

# Statewide Arizona American Indian Behavioral Health Forum II

“Policy & Service Delivery in a Changing Environment”

## **Final Report**

February 15-16, 2012  
Cliff Castle Conference Center  
Camp Verde, Arizona

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*\*Note: All power point presentations can be found at the ADHS Native American website at <http://www.azdhs.gov/diro/tribal/> and at the ADHS/DBHS website.*

## **Acknowledgements**

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- Pascua Yaqui Tribe TRBHA
- Gila River Indian Community TRBHA
- Verde Valley Guidance Clinic
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- Community Partnership of Southern Arizona RBHA
- Magellan Health Services of Arizona RBHA
- Cenpatico Behavioral Health of Arizona RBHA

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The Yavapai-Apache Nation

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Walk-in-Balance Center, Inc.

## Executive Summary

On February 15-16, 2012, the Statewide American Indian Behavioral Health Forum II: *Policy and Service Delivery in a Changing Environment* was convened. Multiple agency partners sponsored the Forum. The primary partners were the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), the Tribal and non-tribal Regional Behavioral Health Authorities (TRBHA/RBHA) and the Yavapai-Apache Nation. The Forum's overarching goal was to provide an opportunity for Arizona tribal representatives and behavioral health providers to present updates and share accomplishments and challenges, to discuss current state and federal policy issues impacting service delivery, and share concerns and barriers to enhancing the delivery of behavioral health services for American Indian communities. The Forum was designed to build upon Forum I recommendations and provide an opportunity for participants to describe how past issues had been addressed and convey any outstanding concerns.

The Forum included general session speakers and panel presentations. The event was attended by 111 individuals from across the state, including state, tribal, and federal representatives and consumers of behavioral health services. This Final Report includes summaries of presentations and discussions, as well as a synthesis of needs and priorities expressed by the attendees. Considerable progress has been achieved in strengthening the behavioral health delivery system, although several recommendations were made to address the strict requirements that TRBHAs are subject to, additional funding to support integration in rural areas, and continued consideration for the value and need for cultural competency. It is apparent that service and infrastructure gaps and barriers still exist. This underscores the need for further discussions and service improvements. The evaluation summary shows an overwhelming number of participants' expressed overall satisfaction with the Forum, presentations, and presenters' level of knowledge of the topics. They were pleased with the content and usefulness of the presentations. The venue and location garnered high praise.

## Introduction

On February 15 and 16, 2012, multiple agency partners including the Arizona Department of Health Services (ADHS), the Tribal and non-tribal Regional Behavioral Health Authorities, and the Yavapai-Apache Nation sponsored the statewide American Indian Behavioral Health Forum II. The theme for Forum II was *Policy and Service Delivery in a Changing Environment*. This report summarizes the proceedings and participant input received at this event.

## Purpose

The purpose of Forum II was to provide an opportunity for Arizona tribal representatives and behavioral health providers to provide updates and describe accomplishments and challenges to tribal, state, and federal leadership and participants in Forum II.

Forum II Objectives build upon Forum I, to:

- Provide an opportunity to offer input on outstanding concerns;
- Provide information on current state and federal policy issues affecting service delivery; and,
- Provide opportunity for T/RBHA, IHS, Tribal (638) and Urban Indian Health programs to address their concerns for enhancing service delivery in Arizona American Indian communities.

## Background

Tribal, state and federal behavioral health board members, administrators and clinical leaders from all Arizona Indian Tribes were invited to participate. One hundred eleven individuals attended with 43 representing 12 of Arizona's 23 Tribes. Chief Executive Officers and staff from Tribal and Regional Behavioral Health Authorities (T/RBHAs) were present. Eighteen representatives from the Urban Indian Health Programs (UIHP) and the Indian Health Service (IHS) also attended. See **Attachment 1** for a full list of Forum II attendees.

The event included general session speakers and panel presentations on various topics and behavioral health program updates. See **Attachment 2** for a copy of the Forum II agenda.

A statewide Planning Committee designed the agenda to fulfill the Forum II objectives, to build on Forum I recommendations and to provide an opportunity for participants to describe how the issues had been addressed in their areas, as well as any outstanding concerns. See **Attachment 3** for a listing of the Planning Committee members.

## Evaluation Summary

Overall, the Forum was given a 96% satisfactory rating. An overwhelming number of participants expressed overall satisfaction with the Forum, presentations, and presenters' level of knowledge of the topics. They were pleased with the content and usefulness of the presentations. The venue and location garnered high praise.

According to the feedback, respondents enjoyed the length and format of the Forum. They would like to hear more from tribal leaders, and suggested topics for future forums, such as RBHA and Tribal success stories, cultural sensitivity, rural/tribal service issues, AHCCCS reimbursement and billing specifics, etc.

Areas of follow up activities that respondents suggested include getting shared updates on urban and tribal programs, listing of contact information for attendees, and receiving status updates on ADHS and AHCCCS for the upcoming fiscal years. See **Attachment 4** and **5** for a detailed evaluation report and list of abbreviations.

## Proceedings – Day One

**Welcome and Opening Remarks:** Michael Allison, Native American Liaison, Arizona Department of Health Services (ADHS) and Fred Hubbard, Executive Director of the Advisory Council on Indian Health Care, both welcomed the attendees. Don Decker, Apache Spiritual Leader, gave the opening prayer. The Yavapai Apache Nation Honor Guards, Larry Jackson and Billy Garner, posted the colors. Opening remarks were offered by Linda Evan, Councilwoman of the Yavapai Apache Nation. The Honorable Chairman, David Kwail, Yavapai-Apache Nation, also joined the Forum and addressed the Forum attendees.

**Forum I Report and Forum II Objectives:** Following the opening welcome and remarks, a report of the Forum I proceedings was provided by Lydia Hubbard-Pourier, ADHS/DBHS Tribal Contract Administrator, followed by a description of the intended objectives of Forum II by Alida Montiel, Health Systems Analyst, ITCA.

All power point presentations can be found at the ADHS Native American website at <http://www.azdhs.gov/diro/tribal/> and at the ADHS/DBHS website.

**Budget and Economic Overview:** Tom Betlach, Director, AHCCCS, presented an update on the state's economy and the budget for the state, including AHCCCS. Mr. Betlach described the Arizona economic trends, recent Federal policy and budget decisions, including the impact on the AHCCCS budget. He showed the growth in the AHCCCS population, as well as the trends in enrollment and AHCCCS spending. He also described the status of Tribal issues recently

changed or still pending at AHCCCS. Mr. Betlach reported that numerous tribal consultation sessions have been held over the past two years, due to the many policy and budgetary changes. He noted the accomplishment of the federal waiver status and shared that payment levels continue to increase for IHS and 638 tribal facilities. He stated the future challenges facing AHCCCS and consequently delivery of behavioral health services and health care to tribes and tribal members are: (a) Implementation of Health Care Reform – Impact of 350,000+ additional enrollees; (b) Development of the Health Insurance Exchange – Arizona received a \$29 million establishment grant and RFP development for Exchange functions; (c) Development of Health-e-Arizona as part of infrastructure development; (d) Developing a contract for health integration efforts; (e) Establishment of Maricopa County Seriously Mentally Ill (SMI) integrated health home for SMI members; and, (f) Children’s Rehabilitative Services moving to develop a single health care plan for all eligible kids.

Participant Comments/Questions: *How will the elimination of the one-cent sales tax affect Medicaid services in FY2014?* Mr. Betlach replied that the expiration of the one-cent sales tax would create a loss of approximately one billion dollars; however, voters must approve to eliminate the one-cent sales tax initiative.

Participant Comments/Questions: *There is a lack of available services and there are challenges with bringing staff to rural areas. Non-Title XIX client needs are not being addressed or met. For example, young men without children are no longer eligible for behavioral health services. They are often in high-risk categories for needed services.* Mr. Betlach commented that the decrease in covered services to only medication management of childless SMI adults was necessitated by state budget cuts. Mr. Betlach indicated that this coverage for childless adults previously cut in the state budget is being reviewed for return of some of the coverage benefits and the reinstatement of those particular benefits might be based on outcomes of pending lawsuits.

Participant Comments/Questions: *What is the status of exemptions for American Indians?* Mr. Betlach indicated that CMS is still reviewing this. AHCCCS hopes to receive a response from CMS soon.

Participant Comments/Questions: *Verde Valley Guidance Center (VVGCC) has hired primary care providers in the NARBHA region and has experienced good outcomes. VVGCC has found there is no integrated health IT system in existence. Is AHCCCS aware that communication systems do not “speak” to each other, as there is no “one” medical record for integrated health services?* Mr. Betlach agreed that there is a need for IT/data to flow between agencies and that the integrated health model is forcing systems to recognize that it is time to change the way AHCCCS does Medicaid/Medicare business. AHCCCS is facing these challenges head on.

Participant Comments/Questions: *Due to current issues with auto-enrollment, there have been recent recommendations to include a choice box on the AHCCCS eligibility form for American Indians (AIs) to choose their RBHA/TRBHA. Will this be implemented?*

Mr. Betlach indicated that he would be following up on this when planning for the changes to be implemented in FY 2013.

**Regional Behavioral Health Authorities (RBHA) - Tribal Liaison Panel:** This panel presentation finished the morning session of the first day. Each of the four RBHAs, Northern Arizona Regional Behavioral Health Authority (NARBHA), Community Partnership of Southern Arizona (CPSA), Cenpatico, and Magellan provided an overview of the Tribal Liaison's role in the RBHA system, including a description of the structure, unique aspects, accomplishments and efforts to enhance behavioral health services to tribal members on-and-off reservations in their ADHS contracted geographic service areas (GSAs).

NARBHA – Northern Arizona Regional Behavioral Health Authority – Cheri Wells, Tribal Liaison opened up the panel presentations by commenting that NARBHA serves eleven tribes in their GSA. She highlighted NARBHA collaboration efforts with Tribes, including honoring sovereignty by formalizing agreements, developing crisis protocols with local stakeholders, advancing communication through telemedicine and Protocol crisis line, providing trainings to advance skills of providers, and facilitating ongoing monthly and quarterly tribal coordination of care meetings. Ms. Wells indicated that Memoranda of Understanding (MOUs) are in place for NARBHA providers, including Mohave Mental Health Clinic (MMHC) with Hualapai and Ft. Mojave Indian Tribes and Southwest Behavioral Health Services (SBHS) with Hualapai and Ft. Mojave Indian Tribes, and The Guidance Center (TGC) with the Havasupai Tribe. She noted 33 crisis calls and 23 non-crisis calls were received from Havasupai, Hualapai, and Hopi (July to December 2011). Ms. Wells concluded by sharing that various trainings are offered, such as Applied Suicide Intervention Skills Training (ASIST), Tribal Involuntary Commitment Process, and Mental Health First Aid.

Magellan Health Services of Arizona – Darcy Roybal, Tribal Liaison, presented an overview and stated that Magellan serves three tribes and partners with two TRBHA's in their GSA (Maricopa County). She notes their efforts to improve coordination, quality, access to care, and trust relationships with tribes through enhanced tribal coordination and community involvement. She further highlighted their successful collaborations: Crisis Services in two tribal communities with formal agreements with tribes; IHS and Urban Indian health providers, advanced Adult and Children services in the San Lucy Village of the Tohono O'odham Nation; Transition Age Youth Forum; Southwestern Institute for the Education of Native Americans (SIENA), Native Youth Suicide Prevention initiative; and Tribal Raise Your Voice. She also mentioned a co-located

collaborative agreement with IHS Phoenix Indian Medical Center (PIMC) to place Magellan providers at their facility. She emphasized that the agreement strengthens service delivery in the areas of crisis preparation and recovery, mental health evaluations, and connectivity with high-risk patients with primary care.

Cenpatico Behavioral Health of Arizona – Sheina Yellowhair, Tribal Liaison, commented that Cenpatico serves seven tribes in their three GSAs and eight counties. She highlighted their ongoing initiatives, including letters of agreement, tribal collaboration, improving access to services, community outreach, and cultural competency. Tribal collaboration efforts include monthly and quarterly collaboration meetings and representation on a Tribal Task Force. She further noted successful collaborations in developing crisis services protocols. Ms. Yellowhair concluded by highlighting the expansion of the MMWIA initiative - “Meet Me Where I Am for Tribal Communities.” The initiative focuses on keeping the family unit together and providing the services that will most benefit the child including access to support services. This local tribal model incorporates tribal input to enhance a culturally specific service for each tribe.

Community Partnership of Southern Arizona (CPSA) – Julia Chavez, Tribal Liaison, commented that CPSA serves the Tohono O’odham Nation and partners with the Pascua Yaqui TRBHA located in their GSA, Pima County. She shared their accomplishments: established MOU, expansion of adult and children services, and enhanced crisis services are successful collaborative efforts with the Tohono O’odham Nation. She noted they were the first outpatient facility located on tribal lands. Ms. Chavez also described other community involvement efforts, including meetings and participation on Prevention Coalition/Suicide Prevention Task Force, and the Red Road to Wellbriety/Not Simply Red Committee.

Common threads running through the presentations were: recognition of tribal sovereignty through the development of formal agreements with tribes to provide services on tribal lands, enhanced crisis services for tribal members, and technical assistance to tribal behavioral health programs. Staffing inconsistencies were noted as one GSA (NARBHA) geographically covers approximately 50% of the state, serving 11 of the 22 tribes in Arizona, and 50% of the state’s American Indian population. Another Tribal Liaison works with tribes in three of the state’s six GSAs. It was noted that all the Tribal Liaisons travel great distances to carry out the RBHA responsibilities in coordination with Arizona tribes.

Participant Comments/Questions: *A participant commented on the numerous positive developments, which have been accomplished since Forum I, two years ago, when the RBHA Tribal Liaisons were hired.*

**Tribal Regional Behavioral Health Authorities (TRBHA) Panel:** This panel presentation opened the afternoon session of the first day with the Gila River, Pascua Yaqui, and White Mountain TRBHAs and the Navajo Nation case management IGA all presenting. The panelists provided overviews of their unique TRBHA structure, descriptions of service populations, accomplishments, and challenges or barriers to enhancing services to tribal members.

Navajo Nation Department of Behavioral Health Services - NRBHA – Genevieve NezHolona, Clinical Director, began the panel presentation by describing the unique offering of comprehensive case management services on the Navajo Nation. She specified revenue is generated from treatment and case management services. She highlighted staffing coverage, the utilization and volume of services provided, sizeable geographic areas covered, and demographics of the population served. The ADHS/DBHS-Navajo Intergovernmental Agreement (IGA) allows for the provision of case management services with additional funding from ADHS/DBHS for SMI housing and crisis services. Navajo RBHA will be moving toward full electronic case management, independent behavioral health professional for oversight of the paraprofessional case management services at each agency, and billing system modifications for case management services as a Tribal 638 provider.

White Mountain Apache Behavioral Health Services, Inc. (WMABHS) – Dr. Bill Arnett, CEO of the WMABHS, presented the tribal demographics, organizational history, and structure. Dr. Arnett shared the benefits of becoming a TRBHA and challenges in being a TRBHA. Two benefits highlighted were the prestige that being a TRBHA brought to the White Mountain Apache Tribe (WMAT) and the increased knowledge of services and of “what is possible” as a behavioral health program. Two challenges identified by Dr. Arnett are on changes in how the WMAT behavioral health program conducts business; transition from tribal management to a corporate board oversight and the necessity and requirement to develop and implement quality management. A main challenge indicated by Dr. Arnett is the ADHS/DBHS reporting requirements are burdensome and excessive. He further stressed that TRBHAs are not mini-RBHAs and that the reporting requirements are applicable to the RBHAs not the smaller TRBHAs with fewer resources. For the future, Dr. Arnett added that future business opportunities would be explored such as direct contracting with on-and-off reservation programs to increase quality and quantity of programming.

Gila River Behavioral Health Services (GRBHS) – Steven Green, Executive Director, and Priscilla Foote, Director, Gila River Behavioral Health Services (GRBHS), provided an overview of the organization’s transformation since 2005. They described the system integration of the four separately administered tribal and corporate behavioral health and substance abuse operations under the leadership of the TRBHA. The additional changes brought on by tribal council action

in 2011 joined the tribal substance abuse component and the Residential Treatment Center, under the TRBHA oversight, making the TRBHA the largest department of the Gila River Health Care Corporation. Gila River TRBHA has grown in size, employees, enrollees and types of services, including community-based services. System integration benefits included increased coordination of care, efficacy of care, uniform standards of care, improved access - “no wrong door” into the behavioral health system, and improved understanding of program services availability which resulted in better referrals and outcomes. Various issues related to continuity and service fragmentation were identified. Challenges identified by the Gila River TRBHA include excessive Quality Management (QM) requirements and reports to ADHS/DBHS. GRBHS suggested that ADHS/DBHS consider waiving some of the requirements that are not applicable for a smaller TRBHA as they are with the larger RBHA system.

Gila River TRBHA offered the following thoughts: (a) System integration and quality management are on-going processes, (b) Coordination and communication across the system is critical, (c) Common clinical documentation methods improve client care across the GRHCC system, (d) Opportunities for additional service expansion include the addition of “the Caring Housing”, the Gila River Indian Community (GRIC) nursing home, and (e) GRBHS is involved in more community initiatives and collaboration than ever before.

Pascua Yaqui Tribe - Sea Takah Na’ asuku (*Centered Spirit Program*) TRBHA – Dr. Clare Cory, Clinical Director of the Guadalupe Clinic, presented a description of services at Tucson and Guadalupe (Tempe). She stated that there are eight Yaqui communities in Arizona. She further highlighted the successful SAMHSA/SAPT funded prevention program at Guadalupe and the Lutu’uria Youth Group. Pascua Yaqui operates two off reservation services, a level II group home for boys and the Guadalupe Outpatient Clinic, both of which are the only tribal facilities that are state licensed. A unique aspect of the TRBHA is its CARF accreditation attained in 1999. A number of advantages to being a TRBHA were cited, consisting of the focus on enhanced network services, increased clinical coordination and services, access to grant funding, clinical training and collaborative efforts to improve services. Dr. Cory drew some attention to challenges such as the auto enrollment issue being a significant burden due to the large number of tribal members living off-reservation, and the administrative oversight by ADHS/DBHS and mandated requirements placing burdens on a small TRBHA with very limited resources. Future endeavors consist of negotiations with ADHS/DBHS to accept CARF accreditation in lieu of the annual Administrative Reviews. Additionally, Pascua Yaqui will work to advocate for traditional medicine as a reimbursable covered service. Pascua Yaqui will also participate in the TRBHA/RBHA/ADHS/DBHS workgroup to determine allocation criteria for the CMHS and SAPT block grants to ensure there is more equitable funding from the block grants for the TRBHAs and tribes.

Participant Comments/Questions: *Are referrals accepted by Gila River from other tribes?*

Steven Green responded yes, outside tribal referrals are accepted with consideration of GRIC tribal members having first priority.

**Tribal/638/Urban Program Panel:** The panel presenters of this mid-afternoon panel described the operations of non-TRBHA tribal and urban behavioral health programs. In addition, the presenters described their service populations, accomplishments and challenges affecting their programs.

San Carlos Tribal Wellness Center – Dr. Thea Wilshire, Clinical Director of the Wellness Center began the panel presentations by providing an overview history of the organization, the establishment of a P.L. 93-638 contract, integration into the Wellness Center, achievement of CARF accreditation and state and national performance awards. Dr. Wilshire described the challenges of the integration and bringing together three separate related programs to shape the Wellness Center. She further highlighted the benefits reaped of greater effectiveness and cultural competence, as well as the growth of additional services through the years. She added how accreditation, staff development and a team approach have contributed to the Wellness Center’s development into a well-established program. The Wellness Center, with offices in several locations throughout the reservation, provides a wide array of services, programs, activities, and resources to tribal members. Dr. Wilshire highlighted the telepsychiatry clinic initiated in 2009. Dr. Wilshire summed up by sharing their future goals: (a) greater use of performance indicators; (b) increased children services; (c) specialized services for Veterans; (d) Deaf Support Groups; (e) Post-Graduate training for Native American clinicians; (f) statistical tracking of program treatment data; and (g) Reservation-based specialized group homes.

Hualapai Health-Education and Wellness – David Brehmeyer, Special Projects Program Manager, Hualapai Health Education and Wellness Program, presented on the history of the tribal program and its current offering of services along with their new health building. Mr. Brehmeyer further discussed barriers including funding, geographic remoteness, and lack of access to qualified professionals. He thanked agency staff at NARBHA, AHCCCS, and ADHS/DBHS for their guidance and technical assistance provided to Hualapai.

He went on to share how billing and generated revenue have allowed Hualapai to expand services and hire additional staff. He concluded with sharing future plans to expand behavioral health services to their tribal detention center and Head Start program. Additionally, Hualapai intends to institute a new patient management system, and possibly acquire CARF accreditation.

Native Americans for Community Action (NACA) – Rob Robin, PhD, NACA Executive Director, described the early origin of the urban Indian Center in Flagstaff. Dr. Robin noted that NACA is a near full-service organization offering a comprehensive set of services and programs comprised of economic development, health promotion and prevention, substance abuse prevention, wellness center, family health center, workforce development and emergency social services. He stated there have been over 4,000 visits by clients of which 600 are substance abuse clients and 100 are mental health clients. Dr. Robin declared that while NACA Behavioral Health Program will continue work on improving program capacities, their main challenges are establishing a billing system for revenue generation and raising staff professional competencies and capabilities. A NACA Counselor gave a verbal presentation on the value of and need for cultural competency in working with tribal clients using tribal languages and clan relationships.

Participant Comments/Questions: There were no comments and/or questions for the panelists.

**Indian Health Service (IHS) Presentation** – The IHS Implementation of the Indian Health Care Improvement Act, Title I and VII – Behavioral Health Services and Related Provisions – The closing presentation of the first day was provided by Dr. Patricia Nye of the Tucson Area IHS, representing George Bearpaw, Acting Area Director of the Tucson Area. She presented a two page document. The first page depicts all of the twenty sections of Title I and VII, the status of implementation, and whether or not additional appropriations are needed to implement the program indicated in each section. The second page covered the references, and where to locate the IHS implementation updates on the IHS website. The handout provided a wealth of information and references.

Participant Comments/Questions: There were no comments and/or questions.

**Open Dialogue Session:** An “Open Microphone” session was held at the end of the first day to allow participants to ask questions and make comments on the first day proceedings. Fred Hubbard, Executive Director, Advisory Council on Indian Health Care, moderated this session.

Participant Comments/Questions on Funding Reimbursements for Behavioral Health Services Provided to Clients in Detention Centers: *Funding/reimbursement for behavioral health services for tribal detention center detainees is not available. How can we make this happen? San Carlos Apache Tribal Wellness Center stated it delivered approximately \$600,000 unreimbursed services at their tribal detention center.* Participants agreed that this is a problem throughout Arizona. Someone asserted that under the Utah correction system any Native American medicine man can go into the detention center as a clergy and get funding as a faith-based organization. An Inter-

Tribal Council of Arizona (ITCA) representative commented that this question was posed to the National Indian Health Board (NIHB). NIHB responded that services could be delivered up to adjudication. The ADHS/DBHS representative indicated that this prohibition of reimbursement is a CMS regulation. Each state can determine when eligibility stops. In Arizona, eligibility/funding stops once a detention center is entered. Some history about the issue was also imparted. The CMS regulation is based on the assignment of responsibility to the state prison systems and the responsibility of each state for care provided to state prisoners. Each state funds their prison systems to include health and behavioral health services. Tribal jails/detention centers are separate from the federal and state prison systems. Tribal jails were originally set up and funded through the Bureau of Indian Affairs (BIA). Health services including behavioral health services in the BIA operated jails were to be provided by the IHS facilities in tribal communities through Interagency Agreements. However, IHS is 60% underfunded to meet the health needs of Indian communities and most IHS facilities do not have sufficient behavioral health resources to provide services needed by tribal detainees. Tribes need to work with CMS to waive this requirement for tribes and 638 behavioral health programs and services to tribal jail and detention center detainees. An additional comment was made that there needs to be flexibility in the provision of services for youth in detention centers as they drop off AHCCCS when they are incarcerated. Additionally, there is a need for tribes to coordinate care prior to adjudication.

Participants Respond to the Question of What was Learned Today: An ITCA representative indicated that in the past there was a provision in RBHA contracts that excluded the reservation from the RBHA service areas. She stated she was glad to see that this had changed and that the RBHA Tribal Liaison positions had been established. Further, she indicated that there had been concern that these RBHA positions would be cut but was glad to see they remained as required Key Personnel in the RBHA contracts.

An IHS Psychiatrist expressed that he was impressed with the programming reported from the tribal behavioral health programs and the TRBHAs. He felt that people were thinking outside the box. He indicated that all areas needed to be involved in discussion regarding early childhood programs including support for expectant mothers. Further, he stated that there is a dilemma due to the inability to bill for pre-clinical services. He indicated discussion needs to occur on how to accomplish this needed change. He commented that there is obvious commitment to improving behavioral health service delivery to tribes as demonstrated by the number of participants at this forum.

A RBHA Tribal Liaison stated the TRBHA leadership impressed her. She appreciated TRBHA leadership being vocal about challenges. She explained that RBHA challenges are very different and declared that sovereignty status of tribes is apparent but not always taken into consideration in building working relationships with the tribes. She also stated that it is obvious that the 638 program at San Carlos Apache Tribe is flourishing.

A tribal participant indicated that a segment of the population with needs is not being addressed at this forum and that is the non-AHCCCS eligible adults. There are many men with emotional problems but are non-TXIX eligible.

A Hopi Guidance Center staff member commented that there is still a lack of services on reservations and challenges are high. The participant stressed the behavioral health needs on reservations are high and stated it is helpful to hear what other agencies are doing but some needs are still not being addressed. The participant highlighted CPS custody cases where children are removed from the home and then the parents are classified as “childless adults” and no longer qualify for AHCCCS benefits.

**Closing:** A summary of Day One was given by Fred Hubbard. The presentations and sessions for the first day of the Forum were completed and the Forum recessed.

**Reception:** An evening reception was held as a networking event and also as an opportunity to recognize the financial sponsors of the forum. Fred Hubbard was the EMCEE. The recognition was followed with a cultural presentation made by James Uqualla, Havasupai Medicine Elder and a performance by the Yavapai-Apache Nation Bird Singers.

### **Proceedings – Day Two**

Following welcoming and introductory remarks by Michael Allison, Native American Liaison, ADHS, the second day began with an ADHS status update.

**Status of State Behavioral Health Program & Health Integration:** Dr. Laura Nelson, Deputy Director, Division of Behavioral Health Services, ADHS, presented updates on Substance Abuse and Mental Health Services Administration (SAMHSA) initiatives, a budget overview and the Essential Health Benefits as a part of the Affordable Care Act. She further shared Arizona Governor Brewer’s Non-TXIX SMI proposed budget and anticipated benefits in controlling costs and improving healthcare outcomes through the integration of behavioral health and physical health services. Dr. Nelson summed up the outcome of community input sessions.

**Participant Comments/Questions:** *A comment was made by an ITCA representative that dialogue needs to occur regarding tribal choices for care. A question followed the*

*comment. Are the Health Resources and Services Administration (HRSA) 330 clinics going to be considered a part of the network in the Maricopa County pilot?* Dr. Nelson responded, yes.

Participant Comments/Questions: *What about services to the elderly with ALTCS?* Dr. Nelson replied that ALTCS receives funding and contracts with providers for those services. Provider contracts need to be reviewed and expectations need to be built into the contracts for improvements in coordination of care. She indicated that Electronic Health Record (EHR) is a part of the solution. In response to the comment that there are challenges of an EHR, Dr. Nelson replied there is currently no health record or system that talks to its counterpart.

Participant Comments/Questions: In regards to the comment concerning the need for increased funding to implement integration health care solutions for rural parts of Arizona and the need for additional funding to increase rural health services, Dr. Nelson indicated the need for more funding to develop the collaborative efforts as well as provide training. She also indicated that Telemedicine and the EHR should be considered as targets for consideration.

Participant Comments/Questions: *Where will the health information be housed? – Who will own it – the RBHA?* Dr. Nelson replied that as the RBHA contracts are transient, health information exchange issues are being reviewed. She indicated there is not an answer at this time.

**Integrated Health Panel:** This panel provided information on how their organizations integrate physical health care with behavioral health, discussed the implications of expanding health care integration program requirements, and evaluating unique issues that arise.

Phoenix Indian Medical Center - IHS – Dr. John Molina, Chief Executive Officer, began the panel presentations by describing the Phoenix Indian Medical Center and its service population. He drew attention to the three IHS agency-wide initiatives, which provide a strategic framework for reducing the unacceptable health disparities and improving the health status of American Indians and Alaska Natives. The three related initiatives of health promotion and disease prevention, chronic care and behavioral health were underscored. The behavioral health initiative will work to integrate primary care and behavioral health care in the IHS facilities through development of individual care teams working together in clinic settings. Dr. Molina stressed that IHS has a lot of work to do to integrate care and indicated that internally they have often “worked in silos”.

Native Health, Inc. – Walter Murillo, CEO, said that Native Health is a Federally Qualified Community Health Center (FQHC) or Community Health Center (CHC). Native Health is

structured and designed to eliminate system-wide barriers to accessing health care and offer comprehensive primary and preventive medical, dental, and mental health/substance abuse services to predominantly uninsured and medically underserved populations. Native Health primarily focuses on offering services to the American Indians residing in the Phoenix urban area. Native Health and its clinic are co-located with the Phoenix Indian Center and Native American Connections in a full-service center easily accessible to their target population in central Phoenix. Mr. Murillo concluded by sharing a description of several integrated health care delivery models, and the collaborative and integrated care and practice models of integration.

ADHS/DBHS – Bob Sorce, Assistant Director for Health Care Development, ADHS informed the audience that in order to avoid a repeat of Dr. Laura Nelson’s presentation, he would change his presentation format to an open dialogue session regarding integrated care. The following narrative documents the dialogue between Mr. Sorce and the Forum participants.

*A representative of the Advisory Council on Indian Health Care (ACOIHC) indicated there is a difference in the TRBHAs’ and RBHAs’ reporting capacities. TRBHAs are currently working on capacity building to improve and increase service delivery. A question was posed to Mr. Sorce: Is there a chance that requirements will be reduced for the TRBHAs? Bob Sorce explained the history. The requirements are passed down from CMS and are out of ADHS/DBHS’ control. He further explained the TRBHA IGAs are not completely the same – they are based on each tribal nation’s needs. He noted that ADHS/DBHS hears the same concerns from the RBHAs regarding administrative burdens and reporting. He concluded that ADHS/DBHS is open to suggestions on streamlining the reporting process.*

*The CEO of a NARBHA provider indicated that there is no funding (administrative or reimbursement) for Primary Care Provider (PCP) integration. Incentives need to be provided in order for providers to manage and improve outcomes.*

*A Yavapai Apache Behavioral Health Program representative indicated that tribes have concerns about this issue as eligibility and reimbursement for services stops when the person is incarcerated. He further indicated that alternative treatments and prevention services are not funded. Mr. Sorce shared that this is an AHCCCS eligibility issue where services stop once the client walks through the door. He agreed that coordination of care is needed and there is a need to ensure discharge planning, medication management, and ongoing treatment after discharge, etc. He further noted that prevention is a cornerstone to efforts to improve care delivery.*

*Verde Valley Guidance Center has found that in their experience of providing services to SMIs, effective treatment costs for care is more for higher acuity clients. For example, “no shows” for SMI clients are higher, and are not reimbursable.* Bob Sorce replied that the hallmark of integrated health care is the multidisciplinary team. He further indicated the use of peer support adds to efforts to increase compliance with treatment goals and that costs do increase as additional primary care issues are identified. He emphasized the cost model for integrated health care is based on assumptions, as there is currently no data.

*A Hopi program representative indicated that there is a high need for substance abuse treatment for young pregnant mothers. There still are many challenges and service gaps on reservations.*

*The ADHS/DBHS Tribal Contract Administrator remarked that the planning and implementation of the Maricopa County pilot, ADHS/DBHS needs to ensure partnerships with urban Indians. She recommended the need for a focus on partnering with IHS for integration efforts on rural reservations. American Indians receive their physical care from IHS in rural areas of the state.* Mr. Sorce noted ADHS/DBHS has begun dialogue with IHS regarding coordination of care. He indicated there are privacy issues (HIPAA) in the sharing of service data between the two systems. He highlighted the pilot focuses on Maricopa County and that ADHS/DBHS is aware of the drastic differences in remote areas of the state as compared to Maricopa County. He shared that these differences will be taken into account and ADHS/DBHS will treat each community differently in the planning process.

Gila River Residential Treatment Center, Gila River Health Care Corporation (GRHC) – Cheryl Cuyler, Residential Services Director, *Thwajik Ke* Residential Treatment Center, provided a brief history of the 82-bed facility since it opened in 2007. The Center houses both women and men, including transitional units, and a detox facility. Ms. Cuyler stated the center has been very successful since it’s transition from the GRIC Department of Human Services to the Gila River Health Care Corporation in December, 2010. She indicated they currently employ six (6) independently licensed staff, and have increased their census from 5 to 48 with over 60 successful graduations in 2011. The Center delivers integrated care and is positioned to address behavioral health issues as part of a comprehensive health home model. Primary care, psychiatric services, and nursing care are all provided on-site. Furthermore, the integration of traditional, cultural, and spiritual philosophies as part of the continuum of services was emphasized. Ms. Cuyler emphasized that the Center has improved its capacity to deliver

coordinated and integrated care to clients with complex needs. Education, employment, and prevention issues are also addressed.

Banner Alzheimer's Institute – Filmer Lallo, Native American Program Coordinator, presented on their outreach initiatives for Arizona tribes. He indicated their efforts focus on increasing community awareness, education, collaboration and partnering with health care providers in American Indian communities (i.e., tribal and IHS clinics, CHR, elderly and caregiver programs). The Institute provides training and workshops. He concluded by stating health care providers are becoming more aware and educated regarding Alzheimer's disease and American Indian families are seeking information on the disease and coping with the disease.

Participant Comments/Questions: There were no comments and/or questions for this panel other than the open dialogue with Bob Sorce.

**Telemedicine in Behavioral Health Panel:** Panel participants described their Telemedicine program, accomplishments, plans, and efforts to resolve barriers to utilization and needed improvements to expand telepsychiatry and training to American Indian communities.

Parker Indian Health Center - IHS - Dr. Peter Stuart, Telemedicine Psychiatrist and Mental Health Services Director at the Parker Indian Health Center, began the panel presentations by sharing the history of Telemedicine from an IHS perspective, early challenges of implementing Telemedicine in rural and tribal areas, and lessons learned in implementation at local tribal program sites. He further covered the benefits to the patients and unexpected cost of having a Telemedicine program in a tribal setting. He emphasized that in future development, consideration should include connection to larger programs for more comprehensive coverage, increased use of the Telemedicine system for non-psychiatric providers, and the establishment of standard MOUs for connecting to non-IHS sites, including tribal behavioral and mental health programs and RTCs. Dr. Stuart stressed that the implementation of Telemedicine should be less about the technology and more about the integration of type of service delivery.

Northern Arizona Regional Behavioral Health Authority (NARBHA) – Dr. Sara Gibson, Medical Director, NARBHA Telemedicine Program, provided a brief overview of NARBHA and its service area and further described the purpose for telepsychiatry. She said the focus is on access to care in rural areas, and indicated the need for services are greater than the ability to supply services. Dr. Gibson further noted the benefits of the availability of psychiatric services in rural areas where there is a psychiatric shortage, as well as patients could be treated in their own communities, and the involvement of families in the treatment and support. She also indicated the improvements in recruitment and retention of psychiatric providers preventing travel burnout. She highlighted many other benefits. Dr. Gibson also described some of the

challenges, such as the difficulty to obtain the “real presence” of the patient and the lack of physical “sense” of patients’ condition. She further described the evidence that supports that patients quickly adapt and build a rapport with the Telemedicine provider as they experience a personal benefit in their recovery. In closing, Dr. Gibson outlined some literature that suggests that American Indians accessing services through telemedicine experience patient comfort, satisfaction with services, and cultural acceptance.

Hopi Guidance Center (HGC) – Jon Joshevama, Quality Assurance Program Manager, with the Hopi Guidance Center (HGC), noted that HGC is a tribal provider of NARBHA and a user of the NARBHA Telemedicine system. He described the tribal cultural perspectives on the use of technology in rural, tribal settings and mentioned some benefits of the use of Telemedicine. He displayed a cost analysis, which demonstrated that Telemedicine implementation provides costs savings to the HGC. He summed up by highlighting some value comparisons between Hopi communities and the larger behavioral health system to illustrate potential implementation issues.

Participant Comments/Questions: There were no comments and/or questions for this panel.

**Final Thoughts:** Final thoughts on the two-day forum were provided by Cora-Lei Marquez, Tribal Representative, Yavapai Apache Nation.

**Closing Prayer:** Forum II concluded with a closing prayer provided by James Uqualla, Havasupai Medicine Elder. The Yavapai-Apache Tribal Color Guard retrieved the colors at the Closing.

## **Challenges/ Recommendations**

The following is a summary of challenges and recommendations made by participants and presenters.

### **Challenges:**

- No integrated health IT system in existence.
- Tribal behavioral health programs transition to a corporate board oversight and the necessity/ requirement to develop and implement quality management programs.
- ADHS/DBHS reporting requirements are burdensome and excessive. TRBHAs are not mini-RBHAs and the reporting requirements are applicable to the RBHAs, not the smaller TRBHAs with fewer resources.
- Excessive Quality Management (QM) requirements and reports to ADHS/DBHS.

- Auto enrollment issues are a significant burden for TRBHAs due to the large number of tribal members living off-reservation.
- Administrative oversight by ADHS/DBHS and mandated requirements place burdens on a small TRBHA with very limited resources.
- Funding, geographic remoteness, and lack of access to qualified professionals.
- Establishing a billing system for revenue generation and raising staff professional competencies and capabilities.
- Addressing/meeting the needs of non-Title XIX clients. For example, young men without children are no longer eligible for behavioral health services. They are often in high-risk categories for needed services.
- Lack of AHCCCS billing code for patients/clients in tribal detention centers.

Recommendations:

- ADHS/DBHS needs to consider waiving some of the requirements that are not as applicable for a smaller TRBHA as they are for the larger RBHA system.
- Consideration of the value of and need for cultural competency in working with tribal clients is needed.
- Flexibility in the provision of services is needed for youth in a tribal detention center as they drop off AHCCCS when they are adjudicated. Flexibility could provide opportunities for tribes to coordinate care prior to adjudication.
- Future discussions need to be held regarding early childhood programs including support for expectant mothers. There is a dilemma due to the inability to bill for pre-clinical services. Discussions need to occur on how to accomplish this needed change.
- Conduct meetings to discuss tribal choices of care, to ensure that dialogue on this topic occurs.
- Increased funding is needed to implement integration health care solutions for rural parts of Arizona to increase rural health services.
- Future Telemedicine developments need to include connection to larger program system for more comprehensive coverage.
- Increase use of the Telemedicine system for non-psychiatric providers.
- Establish standard MOUs for connecting to non-IHS sites, including tribal behavioral and mental health programs and RTCs.
- Implementation of Telemedicine should be less about the technology and more about the integration of type of service delivery.

As highlighted in the Challenges and Recommendations section, themes appear to emerge similar to preceding Forum I themes.

- Improving tribal consultation
- Building stronger relationships with tribes
- Building service capacity
- Addressing cultural preference
- Leveraging resources
- Improving access and operations
- Feedback on the Governor's proposal for integrated care

## Attachment 1: List of Forum Attendees

LAST	FIRST	TITLE	AGENCY
Damon	Lafe	Resource Coordinator	Acadia Health Care
Hubbard-Pourier	Lydia	TRBHA Contract Administrator	ADHS/DBHS
Morrison	John	Contract Administrator	ADHS/DBHS
Sorce	Robert	Assistant Director	ADHS/DBHS
Kramer	Dianna	Cultural Competency Manager	ADHS/DBHS
Nelson, MD	Laura	Deputy Director	ADHS/DBHS
Enriquez	Lydia	Administrative Assistant	Advisory Council On Indian Health Care
Hubbard	Fred	Director	Advisory Council on Indian Health Care
Betlach	Tom	Director	AHCCCS
Chicharello	Carol	Tribal Liaison	Arizona Department of Economic Security
Allison	Michael	Native American Liaison	Arizona Department of Health Services
Lalio	Filmer L	Coordinator, NAP	Banner Alzheimer's Institute
Yellowhair	Sheina	Tribal Liaison	Cenpatico Behavioral Health of Arizona
Barbara	Daniel	Executive Director, DH&HS	Colorado River Indian Tribes
McCluskey	Michael	Clinical Director	Colorado River Indian Tribes
McGinnis	Sheila	Community Relations Coordinator	Community Partnership of Southern AZ
Chavez	Julia	Tribal Liaison	Community Partnership of Southern Arizona
Grijalva	Edward	Program Coordinator	Compass Health Care-Tucson
Perez	Betty	Special Population Liaison	Compass Health Care-Tucson
Yepiz	Adam	Crisis Specialist	Crisis Response Center
Deschine	Desirae	Crisis Specialist	Crisis Response Network and Corporation
Nez-Holona	Gen	Clinical Director	DBHS Navajo Nation TRBHA
Vargas, PhD	Pilar	Director, Crisis & Trauma Healing Svcs	EMPACT- Suicide Prevention Program
Brown	Michele	Training Coordinator	EMPACT- Suicide Prevention Program
Wright	Joe	CEO	Encompass Health Services - Tucson
Burggraff	David	Supervisory Psychologist	Ft Defiance - ACU
Descheenie	Beverly	Case Management Specialist	Ft. Defiance Indian Hospital
Lewis	Collette	Behavioral Health Director	Ft. Mojave Behavioral Health
James	Maurice	Acting Director, DH&HS BHS	Ft. Mojave Indian Tribe
Lee	Samantha	Director of Behavior Health	Ganado Sage Memorial Hospital
Cuyler	Cheryl	Director, RTC	Gila River Behavioral Health Program
Foote	Priscilla	Behavioral Health Director	Gila River Health Care Corporation
Green	Steve	CEO	Gila River TRBHA
Joshevama	Jon	Quality Management Coordinator	Hopi Guidance Center
Brehmeyer	David	Special Program Manager	Hualapai Health-Education Wellness
La-Nae	Perci	Medical Social Worker	Indian Health Service - Peach Springs
Flood	Mike	Clinical Social Services Director	Indian Health Service Sells Hospital

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Stuart, PhD	Peter	Mental Health Director	Indian Health Services - Parker Service Unit
Montiel	Alida	Health Systems Analyst	Inter-Tribal Council of Arizona, Inc.
Russell	Kim	AAA Program Specialist	Inter-Tribal Council of Arizona, Inc.
Levine-Mata	Mayday	BH Clinical Director	LA Frontera - Tucson
Clarke, PhD.	Richard	CEO	Magellan Health Services of Arizona
Roybal	Darcy	Tribal Liaison	Magellan Health Services of Arizona
Brown	Wilbur	JPO Prig. Svcs. Staffing Coord.	Maricopa County Juvenile Probation
Schultz	Pamela	Office Sup./Detent. Manager	Maricopa County Juvenile Probation
Baker	Stephanie	Administrative Assistant	Mercy Care - Gilbert
Baker	Evan	Intervention Cardiovascular Tech.	Mercy Care - Gilbert
Wells	Cheri	Tribal Liaison	Northern Arizona Regional Behavioral Health Authority
Moreno	Richard	Director of Behavior Health	Native American Connections, Inc.
Yazzie-Devine	Diana	President-CEO	Native American Connections, Inc.
Robin, PhD	Robert	CEO	Native Americans for Community Action, Inc.
Chavez	Ana	Behavioral Case Manager	Native Health - Phoenix
Etsitty	Shannon	Billing & Coding Specialist	Native Health - Phoenix
Hubbard	Sara	Third Party Program Supervisor	Native Health - Phoenix
Huff	Dennis	Behavioral Health Director	Native Health - Phoenix
Leon	Erinn	Adolescent SA Counselor	Native Health - Phoenix
Murillo	Walter	CEO	Native Health - Phoenix
Philpot	Wendy	Adolescent Therapist/PM	Native Health - Phoenix
Yazzie	Janice	Adolescent Cont. Care Manager	Native Health - Phoenix
Yellowhair	Candice	Case Management Specialist	Navajo Nation DBHS - Kayenta
Gorman	Clara	Case Manager	Navajo RBHA - Chinle
Tsosie	Marsha	Case Management Specialist	Navajo RBHA - Chinle
Toadlena	Martha	Case Management Specialist	Navajo RBHA - Ft. Defiance
King	Lisa	Clinical Specialist Intern	Navajo RBHA - Window Rock
Jackson	Letitia	Case Management Specialist	Navajo RBHA Tuba City
Tom	Patricia	Case Management Specialist	Navajo RBHA Winslow
Lester	Minnie	Case Management Specialist	Navajo RBHA-Dilcon
Lowman	Paul	Case Manager	Navajo RBHA-Kaibato
Gibson	Sara	Telemedicine Director	Northern Arizona Regional Behavioral Health Authority
Hartgroves	Laura	Director, Provider and Network Svcs	Northern Arizona Regional Behavioral Health Authority
Pattinson, PhD	Mick	CEO	Northern Arizona Regional Behavioral Health Authority
Mooney	Warren	Medicine Man	Oklevueha Native American Church
Salgado	David	Coordinator	Parc Place Adolescent Residential Treatment
Cory	Clare	Program Director, CSP	Pascua Yaqui Tribe
Claus, PhD	Cynthia	Director, OHP	Phoenix Area Indian Health Service

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McIntyre, PhD	Dave	Mental Health Consultant	Phoenix Area Indian Health Service
Molina, MD	John	CEO	Phoenix Indian Medical Center
Webb	Charlotte	Director of Recovery	PSA-Behavioral Health Agency
Godfrey	John	Assistant Director of HHS	Salt-River Pima-Maricopa Indian Community
Pavatea	Myrna	Division Director of BHS	Salt-River Pima-Maricopa Indian Community
Taylor-Disir, MD	Monica	Psychiatrist, HHS Clinical Svcs Prog	Salt-River Pima-Maricopa Indian Community
Wesley	Phyllis	Program Manager, Youth Home	San Carlos Apache Tribe
Wilshire, PhD	Thea	Clinical Director, Wellness Center, DH&HS	San Carlos Apache Tribe
Powers, MD	Pamela	Psychiatrist	Self employed
Shoemaker	Jarrett	Community Liaison	Sequel Care of AZ
Zantopp	Michael	Utilization Manager	The Guidance Center
Bowman	Barry	Clinical Supervisor, DH&HS	Tohono O'odham Nation
Henry	Leona	Counselor, DH&HS	Tohono O'odham Nation
Homer	Juanita	Behavioral Health Director, DH&HS	Tohono O'odham Nation
Sampson	David	APS Clinical Director, DH&HS	Tohono O'odham Nation
Nye, MD	Patricia	Behavioral Health Consultant	Tucson Area Indian Health Service
White, PhD	Cynthia	Medical Director	VA Hospital - Prescott
Phelan	Cheryle	Suicide Prevention Coordinator	VA Prescott
Dehnert	Richard	Community Relation Coordinator	Verde Valley Guidance Center
Roderick	Scott	Children's Program Director	Verde Valley Guidance Center
Bondurant	Monty	Adult Program Coordinator	Verde Valley Guidance Center Inc.
Cartia	Robert	CEO	Verde Valley Guidance Center Inc.
GreyWolf	Joseph	Fiscal Agent	Walk-N- Balance Center Inc.
Rick	Ayanvli	Fiscal Agent	Walk-N- Balance Center Inc.
Aday	Noreen	Board Chairperson	White Mountain Apache Behavioral Services, Inc.
Arnett	Bill	CEO	White Mountain Apache Behavioral Services, Inc.
Cromwell	Xena	Board of Directors	White Mountain Apache Behavioral Services, Inc.
Kayson	Bonnie	Board Member	White Mountain Apache Behavioral Services, Inc.
MCune	Robin	Adolescent Case Manager	White Mountain Apache Behavioral Services, Inc.
Numkena	Doreen	BH Program Manager	White Mountain Apache Behavioral Services, Inc.
Prince	Brett	Children and Adolescent Sup.	White Mountain Apache Behavioral Services, Inc.
West	Darwin	Clinical Director	White Mountain Apache Behavioral Services, Inc.
Hamilton	Charlene	Executive Director, DH&HS	White Mountain Apache Tribe
Evan	Linda	Tribal Councilwoman/ASA Case Manager	Yavapai-Apache Nation
Marquez	Cora-Lei	Tribal Representative	Yavapai-Apache Nation
Hicks	Alan	Program Manager	Yavapai-Apache-Nation Behavioral Health Program

## Attachment 2: Forum Agenda (amended)

### Statewide Arizona American Indian Behavioral Health Forum II “Policy and Service Delivery in a Changing Environment”

February 15, 2012:

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<b>6:30 a.m.</b>	<b>Restaurant Open</b>	
<b>7:15 a.m.</b>	<b>Registration</b>	<i>Hotel Lobby</i>
	<b>Continental Breakfast</b>	<i>Sedona Room</i>
<b>8:00 a.m.</b>	<b>Welcome</b>	<b>Fred Hubbard, Master of Ceremonies</b> <i>Executive Director, AZ Advisory Council on Indian Health Care</i>
	<b>Opening Prayer</b>	<b>Don Decker</b> <i>Apache Spiritual Leader</i>
	<b>Posting of Colors</b>	<b>Yavapai-Apache Tribal Color Guard, Larry Jackson</b>
<b>8:30 a.m.</b>	<b>Opening Remarks</b>	<b>Linda Evan</b> <i>Councilwoman, Yavapai Apache Nation</i>
		<b>Honorable David Kwail</b> <i>Chairman, Yavapai-Apache Nation</i>
	<b>Eagle Feather Sponsor Comments</b>	
		<i>Northern Arizona Regional Behavioral Health Authority (NARBHA)</i>
		<i>Verde Valley Guidance Clinic</i>
		<i>Pascua Yaqui TRBHA</i>
		<i>Gila River TRBHA</i>
	<b>ADHS Welcome</b>	<b>Michael Allison</b> <i>Native American Liaison, ADHS</i>
<b>9:00 a.m.</b>	<b>Forum I Report</b>	<b>Lydia Hubbard-Pourier</b> <i>TRBHA Contract Administrator, ADHS/DBHS</i>
<b>9:20 a.m.</b>	<b>Forum II Objectives</b>	<b>Alida Montiel</b> <i>Health System Analyst, Inter Tribal Council of Arizona, Inc.</i>
<b>9:40 a.m.</b>	<b>Budget and Economic Overview</b>	<b>Tom Betlach</b> <i>Director, AHCCCS</i>
<b>10:15 a.m.</b>	<b>Break</b>	
<b>10:30 a.m.</b>	<b>RBHA Panel Presentations</b>	<b>Lydia Hubbard-Pourier, Moderator</b> <i>ADHS/DBHS</i>
	<b>Panel Members:</b>	
		<i>Cheri Wells, Tribal Liaison, NARBHA</i>
		<i>Darcy Roybal, Tribal Liaison, Magellan Health Services of Arizona</i>
		<i>Sheina Yellowhair, Tribal Liaison, Cenpatico of Arizona</i>
		<i>Julia Chavez, Tribal Liaison, Community Partnership of Southern Arizona</i>

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<b>11:45 a.m.</b>	<b>Box Lunch</b>	<i>Sedona Room/Patio</i>
<b>1:00 p.m.</b>	<b>TRBHA Panel Presentations</b>	<b>Lydia Hubbard-Pourier, Moderator</b> <i>ADHS/DBHS</i>
	Panel Members: Gen Holona, <i>Clinical Director, Navajo Nation TRBHA</i> Dr. Bill Arnett, <i>CEO, Apache Behavioral Health</i> Steven Green, <i>TRBHA CEO, Gila River Health Care</i> Priscilla Foote, <i>Director, Behavioral Health Services, Gila River Health Care</i> Dr. Clare Cory, <i>Program Director, Centered Spirit Program, Pascua Yaqui Tribe</i>	
<b>2:15 p.m.</b>	<b>Tribal/638/Urban Panel</b>	<b>Diana Kramer, Moderator</b> <i>Cultural Competency Manager, ADHS/DBHS</i>
	Panel Members: Thea Wilshire, PhD, <i>Clinical Director, Wellness Center, San Carlos Apache Tribe</i> David Brehmeyer, <i>Special Projects Program Manager, Health Education &amp; Wellness Department, Hualapai Tribe</i> Robert Robin, PhD, <i>CEO, Native Americans for Community Action, Inc.</i>	
<b>3:30 p.m.</b>	<b>Break</b>	
<b>3:45 p.m.</b>	<b>Indian Health Service</b>	<b>Dr. Patricia Nye</b> <i>Psychiatrist, Tucson Area Office, Indian Health Service</i>
	IHS Implementation of the Indian Health Care Improvement Act Permanent Reauthorization— Title VII, Behavioral Health Services & Related Provisions	
<b>4:15 p.m.</b>	<b>Open Dialogue</b>	<b>Fred Hubbard</b> <i>Director, Advisory Council on Indian Health Care (ACOIHC)</i>
<b>4:45 p.m.</b>	<b>Summary of Day One</b>	<b>Fred Hubbard</b> <i>ACOIHC</i>
<b>5:30 – 7:00 p.m.</b>	<b>Reception with Informal Buffet Meal</b>	<i>Sedona Room</i>
	<b>Recognition of T/RBHA CEOs &amp; Forum Sponsors</b>	<b>Fred Hubbard, Master of Ceremonies</b>
	<b>Cultural Presentation</b>	<b>James Uqualla</b> <i>Havasupai Medicine Elder</i>
	<b>Yavapai Bird Singers</b>	

**February 16, 2012:**

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<b>6:30 a.m.</b>	<b>Restaurant Open</b>	
<b>7:30 a.m.</b>	<b>Registration</b>	<i>Hotel Lobby</i>
	<b>Continental Breakfast</b>	<i>Sedona Room</i>
<b>8:00 a.m.</b>	<b>Welcome and Day Two Schedule</b>	<b>Michael Allison</b> <i>ADHS</i>
<b>8:15 a.m.</b>	<b>Status of State Behavioral Health Program &amp; Health Integration</b>	<b>Dr. Laura Nelson</b> <i>Deputy Director, Division of Behavioral Health Services, ADHS</i>
<b>9:00 a.m.</b>	<b>Integrated Health Panel</b>	<b>Carol Chicharello, Moderator</b> <i>Tribal Relations Liaison, Arizona Department of Economic Security</i>
	Panel Members:	
		<i>Dr. John Molina, CEO, Phoenix Indian Medical Center</i>
		<i>Walter Murillo, CEO, Native Health</i>
		<i>Bob Sorce, Assistant Director, ADHS/DBHS</i>
		<i>Cheryl Cuyler, Director, RTC, Gila River Health Care</i>
		<i>Filmer Lalio, Native American Program Coordinator, Banner Alzheimer's Institute</i>
<b>10:30 a.m.</b>	<b>Break</b>	
<b>10:45 a.m.</b>	<b>Telemedicine in Behavioral Health Panel</b>	<b>Cheri Wells, Moderator</b> <i>NARBHA</i>
	Panel Members:	
		<i>Dr. Peter Stuart, Mental Health Director, Colorado River Service Unit, Parker Indian Health Center</i>
		<i>Dr. Sara Gibson, Associate Medical Director, Medical Director Telemedicine, NARBHA</i>
		<i>Jon Joshevama, Quality Assurance Program Manager, Hopi Guidance Center</i>
<b>11:45 p.m.</b>	<b>Final Thoughts</b>	<b>Cora-Lei Marquez</b> <i>Tribal Representative, Yavapai Apache Nation</i>
<b>12:00 p.m.</b>	<b>Closing Prayer</b>	<b>James Uqualla</b> <i>Havasupai Medicine Elder</i>
	<b>Retiring of Colors</b>	<b>Yavapai-Apache Tribal Color Guard, Larry Jackson</b>

### Attachment 3: Planning Committee Members

<b>Michael Allison</b> , Co- Chair, Native American Liaison, Arizona Department of Health Services
<b>Lydia Hubbard-Pourier</b> , Co-Chair, Tribal Contract Administrator, ADHS/DBHS
<b>Alan Hicks</b> , Behavioral Health Counselor, Yavapai-Apache Nation
<b>Dr. Clare Cory</b> , Program Director, Center Spirit Program, Pascua Yaqui Tribe
<b>Albert Long</b> , Senior Program & Project Specialist, Navajo Department of Behavioral Health Services, Navajo Nation
<b>Gen Holona</b> , Clinical Director, Navajo Department of Behavioral Health Services, Navajo Nation
<b>Priscilla Foote</b> , Behavioral Health Director, Gila River Health Care Corporation
<b>Dennis Huff</b> , Behavioral Health Director, Native Health
<b>Alida Montiel</b> , Health System Analyst, ITCA, Inc.
<b>Dr. Patricia S. Nye</b> , Behavioral Health Consultant, Tucson Area Indian Health Service
<b>Cheri Wells</b> , Tribal Liaison, Northern AZ Regional, Behavioral Health Authority
<b>Sheina Yellowhair</b> , Tribal Liaison, Cenpatico Behavioral Health of AZ
<b>Darcy Roybal</b> , Tribal Liaison, Magellan Health Services of AZ
<b>Julia Chavez</b> , Tribal Liaison, Community Partnership of Southern AZ
<b>Fred Hubbard</b> , Executive Director, Advisory Council on Indian Health Care
<b>Lydia Enriquez</b> , Administrative Assistant, Advisory Council on Indian Health Care
<b>Carol Chicharello</b> , Tribal Relations Liaison, AHCCCS
<b>Filmer Lalio</b> , Native American Coordinator, Banner Alzheimer’s Institute
<b>Linda Evans</b> , Councilwoman, Yavapai-Apache Nation
<b>Cora-Lei Marquez</b> , Tribal Representative, Yavapai-Apache Nation

## Attachment 4: Evaluation Feedback Summary

### Introduction:

This attachment summarizes the results of the evaluation forms completed by participants of the American Indian Behavioral Health Forum II - *Policy and Service Delivery in a Changing Environment*. The evaluation form contained a number of questions regarding select elements of the forum from the forum venue and location to the quality of presenters. The planning committee sought to measure the success of the forum and aimed questions at eliciting responses to identify elements for improvement. The evaluation findings will be considered when planning for Forum III. The evaluation form was divided into two main sections: closed-end and opened-ended questions. Approximately 46 forum participants submitted completed evaluations.

### Section I: Respondents' Perceptions of Forum Characteristics

The first section of the evaluation was composed of 10 categories. Attendees were asked to express their degree of satisfaction or dissatisfaction based on the following scale.



For purposes of this summary, the responses to the ten categories in the first section have been divided into the following: (1) *Overall Forum Satisfaction*; (2) *Forum Logistics*; and, (3) *Forum Presentations & Content*.

Positive responses (highlighted in blue on the following exhibits) refer to responses of “*very satisfied*” and “*satisfied*.” Neutral responses refer only to responses of “*neutral*.” Negative responses refer to responses of “*dissatisfied*” and “*very dissatisfied*.”

#### **Overall Forum Satisfaction:**

The respondents reported positively (96%) in their satisfaction of the Forum, displayed in Exhibit A.

#### **Forum Logistics:**

As shown in Exhibit B, the majority (approximately 76%) of respondents were either “*very satisfied*” or “*satisfied*” with the scheduled date of the forum. About 20% of respondents indicated that they were neutral to the scheduled date of the forum. Only 5% indicated that there were dissatisfied with the date of the forum.

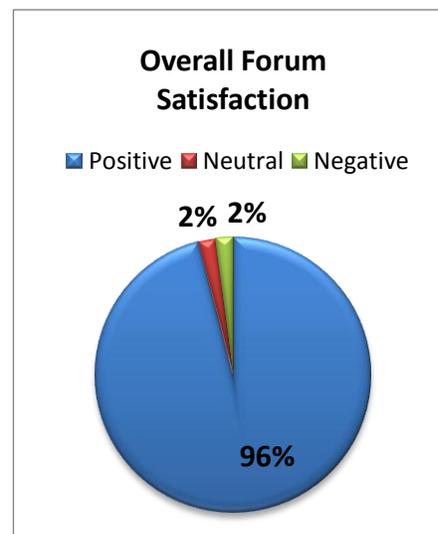


Exhibit A – Overall Conference Satisfaction

Most respondents expressed satisfaction with the forum venue and location (Exhibit C & D), 95% and 93%, respectively.

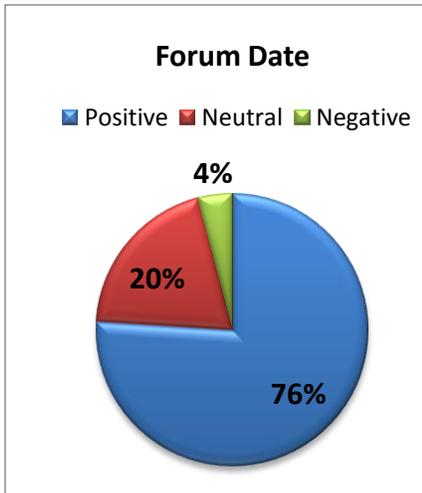


Exhibit B – Forum Date

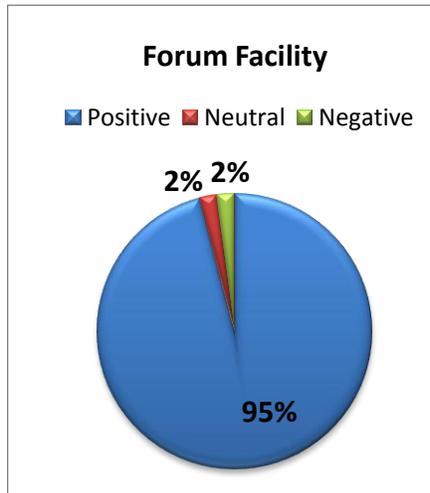


Exhibit C – Forum Facility

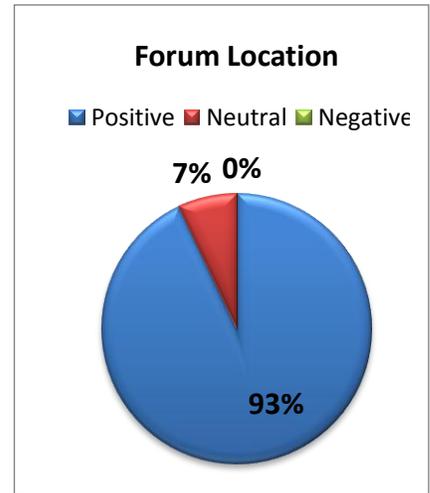


Exhibit D – Forum Location

In terms of publicity level (Exhibit E), approximately 70% of respondents specified they were “very satisfied” or “satisfied” with the publicity level of the forum. About 23% were “neutral” on the matter and only 7% of respondents were “dissatisfied” at some level.

The majority of respondents (approximately 76%) indicated they were “very satisfied” or “satisfied” with the convenience of registration (Exhibit F). The remaining 24% of respondents were “neutral” on the matter.

As illustrated in Exhibit G, the majority of respondents (approximately 88%) reported that they were either “very satisfied” or “satisfied” with the registration fees for the forum. The remaining 12% remained “neutral.”

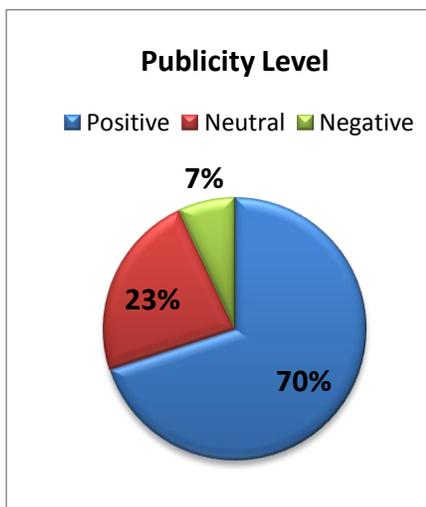


Exhibit E – Publicity Level

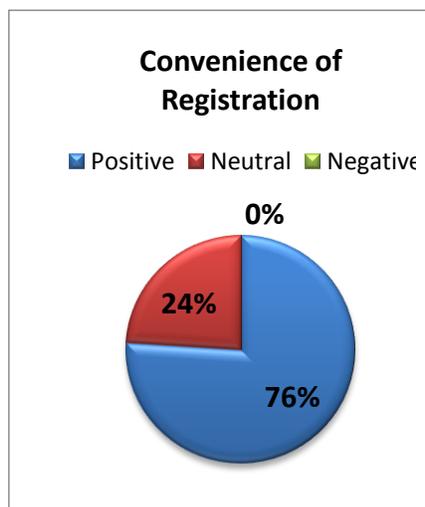


Exhibit F – Convenience of Registration

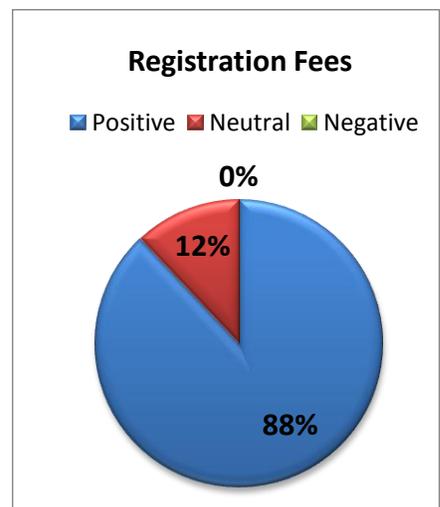


Exhibit G – Registration Fees

### Forum Presentations & Content

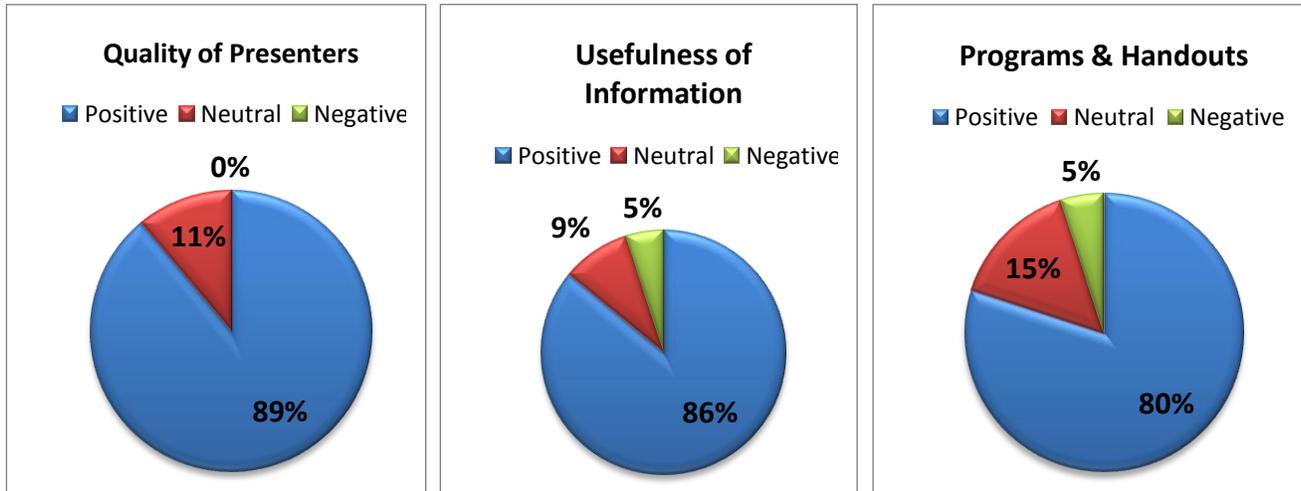


Exhibit H – Quality of Presenters

Exhibit I – Usefulness of Information

Exhibit J – Programs & Handouts

The majority (about 89%) of respondents expressed they were “very satisfied” or ‘satisfied” on the quality of presenters. No “dissatisfaction” was denoted on the quality of presenters (Exhibit H).

In terms of the usefulness of information, most respondents (approximately 86%) specified that they were “satisfied” (Exhibit I). Only 5% were “dissatisfied” at some level. Similarly participants (about 80%) responded positively on the programs and handouts, while about 5% reported their “dissatisfaction” (Exhibit J).

### Section II: Respondents’ Recommendations & Other Comments

The second section of the evaluation form was comprised the following three open-ended questions.

1. What suggestions would you like to make for a future Forum?
2. What might be helpful follow-up from the Forum II?
3. Other/Additional Comments

The responses collected from the evaluation forms are summarized and grouped by subject matter according to the following characteristics:

- Forum Length and Format
- Forum Venue, Location & Accommodations
- Breakout Sessions
- Timeliness
- Reception

- Food & Beverage
- Convenience of Registration
- Level of Publicity
- Programs & Handouts
- Quality of Presenters
- Presentation Content & Usefulness of Information
- Recommendations for Future Presenters/Speakers
- Recommendations for Future Topics
- Follow-Up Activities
- Other Comments

***Forum Length and Format -***

In terms of the overall length, some respondents reported that the forum should be longer than 1 ½ days because there appeared to be time restraints given the many topics that were discussed. Many respondents expressed that the forum format should have less presentations and more time for participants to have meaningful discussions regarding the concerns at hand. Additionally, some respondents suggested that there be small group discussions and formulated recommendations.

In terms of the overall forum, it was recommended that the speakers be more sensitive when telling jokes so as not to offend tribes or individuals. In addition, it was recommended that ADHS executives participate more than a ½ day in order to attain a better understanding of the spirit of the conference.

***Forum Venue, Location & Accommodations -***

In terms of the forum facility, there were recommendations for:

- Larger meeting space;
- Better microphone/PA system;
- Better visibility by adding a camera image of the presenter; and,
- Adjustment of room temperature.

Overall, the venue and location garner high praises as shown in first section. The respondents again expressed that the venue was excellent and the accommodations were close. A recommendation was made the next forum be hosted at Hon-Dah (White Mountain Apache Reservation). Another recommendation is to move the forum venue to various tribal lands so participants can learn about diverse tribal cultures.

***Breakout Sessions -***

Respondent's breakout session comments centered on the need for timeliness and more discussion among providers and the T/RBHAs. One respondent requested more training and less updates.

***Timelines -***

Many recommendations by respondents were made to stay on schedule. Moreover, recommendations made to shorten some of the presentations and allot more time for questions and answers.

***Reception -***

Respondents commended the presentation, presenters, entertainment, and food was excellent.

***Food & Beverage -***

Comments were made the refreshments were tasty, but that more healthy snacks be considered. The respondents commended the quality of the reception meal was excellent.

***Convenience of Registration -***

It was recommended that the registration process and set-up be organized better.

***Level of Publicity -***

One respondent commented to open the forum to non-Indian network providers.

***Programs & Handouts -***

Respondent conveyed the need for the distribution of an electronic and hardcopy of the updated participant list and presentations, following the conclusion of the forum. Respondents did share their appreciation for the conference binders and their contents.

***Quality of Presenters -***

Respondents bestowed high praise on the presenters. Many respondents expressed satisfaction with the presentations and the presenters' level of knowledge of the topics. A minimal number of respondents commented presentation delivery could be improved for certain presenters, as well as presenters keeping presentations to the time allotted.

Some of the respondents expressed signified concern that ADHS executives were not able to have a genuine discussion with participants regarding issues related to behavioral health.

***Presentation Content & Usefulness of Information -***

Respondents reported the presentations were very good and informative. Moreover, they commented the challenges experienced and discussed by individual programs were very helpful. The respondents denoted the panel presentation discussions were very positive and one respondent made particular note of the TRBHA panel. Another respondent indicated the integrated health panel could be strengthened. It was expressed the difficulty for a respondent to relate to presentations regarding outpatient and medical services, as they are not provided by their program.

Several comments were made of the AHCCCS budget presentation provided. Overall, feedback regarding the presentation was good, but respondents specified the need for more information on tribal reimbursement and billing. In addition, concern was expressed on the eligibility for childless adults ages 18-50, primarily because of the need for substance abuse rehabilitation and other services among this population.

***Recommendations for Future Presenters/Speakers -***

Recommendations for future speakers and presenters were shared. It was recommended IHS representation on the tribal/urban panel and/or as an IHS direct care behavioral health facility service provider. Inclusion of tribal leaders as speakers was recommended. A respondent requested a presentation by a Native American medicine person who works with incarcerated people.

***Recommendations for Future Topics -***

Respondents suggested the following topics for future forums.

- Cultural sensitivity, awareness, and integration of values
- Case study recommendations
- Peer-centered services
- Juvenile mental health services; available child and adolescent services; juvenile early intervention programs (birth to 17), anger management, substance abuse, detained youth, AHCCCS suspensions and needed services and care coordination
- Telepsychiatry and other emerging trends
- Rural tribal services; consideration of rural problems, i.e. transportation, case management, home care, alcohol issues, etc.
- TRBHA-specific session
- RBHA success stories
- Trans generational trauma and dependency
- Funding status of 2014
- Affordable Care Act behavioral health changes
- AHCCCS tribal reimbursement and tribal billing specifics; AHCCCS changes as the program evolves and its impact on the RBHA
- Pressing Issues and Solutions (Example: AHCCCS eligibility for single individuals and incarcerated individuals seeking help)

***Follow-Up Activities -***

Respondents were asked to specify any follow-up activities that should occur after the forum. A number of follow up activities were requested as follow:

- Report a timeline, method to measure success, actual success, and topics submitted to the ADHS;

- Provide a status of ADHS and AHCCCS in FY 2012 and FY 2013;
- Follow-up on T/RBHA, urban program, and tribal program advancements or barriers. As well as issues with coordination and continuation of services for juvenile placements off-reservation and general reimbursement topics;
- Share updates on urban and tribal programs;
- Improve collaboration between IHS and urban Native services;
- Send thank you notes to attendees;
- Send e-mail or post any missing presentations and notes from the sessions; and,
- Send out attendees contact information of attendees, including name, agency, and e-mail address.

***Other Comments -***

The following are insightful comments and observations that were made, but did not fit in a particular category previously mentioned.

- Appreciated the limited amount of participants
- High-level participants who can change the system were present
- It appears that Indian Country has similar challenges
- It was great to see unity between tribal entities
- Empowering peers strengthens the system
- Great to hear accomplishments of others
- Many thanks for all of your hard work

The planning committee is appreciative of all the responses and comments submitted by respondents. All comments will be fully considered by the planning committee in preparation for the next forum.

## Attachment 5: List of Abbreviations

638	P.L. 93-638 contracted Tribal health facility
ACOIHC	Arizona Advisory Council on Indian Health Care
ADHS/DBHS	Arizona Department of Health Services/Division of Behavioral Health Services
AHCCCS	Arizona Health Care Cost Containment System
AI	American Indians
ALTCS	Arizona Long Term Care System
BIA	Bureau of Indian Affairs
CARF	Commission on Accreditation of Rehabilitation Facilities
CMS	Centers for Medicare and Medicaid Services
CPSA	Community Partnership of Southern Arizona
EHR	Electronic Health Record
GRHCC	Gila River Health Care Corporation
GRIC	Gila River Indian Community
GSA	Geographic Service Area
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
IGA	Intergovernmental Agreement
IHS	Indian Health Service
IT	Information Technology
ITCA	Inter Tribal Council of Arizona
MOU	Memorandum of Understanding
NARBHA	Northern Arizona Regional Behavioral Health Authority
NIHB	National Indian Health Board

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PCP	Primary Care Provider
PIMC	Phoenix Indian Medical Center
QM	Quality Management
RBHA	Regional Behavioral Health Authority
RTC	Residential Treatment Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment
SMI	Seriously Mentally Ill
TRBHA	Tribal Regional Behavioral Health Authority
UIHP	Urban Indian Health Program
WMABHS	White Mountain Apache Behavioral Health Services
WMAT	White Mountain Apache Tribe