MONTANA HEALTHCARE FOUNDATION

MONTANA DEPARTMENT OF HEALTH AND HUMAN SERVICES TRIBAL CONSULTATION, OCTOBER 20, 2015:

Executive Order Establishing an Office of American Indian Health

And

The Use of State Appropriation for American Indian Youth Suicide Prevention

A summary report prepared by the Montana Healthcare Foundation

January 30, 2016

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

Contents

Introduction

On October 20, 2015, the Montana Department of Public Health and Human Services (DPHHS) held a formal government-to-government consultation with tribal government leaders and tribal health directors. The consultation addressed two important Governor's Initiatives: the implementation of Governor Bullock's executive order establishing an Office of American Indian Health, and use of the funds appropriated for prevention of suicide among American Indian youth.

Dr. Aaron Wernham, CEO of the Montana Healthcare Foundation (MHCF), was asked by DPHHS and the Governor's office to facilitate this consultation. Given the agency-wide impact of these initiatives, the department asked their senior management team (which includes the department director, branch managers, and division administrators and human resources) to attend the consultation. This facilitated conversation allowed the department to be in a listening role and offered tribal representatives a greater opportunity to offer their ideas, suggestions and speak at length on these two important topics.

Prior to the October 20 meeting, Dr. Wernham had pre-consultation discussions with a number of the tribal health directors and urban Indian health center leadership. The department director, state Medicaid director and tribal relations manager also traveled to each reservation prior to the consultation to meet directly with each tribal council to seek their input.

This is the Montana Healthcare Foundation's summary of comments received from participants on October 20 as well as during the pre-consultation discussions. This report was presented to the tribal leaders who attended the October 20 consultation, along with a draft description of the Office of American Indian Health and a draft position description for the director of that office. The Office and Position descriptions were revised based on comments received, but no comments suggested revisions to this report, so this version is unchanged from the draft. *We invite those who participated to provide any corrections, additions, or other comments in order to make sure that this report is an accurate and fair summary of the discussion.*

Participants provided many practical recommendations for actions that the state could take to help address these challenges. The recommendations in this report include suggestions offered by participants at the October 20 consultation as well as in the pre-consultation meetings. Where appropriate, the Foundation has also added references or specific program ideas based on our own work in American Indian health.

Comments about the consultation

Nearly 60 people attended the October 20 consultation, representing a diverse group of tribal leaders and interested parties. In both introductory and closing remarks, multiple participants expressed appreciation for the consultation. Participants said that the format for the consultation created an important opportunity to explain their perspectives on health disparities and the challenges in Native communities. As one participant said, "showing up and listening makes a big difference." Participants also emphasized that the executive order and this consultation present a new and important opportunity to address longstanding problems.

People expressed deep appreciation for Kevin Howlett's leadership in starting the conversations with the Governor's office that have led to this point. As one participant said, "I'm amazed at how far we've come in a year."

Participants also emphasized that they are not looking to the state to solve all the problems discussed during the consultation. Tribal leaders emphasized that they must create their own solutions, but that there are certainly many ways in which the state could support their efforts.

Comments on health disparities, and how the state can support health among American Indian people

Participants offered many insights into health challenges, strengths, and resiliency in their communities.

The Roots of Health Disparities

Historical trauma, racism and discrimination (both past and present), childhood trauma and abuse, poverty, loss of traditional culture, lack of opportunity, and hopelessness were discussed by many participants as fundamental problems that must be overcome in order to improve health. One health director described this problem as "death by poverty." Another person noted that the problems of health disparities and youth suicide are inseparable because health is, in reality, "everything in an Indian's life—it all connects." Many people emphasized that trauma lies at the root of health disparities, and underlies problems including drug and alcohol use, suicide, and even illnesses like diabetes. Specific concerns include:

1. Culture: Native culture and language, strong family and community ties, and traditional diet and activities were described as major sources of strength and resiliency. One person related a story of a woman who struggled with binge drinking, but stayed sober for a prolonged period while working on a traditional language project, saying "she didn't have time to drink because she was too busy being Crow." People emphasized that family and community ties are inseparable from people's identity, health, and well-being.

2. Housing: There is a shortage of housing on Montana's reservations. Overcrowded housing is common and sometimes severe (one participant related that it is common for multiple families to occupy a single small home). Problems of housing disrepair and safety hazards are also common. Two health directors noted a newer problem: many houses are now boarded up because of contamination by methamphetamine; participants reported 50 on the Confederated Salish and Kootenai (CSKT) reservation, and 75 on the Blackfeet reservation.

3. Education: Education was a major concern. Graduation rates are low in many communities. One participant mentioned that he thought there may have been few or no reservation schools that achieved "AYP" (adequate yearly progress) last year in Montana. Several people talked about the problem of low academic expectations in schools serving their communities. One participant related that a high school guidance counselor had laughed at her when she sought guidance on applying to college. Overt discrimination, a lack of Native teachers (for example, only roughly 30 out of approximately 500 teachers serving the CSKT region are Native), and the need for a trauma-informed approach to students were described as critically important issues.

4. Corrections: Disparately high rates of incarceration, coupled with the lack of support for people once they enter the corrections system (leading to high recidivism), are a prominent concern. People who are incarcerated may need help with addictions, mental illness and trauma, job training and employment counselling, housing, and so on: without this help, recidivism is likely.

5. Transportation (highway fatalities): Traffic injuries and death are far too common—many participants noted the tragically high rates of death and injury in traffic accidents. Driving under the influence and poor road conditions in some areas were discussed as causes.

6. Casinos: Several participants noted that reservation casinos are creating problems. One participant said that they "take from children," and several referred to the problem that parents may end up spending an unhealthy amount of time and money in casinos.

7. Trauma: Historical trauma, ongoing discrimination, exposure to adverse childhood experiences, and the pain and loss from all-too-frequent suicides, car accidents, and other fatal illnesses were described by many participants as ongoing sources of trauma. State programs and services, however, are generally not "trauma-informed." That is, the staff is not trained nor the services designed in a way that helps reach people who have experienced so much trauma.

DPHHS Administration

Participants commented on a number of issues related to the role of DPHHS in supporting American Indian health:

1. Helping tribes access state and federal programs: Several people noted that there are many longstanding and new state programs, state-managed federal programs, grants, Medicaid waiver programs, etc. that may be available and helpful to tribes, but often tribes do not hear about these opportunities, and often they do not receive enough training and support to access and appropriately use them.

2. Making sure that state programs have a cultural component: Given the importance of culture to people's health, several commenters noted that state programs—such as the Montana Youth Challenge Program—are often not designed with Native culture in mind.

3. Administration, billing, and coding of Medicaid programs: Many health directors note that their departments lack the administrative capacity and skillset needed to take full advantage of the Medicaid program, particularly in view of the expansion, and felt that state assistance with enrollment, coding, and billing capacity would be extremely helpful.

4. Alcohol control: Several people commented on the problem of bars and casinos that "over-serve" customers, and at least one person raised the question of whether state agencies could play a stronger role in enforcement of relevant laws to prevent this.

Health Data

Data on the health status of Native American people was a common area of concern among participants. Issues raised include:

1. The need for better data: There is a need for more accurate and community-specific data to allow communities to plan and implement appropriate interventions, and set benchmarks to evaluate programs. Methamphetamine abuse was raised as a prominent issue in some communities, yet there is little data available to characterize the nature and extent of the problem, for example. Several people questioned whether suicides are being under-counted, because they felt the state's recent vital statistics seemed to include fewer American Indian suicides in these communities than expected.

2. Stigma and misuse of tribal data: Many people voiced concerns about potential and historical misuse of tribal health data. People stated that tribal health data should be controlled by tribes, and any plans for public reporting or use of data should be discussed with tribes. People are concerned about the potential to further stigmatize communities when data on health disparities are reported. One person commented that the tribal health problems, such as short life expectancy, reported in the "State of the State's Health" had not been discussed with his community prior to release, and he felt this was not appropriate.

3. Use of data to support programs that do not ultimately collaborate with or serve tribal communities: Two commenters noted that tribal health statistics were used to justify Health Resources and Services Administration (HRSA) funding for community health centers in neighboring communities, but felt that these facilities were not planned in partnership with tribal health departments and are not currently providing substantial outreach to or collaboration with tribal health programs and members. In a separate recent meeting, tribal health directors also expressed concern that the two federal Navigator grants awarded in Montana this year include plans for tribal outreach that relied on tribal data, but again the health directors did not feel this outreach had been planned or coordinated with tribes, and there is concern that tribal outreach efforts may be lacking to date.

4. Data sharing and collaboration between tribes, DPHHS, and the Rocky Mountain Tribal Epidemiology Center: Several people mentioned the tribal epidemiology center, the Indian Health Service (IHS), and DPHHS when talking about data issues. Participants see a need for tribal consultation and control over tribal data, as well as clearer lines of communication and, under the right circumstances, better collaboration and data sharing among these entities.

Specific Health Issues

People discussed many different illnesses that affect their communities. Three that seemed to be particularly prominent are listed here, but many other concerns were mentioned as well. Participants noted repeatedly that trauma—more than casinos, bars, or other external influences on health—is at the root of these and many other prevalent illnesses.

1. Methamphetamine: Many leaders felt that methamphetamine abuse may be the single most concerning health problem in their communities. One person noted that things were better during the meth prevention campaign, but seem to have become much worse again.

2. Prescription drug abuse: Abuse of prescription opioids was also a major concern. People noted that doctor shopping and the lack of stronger state limits and oversight on opioid prescribing are areas of concern. In a separate conversation, one health director also raised concerns regarding the very high rate of prescription of stimulants for treatment of attention deficit/hyperactivity disorder among minors, and believes this may be a substantial source of addiction as well.

3. Diabetes: Many leaders commented on the prevalence of diabetes and its complications, such as renal failure, in their communities. This discussion also included comments on the benefits of traditional culture and diet. Another person mentioned that convenience stores and casinos are contributing to dietary problems, and wondered whether there are any levers available through state data on purchases as well as state oversight.

Recommendations: state actions to support American Indian health

The following recommendations relate directly to concerns raised during the consultation. Some were raised during the October 20, 2015 in-person consultation, and others were raised by tribal health directors and urban Indian health center directors during pre-consultation meetings. In some cases, MHCF has also drawn on our own work with Montana's tribes and other American Indian health leaders to offer suggestions that address the concerns summarized in the preceding pages.

The Roots of Health Disparities

- Housing: [No recommendations from participants to address the issues raised during the consultation were recorded. This recommendation is offered by MHCF.] The Montana Housing Division could work with tribal housing authorities to update state information on reservation housing and housing needs, identify any state or federal programs that might be available to address these needs, and collaborate with other stakeholders, such as the Minneapolis Federal Reserve's newly-formed Center for Indian Country Development (https://www.minneapolisfed.org/indiancountry.)

- Education:
  - The Office of Public Instruction could support or encourage a more trauma-informed approach to education in schools.
  - The Office of Public Instruction could focus on increasing expectations in reservation schools, and creating "magnets of success."

- Transportation: [This recommendation is offered by MHCF to address the issues raised by participants, and as a summary of conversations with tribal health leaders over the past year.]:
  - DPHHS and the Montana Department of Transportation could analyze the sites of injury-resulting accidents to determine whether there may be specific infrastructure improvements that could improve injury rates.
  - Tribal law enforcement and state law enforcement could collaborate to determine whether there may be any opportunities to reduce DUI rates.

- Corrections: The Montana Department of Corrections could provide training, education, and other resources to enable prisoners to be more successful when released, and reduce recidivism.

DPHHS Administration, Operations, and Programs

- Strategic planning and technical assistance: Many suggestions focused on the opportunity for DPHHS to fill a critically-needed role through providing assistance with strategic planning and technical assistance, to help tribes develop and implement strategic plans or action plans that address priority health issues.

- Administration, billing, and coding of Medicaid programs: The Medicaid expansion creates a historic opportunity to address the underfunding of Indian healthcare in both reservation and urban communities. In pre-consultation conversations and during MHCF's strategic planning, tribal capacity to administer and bill Medicaid emerged as a major challenge and opportunity for improvement. Several health directors suggested the creation of some sort of DPHHS technical

assistance function for tribes. Many health directors and urban Indian center directors have requested assistance with aspects of the Medicaid program, such as:

- Guidance, training, and technical assistance on how to use the various Medicaid waiver and state plan amendment programs
- Identifying billing opportunities and on-site technical assistance on coding and billing
- Assistance with Medicaid enrollment, such as through enhanced staffing of offices of public assistance located on or near reservations
- Assistance with enrollment, such as through the use of participation in tribally run programs, such as Commodities, TANF, or General Assistance (GA), to determine eligibility for the Medicaid expansion group

- Helping tribes access state and federal programs (includes Medicaid, but more general to other state and federal programs as well):
  Participants requested better notification and training on how to access state and federal programs that may be available and helpful to them. Several participants noted that ongoing technical assistance on how to access and appropriately use these programs would be helpful as well. Specific suggestions include:
  - DPHHS could hold workshops and mentoring sessions for a group of health administrative staff (e.g., tribal benefits coordinators and vocational rehab counselors) from each tribe to help them understand all of the state's Medicaid waivers and special programs, and how to use them more effectively.
  - One commenter noted that DPHHS used to have a Crow-bilingual benefits coordinator stationed on the reservation, and that person was extremely valuable.

- DPHHS Internal Structure and Operations:
  - DPHHS could draw on the Association of State and Territorial Health Official's (ASTHO) strategies for state health departments to improve health equity to develop and assess department-wide efforts to address American Indian health disparities (see http://www.astho.org/Programs/Health-Equity/Health-Equity-Orientation-for-SHOs/).
  - DPHHS should engage tribes in all aspects of the federal grant cycle—from identifying opportunities to developing proposals, to determining how funds will be used.
  - DPHHS could prioritize hiring people who have demonstrated experience and success in working with tribes, and hiring qualified American Indian employees.
  - Master contracting for DPHHS functions should include tribal consultation.
  - Many people specifically noted that Lesa Evers (DPHHS Tribal Relations Manager) is doing a great job and has helped tribes tremendously in their work with DPHHS, and noted that the Office of American Indian Health should not subsume or replace her or her position.
  - One person mentioned establishing some sort of advisory or working group that would involve existing leadership groups (such as business leaders, native attorneys, etc.) to work with DPHHS to develop and implement an action plan.

- Making sure that state programs are culturally relevant:
  Given the importance of culture to people's health, several commenters noted that state programs—such as the Montana Youth Challenge Program—should be designed to make them relevant to and effective for American Indian people.

- DPHHS could help tribes with recruitment and retention: This could include efforts to work with tribes to strengthen the pipeline of health and allied professions interested in working in Indian country. The Department could also assist in efforts to recruit and retain health professionals.

- DPHHS could support leadership development for Indian health: DPHHS could create internships or fellowships for American Indian students interested in or currently pursuing health careers.

- Determining the need for and licensing of Community Health Centers and other facilities near reservations: Participants asked whether the state has any role in the process of planning, approving, or licensing community health centers. They noted that it would be helpful for DPHHS to ensure that if tribal health statistics are used to justify the need for the facility (such as in applications for funding for Community Health Centers from HRSA), the facility will be planned in consultation with and serve the tribes.

- Alcohol control:
  Regarding the problem of bars and casinos that "over-serve" customers, one person raised the question of whether state agencies could play a stronger role in enforcement of relevant laws. [This suggestion may be relevant to DPHHS, the Liquor Control Division, or other state agencies.]

Health Data

[Note: these recommendations relate directly to concerns raised during the consultation, but also draw on multiple conversations between MHCF, tribal health directors, and other stakeholders over the past year.]

- Use of tribal data: Because this is a consistent concern addressed in multiple comments during the consultation, it may be reasonable for DPHHS to consider convening with stakeholders to develop consistent guidelines for the use of data regarding American Indian health.

- Collaboration between tribes, DPHHS, IHS, and Rocky Mountain Tribal Epidemiology Center: Many comments called for better coordination between the entities that have and use tribal data. DPHHS could examine successful efforts in other states, and help facilitate a multi-stakeholder dialogue with the goal of developing a clear plan for data sharing, analysis, and use of data between the tribes, IHS, tribal epidemiology center, and state. This plan could include, for example, defined roles and responsibilities, data sharing agreements, guidelines for partnership on grant applications and data analysis, and clear protocols for release of tribal data.

- Better data on health status and contributing factors: Many comments also requested better data on health problems and contributing factors (as called for in the executive order.) DPHHS could work with tribes to identify salient health questions, and develop study plans to address these questions.

Recommendations: Office of American Indian Health, Role and Staffing

1. Multi-agency focus: Participants emphasized that the office should reach beyond the health department and include the other state agencies outlined in the executive order whose work is important to health, such as education, corrections, housing and economic development, and transportation. The office should not be embedded in the bureaucracy of DPHHS.

2. Power and authority: Participants uniformly said the office should not be staffed by a single, mid-level manager. The office needs the staffing and authority to allow it to function effectively in high-level policy decisions, to achieve credibility and strong relationships with the tribes. The leadership of the office should also have the health expertise and deep understanding of tribal health issues and working with Native communities necessary to guide development of an effective action plan.

3. Staffing:
   - The office should be led by someone with a strong connection to Native identity, and deep experience and demonstrated skill and leadership working with tribes. This person should be American Indian.
   - The person leading this office should understand the differences between different Native communities in Montana, and be capable of establishing strong partnerships with them.
   - The leadership of this office will also need to work closely with the urban Indian health centers, and will need to establish a strong relationship with the IHS as well.
   - A single person will not be enough.
   - A hired person, rather than a politically appointed one, might create more stability.

4. Visibility: The leadership and work of the office should be highly visible, both inside state government and externally.

5. Function of the office: A prime function of this office would be to develop an action plan and oversee its implementation. In carrying out this function, this office should be a research-driven one: it should work with tribes and DPHHS divisions to identify the causes of health disparities and effective solutions. It should engage and work with DPHHS divisions and other state agencies to develop and oversee an implementation plan. Other related points include:
   - The office must take a slow, methodical approach, given the long-standing complexity of the challenge it was created to address.
   - It should work with urban stakeholders as well as with tribes.
   - It should build relationships and coordinate with the Rocky Mountain Tribal Leaders Council and the IHS.
   - The person in this office should also be aware of the value of using personal stories as a way of gaining understanding of communities' needs.
   - This office should NOT be seen as responsible for actually DOING everything related to Indian health: it should provide strategic guidance, oversight, and coordination to allow DPHHS divisions and other agencies to more effectively serve Indian communities.

Comments on Youth Suicide in Indian Country, and on use of the appropriation for American Indian youth suicide prevention

Participants provided compelling professional and personal testimony about the frequency, causes, and costs of suicide in their communities. Participants made the point that the problem of youth suicide is inseparable from the larger issues that had been discussed over the course of the day.

Participants described the many challenges facing American Indian youth in Montana. For example:

- Native American youth are not used to having a voice in things that affect them, and don't feel they are important.
- The problem of stigma is an important barrier—these are hard issues to talk about, but ignorance of the problem keeps people from getting help or recognizing warning signs.
- Youth are traumatized by having witnessed suicides and by knowing so many people who have attempted or committed suicide. One person related a story of a boy whose brother committed suicide in his presence, and noted that she knows 17 people who have committed suicide. Youth who experience these traumatic events need strong, effective, and stable support, or they will be at higher risk themselves. The frequency of suicide in some communities is, in other words, a major source of trauma and may therefore create a risk for suicide among survivors.
- Cultural activities are helpful: youth need to feel involved, and loved.
- Discrimination in schools was a persistent theme. One person related that a 4th grader in her community was expelled from school, with a comment from the teacher that "he is headed straight for Deer Lodge." Another noted that when she sought help from a high school guidance counselor on applying to college, the counselor "basically just laughed."

Recommendations: use of the Youth Suicide Prevention funds

Opinions were not unanimous, but many people expressed a sense that these funds would be less effective if they were divided among tribes and given out as small grants.

General Comments on the Use of the Youth Suicide Prevention Funds

- Don't do "more of the same" (i.e., current approach to suicide prevention); one person noted that current suicide prevention programs on the reservation are "a mess." Another commented that there are well-funded suicide prevention efforts already on the reservation, but they are working in silos and not sharing expertise and resources or planning/working together.
- Don't split up the money. Splitting it up would be "a drop in the bucket."
- Involve youth in developing the program, and put it toward programming for youth.
- Suicide is a tragic outcome of a much broader, deeper problem. The funds should be used to focus on upstream prevention—on "putting people back together who are broken," rather than on specific suicide prevention programs. Another person offered this analogy: if people keep falling off a cliff, do you buy an ambulance, or build a safety fence?
- One participant offered a counter to this idea, saying, "What makes you think doling it out would be less useful than making a committee? I think we should invest in education." Another young participant said she thought providing youth scholarships might be her preferred option, if she had to choose.
- Don't hire FTEs at DPHHS to administer this program.

- Don't forget to include the urban Indian centers.

Specific Suggestions for Ways to Use the Youth Suicide Prevention Funds

1. Data:
   - One person commented that the numbers of Native suicides reported by Vital Statistics is too low, and suggested that getting more accurate data is one priority.
   - Several commented on the need to better understand what is happening when someone commits suicide; i.e., understanding more about the circumstances of individual suicides in order to better understand what might have prevented them.

2. Identifying best practices: Many people were interested in some sort of research or technical assistance to help identify successful programs and practices, and plan for implementation in Montana. Related ideas include:
   - The universities and tribal colleges could be engaged as resources to carry out this work.
   - Hire or contract with someone to develop a tribally-led curriculum and framework for effective suicide prevention.

3. Coalition of tribal leaders and health experts:
   - The money could help the tribes and urban Indians come together to form a coalition that develops a strategic plan, and works on finding larger sources of funding.
   - A coalition could bring young people together as well, so that they can participate and provide guidance on what is needed.
   - Consult communities to understand their needs and priorities.
   - Consult youth, and involve them in the effort.

4. Use these funds to raise more money: By developing a strategic plan to guide American Indian youth suicide prevention, maybe these funds could be used (at least in part) to bring in additional funds through grants or investments.

5. Youth focus:
   - Focus the dollars on youth-based programming: convene youth, work with them to develop interventions, etc.
   - Work on stigma through mandatory training and education in schools (for youth and teachers).
   - Spend the funds on youth scholarships, because education is the first way to get rid of suicide. If you feel like you're contributing, it will erase the sadness.