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with comments from Earl Evans, Keisha Bailey, Barbara Pullen-Smith

The NC Department of Health and Human Services' Secretary
And Commission of Indian Affairs'
Joint Task Force on Indian Health

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Recommendations for Improving American Indian Health In North Carolina

Submitted by:

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The American Indian Health Task Force was charged to:

- Review and assess the health care needs of American Indians in NC.
- Develop a set of recommendations that will focus on improving health care and services for American Indians in NC.
- Identify ways to maximize existing resources and programs to provide culturally appropriate health care services and programs to American Indians in NC.
- Review and improve the existing data and information regarding American Indians in NC.
- Develop a contractual relationship with the Tribes to provide direct care and services to American Indians in NC.
- Strengthen the relationship between public health services and programs to American Indian Tribal governments in NC.

American Indian Health Task Force Committees are listed below. Committee topics were identified by Task Force members and by ranked the most important areas to be addressed as they related to Indian Health Issues:

1. Data, Information and Gaps
2. Sovereignty, Governance and Systems
3. Access to Prevention and Care Services

RECOMMENDATIONS FROM COMMITTEES

1. Data, Information and Gaps Committee – *Ronnie Bell, PhD, Chair*

Background:
American Indians in North Carolina suffer from a critical number of health disparities. Understanding the American Indian culture can be complex and each Tribe has its own identify. It is very important to understand the causes and conditions, and to develop models of care and practices for eliminating these disparities. Many of the Tribes in NC do not know the extent of the health problems that exist within their communities and do not have the infrastructure to begin the process of providing services and assistance. A directed effort is needed to document the health priorities in American Indian communities in North Carolina, and a means to which these areas can be effectively addressed.

Recommendations:

1. To develop a health data inventory that would include information on data sources that includes significant numbers of American Indians in North Carolina. The inventory would consist of completed and on-going research studies and completed and on-going public health and health care databases. The inventory would include the source of the data (e.g. public dataset, research studies, community projects), the year the data represent, contact information for the persons responsible for collecting and managing the data, a brief paragraph describing the data, variables in the dataset, and publications based on the data. The inventory would be based on the models previously established by the State Center for Health Statistics and the State Division of Aging and Adult services.

2. To review on–going data collection efforts (e.g. NC BRFSS) to determine the feasibility of adding questions or data collection elements relevant to American Indian health issues.

3. To identify specific priority areas for data collection and analysis. These areas might include:
    a. Health conditions of interest (e.g., diabetes, AIDS, cancer)
    b. Risk factors of interest (e.g., smoking, obesity)
    c. Feasibility of collecting tribal-specific data
    d. Health care access and utilization
    e. Barriers to optimal health and health care
    f. Health beliefs and practices
    g. Funding differences for health care services in American Indian communities and exploring “best practices” models

This listing of priority areas would include a listing of resources for which collection and analysis of these data would be possible.

4. To review and update publications including American Indian health data, including the American Indian Facts Sheet (1999), Racial and Ethnic Disparities Report Card (2003) and Racial and Ethnic Differences in Health in North Carolina (2004). Updating these documents would include new sources of data, and a listing and review of the issues listed in #3.

5. To catalog existing resources, and identify resources, which can be used to encourage American Indian students to pursue research degrees to conduct research in American Indian communities. These resources include programs (e.g., The NC Health Careers Access Program (state) and the Health Careers Opportunity Program (federal), institutions (e.g., UNC-Pembroke, UNC-Chapel Hill, Duke, Wake Forest), role models and websites.

6. To encourage local universities and other research institutions to foster culturally appropriate research in American Indian communities. This endeavor would include:
    a. Providing intramural funding and personnel support for research studies in American Indian communities.
    b. Conducting and supporting activities that promote research in American Indian communities, including seminars, newspaper articles, and training.
    c. Assisting in the development of Tribal Health Boards based on federally mandated Institutional Review Boards.

7. To create opportunities for researchers and data collectors to network to discuss research activities and future directions, as well as to share research activities with community gatekeepers and the general public.

8. To provide recommendations to create a conducive environment for conducting research in American Indian communities. These recommendations would include:
    a. Assist in the development of Tribal Health Boards.
    b. Assist tribes in setting priorities or research and data collection.
    c. Develop strategies for enhancing participation in research.
    d. Streamline processes for collection of letters of support from Tribal Councils and the North Carolina Commission on Indian Affairs.
    e. Provide opportunities for tribes to develop infrastructure for participating in research and data collection, including grant writing skills and research assistants.

* Goal for Recommendations 6 - 8. Develop a research agenda with and for the American Indian community, by active collaboration between tribes and experts in research.

Strategies:

A. An annual review of status and identifying needs for research.

B. Create a Research Task Force with representatives from the Commission health committee (or their appointees), State Center for Health Statistics, Indian health providers, universities and other research institutions for the purpose of making recommendations on research priorities.
C. Set strategic 5-year plan, reviewed annually for progress.
D. Report annually to the Commission and the DHHS Secretary.

2. Sovereignty, Governance and Systems Committee – Casey Cooper, Earl Evan, Co-Chairs

Background:

A barrier for services exists for American Indians in NC due to the lack of cultural congruency in state funded health programs. The interests of Indian Tribes are often non-existent in health policy and development. The Tribes in NC are units of government that provide services to their citizens in a manner similar to state and local governments. The Department should implement the infrastructure necessary to consult with the Tribes as well as contract with them for provision of programs and services to their enrolled members.

Currently, the Department provides services to Indians paternalistically, as individuals of the same minority ethnicity that same as other minorities. In a manner consistent with tribal self-determination, the Department in working in a government-to-government relationship with the Tribes must change its role from that of a service provider and manager to that of a provider of financial resources and an advocate for Tribal self-governance and control.

It is highly recommended and would be valuable for the Department to review the current relationship between the Federal Government (USDHHS and the Indian Health Service (IHS)) and Indian Tribes, to gain a better understanding the self-governance contracting model. There are currently models of state and tribal relationships that are successful in New York, Wisconsin and California and would be beneficial for the Department to adopt a NC state model for working and consulting with the Tribes. If so, this could be a model for other states on the eastern coast.

Recommendation:

1. In recognizing that American Indian tribal governments are sovereign nations, implement the appropriate infrastructure to facilitate a government-to-government relationship between DHHS and the 8 recognized Tribes of NC.

Strategy:

A. The Commission and DHHS adopt a formal consultation policy, which will guide the working relationship between DHHS and the Tribes. A draft of a *DHHS and Tribal Consultation Policy* has been designed and is modeled after the US DHHS and Indian Health Service policy. A draft of the NCDHHS and Commission policy will be presented at a later date.

B. The Commission and DHHS will seek resources to create an office and a full time position within the Secretary's office to be responsible for leading the department's efforts to institute and maintain a government-to-government relationship with the Tribes. It is recommended the position be involved in policy and planning. Ultimately it is preferred that the position be an

advisor to the Secretary, but at a minimum have senior level authority in the Government Affairs or Policy and Planning Office. The position would need to not be vulnerable to reorganization. A position description has been designed and will be presented at a later date.

C. All Departmental managers in DHHS should be required to complete training concerning the governmental and health status of American Indians in NC. The Commission would sanction all training.

Recommendation:

2. Consistent with the principles of Indian Tribal self-determination and self-governance, it is recommended that DHHS devise and implement an plan for direct contracting or block granting of health care financial resources to the 8 recognized American Indian Tribes in NC.

Strategy:

This recommendation can be achieved by convening a Consultation Committee in accordance with the recommended Tribal Consultation Policy to develop DHHS's programming consistent with this recommendation.

3. *Access to Care and Prevention Services, Jinny Lowery, Robin Cummings, Co-Chairs*

Background: American Indians in NC have serious health disparities in many of the chronic diseases. The diabetes death rate for NC American Indians is three times higher and the death rate for stroke and heart disease are at least 25% higher than the rates for non-Hispanic whites. Nearly one-quarter is below the poverty level and rates of unemployment are at least 2-3 times higher compared to whites. About three-quarters of the NC American Indians have a high school education or less, compared to 56% of whites. A plan of action to address access to prevention and care services is critically needed in the tribal communities of NC.

Recommendation:

1. It is recommended that DHHS support and enhance the work of the North Carolina Commission on Indian Affairs' current efforts to work with tribal leaders to address the health status of the Tribes and to educate legislators on Indian health issues.

Strategies:

A. These recommendations will be presented to the Commission Board for adoption into the Commission's 5-year strategic plan to design programs and services for American Indians in NC. The NC Office of Minority Health and the Priority Population Institute will identify appropriate community based organizations to provide training on advocacy and educating the NC General Assembly and general public on Indian Health issues.

B. A copy of the recommendations will be presented to Representative Ronnie Sutton for distribution throughout the NC General Assembly and other interested state officials.

Recommendation:

2. It is recommended that DHHS address health disparities and access issues by increasing outreach and utilization to the Tribes of the current DHHS, Division of Medical Assistance's *Community Care Program*. This program is proving effective in delivering medical care to Medicaid patients, and improving access.

Strategy:

Recognizing funding, manpower and other constraints, it is recommended that DHHS and the Commission work within this program to increase and address access to care within the Tribes. The initial stages would involve case managers assigned to counties and/or zip code where significant numbers of Indians reside. The group served would be **those individuals who fall outside Medicaid but are within 200% of the poverty level** for North Carolina.

These case managers would assist individuals in accessing the medical system. For example: qualifying patients for existing programs. A complete assessment of the patient's health and other needs could be generated which would also assist in data collection and documentation for future use. Much as with case managers utilized within the present Medicaid system, these

managers would follow assigned patients to ensure medical compliance in terms of physician visits, medications, and personal responsibility. Physicians, hospitals or other healthcare providers would refer patients to these managers. Again, a complete assessment of needs and possible resources available would be coordinated.

A case manager model would work in Indian communities. These American Indian Health case managers would report to the Community Care Regional Director, the Commission and DHHS.

Recommendation:

3. It is recommended that DHHS address health disparities and access issues by increasing the outreach and utilization of the current DHHS, Division of Medical Assistance's *Community Alternatives Programs*. NC operates four programs to provide home and community care as a cost-effective alternative to institutionalization. These "waiver" programs are not effectively reaching and meeting the needs of the Tribes. The program that deals with Disabled Adults and Developmental Disabilities are critically needed in the Indian communities.

Strategy:

The same strategy that to be used with the Community Care Program listed above should be used with this program to ensure better access of services for the Tribes.

Recommendation:

4. It is recommended that DHHS address health disparities and prevention by expanding within Tribes the recently approved School Nurses' Program. Many Tribes already qualify based on health and economic needs, but our recommendation would be for additional school nurses in predominantly American Indian schools whose primary task is separate from that of the regular school nurse as outlined in the program.

Strategy:

A. These nurses would primarily focus on the early years - For example, 4-6 year old youth to teach and proselytize good health habits, proper diet, and physical activity and encourage strong mental health development.
B. Nurses working in predominately American Indian schools would be educated to be culturally sensitive.
C. These individuals would be under the direction of the local school system and/or health department but would, report their action plans and results to the Commission and DHHS. Parameters would be developed to ensure action and document results.

Recommendation:

5. It is recommended that the Commission assess current transportation availability and services in all the Tribes and seek solutions.

Strategy:

Access to prevention and care is directly associated with the availability of transportation to healthcare services. Transportation is an ongoing concern and barrier in terms of ensuring access to care in a timely fashion. Many of the Tribes exist in very rural communities where transportation to the doctor and basic social services is almost non-existent. The Commission will review the transportation services among all tribes and report the outcome of the findings.

Recommendation:

6. It is recommended that an assessment be made of the number of American Indian students applying and completing health professional schools and programs in NC as well as the number employed in DHHS and returning to Indian communities.

Strategy:

A. There is a critical need to increase the outreach, monitoring and reporting of the number American Indian health professionals who work in DHHS and who are recruited to return to work in American Indian communities. A monitoring system will be needed to track the graduation, recruitment and retention, and employment of Indian students. The health professional schools in NC will use the results to improve the recruitment and graduation of American Indian students into the health professions. The NC Health Careers Access Program, UNC at Pembroke, and the Priority Populations Institute will work collaboratively to compile a report on the findings of this issue and submit a report to health professional Deans of Admission in health professional programs within the UNC system as well as private institutions of higher education.

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