal Year 1982 are enacted.

The Health Advisory Committee of the Montana United Indian Association has prepared the following data summary for your personal attention: Indian programs will suffer a disproportionate share of the proposed budget cuts. Indian programs, which account for only .4% of the total federal budget, would absorb nearly 3% of the national budget cut.

It cannot be disputed that American Indian people are the neediest of Montana's poor. In this, the most affluent country in the world, Indian people rank at the bottom of every social and economic statistical indicator:

- \* lowest per capita income
- \* highest unemployment rate
- \* lowest level of education
- \* shortest lives
- \* worst health conditions
- \* poorest housing
- \* highest suicide rate
- \* family poverty 300% greater than national average

Contrary to OMB justifications, Block Grants to states will not guarantee provision of Urban Indian Health Care Services to our population. All of the truly remarkable accomplishments achieved by Urban Indian health care programs in the past five years will be utterly negated - clinics will cease to exist, trained Native American health care personnel will not be able to fulfill their commitment to Indian people and, worst of all, another successful Urban Indian program will be eliminated precisely at the moment of fruition.

We can no longer look to the Federal Government to meet all our financial needs. Proposed budget cuts from the Reagan Administration will zero out urban Indian health care in Fiscal Year 82. We are requesting financial support from the State of Montana so that the MUIA may continue its commitment to all urban Indians in the State of Montana.

## THE EFFECTIVENESS OF UTILIZATION OF URBAN INDIAN HEALTH CENTERS

Urban Indian Health Care Centers are a vital key to meeting the health needs of urban and rural non-reservation Indians. In meeting those needs, Montana's urban Indian health centers have demonstrated an ability to be:

- \* cost effective and well utilized.
- \* developing and/or maintaining a quality assurance program
- \* improving the health status of American Indians
- \* developing linkages with other providers

### I. Cost Effective

In a study on several health centers, it was shown that:

- \* per patient costs are lower than national norms
- \* \$19.50 was the average cost of a patient encounter
- \* health care centers can deliver quality care at reasonable costs. Last year's average administrative costs was 19.74%, below the 20% criteria
- \* for every dollar of Title V funds, a dollar or more was matched by other sources of revenue
- \* financial audits have indicated strong financial management
- \* productivity rates are in keeping with standard norms. An average 2.6 patient encounters per hour was maintained by several of the health centers

### II. Utilization

Urban Indian Health centers have shown a marked increase in medical and dental encounters over the years and are leveling off at full productivity. Since 1979, the health care centers have had an average 55 percent overall increase in services provided. This remarked increase is attributed to:

- \* institution of more comprehensive health services where none existed before. More health centers have moved from Phase II to Phase III, increasing the level of health care.
- \* Changing patterns of utilization of expensive episodic health care (emergency rooms, hospitalization, for preventive diseases) to prevention and early intervention primary care.

### III. Quality Assurance

Initiative has been taken by the health centers to improve and maintain a high degree of professional training and responsibility. This is being achieved by:

- \* peer review
- \* on-going continuing education
- \* implementing of services, where careful review has shown a need
- \* patient evaluation of centers
- \* treatment compliance review process

### IV. Improving the Health Status of American Indians

In the past American Indians have been the victim of non-existent or poor medical-dental services. Consequently Indians suffered from a higher death rate, higher infant death rate, and higher preventable death rate.

- \* statistics have shown that the death rate of Indians is 841.4 deaths per 100,000, this in contrast to the overall USA population which is 606.1 per 100,000.

# Montana United Indian Association



Phone:  
443-5350

846 Front Street  
Helena, Montana  
59601

## MONTANA UNITED INDIAN ASSOCIATION POSITION PAPER

### DUPLICATION OF SERVICES

By far the most controversial aspect of Minority oriented social service programs is the question of duplication of services, or in the jargon of the bureaucrat, "duplicative" services.

Opponents of urban Indian health programs are fond of loudly and persistently exclaiming that these programs duplicate services available to "everybody" through "private sector" health care providers. This issue has become an emotional area since detractors of the program's progress make the claim without examining the facts.

Fact: The United States Government policy of relocating reservation Indians to the country's urban and rural areas in 1952 left those people in a "limbo" status insofar as health care provision is concerned. There were no health care services waiting for the relocated Indian people. Indians who have lived off-reservation for 180 days are no longer eligible for health services. The Indian Health Service does not universally care for all Indian people. There is no "Indian Insurance Card" which will provide free health care to urban or rural Indians. Where "free" health care has been provided through Public Health Service projects and charitable institutions, blatant discrimination has caused extreme resentment among Indians. A person should not have to suffer degradation at the hands of tax supportive institutions' personnel in order to secure health care. The public blithely assumes that Indians' health care is provided for ... this is not the case.

Fact: Public Law 94-437, reauthorized by the Congress of the United States in 1980, states categorically that: "The purpose of this title is to encourage the establishment of programs in urban areas to make health services more accessible to the urban Indian population." In the opinion of the 94th and 95th Congresses of the United States, urban Indian health programs are not duplicative.

Fact: The American Indian Policy Review Commission in their "Report on Indian Health," does not see urban Indian health programs as duplicative

### MUIA IS AN EQUAL OPPORTUNITY EMPLOYER

—SINGS AMERICAN INDIAN COUNCIL  
—SINGS MONTANA

—ORTH AMERICAN INDIAN ALLIANCE  
—ORTH MONTANA

—EAT FALES — AN EDUCATION CENTER  
—EAT FALES

—HELENA INDIAN ALLIANCE  
—HELENA MONTANA

—MISSOULA OJA-OJIC CORPORATION  
—MISSOULA MONTANA

—HELENA INDIAN ALLIANCE  
—HELENA MONTANA

—NORTH AMERICAN INDIAN LEAGUE  
—DEER LODGE MONTANA

—ANACONDA INDIAN ALLIANCE  
—ANACONDA MONTANA

—NATIONAL ASSOCIATION OF  
—BLACKFEET INDIANS

since they recommend that: "Congress appropriate sufficient funds for the continuance of present Indian centers in urban areas which assist Indians in obtaining medical ... services; and should encourage, with funds and guidance, the establishment of additional such centers in all urban areas where Indians live."

Fact: Health Departments in many states recognize the necessity of urban Indian health centers and contract with them for delivery of services to the Indian population that would not otherwise be provided at all. This would not occur if the states considered these programs duplicative.

Fact: Transportation and referral alliances provide urban people with the means of accessing health care. It is hardly a duplication of services to transport Indian people to a health care provider since no alternative exists.

Fact: If a patient does not have the financial resources to visit a private provider of medical care, that provider will cease to deliver services. It is not then duplicative to provide medical services to that patient.

Fact: The American Public Health Association (APHA) has acknowledged the severity of (urban) Indian health in their meetings on November 1 through November 5, 1981. The opinion of the APHA is that these programs are not duplicative.

Fact: Preventive health provision in lieu of episodic and emergency room usage reduces duplication by eliminating an increasing burden on the taxpayer. In this sense, the programs are financially non-duplicative and cost-efficient.

Therefore, it is apparent that urban Indian health programs do not duplicate services, but provide medical services where none have existed before and at a lower per patient rate than available in the private sector.

References: Montana Senator Max Baucus  
American Indian Policy Review Commission  
American Public Health Association  
State of Montana Department of Health  
The Congressional Record - October 27, 1981  
California Urban Indian Health Council  
Montana United Indian Association



PAT WILLIAMS  
 MONTANA  
 WESTERN DISTRICT  
 CITY WHIP AT LARGE

CONGRESS OF THE UNITED STATES  
 HOUSE OF REPRESENTATIVES  
 WASHINGTON, D.C. 20515

COMMITTEE ON  
 EDUCATION AND LABOR  
 ELEMENTARY, SECONDARY AND  
 VOCATIONAL EDUCATION  
 LABOR STANDARDS  
 HUMAN RESOURCES  
 INTERIOR  
 PUBLIC LANDS AND  
 NATIONAL PARKS  
 ENERGY AND ENVIRONMENT

WASHINGTON OFFICE:  
 2 LONGWORTH BUILDING  
 WASHINGTON, D.C. 20515  
 TELEPHONE: (202) 225-3211

TOLL-FREE NUMBER  
 1-800-332-6177

September 28, 1981

Mr. Ben Bushyhead  
 Executive Director  
 Montana United Indian Association  
 846 Front Street  
 Helena, Montana 59601

Dear Ben:

I just wanted to let you know that I've written to the conferees meeting on the Interior Appropriations Bill for FY 82 in support of the \$9.7 million for Title V of the Indian Health Care Improvement Act.

Best regards.

Sincerely,

*Pat*

Pat Williams

Enclosure

RECEIVED

OCT 1 1981

MONTANA UNITED  
 INDIAN ASSOCIATION



PAT WILLIAMS  
MONTANA  
WESTERN DISTRICT  
SENATE WHIP AT LARGE

CONGRESS OF THE UNITED STATES  
HOUSE OF REPRESENTATIVES  
WASHINGTON, D.C. 20515

COMMITTEES:  
EDUCATION AND LABOR  
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VOCATIONAL EDUCATION  
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HUMAN RESOURCES  
INTERIOR  
PUBLIC LANDS AND  
NATIONAL PARKS  
ENERGY AND ENVIRONMENT

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TELEPHONE: (202) 225-3111

TOLL-FREE NUMBER  
1-800-332-6177

September 15, 1981

The Honorable Sidney R. Yates  
Chairman  
Subcommittee on Interior  
Committee on Appropriations  
8308 Rayburn House Office Building  
Washington, D.C. 20515

Dear Chairman Yates:

As you prepare to go to Conference regarding the FY'82 Interior Appropriations Bill, I urge you to insist on the House version regarding Title V of the Indian Health Care Improvement Act - dealing with Urban Indian Health.

There are currently more than 240,000 Indian people living in urban areas--many of them forced to urban centers because of the lack of employment on the reservations. With the severe impact of the budget cuts for Indian programs on the reservations, we can expect to see more Indian people moving to urban centers to seek employment. Whereas the \$9.7 million as contained within the House Interior Appropriations Bill is not nearly enough to meet the health care needs of our urban Indian population, it will allow the work and success of the program to date to continue.

Monies spent in the Urban Indian Health Care Centers has been one of the best uses of federal monies evident. For every dollar of Indian Health Service funding to Urban Indian Health Centers, projects have been able to match funds from other sources. The health of urban Indians has improved and per-patient costs are well below the national norm.

My thanks for your help.

Best regards,

Sincerely,

  
PAT WILLIAMS

October 27, 1981

economic conditions in rural areas, the percentage could be even higher.

Indians were not received in the cities with health care waiting for them, and currently the Indian Health Service of the Department of Health and Human Services will not provide direct health care to urban Indians.\* Individuals cannot afford to go to a reservation health center in most instances, and because people assume the Federal Government provides for its Indian wards, there are no urban health care delivery systems which have served Indian people. Where there are free health care systems, Indians are denied their services.† It has also been found that there has been gross discrimination against Indians in tax-supported institutions.‡ In other words, urban area facilities simply assume Indians have been provided for, and some discriminate against Indian people for reasons too lengthy and complex to comment upon here.

As a result of this situation, Indian and urban community leaders attempted to establish part-time volunteer community clinics. While those experiments were noteworthy and noble, they found that the health needs of urban Indians were larger than anticipated, due to the numbers of people to be served and due to the frequency and kinds of ailments to be treated. Thus they found they simply could not go further without outside funding.†

As a result of this situation, we enacted the Indian Health Care Improvement Act, which was designed to bring Indian health to an acceptable level.† Funding for programs under the act did not begin until fiscal year 1978, and now that the program has gotten off the ground for funding urban Indian health programs, it is in great danger of death at an early age.†

Our American Indian Policy Review Commission looked at these problems in a great deal of detail, and it developed the expertise to tell Congress what is needed to address some of the problems I mentioned earlier. On the issue before us the Commission recommended:†

Congress appropriate sufficient funds for the continuance of present Indian centers in urban areas which assist Indians in obtaining medical and other social services; and should encourage, with funds and guidance, the establishment of additional such centers in all urban areas where Indians live.†

That is some of the background to the problem, but what is the current problem?

Of the 50 percent of all American Indians who live in cities, over 50 percent of that number are children of school age or younger.† In other words, 25 percent of all American Indians are urban children. They, along with other urban Indians, have an unusual incidence of special medical problems.† Some of the

more recent studies of Indian health problems show that the No. 1 ailment among Indians is otitis media, an ear infection which is related to poverty, and which can cause deafness.† Reports show this ailment to be quite high in children, with 63.6 percent of the children having it being under the age of 5. If those little children are untreated they will have hearing problems which will cause them to do poorly in school, leaving more people in the vicious cycle of poverty. The No. 2 disease is streptococcal throat, a highly infectious disease.† I only make public health sense to make certain there are facilities which can check the spread of this disease. The next highest ailment consists of intestinal infectious diseases, and we know these can cause a great deal of pain and even death.† I will not go through the full list, which is available to you in government reports, but the fourth highest ailment is impetigo, a staphylococcal skin disease, the fifth is pneumonia, and the sixth is influenza. These are all serious ailments and many of them are very highly contagious. However you can, if they are ones which can be treated easily and effectively in a clinic setting. If they are caught early through checkup programs and the encouragement of parents and others to come in, the community protected and, more importantly, Indian people can obtain the medical care they deserve.

That is the background. We owe a debt to the Indian peoples who were sent to our cities, we owe a duty to the cities to assist them in providing services, and the nature of the ailments treated require public attention for the sake of the community at large. This program is one for the truly needy, it is fundamental, and it is in line with the history of the special relationship of the Federal Government to Indians. It is also a step toward a better future. As one of my Indian constituents put it, "I have a vision of a day when being Indian and poor in America is not dangerous to your health."

Mr. President, it is, thus, with great concern that I note the action of the Senate Interior appropriations to totally eliminate funding for the urban Indian health program.

The House, however, has seen fit to fund the urban Indian health program. And it recommended \$9.78 million in fiscal year 1982. When the Interior measure goes to conference, I want to strongly urge my colleagues to adopt the House figures for this very important health care program.

#### FOUNDERS FOR URBAN INDIAN HEALTH CENTERS

• Mr. BAUCUS Mr. President, I have

been hearing the concerns of Indian people who are not only from my State but from other States with significant Indian populations. What I am hearing is evidence Indians are indeed among the truly needy. Indians fall at the bottom of every social and economic indicator. They have the shortest life expectancy; they have the highest suicide rate; their poverty is 300 percent of the national average; they have the lowest per capita income; they have the highest unemployment rates; they have the lowest level of education; they have the poorest housing; and they have the worst health conditions and health care. It is little wonder there is an acute need for health care in urban areas.

How did this problem come about? In 1952, the Government policy of relocating reservation Indians to urban areas caused about one-third of American Indians to move to cities.† As a consequence of that policy it is estimated that about one-third of all American Indians live in urban areas.† These estimates were

\* Id.

\* Id.

† American Indian Policy Review Commission, Final Report, p. 285.

† Report on Indian Health, supra note 1, 144.

WILLIAM B. COHEN, MAINE, CHAIRMAN

BARRY GOLDWATER, ARIZONA  
MARK ANDREWS, NORTH DAKOTA  
GLADE CURTON, WASHINGTON

JOHN MELCHER, MONTANA  
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DENNIS DE CONCINI, ARIZONA

TIMOTHY C. WOODCOCK, STAFF DIRECTOR  
PETER S. TAYLOR, GENERAL COUNSEL

# United States Senate

SELECT COMMITTEE ON INDIAN AFFAIRS

WASHINGTON, D.C. 20510

July 31, 1981

Ben Bushyhead  
Executive Director  
Montana United Indian Association  
846 Front Street  
Helena, Montana 59601

Dear Ben:

Thank you for your recent letter regarding the budgetary problems facing urban Indian health programs. As you may know, the House of Representatives has passed the Interior Appropriations bill which includes \$9.79 million for urban health programs. Although the Senate Interior Appropriations Subcommittee has not provided any funds for Indian urban health care, the Senate bill has not yet been presented to the full Senate.

Although I am not a member of the Senate Appropriations Committee and therefore will not be a conferee on this bill, I know that urban Indian health programs has provided vital health care to many people, and I will do what I can to preserve these worthwhile programs.

Best regards.

Sincerely,



John Melcher  
Ranking Minority Member

1981 07 31  
U.S. SENATE

RON MARLENEE  
MONTANA

MONTANA OFFICES:  
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Congress of the United States  
House of Representatives  
Washington, D.C. 20515

July 27, 1981

Ben Bushyhead, Executive Director  
Montana United Indian Association  
846 Front Street  
Helena, Montana 59601

Dear Ben:

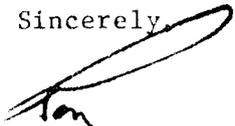
Thank you for your letter regarding funding for Title V of Public Law 94-437, the Indian Health Care Improvement Act. I appreciate knowing of your concerns on funding for urban and rural Indian Health Care Programs.

As you may recall, I wrote to Congressman Yates of the Interior Appropriations Subcommittee and requested that funding be restored for Title V Indian Health Care Programs. The \$9.79 million was then adopted by the Full Committee on Interior Appropriations.

I will not be a member of the House-Senate Conference on Interior Appropriations, and I would suggest that you contact Senator Melcher and Senator Baucus on this matter. The House of Representatives did vote to retain \$9.79 million for Urban Indian Health Care Programs, but the Senate has not yet voted on the Interior Appropriations bill.

Ben, I appreciate your letting me know of your concerns on this matter, and I hope you will always feel free to call on me regarding any issue of interest to you.

Sincerely,



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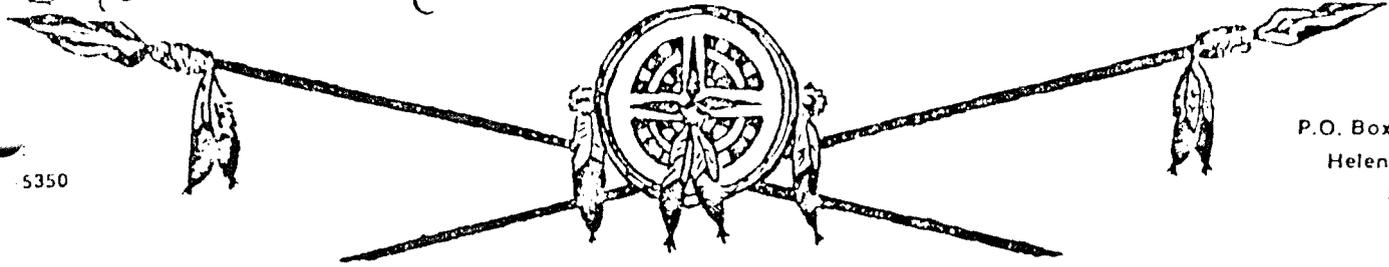
JUL 30 1981

MONTANA UNITED  
INDIAN ASSOCIATION

COUNTIES

BIG HORN B... CARTER CASCADE CHOUTEAU CUSTER DANIELS DAWSON FALLON FERGUS GARFIELD GOLDEN VALLEY HILL JUDITH BASIN  
MCCONE MUSK... LEWIS PHILLIPS POWDER RIVER PRAIRIE RICHLAND ROOSEVELT ROSEBUD SHERIDAN STILLWATER SWEET GRASS TETON  
TREASURE VALLEY WHEATLAND WIBAUX YELLOWSTONE

# Montana United Indian Association



P.O. Box 5988  
Helena, MT  
59601

5350

M U I A

November 10, 1981

Chairman Burt Hurwitz  
Legislative Committee #2  
Room 104  
State Capitol  
Helena, MT. 59601

Dear Chairman Hurwitz:

This letter is written in response to requests for additional information from your committee members.

Senator Wolf requested a breakdown of last year's Indian Health Service funding and the relative percentages delineated below:

FY 1981  
INDIAN HEALTH SERVICE CONTRACT

ALLIANCE

Anaconda	\$22,619.00
Butte	\$22,619.00
*Great Falls	\$83,092.00
*Helena	\$39,266.00
Miles City	\$22,122.00
*Missoula	\$34,845.00
Montana United Indian Association (MUIA)	\$43,762.00
FY 79'-80' Supplemental Carry Over	\$32,336.00

GRAND TOTAL    \$321,815.00

\*Clinic Alliances

Given the awesome inflationary trends in the field of medical service provision, the MUIA's total budget request to the Indian Health Service (IHS) for Fiscal Year 1982 was \$461,412.00. MUIA's request to the State for funding alternative #1 (\$345,000) equals a 25% cut from the IHS request.

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INGS AMERICAN INDIAN COUNCIL  
IS MONTANA

TH AMERICAN INDIAN ALLIANCE  
MONTANA

T FALLS INDIAN EDUCATION CENTER  
FALLS MONTANA

HELENA INDIAN ALLIANCE  
HELENA, MONTANA

MISSOULA QUA-QUI CORPORATION  
MISSOULA, MONTANA

HI-LINE INDIAN ALLIANCE  
HAVRE, MONTANA

NORTH AMERICAN INDIAN LEAGUE  
DEER LODGE, MONTANA

ANACONDA INDIAN ALLIANCE  
ANACONDA, MONTANA

NATIONAL ASSOCIATION OF  
BLACKFEET INDIANS

Chairman Burt Hurwitz  
November 10, 1981  
Page 2

Alternative #2 equals a 38.3% cut from that request.

Since the actual funding received from the Indian Health Service for FY'81 equals \$321,815, funding alternative #1 to the State Legislature equals an extremely modest 7% increase; alternative #2 equals an 11.5% decrease over last year's actual funding.

In response to Senator Van Valkenburg's question asked on November 9, 1981 regarding why all these clinics were proposed to be funded at \$75,000 each, one can see that Great Falls received a larger share of the monies to upgrade their clinic operations in FY'81. Likewise, Helena had previously received improvement funds from a one-time source called Norton-Sound monies. Therefore, it is the MUIA's position that Missoula should be allowed to achieve parity with the other two clinics. However, the budget could be restructured if so desired.

Vice-Chairman Smith cited an example (near Fort Peck) of Indian people receiving reservation benefits while living off-reservation. The MUIA does not have specific knowledge of this example, but we wish to state that the people we serve through the urban clinics located in Great Falls, Helena, and Missoula are solely urban people who live, work and recreate in Montana's cities. The approximate one-way distances from the nearest reservation to each of the urban health centers is detailed below:

Great Falls to Rocky Boys'	= 87 miles
Helena to Flathead	= 173 miles
Missoula to Flathead	= 61 miles

It is important to note that very few Montanans would drive 174, 346 or 122 miles in the summer to receive Primary Health Care, even if they could afford the gasoline, to say nothing of making the same trip in the winter.

Equally important is the fact that appointments have to be made for the service delivery which many times involve planning weeks ahead. In addition, if urban Indians had the money for the gasoline to travel those distances, they could pay for local non-Indian primary care.

After all of the above stipulations are met, the last hurdle is one of tribal affiliations; the tribe's ability to absorb twice as many patients (even if they wanted to) in this year of budget cuts.

The MUIA wishes to thank you, Chairman Hurwitz, and your committee for allowing us the opportunity to present our proposal and for offering us an eminently fair hearing.

Should your committee require further information relative to our testimony, please contact us at your convenience.

Sincerely,



Mike Welsh  
Health Director



Edward Kennedy  
Chairman  
Health Advisory Committee

The hearing was closed on the Department of Health portion.

Chairman Hurwitz called on Michael Welsh for his comments in support of health services for urban native Americans; his testimony is Exhibits 1 and 2, attached:

Mr. Welsh said that the figures listed by the department would not be adequate to serve the Indian population and that there would be no services at all through the Health Department for the urban Indian.

Ed Kennedy, Helena Indian Alliance, testified, Exhibit 3. He wanted a note made for the record that in 1969 when the program was started we had a broad-based community support expressed by letters we received.

Hurwitz: The only situation addressed in the block grants was regarding the reservation Indians? If they made application in 1981 they would be eligible again---and come right off the top, is that correct?

Drynan: I think that is true.

Hurwitz: If the Indians would come to the various Health Department services, they would be served just like anyone else.

Marsha Bolken stated that all people who ask for services are served.

Reverend George Harper, St. Paul's United Methodist Church, spoke in support of the Helena Indian Alliance; his testimony is attached as Exhibit 4.

Yvonne Blackburn, Indian Clinic employee, spoke next, Exhibit 5 is attached.

The hearing on the Indian Health issue was ended.

Solid waste program was the next item for consideration.

Norman Rostocki took the committee through the narrative in the LFA budget analysis book, p. 241, 242. He said the Department of Health wants the program funded totally from the general fund and they haven't requested a cut in spending authority. They didn't lose the carryover, and thus, had actually requested replacement of more funds than they had lost.

Bureau Chief, Duane Robertson, testified next, Exhibit 6.

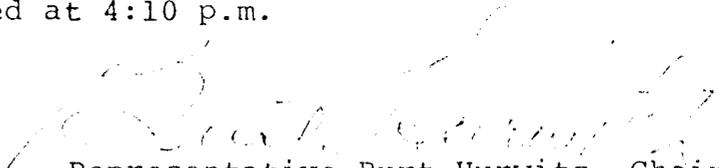
Rostocki said when he had talked to Mr. Robertson, Duane had said the solid waste program had a federal carryover and therefore were able to spend it in the 1st quarter of FY 1982. In session last year, you were authorized for \$30,000 spending authority expected from the federal government. He summarized this by stating the department requests an additional \$12,763 for legal costs. Duane agreed that was correct.

Robertson: All we are saying now is that we weren't aware of legal costs.

In answer to other committee questions, Robertson said that: It is up to local people to get into compliance with landfills; strides are being made in the burner program with the first steam burner to be on line in Livingston very soon; out of 56 counties 20 are bringing their waste to one disposal site; 200+ service stations are accepting used oil, but there is no re-refiner in Montana.

Max Dodson, Director of Montana's EPA office, said the plan had been to get out of the solid waste program by FY 1983, and that the State had been told last year they could count on \$30,000 support. Subsequently, a decision was made to disengage EPA and turn the function to the respective states. Montana is one of the few legislatures to appropriate money for solid waste. He felt lots of work needs to be done to provide technical services to individual governments.

The meeting was adjourned at 4:10 p.m.



Representative Burt Hurwitz, Chairman

Betty Dean, Secretary

November 11, 1981

MOTION PASSED with all voting AYE.

SENATOR WOLF MOVED to accept funding 1 FTE and to be funded from the preventative health block grant which is in essence would be funded out of the EMS money. This would reduce the FTE level by .5, the business manager position.

DR. DRYNAN argued this point by saying it would be necessary to put the microbiologist in the office if there were no business manager to do all the paper work.

SENATOR WOLF WITHDREW HER MOTION.

SENATOR WOLF made a new MOTION to approve the \$19,179 which would be used by the department in its discretion, to come from the Preventative Block Grant, the Emergency Medical dollar award.

A SUBSTITUTE MOTION was made by REPRESENTATIVE BARDANOUVE to give the department the \$34,000 from the preventative health block grant and the 1.5 FTEs.

MOTION PASSED with SENATOR WOLF and REPRESENTATIVE STOBIE voting NO.

ISSUE 2:

PREVENTATIVE HEALTH BLOCK GRANT, page 228. Table 4 shows where the department proposes to spend the preventative block grant money. By the last motion the emergency medical services will be reduced in the second year by \$34,000.

JANDEE MAY reviewed this issue and presented a handout (EXHIBIT B) and a copy of the newspaper article.

Question was asked by SENATOR SMITH regarding the 180 days absence required by Indians before they could return to the reservation for medical services in the clinic. MIKE WELSH stated that if they leave, the 180 days is the rule but that each tribe may enforce it differently. BEN BUSHYHEAD stated if the Indians are located where there is no service they may go to their reservation.

It was questioned to the possibility of the Indians receiving the same medical service as other low income people. REPRESENTATIVE HURWITZ asked why they did not put the \$80,000 toward a service that would serve all people not showing discrimination.

JOHN ANDERSON, Bureau Chief of Communicable Disease, MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCE, stated to keep

November 11, 1981

in mind the categorical funding. They are dealing with Preventive Health Block Grant that shows anyone can go in and be served.

SENATOR VAN VALKENBURG stated that urban Indians must be realistic about what they can have since they missed the boat in Washington by not applying for the 1981 funds.

MIKE WELSH, INDIAN HEALTH CLINIC DIRECTOR, stated that he would be willing to accept any trimming and that they do not believe the block grant is the only source of funds available.

MOTION was made by SENATOR WOLF (referring to page 237 that the pass-through money to the counties, that the criteria used for funding the counties, would include addressing the preventative health needs of the urban Indian population.

REPRESENTATIVE BARDANOUE asked for the response of the Lewis and Clark County Health Officer.

BOB JOHNSON, Health Officer, Lewis and Clark County, stated that the health department cannot refuse to service anyone. Funds from the local health department are used for the foot soldiers of the local health departments. He stated he thought the SRS budget was fat.

JOHN ANDERSON said if the committee decides to earmark a certain amount of money to pass through the department to be distributed to these clinics at their request, the problem of the Health and Environmental Sciences Department would be knowing that these monies would be going for the purposes that the federal government says they must be spent.

MIKE WELSH asked if there were money in the SRS budget.

REPRESENTATIVE BARDANOUE said he doubted if there was any SRS money for new programs.

SENATOR WOLF WITHDREW her MOTION.

SEANTOR VAN VALKENBURG moved to approve the Preventive Block Grant as proposed by the Department of Health, with the exception that the committee direct the Department of Health to utilize \$80,000 of the money of that grant to contract with urban Indian health centers to provide services to one center within the State of Montana, with the change that was previously made to fund the microbiology lab with money that has been proposed for EMS funding.

November 11, 1981

DISCUSSION was held and SENATOR VAN VALKENBURG stated that what he was talking about here is contracted services between the Department of Health and a non-profit organization. SENATOR KEATING challenged that by establishing a facility, no matter where it is located, to serve only Indians, we increase the discrimination that we are trying to do away with.

QUESTION was called for. ROLL CALL VOTE was taken.

Rep. Hurwitz	NO	Rep. Stobie	NO
Sen. Smith	NO	Sen. Wolf	NO
Rep. Bardanouve	YES	Sen. Keating	NO
Rep. Hemstad	YES	Sen. Thomas	YES
Rep. Manuel	NO	Sen. Van Valkenburg	YES
		Sen. Stimatz	YES

MOTION FAILED.

MOTION was made by SENATOR THOMAS to accept the Department of Health recommendation with the \$34,000 adjustment.

QUESTION was called. MOTION PASSED with all voting AYE.

DIRECTOR'S OFFICE

ISSUE 2d: grants to local health agencies, page 237, was reviewed by JANDEE MAY. She stated that within the director's office, they are proposing to use block grant money to pass through to the local government.

Attention was called to table 4 on page 228 and also to table 6, page 233 and to the excess authority to be removed, not cash.

SENATOR SMITH MOVED that the Governor's Budget Office and anyone else involved in this money get together, after they get this figure into their budget and we will then act upon their recommendations.

MOTION PASSED.

HOSPITAL AND MEDICAL FACILITIES DIVISION

ISSUE 2: Issue 2c: Medicaid Certification was reviewed by JANDEE MAY, Fiscal Analyst, referring to page 235.

In reference to licensing, DR. DRYNAN stated that they now have a bill which will authorize licensing every three years rather than every year. This money is for licensing hospitals so they

# Urban Indians lose health skirmish

BY JAMES DEWOLF  
IR State Bureau

By a one-vote margin a legislative appropriations subcommittee has scalped a group of urban Indian health service providers, including those in Helena.

But the Montana United Indian Association (MUIA) says it can't give up yet and will probably resubmit its funding request to the entire Legislature.

The 6-5 decision came after Sen. Ed Smith, R-Dagmar, said he had checked with Indian friends who told him that claims that urban Indians can't qualify for medical care on all reservations are untrue.

Smith said some of his friends have left their reservations for decades and are still returning for annual checkups and major medical care.

"I think we've been misled a little bit," said Smith.

MUIA officials said the official rule for Indian Health Service care is that it can't be given to anyone who has lived away from a reservation for more than 180 days. They said

money for Montana's seven reservation health programs is drying up and strict enforcement of eligibility rules is becoming more common.

The MUIA is seeking \$345,000 for each of two years to continue the operation of Indian health clinics in Great Falls, Helena and Missoula along with out-reach transportation programs in Anaconda, Butte and Miles City. The MUIA says it could operate just the clinics for \$285,000 a year.

Backers say the clinics are necessary because urban Indians are often poor and are routinely denied the health services available to other Montanans.

Up until now the health programs have been federally supported. But federal cuts in funding may run as high as 100 percent and the MUIA says if that happens Indian centers, as well as the clinics, may fold.

Legislators said there simply wasn't enough money available in a federal block grant for preventative health care to continue funding state and county health programs while providing for the urban In-

dian clinics.

A tentative motion urging county health departments to make sure Indians are not left out of county health programs failed to even get to the voting stage and some legislators argued that funding the clinics would create an excuse to continue racism.

Sen. Fred Van Valkenburg, D-Missoula, chided the MUIA for being unrealistic in opposing his earlier suggestion that the state could fund one of the clinics for \$80,000 a year.

"You missed the boat in Washington D.C.," said Van Valkenburg before making a surprise motion to fund just one clinic.

The proposal was voted down and afterwards Ben Bushyhead, executive director of the MUIA, said there is a discrimination problem that federal laws have failed to remedy. He said urban Indian clinics were told to expect block grant funding earmarked for them but it was never approved at the federal level.

"If (this committee) had given us \$30,000 it would have been OK," he said.

# But Helena's 'invisible' ones are heard

By STEVE HINTZ  
IR Staff Writer

They are in some ways an invisible people, Helena's landless Indians. The U.S. Census Bureau doesn't acknowledge the existence of many, and the state of Montana has been hardly aware of the half of its Native American population living off reservations. According to Ed Kennedy, director of the Helena Indian Alliance.

But the alliance tried at legislative hearings this week to convey an image of urban Indian needs. And even though an appropriations subcommittee Wednesday voted down 6

to 5 a request for health care funds, Kennedy sees the close vote as "a victory of sorts."

"We were able to get a fair hearing. We're going to regroup and approach the full House Appropriations and Senate Finance committees" during the session that begins Monday.

The alliance hopes to receive at least \$45,000 in block grant money to keep its medical clinic in full operation in the face of federal budget cuts. The request is included in a larger plea for \$345,000 from Indian groups in six Montana cities.

At issue in Helena is whether the desperately poor landless Indians can continue to receive health care in a clinic run by

their own people.

The alliance has turned to the state because Reagan administration budget recommendations call for the total elimination of Indian Health Service funds for such clinics.

Thus, the battle to educate government about the needs of urban Indians, won at the federal level just prior to the coming of Reagan budget cutters, must now be waged again before state officials, Kennedy notes wearily.



Clinical Services Director Jennifer Topash left, and registered nurse Yvonne Blackburn may work for half-pay at the Helena Indian Alliance clinic if the alliance fails in its bid for state financial help.

# Invisible ones

(Continued from page 1B)

Sitting at his desk above the clinic at 436 N. Jackson earlier this week, Kennedy was chagrined over the block grant process. If you believe the logic behind the program, he notes, it's the states, not the federal government, that know best who their needy citizens are.

But in the reports prepared for the upcoming session by the Governor's Office and the Office of the Legislative Fiscal Analyst, the landless Indians were not mentioned, he said.

Federal programs, on the other hand, have documented the problems of landless Indians: an unemployment rate ranging from 30 to 50 percent; a life expectancy of only 55 (15 years shorter than the average); an abnormally high suicide rate; poor housing.

Binding all these problems together is the double-faced tape of poverty and poor health.

Acting on the problems, the Indian Health Service gave the alliance money early this year to start and run the clinic. It is staffed full-time by a registered nurse by a doctor three afternoons a week.

Since January, 1,300 treatments have been received by members of a Indian population numbering about 3,000 in Lewis and Clark, Broadwater and Jefferson counties. (The latest census counted only about half that many.

however. The canvassers miss many, and many Indians ignore the forms out of fear or resentment towards the government, Kennedy says.)

The clinic's work fills a vacuum, he believes. As members of tribes that never had a reservation, or that left the reservations in the 1950s to follow the dream of a better life in the cities promised by the Bureau of Indian Affairs, the Indians here don't have the resources available on those on reservations, he adds.

Most landless Indians have no health insurance. And even those on welfare entitled to Medicaid often resist going to white clinics; many who have tried have been refused, Kennedy claims.

Right now, the clinic -- and the whole range of services offered by the alliance -- are reeling from already enacted budget cuts. When the CETA program was cut, the alliance cut its staff from 30 to 7.

Reductions in Indian Health Service appropriations in October forced the cutting of several services at the clinic that were paid for on a contract basis. The clinic's doctors, David Jordan and Katherine Dawson, began working about 10 hours a week for free.

After the October crisis, local sources responded generously. Two local churches offered a total of \$9,000, the United Way came up with \$4,600 and God's Love Incorporated has promised \$5,000.

If the state doesn't offer any help, the private funds will allow the clinic to pay about one half its costs. The staff insists it will work full-time for half pay.

"It's not easy for a local church to come up with \$600 a month. The community believes in what we're doing. It's a Christian effort," Kennedy says.

Also, he stresses the clinic would not become a perpetual drain on state resources. He says the clinic was about one year away from becoming fully reliant on private funds.

The battle in the legislature is not lost yet, Kennedy says. The 6 to 5 vote against could be reversed, and money for health care exists in other block grants.

Much is at stake in the battle to keep the clinic open, he adds. "What we're talking about is our youth growing up with loss of hearing, with untreated intestinal diseases, with untreated diabetes... or not growing up at all."

# Indian health clinics denied money

**MES DeWOLF**  
**State Bureau**  
**HELENA** — By a one-vote margin, a legislative appropriations subcommittee scalped a group of urban Indian health providers. The Montana United Indian Association says it gave up yet and will resubmit its request to the legislature. The 6-5 decision came after Sen. Ed Smith, R-Dagmar, said he had checked with Indian friends who told him that claims about urban Indians not qualifying for medical care on all reservations are untrue. Smith said some of his friends have left their res-

ervations for decades and still are returning for annual checkups and major medical care. "I think we've been misled a little bit," said Smith.

Association officials said the rule for Indian Health Service care is that it can't be given to anyone who has lived away from a reservation for more than 180 days. They said money for Montana's seven reservation health programs is drying up and strict enforcement of eligibility rules is becoming more common.

**THE GROUP** is seeking \$345,000 for each of two years to continue the operation of Indian health

clinics in Great Falls, Helena and Missoula, along with outreach transportation programs in Anaconda, Butte and Miles City. The Indian group says it could operate the clinics for \$285,000 a year.

Backers say the clinics are necessary because urban Indians often are poor and routinely are denied the health services available to other Montanans.

Up until now the health programs have been federally supported. But, federal cuts in funding may run as high as 100 percent and the association says if that happens, Indian centers and the clinics may fold.

Legislators said there simply wasn't enough money available in a federal block grant for preventative health care to continue funding state and county health programs while providing for the urban Indian clinics.

A tentative motion urging county health departments to make sure Indians are not left out of county health programs failed to get even to the voting stage. Some legislators argued that funding the clinics would create an excuse to continue racism.

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earlier suggestion that the state could fund one of the clinics for \$80,000 a year.

"You missed the boat in Washington D.C.," said Van Valkenburg, before making a surprise motion to fund just one clinic.

The proposal was voted down. Afterwards, Ben Bushyhead, executive director of the association, said there is a discrimination problem that federal laws have failed to remedy. He said urban Indian clinics were told to expect block grant funding earmarked for them, but that it was never approved at the federal level.

"If (this committee) had given us \$30,000, it would have been OK," he said.

8—Missoulian, Thursday, November 12, 1981

## Panel turns down Indian-clinic funds

**Missoulian State Bureau**

**HELENA** — By a one-vote margin a legislative Appropriations subcommittee has turned down a funding request from a group of urban Indian health-service providers.

But the Montana United Indian Association says it can't give up yet and will probably resubmit its funding request to the entire Legislature.

The 6-5 decision came after Sen. Ed Smith, R-Dagmar, said he had checked with Indian friends who told him that claims that urban Indians can't qualify for medical care on all reservations are untrue. Smith said some of his friends have lived away from reservations for decades and are still returning for annual checkups and major medical care.

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That proposal was voted down.

After that vote, Ben Bushyhead, executive director of the group, said there is a discrimination problem that federal laws have failed to remedy. He said urban Indian clinics were told to expect block grant funding earmarked for them but it was never approved at the federal level.

# Indian health service request is scalped

6-C Thursday, Nov. 12, 1981 The Billings Gazette

By JAMES DeWOLF  
Gazette State Bureau

HELENA — A legislative appropriations subcommittee scalped by a one-vote margin a request from a group of urban Indian health service providers.

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# INDEPENDENT RECORD

SATURDAY

November 7, 1981  
Helena, Montana  
Vol. 38 No. 342  
Single copy 25c



## Indian clinics will seek state money

By JAMES DeWOLF  
IR State Bureau

A new and expensive burden will be dropped in the laps of state legislators Monday when operators of three non-reservation Indian health clinics make their case for first-time funding.

Spokesmen for the Montana United Indian Association say they have no choice but to ask for state money because they are facing an anticipated 100 percent reduction in federal funding.

The MUIA will present legislative testimony seeking \$345,000 for each of two years. The money would pay for health clinics in Great Falls, Helena, and Missoula and transportation and referral programs in

Anaconda, Butte and Miles City.

If the Legislature opted to fund only the clinics, the cost would be reduced to \$285,000 annually and patients would be required to provide their own transportation from the outlying areas.

The urban health program is aimed at the more than 50 percent of Montana Indians who have left their reservations and no longer are eligible for tribal and Indian Health Service programs.

Urban Indians should be able to get medical services from doctors and programs that serve the rest of the population. But Ed Kennedy, director of the Helena Indian Alliance, said it doesn't work that way.

(More on CLINICS, page 12A)

## Clinics (Continued from page 1A)

Kennedy said most of the patients his clinic serves are poor and they have difficulty convincing regular physicians they can pay for the service, even when they are enrolled in welfare assistance programs.

"The first question always is, 'How are you going to pay for this?'" Kennedy said. "We had a case yesterday in which a mother took her child to a Helena clinic for treatment of an epileptic seizure. She is an approved welfare patient but she didn't have the paper with her and they wouldn't treat the child."

"After a couple of occurrences like that our people won't go to a regular physician unless they are very sick or about to die."

Because of poor health care the MUIA says middle age in the Indian population begins in the 30s with only a small percentage reaching senior citizen status, which begins at age 45.

Administrator Mike Welsh said the clinics are moving toward self sufficiency in fund raising from foundations, churches, medical insurance reimbursements and local charities.

"We are asking for a hand up, not a hand-out, for two years until we can become self supporting," Welsh said. "It was always our plan to get away from the federal funding but these cuts just hit too fast."

The clinics hire doctors and nurses on a part-time basis to provide preventive care and minor medical treatment. The average cost per patient visit is \$18 and Montana has more than 100,000 potential patients.

Welsh said the clinics often prevent serious medical complications. The prevention reduces the cost to other welfare programs that pay the major medical expenses of the poor, he said.

Funding for the urban Indian health programs has been criticized since January. Congress has extended the program for another two years but the president is expected to veto the appropriation.

Kennedy said promises that block grants would make up the lost federal funding have fallen flat in the past few weeks.

"This is a long shot," he said of the state request. "But we have to try it."

KTVG INTERVIEW AIRED ON FRIDAY, 11-13-81  
@ 5:30 & 10:00 p.m.

"The Montana United Indian Association says it will resubmit its funding request to the entire legislature on Monday. The action follows their 6 to 5 narrow funding defeat by a legislative sub-committee. John Deering has more." "Following the 6 to 5 defeat by legislative sub-committee, Montana United Indian Association Executive-Director, Ben Bushyhead, said his association will resubmit its funding request on Monday.

The defeat came after Senator Ed Smith, a Republican from Dagmar, said he had checked with unnamed Indian friends who told him that Indians not living on reservations were indeed receiving medical attention on reservations.

But as Mike Welsh, the Health Director of MUIA says, the existing law does not require Indians to actively live within reservation boundaries. 'John, this is a very complex issue and I would simply respond that Senator Smith may have asked his friends who are not privy to the Indian Health Service regulations and may also be living on or near the reservation. "On or near" is a concept that says that Indian Health Service contract services may be given to those people who live in a county adjoining an Indian reservation or in a county into which the boundary of an Indian reservation protrudes'.

Welsh said another official rule for Indian Health Service care is that it can't be given to anyone who has lived away from a reservation for more than 180 days. The MUIA is seeking 345,000 for each of two years to continue the operation of Indian Health Clinics in Great Falls, Helena and Missoula along with outreach transportation programs in Anaconda, Butte and Miles City. From the Montana United Indian Association, John Deering reporting for Newsline 12."

4  
Kathy Martin  
Appropriations Secretary

EXHIBIT 4

November 16, 1981

To: House Appropriations Committee  
Re: Family Planning Cuts (state match for FY '83)

The enclosed information is presented in support of continued adequate funding for the Family Planning program and in opposition to cuts in that program.

The enclosed information provides graphic details of the cost effectiveness of the program and the benefits of its continued support.

We urge your support.

Respectfully submitted,

Kathy Van Hook  
517 Waukesha  
Helena, Mt. 59601

Rosalind Kotz  
304 Clancy  
Helena, Mt. 59601

Scot Felderman  
Box 902  
Helena, Mt. 59624

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EFFECT OF FUNDING CUTS ON FAMILY PLANNING PROGRAM

The State legislative joint subcommittee hearing the Department of Health and Environmental Sciences budget this week unanimously recommended a \$22,950 reduction in Title XX for family planning for FY 1983 (July 1, 1982 - June 30, 1983).

Current level Title XX funding is \$229,500 (\$206,550 federal; \$22,950 state). The 10% State match money is no longer required for Title XX under the Social Services block grant and the committee removed the State match which was \$22,950.

The impact this will have in FY 1983 is that 306 women in need of subsidized family planning services will not receive them. If the proposed reduction passes, it will mean an overall reduction of 19% or \$48,450 in Title XX for the biennium and 646 women will not receive family planning services (the legislature removed \$22,500 from Title XX earlier this year, reducing services to 340 women).

The reduction of \$22,950 and loss of services to 306 women will result in approximately 78 unplanned pregnancies. These pregnancies will result in 51 births, 12 abortions and 14 miscarriages. This will include approximately 2 cases of congenital abnormalities, 2 cases of hypoxic brain damage, and 3 cases of high-risk premature deliveries. A single case of a congenital abnormality can cost \$150,000 in medical treatment.

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MONTANA STATEWIDE FAMILY PLANNING PROJECT

(See Attached Fact Sheet for Program Information)

<u>Family Planning Programs (County)</u>	<u>1980 Patient Load</u>
Cascade	2276
Custer	730
Dawson	575
Fergus	386
Flathead	1007
Gallatin	1788
Hill	593
Lake	207
Lewis and Clark	2379
Lincoln	564
Missoula	2657
Phillips	165
Ravalli	142
Silver Bow	1804
Yellowstone	5578
	20852

<u>County (All 56 Counties Served)</u>	<u>1980 Patient Load</u>
Beaverhead	88
Big Horn	63
Blaine	44
Broadwater	63
Carbon	89
Carter	3
Cascade	1926
Choteau	39
Custer	623
Daniels	8
Dawson	462
Deer Lodge	156
Fallon	11
Fergus	284
Flathead	1019
Gallatin	1669
Garfield	16

## MONTANA STATEWIDE FAMILY PLANNING PROJECT

4

County (All 56 Counties Served)1980 Patient Load Served

Glacier	15
Golden Valley	20
Granite	22
Hill	514
Jefferson	176
Judith Basin	30
Lake	209
Lewis and Clark	2075
Liberty	4
Lincoln	565
McCone	21
Madison	45
Meagher	47
Mineral	32
Missoula	2477
Musselshell	48
Park	95
Petroleum	42
Phillips	107
Pondera	48
Powder River	13
Powell	200
Prairie	11
Ravalli	207
Richland	85
Roosevelt	5
Rosebud	72
Sanders	21
Sheridan	5
Silver Bow	1353
Stillwater	54
Sweet Grass	11
Teton	89
Toole	118
Treasure	4
Valley	68
Wheatland	32
Wibaux	15
Yellowstone	5054
Out-of-State	161
Unknown	119
TOTAL	<hr/> 20852

In Montana, 20,852 clients were served by programs in 1980. This is a 442% increase in case-load since the program's statewide inception in 1972.

Family Planning meets the needs of those who otherwise cannot afford services and could eventually become dependent on government agencies.

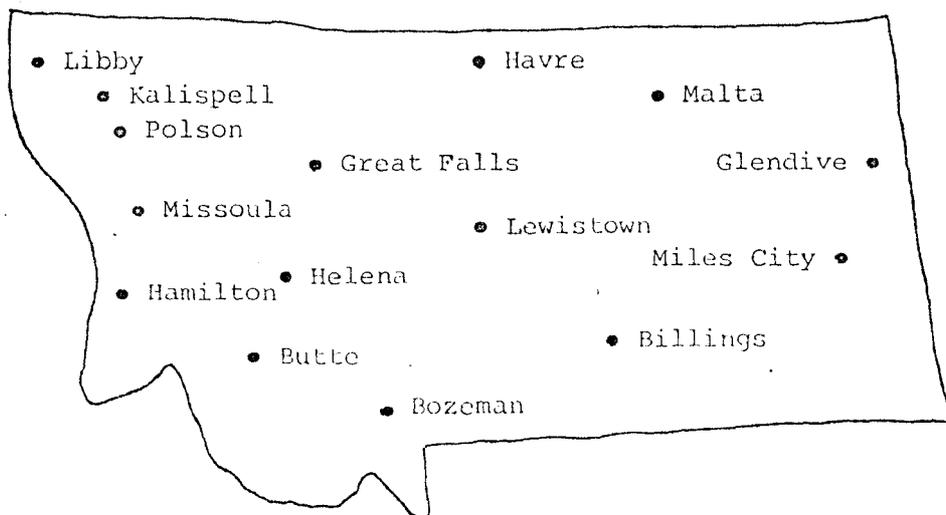
- The cost to the government for a mother on welfare and an unplanned child averages \$2,808 per year plus Food Stamps and Medicaid.
- The average cost per family planning medical encounter is \$17.
- The short-term benefits (savings) to federal, state, and local governments are estimated to be \$2 for each dollar invested in family planning.
- The long-term benefits are estimated to be \$26 for each dollar invested.

Family Planning is a preventive health effort with potential to reduce significantly certain social, psychological and medical problems of women and children. It is characterized by two important aspects:

- Improvement of the health of women and children.
- The acceptance of family planning services must always be the voluntary decision of the individual.

The goal of Montana family planning services is to maintain or improve the reproductive health of Montana people in their reproductive years.

In Montana there are presently 15 family planning clinics. Currently the funding is provided by: Federal Title X monies through the Maternal and Child Health Bureau of the Montana State Department of Health and Environmental Sciences; Federal Title XX monies through SRS; State funds (SFY 1981 - \$60,120); third party reimbursement; local funds, and direct fees paid by the client based on the ability to pay. Total funds expended in 1980 were \$1,478,246.



The preventive health based programs provide:

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• counseling in all aspects of family life</li> <li>• educational services</li> <li>• physical examinations</li> <li>• cervical cancer screening</li> <li>• self-breast exams</li> <li>• blood tests for anemia, rubella and syphilis</li> <li>• immunization for rubella</li> </ul> | <ul style="list-style-type: none"> <li>• blood pressure recordings</li> <li>• urinalysis for sugar and protein</li> <li>• inter-agency referral for other problems</li> <li>• dispensation of contraceptives (Federal, State, Medicaid not used)</li> <li>• screening and treatment for gonorrhea</li> <li>• pregnancy tests</li> </ul> |
|---|---|

Family Planning services are directed toward the accomplishment of the following major health goals:

- Improve and maintain the emotional and physical health of men, women and children, particularly through the detection and prevention of cancer and venereal disease with women.
- Prevent birth defects and mental retardation. Mental retardation tends to be associated with prematurity and low birth weight. The Comptroller General's report to Congress on Mental Retardation, 1977, identified family planning programs as an existing program with the ability to make a significant contribution towards reducing the incidence of mental retardation.
- Reduce the incidence of abortion by preventing unplanned pregnancies.
- Assure that more children are "wellborn" by decreasing the incidence of prematurity and birth defects.
- Decrease maternal and infant mortality and morbidity.
- Assist couples who want to have children but cannot.
- Prevent unplanned pregnancies (particularly in child abuse and poverty situations).
- Improve pregnancy outcome by correction of health problems between pregnancies and by proper spacing and timing of pregnancy.
- Assist couples in having the number of children they desire so that every child is intended and loved.

The Need:

- There are an estimated 52,733 women-in-need of subsidized family planning services in Montana.
- About 26% of these women (or 13,972) are being served by the 15 programs. Roughly estimated, an additional 16,875 women-in-need (or 32%) are being provided family planning services by physicians.
- This leaves some 21,886 Montana women needing family planning services who are not receiving them. They are at risk for unplanned children.

Accomplishments:

- 69% of the 20,852 clients served in 1980 lived in families with incomes at or below 150% of the CSA poverty level.
- Medical and/or educational services were provided by programs to 20 unserved and 8 underserved counties in 1980.

In 1980 the 15 programs detected and referred for treatment;

- 327 positive pap smears for cervical cancer
- 226 cases of anemia
- 242 abnormal urine chemistry results
- 145 cases of gonorrhoea
- 1849 cases of vaginal infections
- 992 cases of breast diseases or other physical findings (heart, thyroid, etc.)

*Handwritten notes:*  
 The general...  
 2/24/80...  
 200 copies...  
 J. J. ...

- FAMILY PLANNING PROGRAM -

UNPLANNED PREGNANCIES PREVENTED

In 1980 the 15 family planning programs in Montana prevented 5,316 unplanned pregnancies. These pregnancies would have resulted in 3,492 births, 851 abortions, and 973 miscarriages. This would have included approximately 105 cases of congenital abnormalities, 105 cases of hypoxic brain damage, 17 cases of chromosomal abnormalities and 234 high-risk premature deliveries.

PROGRAM	Pregnancies Prevented	Births Prevented	Abortions Prevented	Miscarriages Prevented
Billings	1405	923	225	257
Bozeman	518	340	83	95
Butte	490	322	78	90
Glendive	163	107	26	30
Great Falls	453	298	72	83
Hamilton	38	25	6	7
Havre	133	88	21	24
Helena	638	419	102	117
Kalispell	253	166	41	46
Lewistown	100	66	16	18
Libby	150	99	24	27
Malta	39	26	6	7
Miles City	210	138	34	38
Missoula	678	446	108	124
Polson	51	34	8	9
STATEWIDE	5316	3492	851	972

SOURCE: Trussell Method Effectiveness Estimates, "Cost versus Effectiveness of Different Birth Control Methods", T. James Trussell

REQUEST FOR FISCAL 1983 SUPPLEMENTAL FUNDS IN THE AMOUNT OF \$38,000  
FOR THE FOOD & CONSUMER SAFETY BUREAU

The \$38,000 is being requested to replace monies which we previously received under contract from the Federal Food and Drug Administration for an inspection program involving grain storage facilities, food warehouses, food salvage dealers, and bakeries. At our budget hearings for 1982 we had no idea that the FDA contract monies might not be available for Fiscal 1983. This money is used to support all programs administered by this Bureau. This is a cost effective program.

In 1970 the Bureau, in cooperation with the Federal Food & Drug Administration, conducted several meetings in Montana on elevator sanitation. During those meetings information on insect control, rodent control, and proper maintenance of elevators was presented. Significant improvement was made with the elevators, especially relating to exterior cleanup. However, there was no followup inspections to go with this educational program, and many of the elevators reverted back to the conditions that they were in in 1970.

Up to 1977 we had been receiving information from the states of Washington and Minnesota indicating that there were a large number of embargoes being issued on grain shipments from Montana. Our records, which are incomplete in that not all embargoes were reported to us, indicated that in 1977, 6,964,650 pounds were embargoed. Estimates that we have received from shippers indicate there is an approximate loss of 56 cents a bushel when grain is embargoed. This provides us with an estimate of approximately \$65,000 per year which has been lost or saved, whichever way you choose to look at it.

Last year, 1980, the amount of grain embargoed was one-tenth of that which was embargoed in 1977 (600,600 lbs.)

Because of the many embargoes that were occurring we requested assistance from FDA, and FDA agreed by providing monies enough to make unannounced inspections about every two years. There was no limit on the period of time that FDA agreed to provide these monies. There has been some indication that this was a five-year phase out program; however, we have never received any information of this nature from FDA.

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Through receipt of these monies from FDA we have been able to initiate and maintain a much more efficient program of administration of the Montana Food, Drug, and Cosmetic Act which requires inspections as part of the administrative responsibility (Section 50-31-106, M.C.A.).

There has been a statement that inspections are not required. This is not true, in that we are charged with the responsibility for administration of a law that requires that we provide surveillance to ensure that food is not adulterated or misbranded. The only way that we can carry out this charge is by making inspections and investigations.

These monies have permitted us to maintain our present staff level, which was decreased by approximately 25% from Fiscal 1981 staff level. This reduction has created an extreme hardship on our bureau in that one of our prime functions is to provide training and assistance to local health units, and local health department staff has been increasing over the years and therefore requests for assistance have been increasing. As an example, just recently there have been ten new sanitarians employed locally. Six of these positions are ones related to units in which there is only one inexperienced sanitarian. So all the training and consultation which is available to them is obtained from the State Department of Health & Environmental Sciences.

A number of years ago the Food & Consumer Safety Bureau funding was entirely from general fund sources. This was changed to primarily federal funds in order to release state funds which could be matched with federal funds for initiating and expanding programs in other divisions and bureaus of the department. This is why the Food & Consumer Safety Bureau took such a severe loss in Fiscal 1982, with the loss of 3140 funds.

The granting of the supplemental funds in the amount of \$38,000 will permit us to retain staff at the 1982 level, which will permit us to continue reasonable, effective programs including food and drug control plus assistance to local health units.

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Endorsement of this program has been received from Mel Sobolik, President of the Montana Grain Elevators Association; Walter Ulmer, Custer County Commissioner; Ron Andersen, Director of Sanitation of Safety for Buttreys Food Stores; as well as the Local Health Officers Association and all local health units. There has also been endorsements by individual warehouse managers and food salvage facility owners.

C O P Y

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To Representative Francis Bardanouve

I have just been informed that the Food & Consumer Safety Bureau of the Department of Health & Environmental Sciences is requesting supplemental funds to replace monies which they have been receiving via contract from the Federal Food & Drug Administration. I am thoroughly familiar with the specific program that this money supports as well as all the other programs of the bureau, and therefore would like the opportunity to comment on this request.

This bureau suffered a loss of two professional staff members and a secretary between Fiscal 1981 and Fiscal 1982. We sanitarians working alone in the field have experienced the result of this loss of staff in that we are not getting the same amount of assistance that we used to. My understanding is that if the bureau does not receive replacement funds for the FDA Contract funds they will lose additional staff, and this would create a real shortage of assistance to local health departments.

Just recently there have been a number of new sanitarians employed in local health departments, and they are inexperienced and therefore in need of as much assistance as they can get. The monies that are received from FDA are used to support all programs of the bureau in that it provides travel and support funds for other than the specific inspections that are required by the contract.

I would appreciate very much if you would support this request for supplemental funds, not only on my behalf, but on the behalf of all other sanitarians throughout the state.

Sincerely yours,

John C. Herndon  
Blaine County Sanitarian

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# BI-COUNTY ENVIRONMENTAL HEALTH DEPARTMENT

Deer Lodge  
Granite

Courthouse  
801 South Main Street  
Anaconda, Montana 59711-2999

Phone 563-8421  
Extension 248  
Secretary's Hours:  
8 A.M. - 12 NOON



November 9, 1981

Representative Joe Kanduch  
Capitol Building  
Helena, Mt

Dear Representative Kanduch:

As you are aware, some years ago the Food and Consumer Bureau funding was provided entirely from general fund sources. This was changed in order to release state funds which could be matched with federal funds for initiating and expanding programs in divisions and bureaus of the department. The Food and Consumer Safety Bureau took a severe loss in Fiscal 1982 with the loss of 413D funds.

Thirty eight thousand (\$38,000) dollars is being requested to replace monies which we previously received under contract from the Federal Food and Drug Administration for an inspection program involving grain storage, food warehouses, food salvage dealers, and bakeries. At our budget hearings for 1982, we had no idea that FDA contract monies might not be available for Fiscal 1983.

These inspections are required because we are charged with the responsibility of the law which requires that we provide surveillance to ensure that food is not adulterated or misbranded.

In addition, the granting of these supplemental funds in amount of thirty eight thousand (\$38,000) dollars will permit us to retain staff at 1982 level, which will permit us to continue a reasonably effective food and drug program and provide continuing assistance programs to local health units. I urge you to support this funding.

Sincerely,

Jim Norman, R. S.

CC: Vern Sloulin, Chief  
Food and Consumer Bureau

CC: Dan Worsdell, Manager  
Anaconda-Deer Lodge County

RECEIVED



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DIVISION OF JEWEL COMPANIES, INC.  
601 SIXTH STREET S.W.  
GREAT FALLS, MONTANA 59403  
November 10, 1981

AREA CODE 406  
761-3401

P.O. BOX 5008

Mr. Vern Sloulin, Chief  
Food & Consumer Safety Bureau  
Dept. Health & Environmental Sciences  
Cogswell Building  
Helena, MT. 59620

Dear Mr. Sloulin:

We favor the continuation of the Food Storage Facilities inspectional program by the Montana State Department of Health and Environmental Sciences and would encourage that state funding be allocated to fund this program should federal funding not be forthcoming.

Our company has recognized the problems that can develop in a food storage facility and has expended a significant amount of time, money, and effort in developing a strong internal inspectional and preventative sanitation program in our facilities to preclude such problems. We feel this is a vital necessity in protecting the consumers food supply.

The regulatory branch through its inspectional activity can provide guidance in developing sanitation programs, interpretation of the regulatory criteria to be met, and where necessary the impetus to establish such programs.

Through their travel necessitated by other responsibilities, it would appear that state health department personnel are in a position to provide more frequent inspections than their federal sequels with a more efficient use of travel monies. With their frequent and close associations with local sanitarians they are also in a position to provide ongoing training and consultation to local sanitarians who might be involved in such inspections, again with the most efficient use of monies. The uniform application of regulatory criteria, which is of utmost importance to the regulated industry, is greatly enhanced through frequent inspections and proper training.

Sincerely,

A handwritten signature in cursive script, appearing to read "Ron A. Andersen".

Ron A. Andersen  
Director Sanitation & Safety

RA/sn



# County of Custer

Custer County Courthouse  
1010 Main  
MILES CITY, MONTANA 59301

November 13, 1981

Mr. Ed Smith, State Senator,  
Helena, Montana 59601

Dear Ed,

The Custer County Commissioners have been advised that there might be a problem with the Department of Health receiving the approximately \$38,000.00 for the continuation of their inspection programs for Montana grain. It is our understanding that they inspect our grain for contamination and see to it that when grain is shipped from Montana that it does not meet rejection at the various terminals that it is sent to, thereby earning for Montana producers considerably more money.

It seems that the department also uses some of the monies generated by this fund to help fund their program for assisting county sanitarians. I know that Custer County recently had to hire a new sanitarian and we depend heavily on the department of health for guidelines in such a situation. The Department of Health is going to provide a weeks period of schooling for our new sanitarian, together with several new sanitarians, and they also provide help for a new person in the position thru their district field offices.

The County Commissioners feel that we need the assistance we get from the department, particularly since we are in a growing area and find the sanitarian services needed on a regular basis.

The Custer County Commissioners, together with all of the Commissioners in the State of Montana, will truly appreciate your doing everything you can to see that the Department of Health gets the funds needed to continue both these necessary programs - the inspection of our exportable grain to prevent unnecessary embargos by holding down contamination and the training for our local health officials.

Sincerely,

WALTER J. ULMER, Member  
Custer County Commissioners

WJU:ljs

CC: Mr. Vern Sloulin, Dept Health, Food & Consumer Bureau, Helena MT





