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OBJECTIVE IV.2: By initiating a migration flow system which will monitor the health needs of Indians and determine the health trends of Albuquerque urban Indians, this will enable the tribal, inter-tribal and urban health departments to determine necessary programmatic changes and/or to justify additional health care programs.

ACTIVITY IV.2.A: Following the initiation of a migration flow system, participating tribal health departments and service unit health boards and the AUIC Health Department will conduct monthly reviews of the referral system in order to validate the rate of migration, the health needs of the migrating population and special or emergency health care that is necessary for urban Indians of the AUIC service area.

ACTIVITY IV.2.B: The CHR Division of the AUIC Health Department will provide continuous follow-up on those individuals that were identified by participating tribal health departments as needing special or emergency health care. This will provide a programmatic cooperative health care system with the Albuquerque Service Unit and the AUIC Health Department.

GOAL V: To plan and initiate a data collection system within the AUIC service area between Indian and non-Indian health facilities and the AUIC Health Department which will assist in the development and design of a comprehensive urban Indian health care system.

OBJECTIVE V.1: To receive and store data through a computerized collection system with local Indian and non-Indian health providers which will enable the AUIC Health Department to accurately describe the health needs of urban Indians as well as to justify the expansion of the AUIC Health Department in the design of preventive health care programs.

ACTIVITY V.1.A: Hire key punch services or hire the necessary personnel that will key punch health information for the purpose of better utilization of health resources.

ACTIVITY V.1.B: Computerize the health information available from Indian and non-Indian health resources which will be utilized by the AUIC Health Department and other health providers. This will result in better utilization of Indian and non-Indian health care facilities by the CHR Division of the AUIC Health Department due to keeping current information and data available in the AUIC Health Department Resource Directory and Data Bank.

ACTIVITY V.1.C: Computerize health data and health-related information including information from city, state and federal health agencies that will facilitate the expansion of the AUIC Health Department or the addition of preventive health care programs within the AUIC Health Department.

OBJECTIVE V.2: To receive and store data from other urban health projects throughout the U. S. by incorporating the AUIC Health Department into the urban CHR data reporting system established in cooperation with the IHS and the American Indian Health Care Association, Inc., and the National CHR Association, Inc.

ACTIVITY V.2.A: Receive technical assistance and orientation from the American Indian Health Care Association, Data Reporting System, that will enable the AUIC Health Department to propose for the development of computer programs which will be a part of the urban Indian Data Reporting Systems and the American Indian Health Care Association.

ACTIVITY V.2.B: Computerize and store data from the CHR Division of the AUIC Health Department and make such data available to the IHS and American Indian Health Care Association through the purchase of a computer terminal and computer services.

ACTIVITY V.2.C: Receive data for other urban Indian health projects through the IHS and the American Health Care Association which will be entered into the computerized data system of the AUIC Health Department, the results of which will enable the AUIC Health Department to accurately describe and plan the design of health policies and programs being planned, initiated, or are in functional existence with other urban Indian projects in the U. S.

GOAL VI: To be able to utilize Indian and non-Indian preventive health and health educational resources by the AUIC Health Department in the planning of innovative systems of preventive health care delivery in order to meet the needs of urban Indians of the AUIC Health Department service area. This would include those innovative preventive health care programs not represented in Goal II (inclusive), FY 81 program year.

OBJECTIVE VI.1: To hire health educators into the AUIC Health Department which will take data (from Goal II and Goal V) and plan the initiation of preventive health care programs into the AUIC Health Department through the utilization of Indian and non-Indian preventive health modules and preventive health education techniques.

ACTIVITY VI.1.A: Hire and provide orientation to qualified health educators into the Indian Health Education Division of the AUIC Health Department who, in conjunction with the Indian Health Planning Division of the AUIC Health Department and the technical assistance of the American Indian Health Care Association, the National CHR Association and the IHS, will review modules and available data in order to assure educational relevance to innovative programs in preventive health for urban Indians of the AUIC Health Department service area.

ACTIVITY VI.1.B: Following the review of Indian and non-Indian preventive health care modules and programs by the Indian Health Education Division and the Health Planning Division of the AUIC Health Department, a curriculum of innovative health prevention programs, classes, counselors and assistance will be designed in order to meet the health needs of urban Indians of the AUIC Health Department service area.

GOAL VII: To be able to submit to the Indian Health Service an update of the Albuquerque Urban Specific Health Plan through the submission of a close-out report for PL 94-437, Title V, FY 81, which will include a report of achievements in the implementation of the above stated goals, as well as make recommendations for the remaining years of Title V funds under PL 94-437.

OBJECTIVE VII.1: To submit to the IHS a close-out report on the implementation of Phase I, Part II of Title V, PL 94-437, from the AUIC Health Department which will include such information on the successful achievements of implementing Phase I of the Albuquerque Urban Specific Health Plan and the impact of the health care delivery system of the AUIC Health Department.

ACTIVITY VII.1.A: Write and submit a close-out report to the IHS which will provide a comprehensive review of each component of the AUIC Health Department as well as to describe the success of implementing those health care programs identified in this Phase I Plan.

ACTIVITY VII.1.B: Make such close-out report available to any Indian and non-Indian health care facility on the city, state, and national levels in order to assure full utilization of all lines of communication that will result in better health care through more input from such health care facilities.

OBJECTIVE VII.2: To submit to the IHS, as a part of the close-out report, recommendations on the implementations of Phase II, Part II of Title V, PL 94-437, which will include the expansion of those programs initiated in Phase I, Part II, as well as the initiation of those programs planned in Phase I, Part I, of the Albuquerque Urban Specific Health Plan.

ACTIVITY VII.2.A: Submit to the IHS the analysis of the results and achievements of Phase I, Part II of Title V, PL 94-437, by the AUIC Health Department and make recommendations for adjustments of such urban Indian health programs to the IHS and other funding agents during Phase II, Part II.

ACTIVITY VII.2.B: Submit to the IHS, as a part of Goal VII, plans for initiating those health care programs into the AUIC Health Department as planned for in Phase I, Part II of Title V, PL 94-437.

C. Fiscal Year 1982
Oct. 1981 to Sept. 1982

GOAL I: To continue the process of planning through the AUIC Health Department as initiated in Goal I of the FY 81 Plan. This will include the ongoing process of planning preventive health care programs based upon the needs of urban Indians in the AUIC Health Department service area.

OBJECTIVE I.1: To expand the Indian Health Planning Division of the AUIC Health Department and to continue the analysis of health and health-related data in order to initiate programmatic changes within the respective divisions of the AUIC Health Department which will enhance more preventive health care to urban Indians of the AUIC Health Department service area.

ACTIVITY I.1.A: Hire and provide orientation to additional health planning personnel into the Indian Health Planning Division of the AUIC Health Department.

ACTIVITY I.1.B: Through the utilization and continual analysis of urban Indian health data, the Indian Health Planning Division will assist the AUIC Health Department in initiating those programmatic changes as determined necessary by such analysis and input from urban Indians in the service area of the AUIC Health Department.

OBJECTIVE I.2: Through the utilization of the expanded Indian Health Planning Division of the AUIC Health Department, continue to analyze health and health-related data in order to plan the expansion of the AUIC Health Department in those areas identified as priorities in order to enhance more comprehensive health care to urban Indians of the AUIC Health Department service area.

ACTIVITY I.2.A: Following the hiring and orientation of the expanded Indian Health Planning Division of the AUIC Health Department, make an analysis of data as were collected through Phase I (FY 81) and, also, collect and make analysis of additional health and health-related data in order to identify and prioritize those areas of health care necessary for urban Indians of the AUIC Health Department service area.

ACTIVITY I.2.B: The Indian Health Planning Division of the AUIC Health Department will assist with the administrative design and implementation of new and innovative programs identified and prioritized as being needed and necessary in order for the AUIC Health Department to meet the changing needs of the service population within the AUIC service area.

GOAL II: To be able to continue as well as to expand the comprehensive utilization of preventive health resources as identified in Goal II of the FY 81 scope of work by the AUIC Health Department in order to plan and initiate the coordination of those Indian and non-Indian health resources with the AUIC Health Department, its respective divisions and those urban Indians of the AUIC Health Department service area who are in need of preventive health care delivery.

OBJECTIVE II.1: To be able to continue the utilization of those preventive health resources that were identified and used during the Phase I, FY 81 scope of work. This would include making those programmatic adjustments by the AUIC Health Department in order to meet the preventive health care needs as were identified and prioritized by those urban Indians and by those divisions of the AUIC Health Department involved in the coordination of resources during FY 81 program year.

ACTIVITY II.1.A: Through the continued collection of data on Indian and non-Indian health and health-related education materials, information and programs, the Indian Health Education Division of the AUIC Health Department will coordinate with the Indian Health Planning Division for the design and development of more comprehensive preventive health care programs for urban Indians of the AUIC Health Department service area.

ACTIVITY II.1.B: Make use of such data by coordinating with Indian and non-Indian health education resources throughout the AUIC service area as well as city, state, and federal health education agencies, organizations and resources in order to initiate those programmatic changes concerning preventive health care programs through the utilization of data and information by the Indian Health Education Division and the CHR Division of the AUIC Health Department.

ACTIVITY II.1.C: Make use of the media in the AUIC service area that would reach the greatest number of urban Indians within its service area as well as to coordinate with the Indian Health Liaison Division of the AUIC Health Department and make public such information that will enhance the participation of urban Indians in current prevention programs, thus fulfilling such health needs as were identified in FY 81 program year.

OBJECTIVE II.2: To be able to expand the Indian Health Education Division of the AUIC Health Department in order to initiate those preventive health education programs based upon the design of such programs by the Indian Health Planning Division of the AUIC Health Department.

ACTIVITY II.2.A: Utilize such data and information as collected and analyzed by the AUIC Health Department, Resource Bank and coordinate with Indian and non-Indian health education resources for the initiation of such innovative preventive health care programs as identified by the Indian Health Planning Division and the CHR Division of the AUIC Health Department in Goal VI, FY 81 (inclusive).

ACTIVITY II.2.B: Make use of the media and other forms of communication in order to reach the greatest number of urban Indians in the AUIC service area, as well as to coordinate with those divisions of the AUIC Health Department and make public the initiation of such innovative prevention programs into the Indian Health Education Division of the AUIC Health Department as were identified and planned in order to utilize those Indian and non-Indian health resources in the reduction of urban Indian health needs of the AUIC service area.

ACTIVITY II.2.C: Initiate those innovative prevention programs into the Indian Health Education Division of the AUIC Health Department as were identified and prioritized by urban Indians of the AUIC service area through those divisions of the AUIC Health Department that maintain daily input from such urban Indians.

GOAL III: To continue the Indian Health Liaison Division of the AUIC Health Department which will continue to assist urban Indians of the AUIC service area with legal and economic barriers caused by the non-utilization of available Indian and non-Indian health resources.

OBJECTIVE III.1: To continue to plan and promote workshops, in-service training programs and on-site evaluations between urban Indian groups and individuals, and Indian and non-Indian health resources in order to facilitate better individual health care and assistance with legal and economic barriers.

ACTIVITY III.1.A: Hire additional Indian Health Liaison staff in order to continue to plan for those workshops, in-service training programs and on-site evaluations for urban Indians of the AUIC Health Department service area, in conjunction with the Indian Health Planning Division of the AUIC Health Department.

ACTIVITY III.1.B: Initiate such workshops, in-service training programs and on-site evaluations between urban Indians of the AUIC Health Department service area and Indian and non-Indian health resources in order to increase the utilization of such resources that facilitate the reduction of economic and legal barriers to health care for such eligible urban Indians.

ACTIVITY III.1.C: Hire, in conjunction with those activities of III.1.B, additional para-legal services of the Indian Health Liaison Division of the AUIC Health Department which will include the para-legal branch initiated in III.3 FY 81, which includes individual and group counseling sessions in order to reduce economic and legal barriers for urban Indians of the AUIC Health Department service area.

OBJECTIVE III.2: To continue the process of planning as well as to initiate an alternate means of providing special treatment, surgery or other types of medical services/coverage for those urban Indians of the AUIC Health Department service area, once eligible for IHS Contract Health Services, through the Indian Liaison Division of the AUIC Health Department.

ACTIVITY III.2.A: Continue to coordinate with city, state and federal agencies, as identified in III.2, FY 81 program year, and the Indian Liaison Division and the Indian Health Education Division of the AUIC Health Department, those workshops, in-service training programs and referrals in order to continue the utilization of plans, policies and programs by urban Indians of the AUIC Health Department service area.

OBJECTIVE III.3: To expand as well as to continue to utilize the Hospital Procedures and Patient Rights Branch of the Indian Health Liaison Division of the AUIC Health Department which includes legal and para-legal services. This continuation will enable better accessibility to Indian and non-Indian health facilities for urban Indians of the AUIC Health Department service area as well as a better understanding of legal and economic requirements on urban Indians of the AUIC Health Department service area.

ACTIVITY III.3.A: Expand the Patient Rights Branch of the Indian Health Liaison Division of the AUIC Health Department through the purchase and/or employment of legal and para-legal personnel which will assist individuals or groups of urban Indians of Albuquerque in the legal barriers to Indian and non-Indian health facilities.

ACTIVITY III.3.B: Continue to utilize the Patient Rights Branch of the Indian Health Liaison Division in conjunction with the Indian Health Education Division of the AUIC Health Department in designing and implementing workshops and in-service training programs that will result in the better utilization of Indian and non-Indian health facilities as well as the better understanding of those legal and economic barriers to urban Indian health care.

GOAL IV: To continue to plan and initiate an information and referral system between local tribal health departments and the AUIC Health Department as was identified in Goal IV, FY 81 program year.

OBJECTIVE IV.1: Continue the programmatic referral system between participating tribal health departments, service unit health boards, and the AUIC Health Department which will include monthly reviews of follow-up activities and special treatment and emergency health care by all participants of the information and referral system.

ACTIVITY IV.1.A: The CHR Division of the AUIC Health Department will meet with and/or conduct with participating tribal health departments of the Albuquerque Service Unit a programmatic review of the referral system in order to update tribal health data as well as to provide comprehensive health care to urban Indians of the AUIC Health Department service area.

OBJECTIVE IV.2: To make such programmatic referral and review available to other tribes, tribal health departments, service unit boards and inter-tribal organizations and the AUIC Health Department which would include those activities such as monthly reviews, follow-up for special treatment and emergency care and health care services as needed by urban Indians of the AUIC Health Department service area.

ACTIVITY IV.2.A: Make available to tribes, tribal health departments, service unit boards and inter-tribal organizations of New Mexico the FY 81 close-out report which describes the referral system between those participants from the Albuquerque Service Unit and the AUIC Health Department.

ACTIVITY IV.2.B: Through the CHR Division of the AUIC Health Department initiate workshops, in-service training programs and on-site evaluations with those tribes, boards and organizations of New Mexico that could utilize and benefit from such referral system initiated in FY 81 program year.

ACTIVITY IV.2.C: Initiate such programmatic referral systems as established in FY 81 program year between tribes, tribal health departments, service unit boards and inter-tribal organizations of New Mexico and the CHR Division of the AUIC Health Department.

GOAL V: To initiate an urban Indian CHR reporting system into the Data Bank and computer center of the AUIC Health Department and coordinate such system with the CHR Division of the AUIC Health Department which will provide data and information on the AUIC Health Department to the American Indian Health Care Association, Inc., the IHS, and the National CHR Association, Inc.

OBJECTIVE V.1: Based upon the technical assistance provided by those health care agents (mentioned above) as identified in V.2 of FY 81 program year, coordinate such technical assistance with the Indian Health Planning Division and the CHR Division of the AUIC Health Department in order to join and become a part of that national reporting system of tribal and urban CHR program.

ACTIVITY V.1.A: Utilize the technical assistance provided in FY 81 program year, Goal V, and, in conjunction with the CHR Division and the Indian Health Planning Division of the AUIC Health Department, initiate the Indian Data Bank of the AUIC Health Department.

GOAL VI: To be able to initiate those innovative systems of preventive health care into the AUIC Health Department which will include those planned innovative programs, techniques and approaches to preventive health care delivery as identified in Goal VI of FY 81 program year, as well as to continue the process of planning of additional innovative systems of preventive health care based upon the analysis of Indian and non-Indian data and information on urban Indians of Albuquerque.

OBJECTIVE VI.1: To initiate those innovative systems of preventive health care into the Indian Health Education Division of the AUIC Health Department based upon the analysis of Indian and non-Indian preventive health care modules and programs.

ACTIVITY VI.1.A: Make available such innovative systems of preventive health care to urban Indians of the AUIC Health Department service area through the Indian Health Education Division of the AUIC Health Department.

ACTIVITY VI.1.B: Incorporate into those innovative systems of preventive health care, through the coordination of the Indian Health Education Division and the Indian Health Planning Division of the AUIC Health Department, a curriculum of preventive health programs, classes, counselors and assistance in order to meet the health needs of urban Indians of the AUIC Health Department service area.

OBJECTIVE VI.2: To continue the process of planning of innova-
tive systems of preventive health care in order
for the Indian Health Planning Division of the
AUIC Health Department to adequately plan for the utilization of
such data relevant to urban Indian health needs of the AUIC Health
Department service area; such planning of preventive health care
delivery will be coordinated with Indian and non-Indian health re-
sources as well as with those other divisions of the AUIC Health
Department.

ACTIVITY VI.2.A: Plan for those preventive health care programs
based upon data and information received from
and coordinated with Indian and non-Indian
health resources through the cooperative efforts of the Data Bank
and computer center, the Indian Health Planning Division and the
CHR Division of the AUIC Health Department.

ACTIVITY VI.2.B: Utilize in such process of planning for preven-
tive health care programs, Indian and non-Indian
modules designed to meet the health needs of
urban Indians of the AUIC Health Department service area.

GOAL VII: To initiate, into the Indian Health Planning Division
of the AUIC Health Department, the continual process
of planning which will utilize Indian and non-Indian
health resources in the design of alcohol awareness and alcohol
treatment programs for urban Indians of the AUIC Health Department
service area.

OBJECTIVE VII.1: To expand the process of planning of the Indian
Health Planning Division of the AUIC Health De-
partment which will collect, analyze and store
data made available by Indian and non-Indian health resources on
alcohol awareness and alcohol treatment programs for urban Indians
of the AUIC Health Department service area.

ACTIVITY VII.1.A: Hire and provide orientation to additional
Indian health planners into the Indian Health
Planning Division of the AUIC Health Department
who will identify, collect, analyze and store data and information
from Indian and non-Indian alcohol and alcohol abuse programs into
the computer center and Resource Bank of the AUIC Health Depart-
ment.

ACTIVITY VII.1.B: Through the expanded Indian Health Planning
Division of the AUIC Health Department, iden-
tify and coordinate data, information and pro-
gram modules with alcohol and alcohol treatment programs in order
to plan awareness and treatment programs as needed by segments of
the urban Indian population of the AUIC Health Department service
area.

ACTIVITY VII.1.C: Identify and receive assistance from the IHS, NIAAA, etc., in order to adequately plan the utilization of such data, materials, modules, and information that is relevant to the needs of such segments of the urban Indian population, as well as to plan those awareness and treatment programs that will reach the greatest number of urban Indians of the AUIC Health Department service area.

OBJECTIVE VII.2: Through the utilization of the expanded Indian Health Planning Division of the AUIC Health Department and the analysis of such information, data and programs relevant to the health needs of urban Indians of Albuquerque, to prioritize and to plan strategies for the initiation of such alcohol and alcohol-related programs that enhance the recovery rate from alcohol abuse by urban Indians of the AUIC Health Department service area.

ACTIVITY VII.2.A: Coordinate such data, information and programs as identified in VII.1, FY 82 year plan, with those areas of alcohol and alcohol abuse as prioritized by urban Indians of the AUIC service area.

OBJECTIVE VII.2.B: Plan for those alcohol and alcohol-related programs for urban Indians of the AUIC Health Department service area in order to provide treatment, preventive health and health education programs in Albuquerque, New Mexico, short-term care, long-term facility care and AA meetings within the AUIC Health Department service area.

GOAL VIII: To initiate into the Indian Health Planning Division of the AUIC Health Department the continual process of planning which will utilize Indian and non-Indian health resources in the design of stress and hypertension programs for urban Indians of the AUIC Health Department service area.

OBJECTIVE VIII.1. To hire additional planning personnel into the Indian Health Planning Division of the AUIC Health Department which will collect, analyze and store data made available by Indian and non-Indian health resources on stress and hypertension programs for urban Indians of the AUIC Health Department service area.

ACTIVITY VIII.1.A: Hire and provide orientation to additional Indian health planners into the Indian Health Planning Division of the AUIC Health Department, who will identify, collect and store data and information from such Indian and non-Indian stress and hypertension programs into the computer center and Data Bank of the AUIC Health Department.

ACTIVITY VIII.1.B: Through the expanded Indian Health Planning Division of the AUIC Health Department, identify and receive assistance from those health resources and plan stress and hypertension programs that are relevant to the needs of urban Indians of the AUIC Health Department service area.

ACTIVITY VIII.1.C: Through the utilization of all relevant data and information as indicated in VIII.1, FY 82 program year, and the Indian Health Planning Division, coordinate with the Indian Health Education Division of the AUIC Health Department in order to introduce any innovative systems and approaches of preventive health care to urban Indians of the AUIC Health Department service area.

GOAL IX: To initiate into the Indian Health Planning Division of the AUIC Health Department the process of planning a day-care nursery for Indian children up to kindergarten.

OBJECTIVE IX.1: To initiate into the Indian Health Planning Division of the AUIC Health Department additional planning staff which will collect and store data and information made available by Indian and non-Indian health resources in order to propose for an Indian day care and nursery for Indian children up to kindergarten.

ACTIVITY IX.1.A: Hire and provide orientation to additional health planners into the Indian Health Planning Division of the AUIC Health Department who will identify, collect and store data and information from Indian and non-Indian day care and nursery programs.

ACTIVITY IX.1.B: Analyze such data and information by the Indian Health Education Division of the AUIC Health Department in order to plan the curriculum, materials, programs and activities for urban Indian children of the AUIC Health Department service area in those innovative systems to preventive health care.

ACTIVITY IX.1.C: The AUIC Health Department shall propose for day care and nursery for urban Indian children based upon such information of Goal IX, FY 82, program year. Such proposal will include assurances and certifications in order to continue to operate a day care and nursery by the AUIC Health Department.

GOAL X: To be able to submit to the Indian Health Service an update of the Albuquerque Urban Specific Health Plan through the submission of a close-out report for PL 94-437, Title V, FY 82, which would follow the same format as identified in the close-out report for FY 81.

OBJECTIVE X.1: Submit to the IHS a close-out report FY 82 which will include information on the successful achievements of implementing FY 82 programs, a report of problem areas and the impact of the health care delivery system of the AUIC Health Department.

D. Fiscal Year 1983
Oct. 1982 to Sept. 1983

As previously mentioned in the beginning of this chapter, the following two years will include only the goals for those respective years. A more detailed description will be submitted by the AUIC Health Department according to the following schedule:

1. FY 83 -- A detailed scope of work will be submitted as the AUIC close-out report for FY 81.
2. FY 84 -- A detailed scope of work will be submitted as the AUIC close-out report for FY 82.

However, it should be remembered that the goals for FY 83 and FY 84 are subject to change. The following are those goals identified in May, 1979, and projected to 1984.

GOAL I: To continue the process of planning through the AUIC Health Department, Indian Health Planning Division. This will include the ongoing process of planning preventive health care programs. Also, to initiate programmatic changes in ongoing health programs in order to enhance more preventive health care.

GOAL II: To be able to continue as well as to expand the utilization of Indian and non-Indian preventive health resources; this will include the planning and initiation of such innovative programs that are needed by urban Indians of the AUIC Health Department service area.

GOAL III: To be able to continue as well as to expand the AUIC Health Department, Indian Health Liaison Division, in order to assist urban Indians with legal and economic barriers to health care.

GOAL IV: To continue the expansion of the program information and referral system between local tribal health departments and the AUIC Health Department, CHR Division.

GOAL V: To be able to continue the urban Indian CHR reporting system in order to provide data and information on urban Indian health and health-related programs, needs and approaches to preventive health care delivery.

GOAL VI: To be able to continue those health care programs, referrals and services innovatively designed for preventive health care delivery. This would include programs, techniques and approaches based upon the analysis of data, modules, and projects from Indian and non-Indian health resources.

GOAL VII: To continue the process of planning which will utilize Indian and non-Indian resources in the design of alcohol awareness and alcohol treatment programs.

GOAL VIII: To initiate those alcohol awareness programs, classes and meetings that would include the full utilization of Indian and non-Indian health resources with the Indian Health Education Division and the Indian Health Planning Division of the AUIC Health Department.

GOAL IX: To initiate a short-term (post-detoxification) care and counseling program for urban Indians in need of such services. This will include a standard detoxification referral unit, treatment and subsequent counseling programs which will be innovatively designed, systems approaches and environments for Indians of the AUIC Health Department service area.

GOAL X: To continue the process of planning in order to propose for and provide long-term treatment for urban Indians that abuse alcohol. This would include a transition facility, half-way house, or similar facility designed to stimulate the rate of recovery through environmental factors.

GOAL XI: To initiate stress and hypertension programs with emphasis on preventive health care and those treatments relevant to Indian values. These programs will utilize those new and innovative techniques including biofeedback and holistic health as well as those methods that will facilitate the greatest rate of recovery and success.

GOAL XII: To initiate and provide day care and kindergarten for Indian children. This would include a "drop-in center" which will provide free care with structured and unstructured programs and exercises, as well as a certified "kindergarten" which will provide a more structured, designed program for those Indian children going into the first grade.

GOAL XIII: To initiate and provide health education, nutrition education, personal hygiene, etc., programs in an approved curriculum of programs, classes and exercises in conjunction with the day care and kindergarten of the AUIC Health Department.

GOAL XIV: To submit to the IHS an update of the Albuquerque Urban Specific Health Plan through the submission of a close-out report for FY 83.

E. Fiscal Year 1984
Oct. 1983 to Sept. 1984

GOAL I: To continue the process of planning through the AUIC Health Department, Indian Health Planning Division.

- GOAL II: To continue to utilize Indian and non-Indian preventive health resources and incorporate changes, as needed, into the AUIC Health Department.
- GOAL III: To continue the Indian Health Liaison Division of the AUIC Health Department for the reduction of barriers to health care delivery.
- GOAL IV: To continue the program information and referral system between tribes, tribal health departments, service unit boards, inter-tribal organizations and other urban Indian groups and the AUIC Health Department.
- GOAL V: To continue the urban Indian CHR reporting system for the AUIC Health Department through its CHR Division.
- GOAL VI: To continue the innovative design to preventive health care by the AUIC Health Department.
- GOAL VII: To initiate alcohol awareness programs as designed in FY 83 program year by the AUIC Health Department.
- GOAL VIII: To continue the AUIC Health Department short-term care and counseling program by the AUIC Health Department.
- GOAL IX: To initiate long-term care treatment including transition facilities or a half-way house by the AUIC Health Department.
- GOAL X: To continue the stress and hypertension programs by the AUIC Health Department.
- GOAL XI: To continue day care and kindergarten programs for Indian children by the AUIC Health Department.
- GOAL XII: To submit to the IHS the final update of the seven years of Title V, PL 94-437.

VII. FOOTNOTES, BIBLIOGRAPHY, AND QUESTIONNAIRE

A. Footnotes

1. Socioeconomic Indicators, 1975 Estimates, State Planning and Development District III, Middle Rio Grande Council of Governments of New Mexico, June 1978, page 5.
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4. *ibid.*
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6. Health Care Needs of American Indians and Alaskan Natives, USDHEW, Indian Health Service, Office of Research and Development, April, 1979, page I-4.
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8. The Economy 1977, Bank of New Mexico, Bureau of Business and Economic Research, The University of New Mexico, July 1978, page 3.
9. Health Systems Plan, New Mexico Health Systems Agency, 1978, page 18.
10. *ibid.*
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12. *ibid.*, Socioeconomic Indicators, 1975 Estimates, page 11.
13. *ibid.*, page 14.
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17. A Factual Digest, State Planning and Development District No. 3, Middle Rio Grande Council of Governments of New Mexico, November, 1974, page VIII-9.
18. *ibid.*, Albuquerque, Bernalillo County, New Mexico, page IX-1.
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21. *ibid.*, page 10.
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23. *ibid.*, page 5.
24. *ibid.*, page 20.
25. Office of Comprehensive Employment and Technical Assistance, City of Albuquerque, N. M., Albuquerque Urban Indian Center, Inc., August 1978, page 1.
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27. *ibid.*, Health Systems Plan, page 20.
28. *ibid.*, Health Care Needs of American Indians and Alaskan Natives, p. 3.
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30. *ibid.*, page 11.
31. *ibid.*, page 19.
32. *ibid.*
33. *ibid.*, page 21.
34. *ibid.*, page 25.
35. *ibid.*
36. *ibid.*
37. *ibid.*
38. *ibid.*, "A Health Assessment of the Albuquerque Area Off-Reservation Indians," page 3.

39. ibid., Health Care Needs of American Indians and Alaskan Natives, page I-4.
40. Urban Indians, Robert Schultheiss, November 1978, page 41.

B. Bibliography

The sources and references which follow represent those federal, state, county, city, tribal, inter-tribal and Indian and non-Indian documents that were used during the completion and submission of the Albuquerque Urban Indian Center--Urban Specific Health Plan.

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C. Appendix

The Appendix which follows contains the comprehensive health
questionnaire which was administered by the AUIC Health Department.

- (3) For Navajos, the mental disorders rate is approximately 200% greater than the state rate. By combining the two categories of accidents and mental disorders (assuming that alcohol and drug abuse had a significant impact on accidents) for Navajo males, this accounted for 30% of all deaths;
- (4) For Pueblos, the mental disorders rate is approximately 500% greater than the state rate;
- (5) For Apaches, the mental disorders rate is approximately 1100% greater than the state rate.

Therefore, by comparing the leading causes of death among the different ethnic groups to the state of New Mexico, in general, the following health priorities are established:³⁶

New Mexico - Overall

- No. 1 -- Heart Disease
- No. 2 -- Cancer
- No. 3 -- Accidents
- No. 4 -- Cerebrovascular Disease
- No. 5 -- Respiratory Diseases

<u>Anglo New Mexicans</u>	<u>Spanish-American New Mexicans</u>
No. 1 -- Heart Disease	No. 1 -- Heart Disease
No. 2 -- Cancer	No. 2 -- Cancer
No. 3 -- Accidents	No. 3 -- Accidents
No. 4 -- Incomplete Data	No. 4 -- Incomplete Data
No. 5 -- Incomplete Data	No. 5 -- Incomplete Data

Navajo Indians of New Mexico

- No. 1 -- Accidents
- No. 2 -- Respiratory Diseases
- No. 3 -- Mental Disorders
- No. 4 -- Digestive Diseases
- No. 5 -- Incomplete Data

Pueblo Indians of New Mexico

- No. 1 -- Accidents
- No. 2 -- Mental Disorders
- No. 3 -- Respiratory Diseases
- No. 4 -- Digestive Diseases
- No. 5 -- Incomplete Data

Apache Indians of New Mexico

- No. 1 -- Mental Disorders
- No. 2 -- Accidents
- No. 3 -- Digestive Diseases
- No. 4 -- Respiratory Diseases
- No. 5 -- Incomplete Data

Morbidity -- Current accurate morbidity data is largely unavailable for New Mexico. Morbidity, as defined by the New Mexico Health Systems Agency,³⁷ refers to "the number of persons who are diagnosed as having a particular disease." Physicians in New Mexico are not required to report most illnesses; however, there are reporting requirements for diagnosis of communicable diseases.

B. Other Determinants of Health Status

The following information is included in this report in order to adequately describe the health of New Mexicans, without respect to ethnic or racial groups. It must be remembered, however, that there are differences between ethnic groups resulting in a wide variance in leading causes of death.

Both social and physical environments are significant to health status. Aspects of the social environment which influence health status include religious and cultural concepts of health, income and employment patterns, and family characteristics. The physical environment also plays a significant role in determining health status.

Although it is difficult to separate the numerous interrelated elements which comprise the physical environment of New Mexico, eight components have been identified: water, air, housing, food, radiation, biology factors, solid waste, and occupational health.

Priorities have been assigned by the New Mexico Health Systems Agency to environmental problems in New Mexico according to their potential or actual threat to health. The HSA and the sub-area councils in 1977 assigned ratings to various environmental problems. They are, in order of priority:

1. Substandard Housing
2. Water Pollution and Sewage Disposal (tie)
3. Air Pollution
4. Radiation Hazards - Nuclear Waste

Each adult individual has some degree of control over his own health. A person who chooses to smoke, drive while intoxicated, and/or take other risks, is risking his own chances for good health.

In cases of minority/ethnic groups, life styles may vary widely and may play a major role in the structure or future plans of health facilities and systems within the state. That is, eradication of certain diseases, i.e., advanced stages of tuberculosis, are important in New Mexico because of their prevalence among the Indian population.

IV. SUMMARY OF HEALTH SERVICE NEEDS

A. Summary of Needs as Seen by Non-IHS Health Providers and Shown in IHS Data

According to data available from the Public Health Service for the years 1976-78, the primary health needs for the Albuquerque urban Indian population are as follows:

- Respiratory Diseases
- Skin Diseases
- Symptoms and Ill Defined Diseases
- Infective and Parasitic Diseases
- Injuries (from accidents)
- Eye Diseases
- Pregnancy and Childbirth
- Ear Diseases
- Circulatory Diseases
- Endocrine and Nutritional

This information is presented on the following page, broken into three areas--Ambulatory, Out-Patient, and In-Patient, for three years: 1976, 1977, and 1978. Data are presented by per cent of total services provided within each year. The last year, Mental Disorders includes Alcoholism and Drug Abuse related problems. The final column presents, for each need, the average of the percentage of total services provided for all three years for all categories.

PERCENT OF TOTAL
PRIMARY HEALTH SERVICES
PROVIDED BY
PUBLIC HEALTH SERVICE
FOR
ALBUQUERQUE URBAN INDIANS
1976-1978

HEALTH NEED	AMBULATORY			OUT-PATIENT			IN-PATIENT			AVERAGE ALL CATEGORIES
	1976	1977	1978	1976	1977	1978	1976	1977	1978	1976-1978
Respiratory Diseases	19.0%	19.5%	18.1%	8.3%	2.5%	1.5%	33.5%	5.9%	5.6%	12.7%
Injuries	5.1%	4.1%	3.8%	7.8%	11.9%	10.1%	18.0%	11.4%	11.9%	9.3%
Skin Diseases	8.2%	8.0%	8.1%	1.0%	10.6%	.4%	-	-	8.5%	6.4%
Symptoms and Ill Defined Diseases	6.9%	4.7%	4.5%	.5%	2.4%	4.3%*	4.2%	2.3%	2.5%	3.6%
Endocrine and Nutritional Diseases	2.5%	2.7%	4.1%*	-	1.8%	3.3%*	-	-	8.5%	3.8%
Eye Diseases	4.7%	4.2%	4.4%	4.9%	11.6%	28.8%*	-	-	-	9.8%
Infective and Parasitic Diseases	5.4%	4.8%	3.9%	-	.6%	2.4%*	2.4%	2.3%	1.6%	2.9%
Ear Diseases	3.6%	4.0%	4.4%	2.0%	3.8%	2.9%	1.8%	2.7%	1.3%	2.9%
Circulatory Diseases	3.1%	4.0%	3.9%	-	-	-	1.8%	.5%	2.5%	2.6%
Pregnancy and Childbirth	3.8%	4.0%	5.7%*	9.8%	7.3%	10.0%*	33.5%	44.1%	42.8%	17.9%
Digestive System Diseases	-	-	-	-	8.8%	-	7.2%	9.1%	9.4%	8.6%
Disease of Female Genitalia	-	-	-	-	8.5%	7.8%	1.8%	6.4%	4.7%	5.8%
Urinary Disorder	-	-	-	-	-	-	1.2%	2.3%	1.3%	1.6%
Mental Disorders	-	-	-	-	-	-	-	-	6.3%	6.3%

* Categories showing a large increase in 1978.

Areas of service provided which have stayed nearly the same or increased from 1976 to 1978 are summarized in the following table. It should be noted that Ambulatory and Out-Patient figures are derived from Indian Health Service (IHS) figures, while In-Patient figures are direct from contract health services provided from Public Health Service (PHS).

Service Needs Which Have
Remained the Same or Increased
from 1976 to 1978

<u>Ambulatory</u>	<u>Out-Patient</u>	<u>In-Patient</u>
1. Endocrine-Nutritional Diseases	1. Symptoms and Ill Defined Diseases	1. Injuries
2. Ear Diseases	2. Endocrine-Nutritional Diseases	2. Endocrine-Nutritional Diseases
3. Pregnancy and Childbirth	3. Eye Diseases	3. Circulatory Diseases
4. Skin Diseases	4. Infective and Parasitic	4. Digestive System
5. Eye Diseases	5. Pregnancy and Childbirth	5. Symptoms and Ill Defined Diseases
6. Circulatory Diseases		6. Pregnancy and Childbirth
		7. Diseases of Female Genitalia
		8. Mental Disorders

The above table shows only the types of treatments which have INCREASED OR STAYED ABOUT THE SAME for the last three years, while the following table indicates the five areas of treatment which accounted for the GREATEST PERCENTAGE OF TOTAL SERVICES provided in each area.

Service Needs Which Show
the Greatest Percentage of the Total Services
Provided from 1976 to 1978

<u>Ambulatory</u>	<u>Out-Patient</u>	<u>In-Patient</u>
1. Respiratory Diseases	1. Respiratory Diseases	1. Pregnancy and Childbirth
2. Skin Diseases	2. Eye Diseases	2. Injuries Related to Accidents
3. Symptoms and Ill Defined Diseases	3. Pregnancy and Childbirth	3. Digestive System
4. Infective and Parasitic Diseases	4. Injuries Related to Accidents	4. Respiratory Diseases
5. Pregnancy and Childbirth	5. Diseases of Female Genitalia	5. Diseases of Female Genitalia

A 1976 study by the New Mexico Health Education Coalition³⁸ generally suggests the same information, listing the following areas of service priority:

1. Diseases of the Respiratory System
2. Accidental Injuries
3. Pregnancy and Childbirth
4. Infective and Parasitic Diseases
5. Skin Diseases
6. Diseases of the Digestive System
7. Mental Disorders and Alcoholism
8. Ear Diseases

This information was gathered from unspecified "Health Providers" in Albuquerque, including, but not limited to, IHS.

In May of 1979, opinions were offered by three Assistant Administrators and one medical records person representing four Albuquerque medical facilities--Bernalillo County Medical Center, Lovelace-Bataan Medical Center, Presbyterian Hospital, and St. Joseph's Hospital. These persons were asked to indicate what they considered to be the greatest areas of health need among the Albuquerque Indian population. With the exception of alcoholism, which was mentioned by two persons, each of the following was noted once:

- Alcoholism
- Malnutrition
- General Infections
- Accidents
- Delivery (Parturition)
- Prenatal Care
- Surgery

All needs except Malnutrition and Surgery are specifically mentioned among the top ten in the other surveys referenced in this report.

It should be mentioned that the responses listed immediately above are not based on definitive data.

B. Needs Data Identified by AUIC

During February, March, and April, 1979, the Health Department of the Albuquerque Urban Indian Center (AUIC) designed and administered a comprehensive health questionnaire (see Appendix).

A total of 218 questionnaires were processed and analyzed; they represented a total of 536 people. In all cases, all valid responses are reported.

This section of the Albuquerque Urban Specific Health Plan will summarize the data from the questionnaires. Nine subsections related to IHS requirements for an Urban Specific Health Plan will be addressed:

1. Age and Sex Distribution
2. Family Size
3. Disease Incidence and Major Health Problems
4. Traditional Medicine
5. Migration
6. Housing
7. Educational Status
8. Transportation
9. Employment

Additionally, four other areas identified by AUIC will be discussed:

1. Tribal Distribution
2. Alcoholism
3. Income
4. Use of Health Insurance and Contract Health Care

Age and Sex Distribution -- The age and sex distribution of the sampled population is shown below:

<u>Age Distribution</u>		<u>Sex Distribution</u>	
0-14	34%		
15-29	33%	Female	48%
30-49	25%	Male	52%
50 & over	8%		

Family Size -- "Family" in this instance is defined as those people living together in one household. The urban Indian questionnaire showed that the average family size of those interviewed was four people.

Disease Incidence and Major Health Problems -- Seventeen questions were asked concerning health problems and disease incidence. These 17 specific questions were grouped to facilitate analysis into five general questions:

1. How do Albuquerque Indians react to illness?
2. What are the most common diseases reported by Albuquerque Indians?
3. How are health needs ranked by Albuquerque Indians?
4. What are the greatest barriers to health care for Albuquerque Indians?
5. What are implications of changes in contract health eligibility?

HOW DO ALBUQUERQUE INDIANS REACT TO ILLNESS?

When there is an illness in the family, 48% of the people surveyed indicated they would go first to the Indian Health Service, Albuquerque, New Mexico, for treatment. Six other places were indicated as places for treatment:

Anna Kaseman -----	18%
Family doctor (non-PHS) -----	11%
Bernalillo County Medical Center ---	8%
St. Joseph's -----	4%
Lovelace-Bataan -----	3%
Presbyterian -----	1%

Of the people who indicated they would go to IHS, most (71) said they had used IHS within the last year and 29 indicated they had not used IHS within the last year.

WHAT ARE THE MOST COMMON DISEASES REPORTED BY ALBUQUERQUE INDIANS?

Respiratory infections, colds and/or sore throats are listed as the most common type of illness. Earaches, or otitis media, was listed as second in occurring illnesses. Vomiting, diarrhea, or other gastro-intestinal disease was also mentioned as a reoccurring health concern, as well as injury or trauma.

HOW ARE HEALTH NEEDS RANKED BY ALBUQUERQUE INDIANS?

In ranking the health needs for Albuquerque Indians, the following list, from most to least important, was compiled:

1. Alcoholism or drug abuse
2. Preventive medical care
3. Social service (financial assistance)
4. Elderly people's special problems
5. Maternity and infant care
6. General health care
7. Mental health (except alcohol)

WHAT ARE THE GREATEST BARRIERS TO HEALTH CARE FOR ALBUQUERQUE INDIANS?

Language does not appear to be a major barrier to receiving health care. Fifty-one percent of the respondents indicated they spoke English all of the time as a primary language in the home, 35% indicated they spoke English most of the time, and 13% said they spoke English some of the time. Only three respondents (1%) indicated they needed a translator when obtaining health services.

Financial problems appear to exist in obtaining health care. Fifty-six percent of the survey indicated cost was a problem, while 44% said cost was not a problem in obtaining health services. Health insurance, for those who had it, was only used by 20% of the respondents.

WHAT ARE THE IMPLICATIONS OF CHANGES IN CONTRACT HEALTH ELIGIBILITY?

Contract care was received by 43% of the respondents, with 57% indicating they have not received contract health care in the past. The new rules and regulations of eligibility were known by only 35% of the survey, with 65% indicating they were unaware of the new developments. Forty-four percent of the survey said they did have other financial resources for payment of health services, which 56% indicated they did not. Of these 56%, 23% without insurance said they would assume financial responsibility for care which IHS would not provide, 30% would assume financial responsibility with insurance, 8% would not receive the needed medical attention, and 40% said they did not know what they would do if they needed medical care which IHS would not provide.

The need for glasses or contacts was high, with 79% of the survey indicating someone in the household uses one or the other and 21% indicating there was no need for either glasses or contacts. Only 7% said a problem with an eye disease existed in the household, 93% indicating there existed no problems in this area. Of these problems, two persons were listed as having cataracts, four persons with diabetic cataracts or retinopathy, one person with glaucoma, and seven persons with other eye diseases.

Dental care seems to be a problem, with 76% of the responses indicating a need for dental care and 66% saying the price of dental care was a problem. There were many "no responses" to this issue.

Traditional Medicine -- Two questions were asked relative to traditional medicine as it is used by urban Indians. Results showed that nearly half (44%) of the respondents use tribal medicine men. Within the last year, 23% of those returning to the reservation or Indian community for health care went primarily because they wanted the services of a medicine man.

Migration -- It is difficult to identify migration patterns with a one-time administration of a questionnaire. Seven questions were asked relative to migration in an attempt to determine movement into and from Albuquerque. Further, reasons for movement were identified. Results are summarized below.

The population is distributed by quadrant of the city as follows:

Southwest	----	16.2%
Northwest	----	21.6%
Southeast	----	29.4%
Northeast	----	32.8%

General trends within the population include:

- 77% of the population have lived on a reservation or in an Indian community
 - 43% lived on a reservation more than five years ago
 - 20% lived on a reservation one to five years ago
- 44% of the sample moved to seek educational opportunities
 - 36% of the sample moved to seek employment opportunities
 - 15% of the sample moved for personal or family reasons
- 47% of the sample has lived in Albuquerque more than five years
 - 33% of the sample has lived in Albuquerque one to five years
- 33% of the sample has lived at the same address more than five years
 - 32% of the sample has lived at the same address one to five years
 - 22% of the sample has lived at the same address six months or less
- 66% of the sample does not plan to leave Albuquerque within the next six months
- The sample is evenly divided between people who will not, and are not sure if they will, stay in Albuquerque

Housing -- Since most housing to be discussed is within the city limits of Albuquerque, certain standards are met, i.e., indoor plumbing is the rule rather than the exception.

It was found that 44% of the population surveyed owned their own homes. Further, over 60% of the population live in the Heights section of the city, which includes apartments and middle to upper income housing.

Educational Status -- Educational level attained was divided according to ten categories. Results are shown below:

1. Less than kindergarten -----	1.7%
2. Kindergarten through sixth grade -----	22.0%
3. Seventh through ninth grade -----	6.2%
4. Tenth through high school (no diploma) ----	23.3%
5. High school diploma or GED -----	12.3%
6. AA degree or 2 years of college -----	8.2%
7. Bachelor's degree -----	12.3%
8. Master's degree -----	4.3%
9. Doctorate degree -----	.6%
10. Technical certificate or license -----	5.0%
11. Other -----	4.1%

Current status of students was determined also. Twenty-five percent of the respondents included in the study are full-time students. Types of schools being attended and the per cent of students attending each included:

1. high school -----	6%
2. trade or technical school -----	21%
3. college -----	16%

Transportation -- Two questions were asked relative to transportation. Answers are summarized below by question.

WHEN GOING TO AND FROM A HEALTH CARE FACILITY, WHICH FORM OF TRANSPORTATION DO YOU USE MOST OFTEN?

<u>79.0%</u> YOUR CAR	<u>1.0%</u> TAXI
<u>5.0%</u> BUS	<u>.5%</u> TRANSPORTATION SERVICE (E.G. ELDER CARE)
<u>.5%</u> WALK	<u>9.0%</u> COMBINATION
<u>5.0%</u> OTHER'S CAR	

HOW LONG DOES IT TAKE YOU TO GET TO THE HEALTH FACILITY YOU USUALLY USE?

<u>77%</u> LESS THAN 30 MINUTES
<u>19%</u> 30-60 MINUTES
<u>4%</u> MORE THAN 60 MINUTES

Employment -- Employment was divided into three categories. Those categories and the percentages of respondents in each category included:

	<u>Total Respondents</u>	<u>Total Respondents to Questions</u>
1. Unskilled	6%	15%
2. Skilled	21%	49%
3. Professional	16%	37%

It can be seen that 86% of the question respondents are employed in either skilled or professional positions. Income information by category was shown to be:

<u>Income</u>	<u>Percent of Respondents</u>
0 - 2,999	7%
2,000 - 5,999	8%
6,000 - 8,999	16%
9,000 - 11,999	10%
12,000 - 14,999	13%
15,000 - 17,999	7%
Over 18,000	12%
Don't know or do not wish to answer	6%
Blank	13%

Tribal Distribution -- The tribal distribution seen within the questionnaires was shown to be:

Canoncito, Navajo -----	0.0%
Isleta Pueblo -----	3.2%
Sandia Pueblo -----	.4%
Santa Ana, Jemez, Zia Pueblo -----	4.6%
Other Pueblos (non-Hopi) -----	25.1%
Navajo (non-Canoncito) -----	31.1%
Jicarilla or Mescalero or Apache---	4.6%
Other Tribes -----	25.3%
Non-Indian -----	5.7%

These results compare favorably with information collected earlier by AUIC. That is, 33.3% of Albuquerque's urban Indians are Pueblo and 31.1% are Navajo. Less than 8.2% of the total population is eligible for contract health care since eligible people must be from Isleta Pueblo, Sandia Pueblo, or Zia Pueblo. Sixty-nine percent of the total urban population is from New Mexico or the eastern Arizona Navajo reservation, however.

Because of the high number of tribal members in the Southwest, especially Pueblo and Navajo who use their own languages, several questions were asked regarding language usage. It was found that:

1. English is used as the primary language in homes surveyed:

51% all of the time
 35% most of the time
 13% some of the time
 1% none of the time

2. A Tiwa translator is needed for one respondent, no Keres or Tewa translators are needed, and translators are needed for other languages by only two respondents.

Alcoholism -- Because of the high incidence of alcohol-related problems among Indian people, several questions were asked related to drug and alcohol use. Data analysis showed that in approximately one-fourth (22%) of the families surveyed there had been a person with drug or alcohol-related problems within the past year. These people are described on the charts below.

Characteristics of Family Members
with Drug or Alcohol Problems

Sex	Age	Problem
Male ----- 88%	Under 15 ----- 33%	Alcohol ----- 86%
Female ----- 12%	15-18 ----- 6%	Drugs ----- 2%
	19-20 ----- 4%	Both ----- 12%
	21-35 ----- 38%	
	36-50 ----- 12%	
	Over 50 ----- 8%	

Eighty-one percent of the respondents reported that, on a daily basis, no member of the household has at least one drink. Of the remaining respondents, 78% have fewer than three drinks daily.

Forty percent of those interviewed do know a person in Albuquerque with a drinking or drug problem. These people are described in the charts below, and are similar to those described above.

Characteristics of Non-Family Members
with Drug or Alcohol Problems

Sex	Age	Problem
Male ----- 88%	Under 15 ----- 1%	Alcohol ----- 66%
Female ----- 12%	15-18 ----- 10%	Drugs ----- 6%
	19-20 ----- 10%	Both ----- 28%
	21-35 ----- 53%	
	36-50 ----- 19%	
	Over 50 ----- 7%	

Over half (66.5%) of those responding to the questionnaire did not respond to a question concerning alcoholism treatment facilities. Of those who did respond, care had been received from:

Alcoholic Treatment Program -----	7%
Star Lodge -----	10%
Turquoise Lodge -----	0%
Public Health Service -----	14%
Vista Sandia -----	0%
Alcoholics Anonymous -----	14%
Other -----	7%
Combination of above -----	48%

If people answering the questionnaire could identify a family member with an alcohol problem, they were asked to answer some specific questions about that person's drinking habits. The MAST questionnaire was used and includes 27 yes/no questions. A total of 38 MAST questionnaires was completed. Respondents answered the questions for themselves OR for the person in their family who has (or had) a drinking problem. The figures below are percentages of the 38 respondents. Answers to eight questions are of particular interest and are summarized below.

Do you feel you are a normal drinker?	Yes--62%	No--38%
Have you ever awakened in the morning after some drinking the night before and found that you could not remember a part of the evening?	Yes--79%	No--21%
Do you ever drink in the morning?	Yes--66%	No--34%
Does any family member ever worry or complain about the drinking?	Yes--97%	No--3%
Do friends or relatives think you are a normal drinker?	Yes--37%	No--63%
Has drinking ever created problems between you and any family members?	Yes--79%	No--21%
Has any family member ever gone to anyone for help about the drinking?	Yes--62%	No--38%
Have you ever gone to anyone for help about drinking?	Yes--63%	No--37%

An examination of these questions presents a picture of the urban Indian "problem drinker," in addition to what has been noted in the previous pages. These points include opinions of the drinker about him/herself and opinions of the drinker about other's views of him/her. It can be seen that over half of the respondents drink in the morning, have blacked out after drinking, or consider themselves normal drinkers. Also, over half of the respondents have tried to get help to deal with their drinking.

The remaining questions present a picture of the drinker's family's view of the drinker. Family members generally worry or complain about the drinking, and friends or relatives often do NOT think the drinker is a "normal drinker." More than three-fourths (79%) of the respondents noted that drinking has caused problems with family members. Approximately two-thirds of the families being discussed have gone to someone for help with the drinking problem. This is the same number of respondents which have sought help about drinking.

Income -- The breakdown of incomes reported on the questionnaires has already been presented on page 31. Approximately 40% of the population makes between \$6,000 and \$14,999. Fifteen percent of the population had an income last year of less than \$5,999.

Cost is a problem in obtaining medical care for 56% of those interviewed.

Ninety percent of the respondents noted that they were not disabled or handicapped.

Use of Health Insurance and Contract Health Care -- Survey respondents were asked whether family members were covered under any type of health insurance. Eighty-eight percent of the people represented in the survey are covered by health insurance of some type. Types of insurance include:

Group Insurance	-----	45%
Private Insurance	-----	6%
Veterans Benefits	-----	1%
Medicare/Medicaid	-----	2%
Combination of above	-----	31%
Other	-----	14%

Although many people have health insurance:

- 80% of the respondents have not used it although 58% of these have needed it.
- 15% of the respondents needing it do not know how to use it.

Approximately half of those interviewed (48%) have heard of private groups with pre-paid health care. Further:

- 66% of the respondents are interested in learning more about these plans.
- 82% of the respondents are or might be interested in participating in a group for which they were eligible.

It is interesting that nearly half (41%) of the families surveyed noted that a family member HAD served in the military. Only one-third (35%) of these had received care at a Veterans Administration Hospital, however; this is in spite of the fact that only 13% of those receiving VA care were not satisfied with the services received.

Approximately half of the population (43%) surveyed has received contract health care in the past. Sixty-five percent of the respondents were UNAWARE of the new rules and regulations of eligibility. Further, over half (56%) of the questionnaires noted that people had no other financial resources for payment of health services. For these people who have no other resources:

- 23% will assume financial responsibility without insurance.
- 30% will assume financial responsibility with insurance.
- 8% will decrease the amount of health care received.
- 40% don't know what they will do.

C. Growth Trends for Albuquerque Urban Indians

In attempting to calculate growth trends for the Albuquerque urban Indian population, population information has been drawn from several sources--the Bureau of Business Research, regular census figures, and the Indian Health Service, Office of Research and Development. These sources report the following:

<u>Year</u>	<u>Bernalillo County Population</u>	<u>Percent Difference</u>	<u>City of Albuquerque Population</u>	<u>Percent Difference</u>
1960	262,199	---	201,189	---
1970	315,774	+20%	245,751	+22%
*1975	362,100	+15%	279,401	+14%

*Taken from the Bureau of Business Research, while all others are from the standard census.

It should be noted that actual percent of growth for Bernalillo County and Albuquerque are very close for each of the two periods mentioned. If one can assume that general growth trends will continue to be similar for the county and Albuquerque, the following table would result, using figures as projected by the Bureau of Business Research for Bernalillo County. A 10% growth figure is used for Albuquerque.

Projected Population

<u>Year</u>	<u>Bernalillo County Population</u>	<u>Percent Change</u>	<u>City of Albuquerque Population</u>	<u>Percent Change</u>
1980	402,900	+11%	307,341	+10%
1985	449,500	+12%	338,075	+10%
1990	496,500	+10%	371,883	+10%
*1995	545,600	+10%	409,071	+10%
*2000	600,160	+10%	449,978	+10%

*1995 and 2000 figures are calculated at 10% over a five-year period.

Based on available figures from the Bureau of Business Research and Albuquerque Public Schools, the urban Indian population is approximately 4% of the total population. This figure has been used to determine the future minimum Indian population of Albuquerque. Trend analyses are shown below from 1960 through 2000.

<u>Year</u>	<u>City of Albuquerque Population</u>	<u>Number of Indians</u>
1960	201,189	8,048
1965	223,320*	8,933
1970	245,751	9,830
1975	279,401	11,176
1980	307,341	12,294
1985	338,075	13,523
1990	371,883	14,875
1995	409,071	16,363
2000	449,978	17,999

*Extrapolated using average growth of 11%.

V. BARRIERS TO THE DELIVERY OF HEALTH CARE IN ALBUQUERQUE, NEW MEXICO

This section of the Albuquerque Urban Specific Health Plan has been written, based upon the agreement with the IHS Albuquerque Area Office, in order to give a more accurate report of the status of health care delivery for Indians in Albuquerque.

By submitting this section as part of the Plan rather than as an Appendix, the reader's attention is drawn to the fact that barriers experienced on a program level have a definite, measurable impact on the delivery of health services. Also, barriers experienced on a tribal level may differ from those experienced on an urban level.

The structure of a health care program should reflect the needs and values of the Indian people that it is designed to serve. The AUIC Board of Directors is sometimes forced to make decisions for its programs that are based on the needs of the Indian people to be served and not on the rules of a funding agency. However, there are situations (or barriers) that occur which cause a program to be threatened with termination due to the program addressing the needs of the people and not the priorities of a funding agency. Therefore, it can be stated that a barrier to health care delivery is pre-assigned priorities rather than priorities due to programmatic needs.

Indian people are moving to Albuquerque from New Mexico reservations. This results in a barrier to health care delivery due to the inability of tribal and urban Indian programs to build "bridges" between the two types of service programs. There is no established mechanism that enables urban Indian programs to find and assist tribal members leaving the reservation and moving to Albuquerque. Even transferring medical records can be a problem in receiving optimum health care.

Although IHS has established a medical facility in Albuquerque (PHS Indian Hospital), there still exist several barriers to health services to people who use this facility. These include:

1. The Albuquerque PHS Indian Hospital is not a full-service hospital;
2. The Albuquerque PHS Indian Hospital provides no contract health services to Indians not meeting the IHS defined eligibility requirement;

3. The Albuquerque PHS Indian Hospital can provide service in the areas of: general in-patient, general out-patient, and social services; specialized services, i.e., surgery and parturition, cannot be offered. This causes a barrier to the more than 90% of urban Indians who are not eligible for contract health care.

Throughout the past twenty years, IHS has concentrated on the improvement of health, medical and social services to Indian people, and with the creation of PL 93-638 and PL 94-437 the tasks of IHS were more defined. However, only one part of PL 94-437 and none of PL 93-638 were addressed to the urban Indian populations. Approximately 50% of all Indians do not live on a reservation;³⁹ however, there are only 41 IHS funded urban projects which share approximately \$7.25 million, compared to the tremendous amount of funds allocated for the 50% of the Indian population still on the reservation.

Another barrier to health care delivery is in the utilization of medical pre-paid plans for special groups. These plans have had very little utilization by urban Indians. This is due to the fact that many are from reservation areas where needs can more easily be met by IHS. Further, pre-paid plans have not been extensively advertised and, in Albuquerque, there has not been a logical sponsor for such a plan.

Unlike other racial and ethnic minorities, urban Indians do not tend to reside in any one particular area of the city but are dispersed throughout the urban area. It has been stated that it is hard to count, query or even find city Indians.⁴⁰

Community health centers generally serve a specific geographic area of the city and design their services for a particular population, usually only a small number of whom are Indian. Because urban Indians are not "ghettoized," they are often at a disadvantage when compared to other ethnic groups that are ghettoized because finding them is difficult in terms of providing a centralized facility.

The lack of transportation for urban Indians may be a barrier to health care. This would include situations where Indian families have a car, but it is used for work or work-related purposes, and is not available during working hours.

Because of the notable lack of advocates of Indian health care in urban areas, urban Indians are often not informed of available services or are unaware of the changes in regulations which affect the delivery of health services. Even when urban Indians are aware of existing services, they are unfamiliar with the non-IHS health care system and how to use it.

Even in areas where IHS/PHS facilities do exist, such as Albuquerque, there continue to be problems due to the lack of special treatment and uniformity throughout the IHS Hospital/Clinic systems. That is, people changing from a reservation clinic to the Albuquerque Indian Hospital would find differences in procedures, even though both facilities are operated by the same agency.

On August 4, 1978, the Indian Health Service issued regulation changes for Contract Health Services (CHS) to become effective on February 1, 1979. The purpose of the new regulations was to provide uniformity in CHS. However, the eligibility requirement incorporated in the regulations means most urban Indians are ineligible for CHS. This causes confusion among urban Indians due to the fact that according to the AUIC Health Needs Assessment 65% of the survey respondents were unaware of the new rules and regulations of eligibility.

When IHS placed eligibility requirements on the delivery of CHS, it automatically created another barrier to the delivery of some types of health care to urban Indians. However, it has not only created a bureaucratic barrier to health care, it has also placed a financial barrier on the state or city governments, or on the individuals themselves. Fifty-six percent of the AUIC health survey respondents do not have other financial resources for payment of health services.

The migration of people from different tribes and backgrounds into any urban area may cause barriers to health care because health providers are not cognizant of differences. For example, services may differ from place to place. Further, Albuquerque Indian Hospital staff represent a number of tribes, while most reservation clinics are staffed by local people.

Some private providers and general medical facilities assume IHS will reimburse their service only to find out their urban Indian patients ineligible for third party billing, Contract Health Services or some other form of reimbursement and may refuse further treatment to Indian patients. Although medical facilities are mandated by their code of ethics to provide medical treatment regardless of the clients' paying abilities, this is not always the case. Indian patients, therefore, may face circumstances created from the simple fact of being Indian and poor.

Whether discrimination is actually practiced against or only perceived by urban Indians, the consequence is the same--negative health care experiences. This discrimination has caused difficulties in the delivery of health care due to Indians believing that it is easier to obtain medical care if one is non-Indian. An important conclusion is that some Indians may not seek health care from existing providers in order to avoid unpleasant experiences.

Primary among the barriers Indian people face in the utilization of existing health care services are cultural differences. Included in this category are communication and religious differences which do cause barriers to health care delivery. Providers, even IHS providers, expect Indian clients to quickly communicate their health problems and may become frustrated with the apparent vague answers they receive. Providers who attempt to treat Indian patients must consider cultural and religious practices of the people if the treatment schedule is to be followed successfully.

VI. GOALS AND OBJECTIVES AND ACTIVITIES

A. Introduction

The last chapter of the Albuquerque Urban Specific Health Plan presents the goals and objectives of the AUIC Health Department for FY 81 through FY 84. At this time, it is important to note that the first two years of the plan (FY 81 and FY 82) are described in detail; however, the final two years (FY 83 and FY 84) have been described in much less detail because of the time frame of this plan.

In May, 1979, this plan is being submitted to the Indian Health Service; its purpose is to describe and design those health care programs from 1981 to 1984--some two to six years in advance--for Albuquerque, New Mexico. Therefore, the final two years have not received in-depth development due to the almost certain task of revisions and expansions in two, three, or four years from now.

B. Fiscal Year 1981 Oct. 1980 to Sept. 1981

GOAL I: To initiate an ongoing process of planning through an Indian Health Planning Division of the AUIC Health Department, the results of which will be a more comprehensive urban Indian health care delivery system (direct or indirect) as stipulated under Title V, PL 94-437, Part I.

OBJECTIVE I.1: To hire an Indian Health Planning staff who will be able to analyze health data and initiate health or health related programs based upon the needs of urban Indians of the AUIC Health Department delivery area, and incorporate such programs as a part of the health care delivery system of the AUIC Health Department, i.e., CHR Division.

ACTIVITY I.1.A: Hire and provide orientation to the Health Planning Division of the AUIC Health Department.

ACTIVITY I.1.B: Identify sources of health data (either primary or secondary) and analyze such data that will enable the AUIC Health Department to plan for the initiation of health programs and services as indicated by such data and input from urban Indians of the AUIC Health Department service area.

ACTIVITY I.1.C: Collect and computerize data from Indian and non-Indian health facilities which will be utilized in planning and assisting the other Divisions of the AUIC Health Department in expanding its health programs in order to meet the needs of urban Indians in the AUIC service area.

GOAL II: To be able to continue as well as plan for a more comprehensive utilization of health resources between Indian and non-Indian health facilities and the AUIC Health Department, the results of which will encourage better health care for urban Indians due to designing the incorporation of preventive health care delivery into the AUIC Health Department.

OBJECTIVE II.1: To hire an Indian Health Education Division of the AUIC Health Department which will assess the current Indian and non-Indian health care systems of the AUIC service area and plan the utilization of such systems through a preventive health care delivery approach to the health needs of the AUIC Health Department service population.

ACTIVITY II.1.A: Hire and provide orientation to an Indian Health Education Division within the AUIC Health Department that would collect and become assimilated with Indian and non-Indian health education materials, information and programs in those health and health-related areas as identified by the service population of the AUIC Health Department as being necessary in the design of a preventive health care delivery system.

ACTIVITY II.1.B: Coordinate such information collected in II.1.A with the Health Planning Division of the AUIC Health Department as well as those Indian and non-Indian health facilities as are needed in order to incorporate preventive health care into the AUIC Health Department delivery system.

ACTIVITY II.1.C: Through the utilization of the CHR Division of the AUIC Health Department as well as the Indian Health Education Division make available to urban Indians, a series of structured programs, classes, workshops, resources, materials, etc., in order to facilitate preventive health care programs and services cognizant with urban Indian needs of the AUIC service area.

GOAL III: To be able to plan for the additional utilization of health resources between Indian and non-Indian health facilities, and individuals and groups of urban Indians through AUIC Health Department. This would provide for the improvement of health care through individualized representation and counseling.

OBJECTIVE III.1: To hire an Indian Health Liaison Division within the AUIC Health Department which would assist urban Indians with legal and economic barriers caused by the non-utilization of available health resources.

ACTIVITY III.1.A: Hire and provide orientation to an Indian Health Liaison Division within the AUIC Health Department which would promote the comprehensive utilization of available health resources in order to facilitate better individual health care and protection against legal and economic problems.

ACTIVITY III.1.B: Plan and promote workshops, in-service training programs and on-site evaluations between urban Indian groups and individuals, and health resources in order to initiate a uniform system of health care delivery for urban Indians of the AUIC service area.

OBJECTIVE III.2: To include within the Health Liaison Division of the AUIC Health Department the process of planning and initiating an alternate means of providing special treatment, surgery or other types of medical services/coverage for those urban Indians of Albuquerque once eligible for IHS Contract Health Services. This would enable better health care due to better utilization of alternative resources available to the AUIC Health Department.

ACTIVITY III.2.A: Through the Indian Health Liaison Division of the AUIC Health Department coordinate with the proper city, state and federal agencies (i.e., HSA, Gov. Health Plans, insurance companies, etc.) for the utilization of plans, policies and programs by those eligible urban Indians of the AUIC Health Department service area.

ACTIVITY III.2.B: In conjunction with the Indian Health Education Division of the AUIC Health Department, the Indian Health Liaison Division will cooperate in the design and implementation of workshops, in-service training programs and referrals in order to upgrade the utilization of alternative means of providing comprehensive preventive health care delivery for urban Indians of the AUIC Health Department service area.

OBJECTIVE III.3: To include within the Health Liaison Division of the AUIC Health Department a Hospital Procedures and Patient Rights Branch which will involve legal and para-legal services, the results of which will be a better utilization of health facilities by urban Indians of the AUIC service area due to better understanding of Indian customs and non-Indian procedures.

ACTIVITY III.3.A: Hire and provide orientation to the Patient Rights Branch of the AUIC Health Department through the purchase of legal counsel and para-legal personnel which will provide a health-related program designed to enhance more utilization of non-IHS facilities by urban Indians of the AUIC Health Department service area.

ACTIVITY III.3.B: In conjunction with the Indian Health Education Division of the AUIC Health Department, the Patient Rights Branch of the Indian Health Liaison Division will cooperate in the design and implementation of workshops, in-service training programs, group sessions and individual counseling sessions in order to upgrade the utilization of Indian and non-Indian health care facilities through a better understanding of legal and economic requirements by urban Indians of the AUIC Health Department service area.

GOAL IV: To be able to plan and initiate an information flow system through programmatic referrals between local tribal health departments and the AUIC Health Department which will enable the local tribal health departments to update tribal health data as well as to assist the AUIC Health Department in providing comprehensive health care to urban Indians of the AUIC Health Department service area.

OBJECTIVE IV.1: To hire into the Indian Health Liaison Division of the AUIC Health Department a branch which will plan and initiate a referral system between local tribal health departments and the CHR Division of the AUIC Health Department, the result of which will be the reduction of lost health care as well as to insure the continuation of health care for Indians moving into or out of the AUIC service area.

ACTIVITY IV.1.A: Hire and provide orientation to an Indian Health Liaison Division which will be conducted through a series of in-service workshops with participating tribal health departments and Service Unit Health Boards. This will enable a common understanding and full utilization of both Indian and non-Indian health care systems.

ACTIVITY IV.1.B: The Indian Health Liaison Division of the AUIC Health Department, in conjunction with tribal health departments, will provide a series of workshops, in-service training programs and on-site evaluations for both tribal and urban CHR Divisions, and tribal and urban Indian health administrations, councils and boards. This will enable full understanding and utilization of a programmatic health referral system between tribal participants of the Albuquerque Service Unit and the AUIC Health Department.

ACTIVITY IV.1.C: Following the planning and preparations made in order to facilitate a programmatic referral system between tribal health departments of the Albuquerque Service Unit and the AUIC Health Department, such referral system will be initiated by the CHR Divisions of the respective departments.

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ALBUQUERQUE URBAN INDIAN CENTER, INC.

HEALTH DEPARTMENT

ALBUQUERQUE URBAN INDIAN

SPECIFIC HEALTH PLAN

Submitted to:

U. S. Department of Health, Education, and Welfare
Public Health Service
Indian Health Service

Submitted by:

ALBUQUERQUE URBAN INDIAN CENTER, INC.
BOARD OF DIRECTORS

Rev. William D. Lee
Chairman

Mr. Bobby E. Crooks
Executive Health Director

June 1, 1979

PREFACE

With great delight the Albuquerque Urban Indian Specific Health Plan is submitted. The Albuquerque Urban Indian Center, Inc. (AUIC) Board of Directors takes delight in the submission of this report and feel such a comprehensive health plan will enable the Albuquerque Urban Indian Center to structure relevant programs in order to eliminate the health needs of our urban Indian families and individuals. Also, we hope through the dissemination of this comprehensive report that it will be utilized by those city, state, and federal agents in order to fulfill the health goals of our Indian people in Albuquerque.

I, as Chairman of the Board of Directors, would like to make a special acknowledgment and word of gratitude to Mr. Bobby E. Crooks, Executive Health Director of the Albuquerque Urban Indian Center, who labored countless hours engineering this masterpiece of work. It can now be said that due to Mr. Crooks' constant encouragement and energetic leadership this Plan is possible. Also, special acknowledgment is made to the Health Committee of the AUIC, Ms. Mildred Weller and Ms. Rose Sandoval, for their leadership, input, manpower, and individual expertise. Last but not least, I thank the Southwest Research Associates, Inc. and Ms. Janice Lujan for the outstanding consultation and assistance.

Again, the AUIC Board of Directors fully supports this report, its contents and its purpose. I, personally, feel it is a great privilege to be associated with such great people that have made this document complete.

William D. Lee, AUIC
Chairman, Board of Directors

INTRODUCTION

Good health, to most people (Indian and non-Indian), usually involves the absence of medical or dental pain. Good health, in this report, will involve the same concept -- absence of medical or dental pain. However, it will be dealt with in a non-traditional approach through the but then, if I tell you, you won't read the report.

So, let this report start by saying ... as the author of this report, it is with great pleasure that I express my appreciation to the thirty or more individuals that took part in the planning, research, writing, and completion of the Albuquerque Urban Specific Health Plan. Without these people and the work they performed, this report would not have been possible. Thank you.

I would also like to express my gratitude to the Indian Health Services for giving Indian people the opportunity to identify, express, and propose solutions to health problems and health barriers that prohibit good health care delivery for Indian peoples.

Throughout the past few years, all Indians have looked forward to the day when Indian self-determination is a reality rather than a public law or a catchy phrase or a token symbol of a future dream. Today, we are closer; and hopefully our Urban and Tribal Specific Health Plans will be viewed by our Washington leaders as one of the best mechanisms to facilitate one part of the total concept of Indian self-determination.

The second part of this introduction will give the population projection for urban Indians of Albuquerque. It may seem inappropriate to include such a topic in this introduction. Because of its importance and possible impact on the delivery of health care, however, it could be the most outstanding feature of this report.

Also, we have only planned specific objectives for FY81 and FY82. This is because of the possible unpredictable influences that could alter the design and delivery of health care which are unknown at this time. This is 1979 and to plan for 1983 and 1984 could be more harmful than helpful due to the four to five years between now and then.

By submitting this type of an approach to 1983 and 1984, I hope that the Indian Health Service allows all urban Indian organizations and tribes the opportunity for further, continuous up-dates to their respective plans.

"POPULATION"

Determining the possible number of urban Indians in Albuquerque, New Mexico is an extremely important aspect of program planning, as well as one of the most controversial ones. However, population is by far the most difficult aspect of planning since there are several sources for data and there are vast differences in the figures used by different sources. For example, the Indian Health Service projects approximately 5330 urban Indians in Albuquerque for 1979, while the Albuquerque Public Schools projects approximately 11,000, and the Employment Securities Commission of New Mexico projects approximately 10,000.

The Indian Health Service is mandated by Congress to base all population projections on the 1970 U.S. Census figures. However, Indian population figures based upon the 1970 Census count will not be used by the AUIC because of their inaccuracies, which will be proven within the body of this report.

The AUIC will, however, use an Indian Health Service report from the Office of Research and Development, for PL 95-626, Section 116(B), which projects the possible urban Indian population of Albuquerque to be:

<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>
20344	20794	21253	22220

Bobby E. Crooks, AUIC
Executive Health Director

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I. SCOPE OF THE PLAN

A. Background

The Albuquerque Urban Indian Center, Inc. (AUIC) received its certificate of incorporation from the New Mexico State Corporation Commission on May 15, 1974, under the auspices of the Albuquerque Coalition of Indian Organizations, Inc. (ACIO). On September 17, 1977, the State Corporation Commission was petitioned by the ACIO to amend its bylaws and change its name to the AUIC.

The AUIC has been successfully directed by its Board of Directors for six years. Its main purpose is "to develop, conduct, and administer such programs for the preservation of American Indian culture, history, and traditions, and for the improvement of health, education and social and economic well-being of Indians . . ." In December, 1977, the AUIC Board of Directors submitted a proposal to the U. S. Department of Health, Education and Welfare (DHEW), Division of Indian Health Service (IHS), for a Phase I contract under Title V, Public Law 94-437, the American Indian Health Care/Improvement Act. The IHS awarded the AUIC Board of Directors its first phase health project on August 1, 1978. Although the Title V, PL 94-437 funding was delayed one year from IHS, and an additional delay of three months was encountered by AUIC, by November, 1978, a Health Director and staff were hired.

The AUIC Board of Directors is an all Indian Board representing eight different tribes from throughout the United States. A community election is conducted once a year to determine the AUIC Board of Directors. The Board elects its Chairman, Vice-Chairman, Secretary and Treasurer who constitute the Executive Committee.

An AUIC Health Advisory Committee was established to serve in a non-decision-making role with the Health Department and Health contract(s). The Committee works in close association with the AUIC Board of Directors; the Committee is chaired by a member of the AUIC Board.

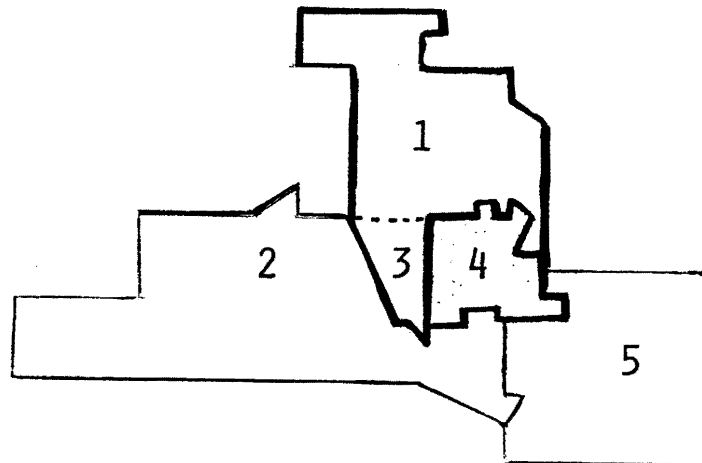
B. Service Area and Service Population

The Greater Albuquerque Area (GAA) has been defined by the Middle Rio Grande Council of Governments of New Mexico (COG) as, "that portion of . . . the Standard Metropolitan Statistical Area (SMSA) having such significant social and economic activities that continuous monitoring is required."¹ This definition points out that not all of the SMSA has been set aside as "The Greater Albuquerque Area." This is the area extending south from Rio Rancho and Corrales to (but not including) the Isleta Indian reservation. By this definition the GAA does not include any part of the Indian reservations of Sandia, Zia, or Isleta Pueblos. The Sandia and Manzano Mountains form the current eastern limit while the western boundary is a line which separates Bernalillo County into halves.² The SMSA is defined as all of Bernalillo and Sandoval Counties.

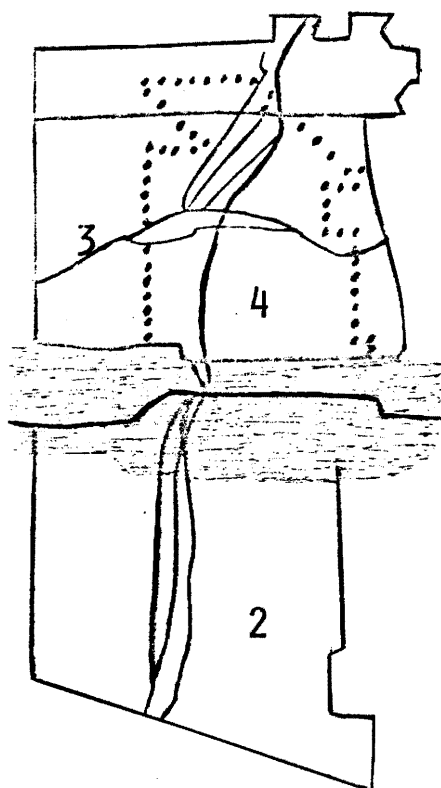
The two maps which follow show the planned service area for the AUIC. The first map indicates five areas:

- Area 1: Sandoval County
- Area 2: Valencia County
- Area 3: Bernalillo County outside GAA
- Area 4: GAA
- Area 5: Torrance County

Areas 1, 3, and 4 constitute the Albuquerque SMSA. The AUIC Health Department will serve all Indian residents of Areas 3 and 4.



BERNALILLO COUNTY AND SURROUNDING AREAS³



ALBUQUERQUE AND ISLETA PUEBLO RESERVATION⁴

The map above enlarges area 4 and the southeast corner of area 2 (Valencia County). The city of Albuquerque is delineated by the dotted lines, while the darkened area is the Isleta Pueblo reservation.

During the period from 1970 to 1975, the city boundaries of Albuquerque grew in proportion to the growth in population and economic development. Land area and population density from 1970 to 1975 are compared below.

1970-1975 Albuquerque Land Area and Population Density⁵

	<u>SQUARE MILES</u>	<u>PERSONS PER SQUARE MILE</u>
1970	80.63	3,023
1973	85.68	(Incomplete data)
1974	86.95	(Incomplete data)
1975	88.12	3,377

The largest metropolitan area in New Mexico is Albuquerque, serving as the state's number one industrial, social, economic, educational and cultural center. Bernalillo County serves as the catchment area of Albuquerque, which is served by the AUIC.

Due to the nature of the state and the migration patterns within the state, the urban Indian population of Albuquerque is constantly shifting, moving, and changing, as are the other populations within the state. New Mexico is fourth in total Indian population for the United States, and is the home of 26 tribes, including Pueblos, Navajos, and Apaches. Because of the location of the National, Area, and Branch offices of the IHS, the BIA, and Office of Indian Child Services, etc., ties are also strong between Albuquerque and the two Ute Indian tribes of Colorado and the Navajo Nation of Arizona.

In the GAA, the Indian tribal breakdown is approximately 1/3 Pueblo, 1/3 Navajo, and 1/3 Other. Other includes both Apaches and non-New Mexico tribes, for example: Chippewa, Choctaw, Sioux, Omaha, Cheyenne, Seneca, etc.

There are factors that affect specific populations and the freedom of the population to migrate, thus affecting population growth and expansion. In defining the Indian population of Albuquerque with special emphasis on defined service area for this urban Indian health project, the points below are emphasized:

- (1) Although mandated by the IHS, population and demographic information based on the 1970 U. S. census figures will not be used in the Albuquerque Urban Specific Health Plan (USHP). The projected population of Albuquerque is made through a formula developed by the IHS. However, those IHS projected figures are not included in this report, but rather, the AUIC has submitted additional figures which serve as its population projections of American Indians in the AUIC service area.
- (2) The boundaries of Albuquerque have expanded since 1970. However, even with the 1979 city boundaries, the AUIC service area does not include the Indian reservations of Isleta Pueblo, Sandia Pueblo, or Zia Pueblo.
- (3) The U. S. Department of Commerce, Bureau of the Census, recognize that there exists a possibility that a 50% under count of American Indians was recorded in the 1970 census.⁶
- (4) The New Mexico Health and Environment Department recognize that New Mexico Indians with Spanish surnames could have been counted as "Spanish Americans." The problem is a result of some 8,000 common Spanish names used by American Indians.⁷

C. Time Frames

The AUIC Urban Specific Health Plan, as mandated, shall be submitted by June 1, 1979, and shall cover the following time frame:

Fiscal Year 1981: From October 1, 1980 to September 30, 1981
Fiscal Year 1982: From October 1, 1981 to September 30, 1982
Fiscal Year 1983: From October 1, 1982 to September 30, 1983
Fiscal Year 1984: From October 1, 1983 to September 30, 1984

II. DESCRIPTIVE DATA

A. Geography

New Mexico, including its middle Rio Grande valley, is located in the heart of the Southwestern United States. Albuquerque, the state's largest city, spreads over 88 square miles in the center of Bernalillo County. Several dormant volcanic caves lie to the west of Albuquerque; to the north and south runs the Rio Grande River basin and the east is bordered by the Sandia Mountains (10,678 feet).

Albuquerque is located approximately 218 miles west of Texas, 138 miles east of Arizona, 130 miles south of Colorado and 260 miles north of Texas and Mexico. The Rio Grande River cuts through the city's downtown business district from the north. It was once used for transportation but now is used only for irrigation.

With an elevation of approximately 5,000 feet above sea level, Albuquerque has the characteristics associated with high, dry, inland climates. The air is dry with an average annual relative humidity of 42%. During the warmer parts of nearly all days the humidity values are 30% or lower.

Rainfall and snowfall in Albuquerque are the result of the mile-high elevation and the nature of surrounding mountain ranges. Roughly 50% of the total annual precipitation in Albuquerque falls between June and September.

The predominant characteristic of Albuquerque's climate is sunshine. Sunshine is recorded during more than three-fourths of the hours from sunrise to sunset including during the winter months. Wind movement averages approximately nine miles per hour throughout the year.

B. Population

From 1970 through 1977, the population of New Mexico grew more than twice as fast as in the previous decade. From 1960 through 1970, the population grew 6.9%; from 1970 through 1977, New Mexico's population grew 17%. The following chart indicates the overall growth of Bernalillo County.

Bernalillo County⁸

<u>April 1, 1960</u>	<u>April 1, 1970</u>	<u>April 1, 1977</u>
<u>Number</u>	<u>Number</u>	<u>Number</u>
262,199	315,774	378,800

The 1975 population estimates for New Mexico indicate that the Indian population was 80,290; this figure, according to the New Mexico Health Systems Agency (HSA),⁹ represents 7% of New Mexico's total population. However, this figure does not necessarily accurately count the urban Indians living in and around Albuquerque. The following two charts indicate the 1975 population of New Mexico according to the racial-ethnic group and district.

1975 Population Estimates for New Mexico¹⁰

	<u>Male & Female Total</u>	<u>% of Total</u>	<u>Male</u>	<u>Female</u>
Anglo	601,028	52.4%	294,503	306,525
Spanish	440,448	38.4%	215,820	224,628
Indian	80,290	7.0%	39,342	40,948
Black	21,793	1.9%	10,679	11,114

1975 Population Estimates for New Mexico by Districts¹¹

	<u>Male & Female Total</u>	<u>% of Total</u>	<u>Male</u>	<u>Female</u>
District I	116,500	10.2%	57,085	59,415
District II	166,500	14.5%	81,585	84,915
District III (Albuquerque)	440,200	38.4%	215,698	224,502
District IV	83,500	7.4%	41,405	42,095
District V	47,100	4.1%	23,079	24,021
District VI	194,000	16.9%	95,060	98,940
District VII	98,200	8.6%	48,118	50,082

The sources for the previous charts do not provide information on Albuquerque's Indian population. This is not to say that a large Indian population does not exist in Albuquerque, but rather, that non-Indian agencies and organizations do not have adequate measures of the Indian population in the city.

In defining the ethnicity of the population by U. S. Bureau of the Census terms, "White" (anglo), included persons who identified themselves or provided information which would be considered

Anglo; "Spanish" included persons who have a surname which matches one of 8,000 common standard Spanish surnames; "Black" (negro), is a self-defined category; "Native American" is also self-defined.¹²

As mentioned in Chapter I, the population of New Mexico has and will continue to grow throughout the time frame of this Plan, with the urban Indian population expected to grow also.

Age distribution of New Mexico residents parallels the national trend toward an increasing proportion of elderly. Age distribution in the various ethnic groups is consistent, with one notable exception: the 0-18 years age group for Native Americans. This age group includes 54% of Indians compared to 42.5% of the population in general.¹³ In order to visualize how Albuquerque urban Indians fit into the overall Indian population trend for New Mexico, 70% of the urban Indians living in Albuquerque are below 30 years of age.¹⁴ This enables a clear picture to be drawn which establishes Albuquerque urban Indians as a major factor in the distribution of age for New Mexico Indians.

The 1970 census figures (which show a population of 3,868) will not be used to describe the Indian population of Albuquerque. The AUIC wishes to make the following points for consideration in projecting the 1981 through 1984 urban Indian population:

- (1) There may exist a 50% under count for Indians in the 1970 U. S. census;
- (2) Due to the mechanism for collecting data, there is limited information and data on urban Indians in Albuquerque;
- (3) Most data that describe the population of New Mexico Indians do not account for urban Indians, but rather treat Indians as one group;
- (4) Many New Mexico Indians have Spanish surnames, and may be counted as Spanish rather than as Indians;
- (5) Because of the large number of federal offices in Albuquerque, there are a large number of BIA and IHS employees living in Albuquerque who are Indians, and they have access to non-IHS facilities due to income standards and health insurance;
- (6) The number of Indians who do not use primarily IHS facilities represent approximately 50% of the urban Indian population, according to the 1979 Health Needs Assessment of the AUIC.

Between 1975 and 1976, the percent increase in number of ambulatory patient care diagnoses doubled over previous years' figures, as shown in IHS data. As can be seen from the chart below, this increase is greater than the percent increase in other years shown.

Ambulatory Patient Care

Total Diagnoses
and
Percent Increase

Albuquerque Urban Indians

FY 73		FY 74		FY 75		FY 76	
Total Diagnoses	Percent Increase	Total Diagnoses	Percent Increase	Total Diagnoses	Percent Increase	Total Diagnoses	Percent Increase
8,636	19%	10,392	20%	12,409	19%	17,126	38%

The total number of diagnoses for FY 72 was 7,228.

Based on the IHS information summarized above, it is the assumption of AUIC that any projections of the Albuquerque urban Indian population based on figures from before 1975 (i.e., the 1970 census) are in error. It is assumed by AUIC that the increase in diagnoses is related to an increase in population, since there is no reason to believe that people suddenly became "sicker." It is especially interesting to note that this sudden increase in the Indian population is paralleled by several other factors:

- During 1976 there was an estimated increase of 43% in new construction in Albuquerque.
- Mobile home sales also increased 19% from 75-76 and 29% from 76-77.

Based on the above factors, it is logical to assume that there were changes in Albuquerque which were reflected by changes in the urban Indian population.

Two additional points may be made relevant to the Indian population of Albuquerque. First, an estimated population of 20,344 can be identified for 1981. Second, there was an unusually large increase in population during 1975. Both of these points will be explored in some detail below.

The 1978 Overall Economic Development Program published by the New Mexico State Planning and Development District III, Middle Rio Grande Council of Governments of New Mexico provides population data for Bernalillo County. Page III-2 states, in part:

"In 1975, Bernalillo County contained an estimated 362,600 people, . . . All but 2 or 3 percent of this population resides in the Albuquerque urban area . . . and on the bordering mesas. The City of Albuquerque, . . . with an estimated 1975 population of 279,401 is the District Growth Center."

The 1977-79 Affirmative Action Plan for the Albuquerque Public Schools was used to determine the approximate percent of Indians residing in Albuquerque. Table A on page III-1 provides information on the percents of various minority groups living in Albuquerque. This table quotes figures derived from 1970 population counts for the Albuquerque SMSA as noted by the Employment Security Commission of New Mexico. The figures show that 3.8% of the population is American Indian.

It is relatively simple to combine the information from the two sources above. When 3.8% of the total Albuquerque population of 279,401 is figured, we find that there are approximately 10,600 Indians living in Albuquerque. This figure is lower than the AUC estimate, but is higher than the IHS figure by 6,732.

A further reason for not putting too much faith in population data from before 1975 can be seen in the Albuquerque Public Schools paper entitled "Rationale for District Coordinator for APS Indian Education Programs," April, 1979. This paper states in part:

"The APS Indian student population is increasing, not declining. The Indian student count conducted by the Title IV Indian Education Program has increased over 5% from 2123 to 2241 in the past two years. These numbers are based on the USOE forms that require a parental signature. The APS Student Registration Cards, which also indicate students who are Indian but do not require a parental signature, have shown a count of at least 2900 Indian students for the 1979-80 school year." (page 1)

C. Transportation

Albuquerque and Bernalillo County are served by four major airlines: Trans World Airlines, Continental, Frontier, and Texas International. Direct passenger and freight services are available to both the east and west coasts. The Albuquerque International Airport is one of sixteen complete Federal Aviation

Air (FAA) traffic control centers in the U. S., and enjoys 99% perfect flight conditions. The airport's 1,400 acres are located in the southeast sector of the city. Two other airfields provide private aircraft facilities, including FAA approved repair and overhaul services.

Albuquerque has 35 trucking companies serving its needs, including 26 interstate carriers and nine local companies. The Santa Fe railroad offers passenger (Amtrak) and freight services to and from Albuquerque. Bus service is provided by Greyhound Bus Lines, Continental Trailways and the New Mexico Transportation Company.

City bus service is provided by a municipal transit system. There are four taxi companies and innumerable car rental and leasing agencies. Albuquerque is also served by the U. S. Postal Service.

D. Utilities and Communications

Electric service to Albuquerque is by the Public Service Company of New Mexico, which has a generating capacity of 858,000 Kilowatts. Approximately \$200 million is budgeted for additional facilities in the 1970's.

The Gas Company of New Mexico is the primary provider of natural gas. In 1976, the percentage distribution of natural gas in Albuquerque was:¹⁵

Residential	30%
Commercial	14%
Industrial	46%
Public Authorities	9%
Irrigation	1%

Total ---- 100%

The city of Albuquerque operates one of the nation's most modern automated water supply systems. In 1977, the water supply system was composed of 80 wells, 23 chlorination systems, 17 flouride stations, 40 reservoirs, 19 pump stations, 1600 miles of waterline and 89,000 service line connections.¹⁶

The present capacity of Albuquerque's two sewage treatment plants is a population equivalent of 400,000 persons. Currently, the load is equal to 327,000 persons. The refuse system of Albuquerque is a municipal operation using one sanitary land fill as its dumping facility.

Mountain Bell Telephone Company provides a complete range of communications services to Albuquerque and seven Rocky Mountain states. Albuquerque is also served by the Western Union Telegraph Company which operates lines to all major cities in the United States.

New Mexico's two largest newspapers are located in Albuquerque. The morning Albuquerque Journal and the evening Albuquerque Tribune combine for a total daily circulation of 110,000 and a Sunday circulation of 102,000. There are four television stations in Albuquerque, three with national network affiliation and one educational network. Eleven AM radio stations and seven FM stations round out a full complement of communication media in Albuquerque.

E. Housing

Albuquerque is one of the few cities where housing styles are so varied. In 1973, the cost of lots in Albuquerque ranged from \$65 to \$100 per frontage foot for residential lots. Building costs per square foot averaged \$18.50 in 1973, not including land costs.¹⁷

In 1978, a study conducted by the Albuquerque Realtors Association, Inc.,¹⁸ indicated that 60.2% of the homes sold were three bedroom, 23.2% being four bedroom, and 15% one and two bedrooms. Out of the total sold, 84.1% were priced at \$35,000 or more.

In a study conducted by COG in June 1978,¹⁹ several recommendations were made based on identified needs, surveillance of housing activities and existing federal, state and local programs. These recommendations are related to the improvement of living conditions in Albuquerque:

- (1) Better dissemination of information regarding housing opportunities;
- (2) Better coordination of housing activities at all levels to avoid the current fragmented approach;
- (3) Development of county-wide housing authorities, either through expansion of existing authorities or creation of new ones;
- (4) Improvement of the housing system through the implementation of the total comprehensive process which includes federal, state, and local governmental agencies and the private sectors, which includes provisions for the allocation of resources based on local needs and decisions.

The report also summarized the housing needs:

"Housing needs are identified in terms of future demands. The information provided in this report is compatible with that required in the 'Housing

Assistance Plan' by the U. S. Department of Housing and Urban Development . . . that conventional homes will be too costly for low and moderate income families, therefore, mobile homes and modular units will continue to increase in popularity."

The projected demand for privately owned housing in 1980 for Bernalillo County is:

<u>Total Housing by Type</u>	<u>Total Housing by Price</u> (1977 dollars)
Single family = 104,430 units	\$25,000 or less = 46,630
Multi-family = 49,210 units	\$25,001 to \$40,000 = 27,110
Mobile homes = 13,100 units	\$40,001 to \$70,000 = 30,370
	over \$70,001 = 4,340 ²⁰

The report also pointed out that "An important aspect of the current housing situation is the number of sub-standard units. These are units lacking some or all plumbing facilities, and/or adequate heating facilities. . . ." ²¹ In a summary of estimated housing assistance needs, 18,428 lower income families were identified, or approximately 16.2% of total families. It must be kept in mind that the above figures were derived from the 1970 census data, which has been estimated at a 50% under count.

Estimates of New Construction²²

	<u>Total Units</u>	<u>Percent Change</u>
1971	9,495	Not Applicable
1972	10,770	+ 13%
1973	5,672	- 47%
1974	3,840	- 32%
1975	3,767	- 2%
1976	5,383	+ 43%
1977	8,209	+ 52%

In addition to these percentages, the city of Albuquerque accounted for 71% of all new housing construction in Bernalillo County in 1977, with 5,826 units being built. Mobile homes also accounted for a significant portion of the new housing, with an increase of 19% from 1975 to 1976 and 29.7% from 1976 to 1977.²³

The average home for 1977 in the Albuquerque area was \$41,000 with building costs rising to \$30 per square foot, according to the Albuquerque Realtors Association, Inc.²⁴ Maximum loan terms and high interest rates also make home ownership an impossibility for many families. Urban Indians, sampled by the AUIC Health Department, generally earn less than \$15,000 per year, thus making it difficult for them to own homes.

F. Education

The Albuquerque area, as a whole, has experienced a large population growth over the past 30 years. This growth is reflected by the school figures for the Albuquerque Public School (APS) system which is composed of ten high schools, 22 junior/middle schools, 77 elementary schools, and six special schools. The figures of growth are as follows:

<u>Year</u>	<u>Enrollment</u>
1949	21,300
1958	47,000
1977	80,134

In addition to the public school system, there are seven non-sectarian private schools and six parochial schools.

Albuquerque has two universities, the University of New Mexico (UNM) and the University of Albuquerque (U of A), which have a combined enrollment of over 23,000 students (approximately 20,000 at UNM and 3,000 at U of A). The Albuquerque Technical Vocational Institute (TVI) provides vocational and technical education. The Southwest Indian Polytechnic Institute (SIPI) is a post high school, occupational, educational facility sponsored by the Bureau of Indian Affairs (BIA).

One important factor for the city schools is the large number of federal employees in the Albuquerque area with the BIA, the IHS, and Kirtland Air Force Base.

New Mexico's 1975 public school enrollment showed the continuation of a downward trend which began in 1972. State enrollment dropped 4.5%, which is consistent with the national population trend of low birth rates and higher median age, resulting in fewer numbers of school age entrants. From 1970 to 1975, the national school age population decreased 6.4%; the national population grew older as the median age rose from 27.9 years in 1970 to 28.8 years in 1975.

The Albuquerque Public Schools (APS) Indian student population is increasing, not declining. The Indian student count conducted by Title IV Indian Education Program indicated over a 5% increase during the past two years. The APS student registration cards, which also indicate students who are Indian, have shown a count of at least 2,900 Indian students for the 1979-80 school year.

Albuquerque Public Schools
Indian Education, Title IV

Student Census Count

<u>Year</u>	<u>Total</u>
1977-78	2,123
1978-79	2,241
1979-80	2,900

In addition, a survey conducted by the AUIIC shows that the urban Indian population in Albuquerque has grown at a rate of 10% per year since 1970.²⁵ This consistent growth rate is going to be reflected in the number of public school age students which was identified as being 52.4% of the Indian population.²⁶ Thus, the importance of health education and health planning is increased.

G. Economic Conditions

New Mexico is an extremely poor state. Nationally, it ranks near the bottom (45th) in per capita income. In 1973, it was estimated that 18.9% of the state's families were below the poverty level. Individuals with below \$1,999.00 account for 50% of all individuals, a dramatic indicator of the level of poverty in the state.²⁷

Median income, like age and population, varies according to ethnic group. Median income for the state in 1970 was \$7,849.00, while median income for Anglos was \$8,117.00 and all others was \$4,637.00. These figures point out once again wide disparity in the well-being of New Mexicans.

Bernalillo County is urban in character, with Albuquerque acting as the financial, educational, cultural, industrial, and business focal point. The municipal, utility and service systems of the city of Albuquerque are among the few systems in the state which have the capabilities of serving large-scale industrial activities. The work force of Bernalillo County and Albuquerque is capable of adapting to a wide variety of industries but is generally unskilled.

Potential economic development in Albuquerque and Bernalillo County represent the diversified economic base prevalent in Bernalillo County. The health needs of the area are met in large part by the wide variety of services available including public health clinics, hospitals, drug rehabilitation, mental health, counseling centers, satellite primary care units, paramedic staffed emergency rescue units and physicians in private practice.

The location of major business offices and headquarters of state and national government agencies in Albuquerque continues to be a major factor assisting the economic development of the county and state. Government spending throughout the city, county and state accounts for a large part of the local economy and represents a major employer of area residents.

Two factors, land and labor availability, enhance other potentials for economic development. The obvious constraint to economic development associated with land is its non-availability or limited capabilities. This factor is being overcome at the local level through the development and implementation of capital improvements.

Natural resources, particularly those related to energy resources, play a significant part in the development of Albuquerque and Bernalillo County. These resources include uranium mines, gas and petroleum production, strippable coal resources and geothermal and solar energy research and development. The prospects for expanding these resources is great and may provide a base for associated economic growth to serve the needs for increasing energy production for the nation.

Housing conditions of Albuquerque and Bernalillo County, as pertains to economic development, have progressed with national trends. The most significant drop in housing construction occurred in 1974 and continued through 1975. Of the total 1975 housing stock, 5% was considered to be in sub-standard conditions.

The 1970 census revealed that in 1969, 15% of the families in Albuquerque were below the poverty level, with a mean income of \$2,108.00. In Bernalillo County in general, the 1970 per capita income was \$3,540.00 as compared to \$5,414.00 in 1975, which was still \$500.00 shy of the national average.

H. Government

The mayor of Albuquerque is elected to a four-year term and may succeed himself once. He then must remain out of office for at least four years before running again. Key personnel in the mayor's office are a legal advisor, a manpower specialist, and the chief administrative officer. The City Council of Albuquerque has nine non-partisan council members who are elected to four-year terms from nine different geographic areas. The Council president is selected by the Council. Councilors' terms are staggered, with either four or five councilors elected every two years.

The Municipal Court has one part-time and four full-time elected judges. All judges serve a four-year term and may succeed themselves indefinitely.

Bernalillo County has a commission-county manager form of government. The county manager is a professional administrator appointed by the commission on his credentials, experience, qualifications, and education. He serves under a one-year renewable contract. The county government of Bernalillo County is operated through a five-member Board of County Commissioners, which is an elected policy-making body for the county and meets twice monthly.

The New Mexico state government is made up of the executive, judicial and legislative branches. The executive branch has ten elected officials, individually responsible to the electorate. The Governor and Lieutenant Governor are elected as a team and serve a term of four years. The Legislature is composed of a Senate of 42 members and a House of Representatives of 70 members. Senators serve four-year terms, on a staggered basis, while terms of House members are two years. The judicial branch is structured along traditional lines, with Magistrate Courts being the lowest level of the system.

The State of New Mexico elects two U. S. Senators and one U. S. Representative. These positions are elected as in all states of the United States.

I. Migration

The migration flow of any particular ethnic or racial group into or out of New Mexico is difficult to document and substantiate due to the lack of proper tracking systems within the state. This inability to document the overall general migration flow leaves no acceptable system to monitor the migration of Indians into or out of New Mexico or Albuquerque.

The migration of Native Americans from reservations to urban areas has been occurring for several decades. Such emigration has been influenced by several major developments. In the early 1940's, large numbers of Indians moved to cities to seek employment in industries created during World War II. In the early 1950's, efforts to accelerate the process of assimilating Indians into the mainstream of American society were undertaken by the federal government. The BIA perpetuated the assimilation process through the veiled disguise of a relocation program with incentives and the promise of assistance. However, once the physical relocation was accomplished, Indians were virtually deserted and were unassisted in learning to function in an alien environment.

Large numbers of Indians continue to move to cities seeking social and economic betterment. Today, approximately 50% of the over one million Indians in the U. S. reside in urban areas.²⁸ In Albuquerque, due to the centralization of the city in the state, this migration trend is even more logical.

III. HEALTH DATA

The definition of health as stated by the World Health Organization (WHO) is: "a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity."²⁹

A report by the New Mexico Health Systems Agency (HSA) in 1978³⁰ established priorities among health problems for the state of New Mexico. Weights for the criteria representing their relative importance were established by the HSA Governing Body as follows:

<u>Criteria</u>	<u>Weight</u>
Premature Mortality	10
Morbidity/Disability	9
Cost to Society	7
Public Concern	6
Public Health Threat	5

The HSA was given the task of establishing a Health Systems Plan (HSP), the purpose of which was to bring together the most reliable and comprehensive data which are available to describe the state of health, illness, and death of New Mexico's citizens.

There are a number of factors which influence health. Four primary factors determining health status are the environment, both physical and social; life style patterns; health care services; and human biology. Although the available statistics concentrate on death and disease, health is an holistic concept, embracing the complete individual in his environment.

The implications of population on the status of health are many.³¹ New Mexico tends to have lower crude deaths associated with diseases of the elderly (i.e., cancer and heart disease); a higher rate of accidental deaths, which are particularly problematic among young age groups; and a low rate of hospital utilizations.³²

A. Overall Indicators of Health Status

The overall indicators of health status in New Mexico are life expectancy, risk of death, cause of death, and morbidity. These topics are discussed in depth below.³³

Life Expectancy -- At birth, life expectancy in New Mexico is 71.2 years or 1/2 year less than the national norm, and was among the highest of the nation.

Risk of Death -- In New Mexico, the risk of death is lower than in the United States in general. The overall mortality rate for New Mexico compares favorably to the U. S. norm.

Leading Cause of Death -- The five leading causes of death for New Mexico are:

- (1) Heart Diseases
- (2) Cancer
- (3) Accidents
- (4) Cerebrovascular Disease
- (5) Respiratory Diseases

These five categories, which account for over half of all deaths, are for the state of New Mexico in general and include all ethnic-racial groups. It is important to note that accidents, the third leading cause of death in New Mexico, accounted for over 11% of all deaths, compared to 5% of all deaths in the U. S. However, with respect to specific ethnic groups, the accident rate is more severe; for example:

- (1) For Indians, indicators show that the accident rate is 300% greater than for the state;
- (2) For Navajos, the accident rate accounted for 40% of all Navajo deaths. This rate was slightly higher than the all-Indian rate, which is 300% greater than the state;
- (3) For Pueblos, the accident rate was 200% greater than the state rate. However, accidents for Pueblo men were 300% greater than the state rate for males;
- (4) For Apaches, the accident rate was 400% greater than the state rate.

Also, by comparing the rate of mental disorders, including alcohol and drug dependence, for Indians to the state in general, the following breakdown³⁴ indicates a wide variance:

- (1) The five leading causes of death for New Mexicans do not include mental disorders;
- (2) For Indians, mental disorders³⁵ are the fourth leading cause of death; this is approximately 50% greater than non-Indian deaths in the state from mental disorders;