MONTANA HEALTHCARE FOUNDATION

American Indian Health Leaders

Summary of first meeting

April 22, 2016

Contents

Overview

On April 22, 2016, the directors of seven tribal health departments, four urban Indian Health Centers, and Fort Peck's Health Promotion/Disease Prevention program met in Missoula at the Payne Family Indian Center. The purpose of the meeting was to develop strategic priorities and identify opportunities for collaboration toward the goal of improving the health of American Indian people in Montana. The meeting agenda is in Appendix A. Meeting attendees are in Appendix B.

Participants said that this was the first time in memory when the leadership of all of the tribal health departments and a majority of urban Indian Health Centers in Montana had met to discuss common challenges and opportunities.

As a result of shared dialogue, the group developed a set of shared priorities and potential solutions. Participants agreed the meeting was valuable and productive, and agreed to come together again to advance work on the priorities described below.

These notes summarize the main priorities, opportunities, and action items identified during the meeting. This is not a complete record of the discussions that occurred during the day.

777 East Main St, Suite 206
Bozeman, Montana 59715
Office 406-451-7060
www.mthcf.org

Action Items

1. ***Next Meeting:*** August 9, 2016. Great Falls (meeting site TBD).
   Participants agreed that it would be valuable to continue meeting in order to pursue the priorities described below.

2. ***Obtain support from Tribal Councils and UIHC Boards***
   Participants agreed to seek resolutions or other support from their leadership (Tribal Councils, Urban Indian Health Center Boards).

3. ***Making progress on the priorities***
   After participants agree on the final priorities (see below), participants and MHCF will identify ways to make progress between now and the next meeting.

Priorities

Relationship building to support each other in doing this challenging work was a strong motivation for participants to come together. Participants developed the following list of priority areas that could form the basis for ongoing collaboration. This section summarizes the discussion for each of these issues, and identifies steps the group could take to make progress in the coming months.

1. ***Technical assistance & capacity building (administration, coding, billing)***
   Summary of discussion:
   Participants talked about the many administrative challenges involved in building and running a successful health program—638 contracting, billing, compliance, data systems, and many others. Technical assistance and training on billing and coding, ACA implementation, accessing Medicaid waiver programs, and general administration is essential for capacity building, self-determination, and addressing key health challenges.

   Next steps:
   - This group can collectively identify resources and advocate for better technical assistance from IHS, state, and other sources.
   - Tribes could apply for IHS Tribal Management grants (TMG), which provide funding to help work on a specific issue such as billing, 638 contracting, tribally-sponsored health insurance programs ("TSHIP), or related issues. IHS recently announced a TMG opportunity.
   - Participants could ask Montana Medicaid to provide technical assistance on the various waiver programs.

2. ***Collaboration between Tribal Health and Urban Indian Health programs***
   Summary of discussion:
   Participants reflected on the importance of strengthening urban Indian health programs. Nearly two thirds of Native people now live in urban areas; even for people who consider a reservation community home, many spend periods of time living in urban areas. For these reasons, strong urban Indian health programs are essential.

   The group discussed the funding and revenue generation and other challenges facing urban Indian health programs. For example, urban programs do not receive the Medicaid all-inclusive encounter rate; none of the urban programs have pharmacies, and two noted that they have to drive patients to reservations to obtain prescriptions.
   Next steps:

- Look into ways to strengthen urban Indian health programs through collaboration with tribal health departments. Ideas that were discussed included some sort of sponsorship/contractual agreement between a tribal health department and an urban Indian health center, and looking into CMS policy and/or legislation that would allow urban programs to bill at the same level as Tribal facilities.
- Improve collaboration between Tribal health, IHS facilities, and urban programs to provide better care to patients that are being seen in both settings.

3. ***Pharmacy—638 contracting pharmacy services***

   Summary of discussion:

   Participants talked about the potential value of tribally-run pharmacy. Participants noted that tribes that 638 their pharmacy program can develop a separate drug formulary, and can also take advantage of federal drug purchasing programs. Pharmacy is a revenue generation center for tribally-run health programs because of the reimbursement structure.

   Next steps:

   Investigate the possibility of 638 contracting pharmacy programs.

4. ***RPMS/Electronic Health Record modernization***

   Summary of discussion:

   A good EHR is essential for patient care, quality improvement, business analytics, and good administration. Participants agreed that RPMS is difficult to use, out of date, and doesn't interface with other systems. Some participants said that IHS is not planning to continue supporting the RPMS EHR. Participants are starting to work on other options, such as contracting for a different system.

   Next steps:

   Investigate options for EHR modernization.

5. ***Role of tribal epidemiology center and IRB***

   Summary of discussion:

   Participants recognized the importance of data in planning, implementing, and evaluating health programs. One participant noted that "dollars follow data," making the point that better data would help drive more equitable investments in health improvement in Indian country.

   Next steps:

   Consider how the Rocky Mountain Tribal Epi Center, DPHHS, the IHS, and the tribal IRB can be useful in providing the data that participants need.

6. ***Representation on national committees***

   Summary of discussion:

   Participants noted that it is critically important to have Montana Tribes represented on federal committees; currently there are important opportunities being missed. One example is the Center for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group: the Billings area spot is vacant. Filling it would require a resolution from RMTLC to appoint a representative.

   Next steps:

   Identify key national committees, and advocate with tribal leadership and RMTLC to take the steps needed to ensure good representation for Montana tribes.

Appendix A: Meeting Agenda

8:30 AM	**Welcome & Introductions** (Coffee and light breakfast provided)	
	• Prayer	*(TBD)*
	• Introductions	*All*
	• Welcome	*Lee Ann, Kevin*
	• Goals	*Kevin*
	• Overview of the day	*Aaron*
9:00 AM	**Brief Updates from Health Leaders: new projects, challenges, opportunities**	
10:00 AM	**BREAK**	
10:15 AM	**Office of American Indian Health: Introduction to Mary Lynne Billy Old Coyote**	
10:30 AM	**Developing a Shared Agenda for Improving Indian Health**	*Kevin, Jace*
	• Establishing common ground; identifying needs, and setting priorities	
	• Potential roles for key organizations: DPHHS, IHS, CMS, Foundations	
12:00 PM	**Lunch** (provided; continue discussion on priorities for the group)	
1:00 PM	**Montana Healthcare Foundation**	*Aaron*
	• Update on current grantees	
	• Integrated Behavioral Health initiative	
	• 2016 Call for Proposals	
	• Looking Ahead: future needs & plans	
1:45 PM	**Technical assistance presentation: CMS policy on services "received through" an IHS or Tribal facility**	*Health Management Associates*
	• Presentation by consultant Health Management Associates explaining this new policy, implications for Montana tribes and urban Indian Health Centers	
	• Questions, technical support needs from Health Leaders	
3:30 PM	**Medicaid Updates**	*Mary Dalton*
4:00 PM	**Future of the Health Leaders group**	*Kevin, Aaron*
	• Developing a common agenda for policy, research, and funding	
	• Logistics and organizational structure: does this need to be a formal group? How often to meet? Leadership structure? Etc.	
5:30 PM	**Adjourn**	

Appendix B: Attendee List

TRIBAL HEALTH DEPARTMENTS:

Blackfeet

- Rosemary Cree Medicine, Director
- Cheryl Reevis
- Denise Heavyrunner

Crow

- Todd Wilson, Director

CSKT

- Kevin Howlett, Director
- Anna Whiting Sorrell

Fort Belknap

- Velva Doore, Director
- Mark Azure, Tribal President
- Lynn Cliff Jr., Councilmember
- Alvin "Jim" Kennedy, Councilmember

Fort Peck

- Dennis Four Bear, Director
- Ken Smoker, HPDP Director
- Dale DeCoteau

Northern Cheyenne

- L. Jace Killsback, Director
- William Walksalong

Rocky Boy

- Jessica Alcorn-Windy Boy, Director

URBAN INDIAN HEATH DEPARTMENTS:

Indian Health Board of Billings

- Marjorie Bear Don't Walk, Director
- Robert Ironmaker

Missoula Urban Indian Center

- LeeAnn Bruised Head, Director
- Lydia Silva

Helena Urban Indian Alliance

- Tressie White, Director
- Ben Horn

North American Indian Alliance, Butte

- Moke EagleFeathers, Director

GUESTS

Montana Healthcare Foundation

- Aaron Wernham, CEO
- Denis Prager, Board Chair
- Melinda Buchheit

DPHHS

- Mary Lynne Billy-Old Coyote, Director, Office of American Indian Health
- Lesa Evers, Tribal Relations Manager
- Mary Dalton, Medicaid Director

Health Management Associates

- Rebecca Kellenberg
- Stephanie Denning

Other

- Mike Andreini, Rocky Mountain Tribal Epidemiology Center Director
- Vonda Redfox, Redfox & Associates CEO
- Dani Howlett, UM Student