



**Arizona American Indian Behavioral Health Forum:
*Communicating and Collaborating for Wellness Needs***

**March 24, 2010
Final Report**

**Arizona Department of Health Services
Division of Behavioral Health Services**

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Introduction

On February 11-12, 2010 the Arizona Department of Health Services (ADHS) sponsored its first statewide American Indian Behavioral Health Forum. The theme for the Forum was *Communicating and Collaborating for Wellness Needs*. This report summarizes the extensive and valuable input received at this event and plans for ADHS' continued focus on addressing the behavioral health needs of Arizona's American Indian population.

Purpose

The purpose of the Forum was to provide an opportunity for Arizona Tribal representatives to dialogue and provide input to the leadership at the Arizona Department of Health Services (ADHS) on a variety of behavioral health issues of mutual interest among the Tribes and ADHS.

Background

Tribal and clinical leaders from all Arizona Indian Tribes were invited to participate. Over 100 individuals representing 14 of Arizona's 23 Tribes were present. Chief Executive Officers from Tribal and Regional Behavioral Health Authorities (T/RBHAs) also participated. [Attachment 1](#) includes a full list of Forum attendees.

The two day event included general session speakers, panel presentations and breakout discussions; the Forum agenda is found in [Attachment 2](#).

A statewide Planning Committee ([Attachment 3](#)) carefully designed the agenda and format for the Forum. Strong collaboration with all Tribal and Regional Behavioral Health Authorities (T/RBHAs) in Arizona, including financial sponsorship, ensured the success of this event. Discussion topics and breakout session focus questions ([Attachment 4](#)) were designed to address important Tribal priorities that had been identified through statewide community input and careful consideration from the planning committee. For example, one panel presentation focused on emerging trends of concern to American Indians in Arizona: prescription drug abuse and gaming addiction.

During the Forum, considerable input from Tribal representatives was received over the two day period. On the first day, general session speakers and panel presentations were followed by afternoon breakout sessions.

Breakout Sessions were designed to obtain input on the following six areas:

1. Adult services
 - a. Crisis services- how can we expand and improve access to crisis services for tribal communities?
 - b. Home and community-based services- how can we improve access to home and community-based services for families living on-reservation?
 - c. Individuals in detention- are there ways to obtain reimbursement for behavioral health services for tribal citizens who are in tribal detention facilities and/or jails?

2. Children and family clinical services
 - a. Wraparound services- how can we enhance wraparound services for individuals and families living on-reservation?
 - b. Child and Family Teams (CFTs)- how can we increase CFT availability on-reservation and their ability to provide culturally appropriate services?
 - c. Youth in detention- is there a way to obtain reimbursement for behavioral health services for tribal youth who are in tribal detention facilities?
3. Addiction, prevention and treatment
 - a. Accessing treatment- how can prevention services and information be made more widely available and more efficient?
 - b. Co-occurring disorders- how can we better identify individuals with co-occurring disorders and better coordinate care to meet their needs?
 - c. Community support services- how can we focus efforts to better help on-reservation families address addiction issues, including gambling addiction, through improved community support services, housing services, and substance-free living and?
4. Challenges to providing on-reservation services
 - a. RBHA and TRBHA Specific Issues- how can we improve the quality of behavioral health care to tribal members, especially on rural reservation areas? How can we improve access to care, transportation services, and overall program management?
 - b. Understanding Governor Brewer's behavioral health proposal to integrate general mental health and substance abuse services with the Arizona Medicaid agency- what feedback can be offered to the Governor's proposal? How would the proposal, if implemented, affect existing services?
 - c. Out of the Box Ideas- If you were designing the behavioral health system, what would be important to you?
5. Revenue generation and program sustainability
 - a. Accessing funding and resources- how can tribes access funding from state and federal programs in a fair and equitable manner to improve tribal behavioral health services?
 - b. The Arizona Healthcare Cost Containment System (AHCCCS)- can we identify methods to make greater use of the 100% FMAP (Federal Medical Assistance Percentage)?
 - c. The Centers for Medicare and Medicaid Services (CMS)- How can we encourage CMS to address regulations impacting tribes that span multiple states?
6. Suicide prevention and crisis services
 - a. Intervention policies- How can we develop greater collaboration among RBHAs, TRBHAs, and tribes to help prevent suicides among American Indians?
 - b. Involuntary commitment- How can we meet the critical need for continued involuntary commitment training?
 - c. Training for RBHAs and providers- How can we best address the need for RBHA staff to be more culturally competent in (a) their working relationships with sovereign tribal governments and (b) their direct care relationships with behavioral health recipients?

On the second day, the Forum concluded in a half day general session where breakout session input was summarized by the session facilitators and further comments were received.

Outcomes

The summary below distills hundreds of comments from the participants on a variety of behavioral health issues. Because of the difficulty of accurately and completely summarizing such a vast amount of input, and to maintain the integrity of the process, a more comprehensive record is included in [Attachment 5](#). This attachment also includes specific behavioral health service recommendations.

Input was organized into the following consistent themes:

- Improving Tribal Consultation
- Building Relationships
- Building Service Capacity
- Addressing Cultural Preferences
- Leveraging Resources
- Improving Access and Operations
- Feedback on the Governor's Proposal for Integrated Care

Each theme is discussed below.

Improving Tribal Consultation

Recommendations in general addressed the importance of tribal consultation and the need to include tribal representatives in policy issue discussions at the beginning. There is an ongoing need to honor Tribal Consultation, and this recommendation came out in all of the breakout sessions. Other recommendations included establishing a Tribal Advisory Council on RBHA issues, asking for the Tribes' help in creating resources that build cultural competency within ADHS and service providers, and following-up on recommendations in this report.

Building Relationships

Recommendations that emphasized the need to build stronger relationships with tribes included: visit reservations, provide more outreach on reservations and to urban Indian programs, listen to the needs of Tribal members, provide stronger coordination between first responders and behavioral health agencies, understand where Tribal citizens come from, and train service providers on the needs of the Tribes.

Building Service Capacity

Recommendations that focused on service capacity needs included: hire qualified Tribal members to provide services, support/sponsor education and training for Tribal members and health care professionals, develop better referral/reference material, encourage expanded licensure of Tribal professionals, educate Tribal citizens on how to better access services and help develop data capture for population and behavioral health needs.

Addressing Cultural Preferences

Recommendations that centered on cultural understanding and preferences included: develop a more holistic approach to wellness based on strength of the family and natural/community supports, expand use of cultural liaisons, show respect for and accountability of individuals and families, approve Tribally appropriate protocols and best practices, recognize and reimburse for traditional healing practices, and help to remove the stigma of receiving services by changing vocabulary and protecting privacy.

Leveraging Resources

Tribal representatives made over two dozen suggestions on expanding, leveraging, re-allocating or allowing creative application of state, federal or other funds. They expressed a desire to better address the needs of rural areas, education and training, crisis services, in-home services, youth in detention, case management, prevention services, holistic and traditional healing, urban Indian health, and the need for additional facilities.

It was suggested that a more fair and equitable approach to funding allocation would be based both on population and needs of the communities.

Tribal representatives that spoke to possible pending voter referendums opposed rollback of Proposition 204 and changes to tobacco tax allocation.

Improving Access and Operations

Recommendations that emphasized improvement to accessing services and overall operations included: use on-line AHCCCS enrollment, maximize AHCCCS enrollment; streamline entry into systems of care (as well as paperwork, documentation and billing); offer continuity of services (for example, after detention); expand services for case management, crisis intervention, prevention, and in-home service needs; provide both health care services and education/training at a place that is convenient to the client; address the unique needs of rural areas; eliminate separation between substance and mental health services; and allow Tribes to make decisions on services and service delivery.

Feedback on the Governor's Proposal for Integrated Care

Input was invited on the Governor's proposal introduced in October 2009, which outlines two recommendations: (a) move administrative responsibilities for serving the General Mental Health (GMH) and Substance Abuse (SA) populations from ADHS and their T/RBHAs to AHCCCS and their acute care health plans, and (b) conduct a pilot program in Maricopa County that integrates behavioral healthcare and physical healthcare for adults with Serious Mental Illness (SMI). This proposal has now been introduced as Senate Bill 1390 and has been sponsored by Senator Carolyn Allen.

Tribal representatives at the Forum asked many clarifying questions and voiced consistent opposition to the proposal. Comments/concerns included: carve Tribes out of the Governor's proposal; ensure RBHA/TRBHA system is successfully transitioned in the event of any change to AHCCCS (MOUs, agreements, relationships); maintain relationships between Tribes and

RBHAs or RBHA providers since these relationships have taken a long time to establish; ensure that T/RBHAs will be at the table in working with health plans as a subcontractor if clients transferred to AHCCCS; ensure funding is not reduced if additional administrative layers are created; ensure as few barriers as possible to participating in an AHCCCS-run system, including ensuring rural services are still available and cultural barriers are considered; ensure that the progress made in the state through child and family teams and other innovative approaches is not lost in any system changes; integrate children and adult systems if adult non-SMIs are transferred to AHCCCS; and consider the needs of urban Tribal members and members who move on and off of reservation settings.

Conclusion

The ideas and input generated at the Arizona American Indian Behavioral Health Forum, 2010 represent a significant step in identifying behavioral health needs of American Indians in Arizona. The implementation of these ideas and recommendations will be the challenge of State and Tribal leaders, as we continue to collaborate and partner so that the care of our people can be improved.

ADHS values and will continue to honor Tribal Consultation. In follow up to the Forum and this report, ADHS will widely distribute this report to staff and stakeholders, including contracts RBHAs and providers. This report will be referenced as annual network analysis and planning efforts are undertaken, as well as annual cultural competency activities are planned. ADHS hopes to sponsor another Behavioral Health Forum next year. At that time, an update on progress resulting from this report can be presented.

Overall, the Forum was a welcome opportunity to share ideas and discuss challenges. [Attachment 6](#) captures the many comments received by attendees as part of the evaluation process of the Forum.

**ATTACHMENT 1
 LIST OF ATTENDEES**

Name	Title	Tribe/Organization
TRIBAL REPRESENTATIVES		
Courtney, Dr. Lisa	Psychologist	Fort Mojave Behavioral Health
Antone, Priscilla	Health & Social Committee	Gila River Indian Community
Foote, Priscilla	Behavioral Health Director	Gila River Health Care
Green, Steven	Executive Director	Gila River Health Care - Behavioral Health Services
Uqualla, Dianna S.	Tribal Council Member	Havasupai
Felter, Mary A.	Hopi Health Advisory Council Member	Hopi Tribe
Joshevama, Jon	Interim Administrative Director	Hopi Guidance Center
Regner, Janet	Consultant	Hopi Tribe
Yazzie-Hunter, Candida	Councilwoman	Hualapai Tribe
Walema Sr., Richard A.	Vice Chairman	Hualapai Tribe
Brannon, Anjanette	Youth & Family Counselor	Hualapai Tribe Health Department
Brummund, Antone	Behavioral Health Director	Hualapai Health Department
Cangialosi, Roger	Substance Abuse Counselor	Hualapai Indian Tribe
Long, Al	Acting NRBHA Director	Navajo Department of Behavioral Health Services
Casuse, Raquel	Contract Analyst	Navajo Nation Department of Behavioral Health Services
Holona, Genevieve	Clinical Specialist	Navajo Nation Department of Behavioral Health Services
Hubbard, Joseph H.	Chief Pharmacist	Navajo Tuba City Regional Health Care Facility
Hunt, Troy	Planner	Navajo Nation Department of Behavioral Health Services
Peterson, Philbert	Program Supervisor	Navajo Nation Department of Behavioral Health Services
White, Elouise	Senior Accountant	Navajo Nation Department of Behavioral Health
Gonzales, Luis L.	Tribal Council Member	Pascua Yaqui Tribe
Alvarez, Catalina	Councilwoman	Pascua Yaqui Tribe
Ybanez, Theresa	Director of BH	Pascua Yaqui Tribe
Aviles, Raquel	Management Assistant	Pascua Yaqui Health
Canez Jr., Luis P.	Program Manager/Men's P.A.T.H.	Pascua Yaqui Tribe

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Alvarez Sr., Alex	Adult Program Manager	Pascua Yaqui Tribe
Alvarez, Jesusita	Program Manager	Pascua Yaqui Tribe
Cory, Clare	Program Manager	Pascua Yaqui Tribe
Henry, Joe	Program Manager	Pascua Yaqui Tribe
Olfano, Chris	Clinical Wraparound Supervisor	Pascua Yaqui Tribe
Valle, Oneida O.	Quality Manager	Pascua Yaqui Tribe
Ybanez, Belia	Coach Mentor	Pascua Yaqui Tribe
Pavatea, Myrna	Behavioral Health Director	Salt River Pima-Maricopa Indian Community
Mendivil, Winnifred	Children & Family Service Manager	Salt River Pima-Maricopa Indian Community
Stevens, Marvin	Manager	Salt River Pima-Maricopa Indian Community
Taylor-Desir, Monica	Psychiatrist	Salt River Pima-Maricopa Indian Community
Reede, David	Vice Chairman	San Carlos Apache Tribe
Kitcheyan, Kathy	Health Director	San Carlos Apache
Lopez, Isidro	Vice Chairman	Tohono O'odham Nation
Quinn, Gary	Health Director	Tohono O'odham Nation
Bowman, Barry	Clinical Director	Tohono O'odham Nation Behavioral Health Division
Miguel, Sgt. Roberta	Correction Officer	Tohono O'odham Nation
Sampson, David	Treatment Coordinator	Tohono O'odham National Behavioral Health Division
Barnick, Louise	Community Health Representative	Tonto Apache Tribe
Arnett, Dr. Bill	Chief Executive Office	White Mountain Apache Behavioral Health Services, Inc.
Hicks, Alan	Counselor	Yavapai Apache Nation
URBAN INDIAN REPRESENTATIVES		
Scranton, Martha	Behavioral Health Director	Native American for Community Action, Inc.
Zephier, Richard L.	Chief Executive Office	Native Health
Huff, Dennis	Behavioral Health Director	Native Health
Yazzie-Devine, Diana	President & CEO	Native American Connections
Fortier, Yvonne	Clinical Director	Native American Connections

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INDIAN HEALTH SERVICE REPRESENTATIVES		
La-Nae, Perci	Medical Social Worker	Indian Health Service – Peach Springs
Phillips Jr., Vernie	Substance Abuse Specialist	Indian Health Service – Supai Health Clinic
Ysaguirre, Julia	CHS Director	Indian Health Services - Phoenix Area
Nye, Dr. Patricia	Behavioral Health Consultant	Indian Health Services - Tucson Area Office
ITCA REPRESENTATIVES		
Montiel, Alida	Health Systems Analyst	Inter Tribal Council of Arizona Inc.
Russell, Kim	Human Services Coordinator	Inter Tribal Council of Arizona Inc.
STATE REPRESENTATIVES		
Nakai, Katosha	Policy Advisor for Tribal Affairs	Office of the Governor
Humble, Will	Director	Arizona Department of Health Services (ADHS)
Allison, Michael	Native American Liaison	Arizona Department of Health Services
Nelson, Dr. Laura	Acting Deputy Director	Arizona Department of Health Services Division of Behavioral Health
Hubbard-Pourier, Lydia	TRBHA Contract Administrator	Arizona Department of Health Services
Lagunas, Jennie	Interagency Services Manager	Arizona Department of Health Services Division of Behavioral Health Services
Lensink, Brian	Bureau Chief	Arizona Department of Health Services Behavioral Health Services Children’s System of Care
Reese, David	Bureau Chief of Financial Operations	Arizona Department of Health Services Division of Behavioral Health Services
Verburg, Angie	Adult Network Operations Specialist	Arizona Department of Health Services Division of Behavioral Health Services
Skurka, Michelle	Clinical Advisor	Arizona Department of Health Services Division of Behavioral Health Services
Luciani, Nicole	Graduate Intern	Division of Behavioral Health Services Office of Prevention
Chicharello, Carol	Tribal Relations Liaison	Arizona Health Care Cost Containment System (AHCCCS)
Jameson, Bruce	Outreach & Planning Manager	Arizona Health Care Cost Containment System

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Westtlake, Kyra	Fee for Service Claims and Policy Manager	Arizona Health Care Cost Containment System
Molina, John	Medical Director/DFSM Assistant Director	Arizona Health Care Cost Containment System
Hubbard, Fred	Executive Director	Advisory Council on Indian Health Care
Guerra, Lydia	Administrative Assistant	Advisory Council on Indian Health Care
Thomas, Kristine	Executive Director	Arizona Commission of Indian Affairs
RBHA REPRESENTATIVES		
Stevens, Terry	Chief Executive Office	Cenpatico Behavioral Health of Arizona
Yellowhair, Sheina	Tribal Liaison	Cenpatico
Calandrel, Jessica	Cultural Competency Coordinator	Cenpatico Behavioral Health of Arizona
Delsi, Olga	Natural Support Specialist	Cenpatico Behavioral Health of Arizona
Chavez, Julia	Tribal Liaison	Community Partnership of Southern Arizona
Deines, Cyndi	Director, Workforce Development	Community Partnership of Southern Arizona
Seaney, Vanessa	Chief, Clinical Systems Management	Community Partnership of Southern Arizona
Clarke, Dr. Richard	Chief Executive Office	Magellan Health Services of Arizona
Roybal, Darcy	Tribal Liaison	Magellan Health Services of Arizona
Covington, David	Chief, Adult Services	Magellan Health Services of Arizona
Jack, Faron	Network Development Specialist	Magellan Health Services of Arizona
Pattinson, Dr. Mick	Chief Executive Office	Northern Arizona Regional Behavioral Health Authority
Wells, Cheri	Tribal Liaison	Northern Arizona Regional Behavioral Health Authority
Harmon, David	Credentialing Manager	Northern Arizona Regional Behavioral Health Authority
OTHER REPRESENTATIVES		
Arnold, Shawn	Marketing Director	ABC Wellness
Siegel, Renee	Director	ABC Wellness
Austin, Cheryl	Consultant	Empowering Leaders
Esposito, David	Consultant	Empowering Leaders
Begay, Carlyle	Principal	American Indian Health & Management Policy
Tonemeh, David	Principal	American Indian Health & Management Policy

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Damon, Lafe	Business Development	Copper Hills Youth Center
Espino, Marc	Clinical Consultant	Zarephath
Williams, Mark A.	Program Manager	Zarephath
Grijalva, Edward	Coordinator Special Populations	Compass Behavioral Health Care
Perez, Betty	Special Populations Liaison	Compass Behavioral Health Care
Hubbard, Marlys A.	LCSW	Bureau of Indian Affairs
Lalio, Filmer	Community Outreach Coordinator	Banner Alzheimer's Institute
Kramer, Loretta	Clinical Director Adult Services	Intermountain Center for Human Development
McHale, Vinnie	Director Adult Services	Intermountain Center for Human Development
Morrow, Diane	Program Manager	Oasis Home
Mounkam, Emmanuel	Administrator	Oasis Home
Nguyen, Le Chi	Student	Western University of Health Sciences
Redhawk-Steele, Victoria	Native Ways Director	The Haven

**ATTACHMENT 2
AGENDA**

**Agenda
ARIZONA AMERICAN INDIAN BEHAVIORAL HEALTH FORUM
*Communicating and Collaborating for Wellness Needs***

Governor's Executive Tower
2nd Floor Conference Room
State Capitol
Phoenix, Arizona
February 11-12, 2010

February 11, 2010

7:00 am	Registration Continental Breakfast (Sponsored by Cenpatico)	
	Master of Ceremonies	Al Long, Acting NRBHA Director Navajo Department of Behavioral Health Services
8:00 am	Opening Remarks	Will Humble, Interim Director Arizona Department of Health Services (ADHS)
	Opening Prayer	Harry Antone, Tribal Elder Gila River Indian Community
	Posting of Colors	Ira H. Hayes American Legion Post Gila River Indian Community
8:20 am	Tribal Leader Remarks	Isidro Lopez, Vice Chairman Tohono O'odham Nation
8:35 am	Tribal/Regional Behavioral Health Authority System (T/RBHA) Overview	Lydia Hubbard-Pourier, TRBHA Contract Administrator, ADHS
	Regional Behavioral Health Authorities Tribal Liaisons Panel	Lydia Hubbard-Pourier, Facilitator Cheri Wells, NARBHA Darcy Roybal, Magellan Sheina Yellowhair, Cenpatico Julia Chavez, CPSA
9:30 am	Children's System of Care	Brian Lensink, Division Chief Children's System of Care and Planning & Development, ADHS/DBHS

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	Tribal Wrap Around Services	Theresa Ybanez, TRBHA Director Belia Ybanez, Coach Mentor Raquel Aviles, Management Assistant Pascua Yaqui Tribe
10:00 am	Refreshment Break (Sponsored by Cenpatico)	
10:20 am	Governor Brewer's Behavioral Health Proposal for Adults with General Mental Health Conditions, Substance Use Disorders, and Serious Mental Illness	Dr. Laura Nelson, Acting Deputy Director, ADHS/DBHS David Reese, Bureau Chief, Financial Operations, ADHS/DBHS
11:00 am	Suicide Prevention and Crisis Intervention	Angie Verburg, Adult Network Operations ADHS/DBHS Markay Adams, Suicide Prevention Coordinator, ADHS
	Clinical and Direct Services Panel	Teresa Ybanez, Facilitator Dr. Clare Cory, Pascua Yaqui Tribe Gen Holona, Navajo Nation Dr. Patricia Nye, Tucson IHS
12:15 pm	Box Lunch (Sponsored by Navajo Department of Behavioral Health Services)	
12:30 pm Nation	Emerging Trends Panel (lunch presentation)	Alan Hicks, Facilitator, Yavapai-Apache Shawn Arnold, ABC Wellness Alex G. Alvarez Sr., Pascua Yaqui Tribe Dr. Joseph Hubbard, Tuba City Regional Health Care Corporation
1:30 pm	Challenges of On-Reservation Behavioral Health Development	David Reede, Vice Chairman San Carlos Apache Tribe Antone Brummund, Behavioral Health Hualapai Tribe
Director,	Revenue Generation and Program Sustainability	Lydia Hubbard-Pourier, ADHS/DBHS
2:15 pm	Refreshment Break (Sponsored by Navajo Department of Behavioral Health Services)	
2:35 pm	First Concurrent Breakout Sessions	
	Adult Services	Co-Facilitators Gen Holona, Navajo Nation Cheri Wells, NARBHA
	Location: 4th Floor Training Room, ADHS, 150 N. 18th Avenue	
	Children and Family Clinical Services	Co-Facilitators Lydia Hubbard-Pourier, ADHS Dr. Clare Cory, Pascua Yaqui Tribe
	Location: 2nd Floor Conference Room, Executive Tower	

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| | Addiction, Prevention and Treatment | Co-Facilitators
Shawn Arnold, ABC Wellness
Renee Siegel, ABC Wellness |
| | Location: Training Room 411, ADHS, 1740 W. Adams | |
| 3:35 pm | Refreshment Break (Sponsored by Northern Arizona Behavioral Health Authority) | |
| 3:55 pm | Second Concurrent Breakout Sessions | |
| | Challenges of Providing On-Reservation Behavioral Health Services: Exciting Opportunities -- Governor Brewer's Proposal | Co-Facilitators
Fred Hubbard, Advisory Council on Indian Health Care (ACOIHC)
Dr. Laura Nelson, ADHS/DBHS |
| | Location: 2nd Floor Conference Room, Executive Tower | |
| | Revenue Generation and Program Sustainability | Co-Facilitators
Al Long, Navajo Nation
Troy Hunt, Navajo Nation |
| | Location: 4th Floor Training Room, ADHS, 150 N. 18th Avenue | |
| | Suicide Prevention and Crisis Services | Co- Facilitators
Lydia Hubbard-Pourier, ADHS
Gen Holona, Navajo Nation |
| | Location: Training Room 411, ADHS, 1740 W. Adams | |
| 4:55pm | Adjournment | |
| 5:30pm | Facilitator/Note Takers Meeting
Location: 1st Floor Conference Room, Executive Tower | |

February 12, 2010

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|----------|---|---|
| 7:00 am | Registration
Continental Breakfast (Sponsored by CPSA)
Master of Ceremonies | Fred Hubbard, ACOIHC |
| 7:15 am | Facilitators Meeting
Location: 1st Floor Conference Room, | Executive Tower |
| 8:00 am | Opening Remarks and Re-Cap of Day One | Will Humble, Interim Director, ADHS |
| 8:30 am | Breakout Sessions Report Out (30 minutes each to include Questions & Answers) | |
| | Adult Services | Gen Holona, Navajo Nation |
| | Children and Family Clinical | Dr. Clare Cory, Pascua Yaqui Tribe Services |
| | Addiction, Prevention and Treatment | Renee Siegel, ABC Wellness |
| 10:00 am | Refreshment Break (Sponsored by CPSA) | |

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10:20 am	Breakout Session Report Out - Continuation (30 minutes each to include Questions&Answers)	
	Challenges of Providing On-Reservation Behavioral Health Services: Exciting Opportunities -- Governor Brewer's Proposal	Dr. Laura Nelson, ADHS
	Revenue Generation and Program Sustainability	Al Long, Navajo Nation
	Suicide Prevention and Crisis Services	Lydia Hubbard-Pourier, ADHS
11:50 am	Summary of Morning Session	Will Humble, Interim Director, ADHS
Noon	Box Lunches (Sponsored by CPSA)	
1:00pm	State Closing Remarks	Katosha Nakai, Tribal Policy Advisor Governor Brewer's Office Will Humble, Interim Director, ADHS
	Tribal Closing Remarks	Gary Quinn, Executive Director Department of Health & Human Services Tohono O'odham Nation
1:45 pm	Relief of Colors	Ira H. Hayes American Legion Post Gila River Indian Community
1:50 pm	Closing Prayer	Harry Antone, Tribal Elder Gila River Indian Community
2:00 pm	Adjournment	

ADHS would like to extend a special "Thank You" to the many individuals and sponsoring agencies that helped in the planning of this Forum. ADHS also wishes to thank consultants Cheryl Austin and Dave Esposito from Empowering Leaders for their expertise and assistance.

**ATTACHMENT 3
PLANNING COMMITTEE MEMBERS**

Michael Allison

Native American Liaison
Arizona Department of Health Services

Planning Chair

Lydia Hubbard-Pourier

TRBHA Contract Administrator
Arizona Department of Health Services

Carol Chicharello

Tribal Relations Liaison
Arizona Health Care Cost Containment System

Bruce Jameson

Outreach and Planning Manager
Arizona Health Care Cost Containment System

Albert Escobedo

IT Business Process Development Manager
Arizona Health Care Cost Containment System

Alexandra “Alex” O’Hannon

Behavioral Health Manager
Arizona Health Care Cost Containment System

Alan Hicks

Counselor
Yavapai Apache Nation

Al Long

Acting NRBHA Director
Navajo Department of Behavioral Health Services

Troy Hunt

Planner
Navajo Department of Behavioral Health Services

Genevieve Holona

Clinical Specialist
Navajo Department of Behavioral Health Services

David Brehmeyer

MST Program Supervisor
Hualapai Indian Tribe Health Department

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Theresa Ybanez
TRBHA Director
Pascua Yaqui Tribe

Fred Hubbard
Executive Director
Advisory Council on Indian Health Care

Dr. Patricia Nye
Behavioral Health Consultant
Tucson Area Office - Indian Health Service

Darcy Roybal
Tribal Liaison
Magellan Health Services of Arizona

Julia Chavez
Tribal Liaison
Community Partnership of Southern Arizona

Cheri Wells
Tribal Liaison
Northern Arizona Regional Behavioral Health Authority

Sheina Yellowhair
Tribal Liaison
Cenpatico Behavioral Health of Arizona

Shawn Arnold
Marketing Director
ABC Wellness

Filmer Lallo
Community Outreach Coordinator
Banner Alzheimer's Institute

**ATTACHMENT 4
FORUM DISCUSSION TOPICS AND FOCUS QUESTIONS**

The following lists the topics, sub-topics and the focus questions for the breakout sessions. Not all groups addressed all questions during breakout sessions due to time constraints, and all participants were encouraged to provide written input to all questions.

(1) ADULT SERVICES

- a. Crisis Services
How can access to crisis services be expanded and improved for tribal communities?
- b. Home and community based services
How can home and community based services be improved to help on-reservation families?
- c. Behavioral health services for detention clients
How can services be maintained for tribal citizens who are serving detention? Is further technical assistance (reimbursement process) necessary?

(2) CHILDREN AND FAMILY CLINICAL SERVICE

- a. Wrap around
How can wrap around services be enhanced to help individuals and families living on-reservation?
- b. Child and family teams
How can child and family teams be developed on-reservation, in a culturally appropriate manner?
- c. On-reservation services for youth in detention centers
How can services be maintained for tribal youth who are serving detention? Is further technical assistance (reimbursement process) necessary?

(3) ADDICTION, PREVENTION AND TREATMENT

- a. Accessing treatment
How can information about prevention services be made more widely available, and how can the provision of these services be optimized?
- b. Dual diagnosis
How can individuals with dual diagnoses be better recognized and how can their treatment be better optimized?
- c. Community support services including housing
What additional efforts can be made to help on-reservation families address addiction issues through community support services and housing?
- d. Sober Living and Gambling
What can be done to encourage substance-free living and address gambling addiction?

(4) **CHALLENGES OF PROVIDING ON-RESERVATION BEHAVIORAL HEALTH SERVICES:
EXCITING OPPORTUNITIES-GOVERNOR BREWER'S BEHAVIORAL HEALTH PROPOSAL**

- a. RBHA and TRBHA specific issues
How can overall quality of care to tribal members be enhanced through RBHAs and TRBHAs, especially within rural reservation areas; including access to care, transportation, program management and scope of services?
- b. Governor Brewer's Proposal
What comments do participants have to offer on the Governor's proposal, and how can the Governor's proposal enhance behavioral health services in tribal communities?
- c. Out-of-the Box
If a new behavioral health system was being designed to best meet the needs of tribal citizens, what would the system look like?

(5) **REVENUE GENERATION AND PROGRAM SUSTAINABILITY**

- a. Accessing Funding and Resources
How can Tribes access fair and equitable funding from State and Federal programs to improve tribal behavioral health services?
- b. AHCCCS issues
How can the 100% FMP (Federal Medical Assistance Percentage) be further used to enhance tribal behavioral health services?
- c. CMS issues (detention and single agency)
Can one state or one set of rules be designated to simplify the programs for reservations in multiple states?
- d. Out-of-the Box
If a new behavioral health system was being designed to best meet the needs of tribal citizens, what would the system look like?

(6) **SUICIDE PREVENTION AND CRISIS SERVICES**

- a. Intervention policies
How can collaboration be increased among RBHAs, TRBAHs and tribes to help prevent suicides?
- b. Involuntary commitment
How can recent education and information on involuntary commitment be continued and built upon?
- c. Mandatory training for RBHAs
How can the cultural competency of staff of RBHAs and other agencies be improved to enhance working with tribal governments and citizens?
- d. Out-of-the Box
If a new behavioral health system was being designed to best meet the needs of tribal citizens, what would the system look like?

ATTACHMENT 5
ADDITIONAL NOTES FROM BREAKOUT SESSIONS, INPUT FORMS & PLENARY SESSION

The following pages capture specific comments and recommendations from the breakout sessions, the General Session on February 12, and written forms available for use throughout the Forum. **These comments have been documented verbatim to the best of our ability, unless otherwise noted.**

Breakout Session #1 - Adult Services

1. *How can access to crisis services be expanded and improved for tribal communities?*
 2. *How can home and community based services be improved to help on-reservation families?*
 3. *How can services be maintained for tribal citizens who are serving detention? Is further technical assistance (reimbursement process) necessary?*
- To improve coordination between first responders and behavioral health agencies and other service providers, those first responders can include: Fire departments, police/sheriff's departments, CHRS, adult protective services, T/RBHAS, court system, local adult care organizations, IHS (Indian Health Services), local behavioral health agencies, etc.
 - It was recommended that a formal MOU be written between targeted agencies to improve communication/coordination. The MOU could also address the role of first responders and who takes the lead when there are cross jurisdiction issues.
 - Tribal cultural sensitivity needs to be provided by local , cultural expertise
 - Don't forget Urban Indians! As well as input from Urban Indian Programs before policy set.
 - Payment for being on call for crisis
 - For example, partner with Havasupai re: cell tower and Telemed to enhance services
 - Detention – still covered by AHCCCS/DBHS – at least automatically re-enroll at release from incarceration to avoid gaps in service at a critically vulnerable time for relapse re: Behavioral Health issues
 - A lot more education is needed around what is T/RBHA? There are a lot of differences between Tribes, and the way services are provided in rural and urban areas.
 - Possible funding for a statewide crisis service/response
 - Define, “when does a crisis end?”
 - Who pays for youth in crisis?
 - How do crisis services get into the most remote areas? (i.e. Havasupai, at the bottom of the Grand Canyon). Approach private sector AT&T, (for example) and see if they can help us.

- In a crisis where there is voluntary transport to a facility; who does it (risky if it is a family member), and who pays? Local development.

Breakout Session #2 - Children and Family Services

1. *How can wrap around services be enhanced to help individuals and families living on-reservation?*
2. *How can child and family teams be developed on-reservation, in a culturally appropriate manner?*
3. *How can services be maintained for tribal youth who are serving detention? Is further technical assistance (reimbursement process) necessary?*

- Important to identify strengths of family (i.e. spiritual) and natural supports
- All departments need to be involved in program development. Avoid silos.
- Barriers include: families don't want to let workers into their home, and don't want others knowing their business
- Use phone communication with families
- Educate families so that they may determine & make choices about services they receive
- Educate others on wrap around process
- Work to make CFT comfortable as possible
- Coordinate with other resources and other agencies (CPS) i.e. communication, to build own & serve own
- See what is "real" on our reservations before policy making & budget decisions
- Acknowledge rural/frontier needs & situations (i.e. travel distances, limited resources, unemployment, less \$)
- Remember & acknowledge traditional values & teachings of the families
- Find & use what worked for our people
- Give families respect, honor, love
- Look at best practice for each child, individually within context of where they come from
- Acknowledge humanity of our children & families
- Allow more time to work way into family
- Acknowledge effect of loss on our children
- Be sensitive to traditional ethics when developing protocols
- Improve access to system
- Improve efficiency to revg (word unknown) services
- Include community/families for strategic planning
- Follow thru on our recommendations
- Online enrollment
- Identify strengths/weakness of family
- Our own people helping us
- Provide "observers"
- Continued support from home RBHA for CFT

- Support educational goals of staff – grow our own
- Expand Telemed – uses
- Get education opportunities information to tribes, for example. U. of Montana
- Overcome-territorial issues
- Breakdown barriers into homes/families
- Include as a part of strategic plan – give it substance
- Collaborate with other service providers
- Barriers include distance, weather (road conditions) and travel costs
- Focus is on the paperwork, guidelines, deadlines, regulations and not the care of the client
- Stigma
- Treatment plans are not congruent with traditional beliefs. Traditionalists have their own ethics and guidelines, and sometimes those clash. Violate a lot of traditional values and beliefs.
- CFT: When training, understand that there are long term interfamily/interpersonal relationships; focus highly on increasing awareness and focus on the positive aspects of the individual and family
- We need to focus on the child & family – know their strengths, needs & natural supports. We need to be “culturally sensitive” and understand that each child, family & tribe is different. Always keep an open mind & realize that “best practices” may not work for the child, family, tribe. There need to be a balance of preserving our culture, history & heritage while still living in today’s world. As native people we live in two worlds!
- Peer supports – Developing and supporting best practices with natural supports in traditional settings that are truly culturally correct.
- As an interim for reimbursement for adult services in detention, until CMS waiver occurs, is to develop recovery peer supports who can go into the detention center & provide peer support run groups. The provision of services to families should be provided to help with the transition home of the person incarcerated in detention.
- Continue svcs during detention (know Fed facilities provide BH svcs – but many tribal detention centers don’t. I know it’s a fed law to not provide svcs – waiver?)
- Get RBHAs to assist with AHCCCS enrollment/RBHA enrollment a few weeks prior to release
- We do get waivers for svc in our area – we’re very grateful.
- Visit the reservation – budgets
- Protocols on clinical manuals – vs tribal
- Rules vs confidential – Individuals/ - Family
- Standards – marriage, step-Parents, common-law provide the treatment – to child
- Have a tribal 638 H. dept hire provide and be reimbursed for providing health and BH services in tribal detention facilities & be reimbursed at 100% FMAP
- State must have state version of the SAMHSA “Strategic Prevention Framework/Tribal incentive Grant” because it: capacity build at community
- educate value of evidence based
- epidemiological focus on substance abuse at community level

- Managed care – current AZ RBHAs based on this concept – erroneous assumption is service providers are on reservations (of course this is not true) – Need tribal input to change this model to better fit tribes - (tribes were not involved when current managed care was developed)
- Tribal – Advisory representatives from each AZ tribes to address issues to RBHAs – state level recognized (each tribes not the same)
- Process orientation versus task
- Not Rx but wellness
- Strength, (word unknown) needs
- Use (word unknown) model to develop best individual community needs and to carry out services
- Need a lot help and money to educate our people, to help tribal members be the teachers
- Help educated and (word unknown) both adult, children, able to help family to visit, or when get out help family when they get out
- Provide training & support to implement services
Manpower – appropriate number of staff to deliver the services & support the family
- In rural areas, find a way to involve the recreation department. Juvenile delinquency is connected to the lack of prosocial activities. Create classes for martial arts, instruments (guitar, flute, drums, etc.). Have field trips to cultural sites and backpacking/camping trips. Less free time means less substance abuse and delinquency.
- Let the tribe create their wrap around and recognize their way as the “right” way.
- Less intake forms, more time to complete intake, focus on the family more than the data/requirements
- Change labeling terms “SMI”. Let the tribe create their own terms.
- If ADHS expects more such CFT’s, provide more resources to hire CFT’s/wrap coordinators
- Less micro-management on IGA’s with TRBA
- Partner with the tribes, visit the tribe to understand tribes barriers and needs before giving mandates and requirements
- Put more heart into the policies & assessments
- Look at ADHS educational requirements for required positions so tribes will be able to have more (entry level) tribal members
- Realize tribe’s own wrap materials and forms
- Give more funds to tribes to hire more wrap/CFT’s coordinators (see menus)
- Allow low level education to bill (third party billings)
- Let tribes develop their own plans to meet their cultural needs
- Build relationships with the tribe by visiting them and listening to their needs understand where they come from
- Community readiness “assessment” before implementing CFT
- Using technology for supervising, educ. & coordination of resources to those conducting CFTs in rural and/or semi-rural areas
- Why does it take so long/hard to start a CFT?

- We develop our own best practices i.e. meeting the client where they are, home visit, school visits, office visits, group homes and foster home. Seeing the client in the least restrictive setting or most comfortable environment and being culturally aware.
- Increase personnel potential by expanding state's student loan repayment program independent of HIS: LRP
- Wrap around: improving entry into the systems of care
- Allow for universal release of information to be available at originating site, decreasing documentation
- If detention is 638 then I believe it may be a possibility for social services, behavioral health or other services come into the facility. Also a possibility would be peer mentoring. I realize it could be a liability issue but if we can work around it that can be helpful. At Hualapai we received a Green Re-Entry grant. We are working to teach youth in the detention center about gardening. The green house will be built at the Boys & Girls Club & detainees will be allowed to go to the green house to do work. The good thing about this is youth will have opportunity to continue work once out of detention & crops grown will be sold in the community.
- The Pascua Yaqui Tribe youth detention facilities is in Globe which makes it very difficult for the youth to receive outreach or counseling svcs. They remain there until time is served or court-ordered treatment. Youth are not given opportunity to see other type of positive services available rather than detention.
- Gila River Tribe contracts (MOU) with Gila River Health care to provide medical and BH svcs to residents at adult detention. Funding is through Tobacco tax. Juveniles are transported to Hu Hu Kaan Memorial for medical and BH services. (Not billable –unless the youth might still be listed as enrolled in AHCCCS.)
- Allow children to maintain AHCCCS eligible while in detention
- Bring services to juveniles in detention
- Bring juveniles to detention center
- ADHS carve-out \$\$ from SAPT Fed. money to service youth in detention. Provide: education, SA; Outcomes: Prevent recidivism
- State needs to understand that on-reservation detention centers/jails do not receive separate/specific funding from federal sources under DOC. On-reservations receive their funds from the Bureau of Indian Affairs – Land Management – Law Enforce = hence the \$ dwindle quickly and tribes must pull \$ from other sources to even provide minimal services in DOC/jails. AHCCCS denies & automatically removes from services because they are to be served by DOC \$. This is not true for on-reservation DOC/jails because they \$ are not allocated by funding sources for BAS services w/in tribal run DOC/jails. Talk to the tribes on this, please.
- ADHS carve out money to service youth in detention.
- Recreation services, a lack of activities is connected to juvenile delinquency
- Develop tribal best practices, with the hope ADHS would recognize the Tribes own best practices.
- There needs to be an advisory council that meets with the RBHAs
- What is the impact of closing JDC's & on tribal youth?
- What are the alternatives to detention? No alternatives, no services in lieu of detention

- No funding for tribes to address possible new responsibilities for juvenile detention

Breakout Session #3 - Addiction, Prevention and Treatment

- 1. How can information about prevention service be made more widely available, and how can the provision of these services be optimized?*
- 2. How can individuals with dual diagnoses be better recognized and how can their treatment be better optimized?*
- 3. What additional efforts can be made to help on-reservation families address addiction issues through community support services and housing?*
- 4. What can be done to encourage substance-free living and address gambling addiction?*

- Need for funding for outreach
- How to access funding for families with problems
- Places for prevention services – schools, community centers, clinics, service centers, chapter houses, grocery stores
- Something like Maricopa Co. Information and Referral Reference Book
- How do I get a prevention program to come into the community and provide a service?
- Capacity to develop and sustain services
- Coordination of care (i.e. assessments, evaluations, etc.)
- Utilization/Integrating staff (i.e. using the Psychiatrist that completed the first assessment instead of just using the Magellan contracted Psychiatrist assessment)
- Individuals not wanting their community to know they are receiving treatment – remove the stigma
- Treat the whole person – holistic
- Funding sources require specific expenditure areas and accounting
- Streamlined system to access SMI services
- Utilization system requires multiple diagnoses
- Provide help when requested, without delay
- Centralized tribal services is a big help
- Change vocabulary to remove stigma
- Increased on-reservation services for families with co-dependency issues
- Transitional treatment after-care on-reservation
- Wellness – balance of harmony – concept is important and needs emphasis – history, tradition, languages
- What happens after treatment – need to involve family
- Increased services provided by tribes to tribal members
- Training of tribal members to meet state licensure requirements
- Model individuals who have overcome addiction
- Focus more on health restoration, obesity, diabetes, eating healthy, for a change free life-style.

- Incorporating substance abuse services with behavioral health services versus clients seeking specific SA services. Otherwise GMH issues are overlooked when sobriety increases and GMH issues begin presenting w/providers who are under qualified to see the indicators of GMH issues. LISAC does not help this concern.
- If discussing return to mind/body/spirit i.e. holistic approach the state must take steps to do away with separation of MHV substance abuse – no GMH or substance abuse but an integrated program of wellness.
- Funding agencies need to recognize Native American Indian traditional practices as best practices. (i.e. best practices have to be researched/researched before it is declared best practices).
- Many tribes have had negative histories of research and do not often allow their traditional practices to be researched.
- I would like to see more alanon & groups of that sort for families on the reservations. There is also a huge need for 12 step groups specifically for teens.
- Importance of self-reflection, self-awareness and traditional values in encouraging and promoting anti-gambling and other substance abuse activities.
- Getting professional certification for tribal providers of services – possible local licensing boards – needs official standing with state
- Dual diagnosis – separation of diagnosis due to funding stream issues – need to break down “silos”. Service people as they need service
- Licensure – frustrating process. That comes up in a sustainability issues. We really need to make something work in Tribal communities.
- State Licensure doesn’t work well for tribal programs
- Reauthorization should include remedy “silo”. Funding – integration in funding issues
- Possible waiver process
- Have a dialogue between mental health and substance abuse and not see them as separate. Historically funding was separated. The providers have done a good job of breaking that down.
- The integration of BH and substance abuse treatment is one of the components of the Indian Health Care Improvement Act. Really advocate for the reauthorization. It’s been reintroduced in a different way. There is a whole section in that which attempts to remedy the historical silo funding.
- More and more licensing is going to be critical. The more tribes that are able to have licensing, it will speed up the reimbursement process.
- ADHS prioritized the requests to go out to tribal lands. That provides a survey report, even though there is no license per say. That goes a long way to helping them meet the requirements.
- Need for increased prevention services especially for rural tribes.
- Economic stability is needed for permanent success.

Breakout Session #4 - Challenges of Providing On-Reservation Behavioral Health Services

- 1. How can overall quality of care to tribal members be enhanced through RBHAs and TRBHAs, especially within rural reservation areas; including access to care, transportation, program management and scope of services?*
- 2. What comments do participants have to offer on the Governor's proposal, and how can the Governor's proposal enhance behavioral health services in tribal communities?*
- 3. If a new behavioral health system was being designed to best meet the needs of tribal citizens, what would the system look like?*

(It should be noted that tribal members expressed consistent opposition to the Governor's proposal. They were concerned with "too many uncertainties" with "how this would affect tribes." More research about how it would affect tribes was suggested. One commented that "TRBHA/RBHA – collaboration & communication is effective & needed." Another said "The system is already difficult to navigate. I don't think this proposal will make it any easier.")

The discussion during the Breakout Session primarily involved clarifying questions about the Governor's proposal itself; therefore the format of this section is slightly different from the others. A summary narrative of the questions posed, answers provided, and comments made are included here.

There are two pieces to the proposal:

- First, administrative responsibilities for serving the General Mental Health (GMH) and Substance Abuse (SA) populations will move from ADHS and their T/RBHAs to AHCCCS and their acute care health plans. This is not a pilot...it will occur statewide. AHCCCS will modify their contracts with their acute care health plans to include behavioral health services for these populations.
- Second, is an SMI pilot program in Maricopa County overseen by ADHS/DBHS. ADHS will contract with a managed care organization to administer both behavioral healthcare and physical healthcare. Outcomes of the pilot will determine if this approach is then carried out statewide.

Most of the questions focused on this first change (i.e. moving GMH/SA to AHCCCS).

Funding that was coming to ADHS and the T/RBHAs for GMH/SA will now go to AHCCCS and their acute care health plans. Better integration of care can save money. TRBHAs pointed out how they already integrate behavioral health with physical health through relationships with IHS/638 providers.

It was pointed out that many tribal members do not routinely use the AHCCCS acute care health plans to access physical health care...they use IHS/638 providers (similar to a

carve-out). Nothing would change as far as access to IHS/638 providers. We will need to figure out how to make access to the behavioral health services easy. Tribal members will likely have access to the same providers, but the providers would contract with different organizations. Tribal members expressed the need to have access to the same providers under any new proposal. The FFS structure for tribal members should not change. There were concerns with AHCCCS being based on financial eligibility, and, by moving GMH/SA services to AHCCCS, it would create barriers for tribal members who do not use the AHCCCS system. The primary focus of the Governor's proposal is on people who qualify for Medicaid. The goal is to ensure that folks that qualify for Medicaid or Medicare get enrolled and stay enrolled.

Tribal behavioral health programs / IHS now are accustomed to integrating behavioral health and physical health care. Perhaps I/T/U's should be carved out of the proposal, because they already integrate care.

It was suggested that a FFS Native American system outside of health plans be developed. Perhaps the tribes could work with AHCCCS to develop a TRBHA system, or merge with a new plan rather than ADHS. There was concern about where the tribes fit if GMH/SA goes to AHCCCS. They asked if we can integrate acute/BH side without system change like this.

It was also suggested that competition among providers is a good thing. The majority are fee for service members; be aware of confusion and possible loss of choice of service providers.

The need to focus on wellness (a holistic approach) cannot be forgotten. Ensure that costs are not reduced by failure to provide needed services. There were concerns expressed about unintended consequences of a decrease in tribal members seeking behavioral health care. They will stick with 638. AHCCCS also believes in community-based services, so would likely pass this along to the acute care plans. For example, Gila River is a community provider, 638 and a TRBHA. They wear whatever hat is necessary to service a client locally. It was recommended that we look at model programs where integrated physical/mental health care already exists. Many of our TRBHAs are ahead in terms of integrated care (i.e. Gila River). Use existing programs as models for new proposal.

Do not lose the innovative things that are good, like Child and Family Teams. An attempt to integrate may actually separate the children's system from the adult system. While the adult GMH/SA would be served through the AHCCCS system, and the children would be served through the ADHS system, the actual providers in the community should not change. There would be no changes in the children's system, including as it relates to children who become a ward of the court.

Lawsuits drive too many of the changes for tribes. Why make such big changes based on something that only applies to Maricopa County? The Governor's proposal is much

bigger than the court order and law suit; her intentions are to look at opportunities across the state.

Rural members have hard time getting services.

There has been much effort to develop the relationships now in place. There are MOUs, and RBHA Tribal Liaisons. We do not want to start all over.

This plan proposes 1 entity for services to SMIs. For the SMI pilot, there were concerns with asking SMI members to learn a whole new system. This can be difficult for them.

Other comments related to questions 1 and 3 above included:

- Indian Health Services (IHS) covered benefits need to better fit (i.e. rural). Reexamine IHS services to meet the needs of tribes.
- Allow TRBHAs to develop their own culturally competent comprehensive assessment rather than require one created by ADHS.
- Make one RBHA responsible for a specific tribe – now some have 3 –let the tribes choose the RBHA they want out of the RBHAs that have tribal land in their Geographic Service Area (GSA)
- Don't forget Urban Indians – 60% of Natives live in urban settings, and behavioral health/acute medical services don't always serve them adequately. Many Native Americans move back and forth between reservation and off-reservation settings for many reasons, including cultural responsibilities; the system must recognize and respond to this.
- IHC Pharmacy reimbursement – better when enrolled in Native American Plan under AHCCCS
- Truly integrated system would include spiritual health/wellness; traditional healers would be recognized the same as BH/MH and PH professionals; reimbursements for these services would be comparable to all other professional services.
- A native person would be given a health/BH card that they could take to any provider of their choice. That provider would then be able to bill at 100% FMAP rates for all services provided by medical or Behavioral Health care.
- Reservations are very different from the majority culture. Carve out tribes from BHS. Expand mandate out of RBHA/TRBHAs to assistance with 638, other aspects of care.
- Vast difference between how TRBHAs and RBHAs operate. Their leadership needs to be included.
- National BH & tribes discussion
- Expand the number of TRBHAs
- Include 1st state & nation treating each tribe as sovereign. Also give tribes the opportunity to provide services in what they feel are the best ways to provide treatment to their people.
- Allow Tribes to identify, choose, and be primary mechanism to determine services and best means of service delivery
- Creation of a Native American health Plan will not better the system when there are providers and tribal based providers who have excellent programs. These existing Native

American Indian providers need to be part of the various members of Health care plans that exist – throughout Arizona.

- Opportunity for Indian Health Plan for both physical & mental health services

There were also questions and comments related to the Governor's Fiscal Year 2011 proposed budget, including:

- Tribal members want to be included in developing budget cut proposals.
- Tribes have a hard time signing clients up with AHCCCS. DES offices are closing. It is hard to get enrolled and stay enrolled with AHCCCS.
- If Prop 204 gets rolled back, there will be many fewer who qualify for AHCCCS.
- Positive comments were made about the Medicare Part D on-line enrollment form. It would be good to have an easy AHCCCS-enrollment form to use.

Lastly, there were questions about who would provide behavioral health crisis services. Dedicated crisis funding would still go to ADHS and the T/RBHAs to provide for crisis phones, mobile teams, and other needed services. But we will need to maximize this money. This will need to serve non-TXIX individuals as well. For non-TXIX individuals, they may not have many service options, because the funding is just not there anymore. If they are SMI, they will still have some services, but the benefit package is likely to change.

Breakout Session #5 - Revenue Generation and Program Sustainability

1. *How can State and Federal programs for fair and equitable funding be better accessed to improve tribal behavioral health services?*
 2. *How can the 100% RMAP (Federal Medical Assistance Percentage) be further used to enhance tribal behavioral health services?*
 3. *Can one state or one set of rules be designated to simplify the programs for reservations in multiple states?*
 4. *If a new behavioral health system was being designed to best meet the needs of tribal citizens, what would the system look like?*
- Work with other funding streams, New Mexico program as an example: ATR (access to recovery grant)
 - Provide services/professionals to be able to bill for svcs psychiatrist/qualified staff
 - More providers on-site for better care and possibly increase cost recovery
 - In-level services for matching funds
 - Continued funding is vital for program continuity
 - Culturally appropriate services
 - Capacity building for tribes to generate better data. Capture data (critical)
 - Get clients AHCCCS enrolled
 - Advocacy across board for Prop 204 – protect what we've got, formal tribal responses. Opposition to redistribution of tobacco tax funds
 - Build more residential treatment facilities on-reservation

- Native American care out – federal funds direct to tribes to manage themselves
- Give money to tribes to manage themselves
- Open case management, transportation, and RTC services to OMB rate
- Open traditional services to FMAP or reimbursement
- Consistent rate (other than OMB Rate) across the board among states
- Licensing reciprocity among states – more friendly/less complicated
- CMS – local state
- Single state agency/single federal region designation
- Allow us to do thing ourselves – svcs.
- Discuss “best practices” keeping in mind unique needs/situations of our tribes
- Use holistic approach to providing access to all BH & support services
- “One stop shop”
- All svcs should be based on individual tribes – can’t have one that meets needs of all
- Build/enhance full spectrum of services, for example better recovery and aftercare
- Single application process
- Purchasing collaborative - all resources/agencies leverage funding for behavioral health services (TANF, Aging, Education)
- Comprehensive BH services inclusive of all (BH, TANF, social services, primary care, mental health, IHS,)
- Integration of all services consistently and parity with other populations, but relevant to Indian Country and Indian health delivery
- Refine system – Build and invest the structure of the system
- Build peer support individuals to be more solid in the community
- Provide services that are community and home based
- Revitalization of tribal traditions, cultures, values, family foundation
- Svcs at/in home community
- Revitalization of our traditions, cultures, family values as a foundation
- Single application process
- Purchasing collaborative – all resources/agencies leverage funds for BH services (Aging, Ed, TANF)
- Comprehensive BH svcs inclusive of all (BH, TANF, soc svcs), primary care, Mental Healthcare, HIS
- Integration of all services consistently with parity
- Build/invest in the structure of the system
- As a component of revenue generation and sustainability I recommend that the Governor explore with the State/Tribal gaming compact renewals that a percentage of the revenues the state receives from gaming tribes is carved out to support the 3 state urban Indian health program for both primary care and behavioral health services in an equal manner
- Tribes have a lot of opportunity to generate funding, and resources by using certain leverages

- Example cited of working with the NM government to access ATR funds in the Gallup area, so when the programs are implemented the tribes get the benefit of those programs. This may apply to other funding sources.
- A theme throughout all of the presentations. Capacity and capability building. Necessary in all tribal programs. Only we ourselves know what the needs of our people are, and how to best meet those needs.
- How do veterans in rural areas that need help, get help, especially the elderly? PTSD, etc. Think about how can provide post traumatic stress treatment to the veterans on the reservations.
- Base funding formula on population and behavioral health care needs. Some Federal agencies are starting to recognize this. They aren't just using a formula just based on population i.e. a \$20,000 base for all tribes plus the number of children you have. Small tribes would be allowed to have consortiums.
- IHS Database difficult to access
- Investment in up to date IT system to capture real time data-treat as business investment. The ITS system is very archaic. Reinforce the tribes need to look at this as a business model. Make as proposal to tribal councils, they have to pass those resolutions. This has to be done.
- RBHAs can be leaders in data developments
- Difficulty in migrating RPMS to local systems. RPMS is so antiquated. Need people who are real time experts, to do the migration of the information.
- Possible state-wide tribal work group to work on issues like this (IT). (Aberdeen tribe doing similar initiative data collection reporting system).
- Tribal sovereignty – Tribes need to address community development needs rather than funding driving actions
- Importance of Tribal Council lawyers
- Estimated impact on tribal nations of Prop 204 is 10%, which is 31,000 people.
- Funds are piecemealed, short term, and grant money is a shot in the arm. It only fixes whatever that fund is for, versus what needs to happen in these communities.
- Theme across the board, give money to the tribes to fund their own services.

Breakout Session #6 - Suicide prevention and Crisis Services

1. *How can collaboration be increased among RBHAs, TRBHAs and tribes to help prevent suicides?*
2. *How can recent education and information on involuntary commitment be continued and built upon?*
3. *How can the cultural competency of staff of RBHAs and other agencies be improved to enhance working with tribal governments and citizens?*
4. *If a new behavioral health system was being designed to best meet the needs of tribal citizens, what would the system look like?*

- Presence and face to face contact goes a long way to create collaboration
- Collaboration developing a community crisis team – work a protocol system (creating an MOU between stakeholders to ensure collaboration)
- Pascua Yaqui – has a 24 hour crisis system
- Collaboration RBHA/TRBHA for crisis hotline/triage
- The RBHAs do provide crisis services but the tribal recipients are reluctant to use the crisis services that aren't provided by tribe
- Training on CBHS system
- Meetings with service agencies to establish protocol & MOU
- Transportation issue with respect to crisis
- Aftercare for families of adolescents – psychoeducational – 5 week multi-disciplinary
- Increase trainings (ASIST, QPR, Native Hope), on suicide prevention and intervention training within the tribes
- Improve orientation of IHS staff
- Increase community-based support
- The tribal nations do not have the same involuntary commitment laws – have attorney involved to define the two law areas
- Co-locating on the tribe (in tribal providers) to get a better understanding and feel for the tribal culture
- Cultural competency is moving away from just focusing on CLAS standards to a more broad aspect – looking at special populations: CBHS has backed away from trying to require CLAS standards to ensuring that tribes are providing services to special populations (specific to language)
- Office space (on reservation) for RBHA staff
- Utilize Cultural Liaisons
- Need to have collaboration with every single entity
- Be flexible in crisis policy development and modification
- Own sub-acute facility on reservation
- Be flexible in crisis policy development/modification
- Tribal govt representatives & Tribal behavioral health representatives need to be given the opportunity to educate the RBHAs about their mental health codes, resources, policies & procedures.
- Making sure that traditional healers are incorporated, covered, & reimbursed by the RBHA, or TRBHA.
- Real need for more training to help providers coming out, and the RBHAs themselves, i.e. when a tribal program calls for a referral to a crisis intervention, they are told, you are not eligible, go to IHS. Also, a high turnover of BH staff.
- In terms of cultural competency, individual tribes work differently. The other part of cultural competency is how tribal programs use their own specific cultural beliefs and values in their treatment models
- Collaboration among tribes, IHS and state to decrease suicide rates needs to continue

- White Mountain Apache Tribe got a grant, when there is a crisis from IHS emergency room, White Mountain staff are called and provide follow-up and after care (TRBHA). Best throughout the state – may be good model for others
- Dramatic decrease in suicides with Gila River TRBHAs. The involuntary commitment process training needs to be expanded to include the judicial system, and be aimed at RBHA providers. Would like technical assistance to tribes on how to develop their tribal code that could be enforced off-tribal lands.
- Look at the 3 TRBHAs and how well they are working, i.e. Gila River's outcomes. The dramatic reduction in suicides with that model
- How do we fill in the gaps in between the Tribes, RBHAs, State, and recipients?

**ATTACHMENT 6
EVALUATION FEEDBACK**

1. What was the most helpful information you learned about Behavioral Health?

- Current legislative and political happenings
- Tribal Liaison activity reports and future direction
- How this addresses needs of tribal members
- Networking, discussion
- Learning about other programs and how others provide services
- The acronyms such as GSA, T/RBHA were explained and understood
- Why HS important to enroll CHS on AHCCCS.
- The explanation on the budget cuts.
- How much work we still have to do
- The most helpful information that was helpful was that the different tribes and programs got together and shared what going on with the tribes and discussions of this Forum.
- How crucial the role and functions of RBHA and T/RBHA are and how important that interface is and that interface must be seamless without any “silo’s”
- It was all helpful and informative.
- More clarity re: fund sources/distribution
- Networking with others
- The whole thing presented was very informative. There information are helpful in working with the Native American people.
- Complexity of system and challenges for solutions for all to Native people both on reservation and in urban areas.
- Needs/focus for tribes
- Coming changes
- All the tribes do need to work more closely to insure that the members/community get what is needed
- Coordination of physical health and mental/behavioral health
- How the RBHA and TRBHAs work
- Where do I begin? The open dialogues format and organization
- Yes to a certain extent. I thought this forum was to discuss impacts to Indian tribes on budget cuts. Instead we basically heard tribal reports in how well they are doing. It was very informative.
- The Governor’s proposal
- Possible budget cuts that my affect services to tribe
- Learning about the processes with ABHS/DBHS
- Learning from the other tribes about their systems of care and challenges they have in accessing care.
- The combined knowledge related about the diverse systems of care – knowledge about new policies/etc. re: BHS
- Comfortable chairs. Haha!
- All information was very important & vital. Information showed that TRBHA’s are on the same page & want to continue to improve.

2. What suggestions would you like to make for a future Forum?

- Minimize educational components – substance abuse, RBHA system review
- To continue not let draw dust
- Time for TRBHA providers to network with one another and ADHS personnel
- Tribes that are 638, have enrolled T/RBHA, RBHA, AHCCCS in place to help those tribes that are (word unknown) to this or thinking about it to help each other out.
- Just to continue these Forums on regular basis

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- My suggestions would be to continue with this types of Forum. There is more of this need especially with the cuts.
- Have another forum to include the Governor.
- A presentation (if possible) by a patient about real experience(s)
- All sessions in one building
- N/A
- Billing for services and comprehensive system that allows for 100% FMAP to include urban priorities
- Make this an annual event
- More representation from Urban Indian Centers & Programs
- To send an update to those in attendance say in six months to see the outcomes of “where we are”.
- More long breaks between sessions to allow for more networking.
- Quarterly meetings for updates on Forum outcome
- Include non RBHAs and non TRBHAs (Tribes) on strengths/programs “model BH programs in Indian Country.
- More of the same
- I still think if this is the case then NARBHA should be on the program to let us know what they are doing.
- Give more time to critical presentation discussion on such topics as Governor’s proposal
- Would like annual and biannual meetings regarding policy changes, budget changes, and organizational changes
- Not starting so early
- First, I really would like it to be a yearly event. I thought it was an outstanding arena to share thoughts and ideas.
- Be interesting to hear response from Governor Brewer. How much of this will she take into consideration.
- I would like more cultural ideas related/how Tribes reach all the on the ...info on program (they ... models, etc.)

3. What might be helpful follow up from the Forum?

- Communication regarding impact of Forum
- Know problem, what are solutions, who to do what with time frames?
- Follow up on recommendations from conference
- New policies from the Governor
- More success stories
- Get ADHS and governor’s staff out to the reservation & Indian communities
- Budget cuts on what can be billed to continue generating revenue
- Monthly or quarterly updates
- I feel that there should be a follow-up with this forum.
- Regular status updates from State, RBHAs, T/RBHAs = e.g. Qtr. Bulletin??
- A report with results succinctly – what will be done? Any changes with proposed cuts tribally Governor Brewer?
- Need to look at follow up report first
- Good to have development of Task Force/Workgroup re: Recommendations
- Need legislative/political grassroots action committee
- Email us the information right away
- In follow up, a possible ½ to the above suggestion. The formation of the work group of all tribes to take on a work plan of the changes that need to be made. As suggested, involve the RBHA Tribal Liaisons to bridge some of the gap.
- Keep attendees informed of further developments before next Forum
- Emails summarizing what follow up steps are being taken
- Invite 3rd parties to the next forum
- To hear on the Governor’s Proposals

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- Dissemination of report by 3-mail to participants and bulletins regarding process in State legislature of Governor's proposal
- Maybe hear real people from different ... to express their needs and how to navigate through all the paperwork.
- The report that will be sent to the Governor
- The forum - ...continue to dialogue – re: change and change agents

4. If we could provide a training or orientation for new staff on the essential components of Behavioral Health Services, what topics would you include?

(Possible examples include: 638, MOU's, eligibility requirements, revenue stream)

- RBHA to host trainings targeting professionals/educators/judicial working with Native population etc. on systems and how to navigate BH systems
- For ADHS staff: * TRIBAL SOVEREIGNTY *
- Information that not all tribes are at the level to advance themselves due to tribal heads to department heads.
- A comprehensive overview
- All of the changes that is coming forward with Behavioral Health Service etc. funding, training, and training.
- Model programs that have faced all issues at hand, that's still operating.
- Available IT resources (vendors?) although I acknowledge the conflict of interest issue – Is there state IT resource person that can present how to build?
- All of the above
- 638, MOU's and eligibility requirements
- Eligibility and continuity of care
- Preparation and implementation of after care.
- Cultural sensitivity. Ways to employ culturally sensitive methods to return control and empower tribes to care for themselves
- Involuntary commitment, Tribal sovereignty, Eligibility requirements
- Eligibility requirements, revenue stream
- All of the above – smaller tribes should be given support on G3P/passe... billing
- I believe a simplified version of flow – chart of how the systems work together would be ...helpful
- Eligibility requirements & revenue stream
- Do a web...., made available to educate on how the Tribal system works
 1. The need to be invited.
 2. A resource directory – for those who don't know – what is on the reservation.

Other comments for the Forum Planning Committee

- Excellent!
- If the Feds put SST aside funds for tribes why not the state. Have a Native American Plan and partner with RBHAs and TRBHAs directly.
- Please help us follow-through on requests to ADHS to provide culturally competent services to TRBHA consumers. Let us do our own, culturally appropriate assessment.
- Use feedback – don't let it sit and gather dust
- Keep it up
- It's good to see and hear from various tribal leaders, have more rep's.
- Hear from the spiritual leaders about how they have impacted mental health issues.
- Very comprehensive agenda and forum discussion – a huge task well done regarding vast issues with daunting challenges.
- Keep up the good work.
- Al Long was very entertaining ☺
- Good job on this session

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- If AHCCCS will be billed directly in any case for behavioral health services out office & case management services
- Make to follow up on many great ideas that have been suggested. Do another Forum in another year, and let us know what was accomplished – what other ideas are being worked on/in progress. The Forum was very informative and educational, thank you for your hard work!!
- Terrific job! Keep up the good work.
- It was an honor and a privilege to attend and participate in this process
- This was not what I expected – thought this was to discuss budget cuts. Just like Katosha said the Governor wanted feedback and what the impacts would be – non of this was discussed.
- The agenda gave a lot of time to highlights of ... DHAS / BITS / RBHAs – if that is the focus than it should be balanced with tribal success also. I would have preferred to hear more and discuss in detail the governor's proposal – this is critical to the states and for tribes to give inputs.
- Great job! Very informative.
- All went well – Thank you for the opportunity to learn more
- Hopefully this will continue to happen every year And that we as TRBHAs get stronger to help our people. Thank you all for your planning of this forum. Great job!