National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program

Exploratory Description of Financing and Sustainability in American Indian and Alaska Native System of Care Communities

Summary Report & Appendices

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Introduction

The Comprehensive Community Mental Health Services for Children and Their Families Program (also referred to as the Child Mental Health Initiative [CMHI]), funded by the Center for Mental Health Services (CMHS) at the Substance Abuse and Mental Health Services Administration (SAMHSA), was initiated in 1992 to provide grants to States, communities, territories, and American Indian and Alaska Native (AI/AN) communities to develop systems of care to serve children and adolescents with, or at risk for, emotional disorders and their families.[1,2] A system of care promotes the full potential of all children and youth by addressing their physical, emotional, intellectual, cultural, and social needs.[3]

AI/AN communities entered the system of care movement in 1994 with the initial Federal grant award to the Restoration of K'e: The Navajo Nation Child Mental Health Project, located on the Navajo Reservation in New Mexico. The experiences of this initial Tribal venture into the world of national system of care reform helped to open the doors for the Tribal communities that followed. Fifteen Tribal communities were funded between 1994 and 2006 and they represent the broad diversity of Tribal people (see Table 1 for a list of the grant communities and their primary States of residence).[4] Their cultures and languages are as diverse as their geographic locations, which include rural reservations, Urban Indian communities, and Alaska Native villages.

Half of the Tribal system of care communities were previous recipients of a 3-year Circles of Care planning grant. The Circles of Care Initiative—

described by community representatives as invaluable—supports federally recognized Tribes, State-recognized Tribes, and Urban Indian communities with financial and technical assistance to plan a culturally respectful mental health system of care.

The material presented in this report is supported by additional material included in the following report appendices:

- Appendix A. Understanding the Challenge: The Cultural Framework
- Appendix B. Purpose and Description of the Exploratory Description Study
- Appendix C. Findings from Discussions with Project Directors, Fiscal Managers, and Tribal Board or Council Representatives
- Appendix D. Findings from Interviews with State Representatives
- Appendix E. National Evaluation Sustainability Study Findings for Tribal Communities

In addition, the discussion guides used to gather the data summarized in this report can be found in Appendix F.

[1] For the purpose of this report, the terms "American Indian/Alaska Native," "Native American," "Indian," and "Tribal" are one and the same.
[2] The 125 communities that have received, or were receiving at the time of the study, funding through CMHI represent all 50 States and two U.S. territories.
[3] http://systemsofcare.samhsa.gov/, retrieved March 25, 2008.
[4] CMHI grants were awarded to 13 Tribal sovereign nations and two Urban Indian organizations between 1994 and 2006.

Table 1. American Indian and Alaska Native System of Care Grant Communities

System of Care	Population of Focus	State	Funding Period
Graduated Communities			
Restoration of K'e: The Navajo Nation Child Mental Health Project	Navajo Nation	New Mexico	1994–1999
Sacred Child Project	North Dakota Tribes	North Dakota	1997–2003
Kmihqitahasultipon ("We Remember") Project	Passamaquoddy Nation	Maine	1997–2003
With Eagles' Wings Project	Northern Arapaho and Shoshone Tribes	Wyoming	1998–2004
M'no Bmaadzid Endaad Program	Sault Ste. Marie Tribe of Chippewa Indians and Bay Mills Tribe of Chippewa Indians	Michigan	1998–2004
People Working Together Project	Yup'ik Eskimo and Athabascan Indians	Alaska	1999–2005
Nagi Kicopi–Calling the Spirit Back Project	Oglala Sioux Tribe	South Dakota	1999–2005
Ak-O-Nes Project	Northern California Tribes	California	2000–2006
Currently Funded Communities (at the time of the study)			
Choctaw Nation CARES Project	Choctaw Nation	Oklahoma	2002–2008
"Ch'eghutsen" A System of Care	Alaska Native Communities	Alaska	2002–2008
Urban Trails Project	Urban Indian Community	California	2003–2009
The Po'Ka Project (Blackfeet Children System of Care)	Blackfeet Nation	Montana	2005–2011
Tiwahe Wakan (Families as Sacred)	Yankton Sioux Tribe	South Dakota	2005–2011
Seven Generations System of Care	Urban Indian Community	California	2005–2011
Sewa Uusim Systems of Care	Pascua Yaqui Tribe	Arizona	2006–2012

Description of the Study

The purpose of the exploratory study, conducted between July 2007 and January 2008, was to examine the unique financing opportunities and challenges of Tribal systems of care in relation to program sustainability. The overall goal of collecting the information from this exploration was to use study results to identify and improve financing and sustainability strategies specifically for Tribal communities. It is important to note that the findings of the study are based on a small number of participants (two or three staff from each of the 15 Tribal system of care communities) and the findings cannot be generalized to all Tribal communities.

The National Evaluation Team facilitated telephone discussions and conducted site visits with Tribal system of care communities funded by CMHS between 1994 and 2006. Telephone discussions with the project director and fiscal manager of all 15 communities covered broad thematic areas that included perspectives on sustainability; the economic, social, and political environment; infrastructure; services; and funding. The discussions, conducted from July through October 2007, were unstructured, but were steered by a topical guide.

In addition, site visits were conducted with five Tribal system of care communities between November 2007 and January 2008. On-site discussions were held with a project director, fiscal manager, Tribal Board or Council representative, and State representative. These discussions explored financing and sustainability successes and challenges in more depth than the telephone discussions. Discussions with State representatives

focused on State agency support for Tribal systems of care.

A Native researcher conducted all discussions in a culturally competent manner; respect for AI/AN historical concerns about data gathering and data analysis guided the entire research process. The notes taken for all discussions were qualitatively analyzed by isolating emergent themes.

Tribal Starting Place—The Cultural Framework

The core values of a system of care specify that services should be child-centered, family-focused, community-based, and culturally competent—all values shared with many Tribal communities as part of their traditional values and beliefs. Most of the Tribal communities further capitalize on this alignment by translating the system of care terminology and approach into phrases and terms that are meaningful to their Tribal cultures. Tribal communities understand the relationship between a cultural foundation to services and improved outcomes for Tribal youth and families, and use the system of care framework to strengthen the development of healthy Tribal nations.

The cultural importance of program sustainability cannot be ignored. Sustainability of community mental health programs is especially important within Tribal communities that lack financial resources. For example, one leader of a Tribal community-based substance abuse prevention and intervention program stated,

> We have a responsibility to our program recipients. They've had so many losses in their lives, and [if we] come in for a year or two or three and give them hope, only to have the program go away, we've just caused another loss and further hopelessness in their lives.[5]

Although the system of care principles and Tribal belief systems may be in alignment, Tribal systems of care continue to face serious challenges in developing and implementing financing strategies for sustainability. Financing any system of care is a strategic endeavor that involves determining what funds will be used, how they will be used, and how they will be managed.[6] However, the financing of Tribal systems of care is particularly complicated. This is due to many reasons, including the lack of financial resources in remote Tribal communities, the impact of Tribal–State history on the willingness and ability to pursue financial partnerships, and the potential funding sources' lack of knowledge about the advantages of working with Tribes.

Adding to the complexity of the challenge is the meaning of federally recognized Tribes' sovereign status as it relates to financing; the role of Tribal self determination; the history of confusing policies guiding support for Tribal services; the financial options of Tribes that are recognized by States, but lack Federal recognition; and the unique financial situation faced by Urban Indian communities. These challenges become barriers to reform when there is

[5] Noe, T., Fleming, C., & Manson, S. (2004). Reducing substance abuse in American Indian and Alaska Native communities: The Healthy Nations Initiative. In Nebelkopf, E. & Phillips, M., (Ed.), *Healing and mental health for Native Americans*. New York: Altamira Press.

[6] Stroul, B. A. (2007). Issue brief 1: *Effective strategies to finance a broad array of services and supports* (RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub. #235-IB1). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

a lack of cross-cultural and cross-system problem solving.

Planning for Sustainability

Findings

Many of the Tribal system of care community representatives stressed that active and early planning for sustainability was critical. Community representatives discussed how planning for systemwide transformation built on a foundation of Tribal beliefs and Tribal ownership provided an opportunity to break away from a previous cycle of non-productive "planning" that had been reactionary and short-term in nature. Some community representatives felt that recognizing the impact of colonialism and historical trauma on the Tribal community's efforts to plan was an essential first step in breaking non-productive cycles. One community representative argued that there was little value in building large-scale services with Federal funding if there was no effort to plan for long-term sustainability. Additionally, a few communities cautioned that fast program growth resulting from an infusion of Federal funds can diminish the quality of service provision if the service structure is not carefully planned; community representatives recommended expanding services carefully and only to the extent that supports are in place to ensure quality service provision.

The Tribal system of care communities engaged in a number of approaches to planning, which usually began with their seeking input from the local community on needs and service priorities as part of their logic model development.[7] Many Tribal community representatives discussed the value of gathering data about their community's strengths and needs to help with program planning and to increase their competitive edge with other funding opportunities.

Some of the planning approaches used by the Tribal communities included

- developing local definitions of health and wellness with the input of community members and Tribal elders;
- having Tribal elders help design strategies to infuse Tribal values, practices, and cultural supports throughout their system of care;
- analyzing all of the fund sources that affected the Tribal youth and families in their States of residence, and then determining which of the fund sources they currently accessed and which they needed to pursue;
- determining the true cost of services using time and cost studies;
- incorporating visits to the State Medicaid office to better understand the Medicaid provider and billing requirements;
- using a backward mapping process to identify the community's ultimate goal and detail the steps necessary to reach the goal without sacrificing cultural integrity;
- developing ways to build evidence of effectiveness and a cost base for traditional practices;
- developing methods to track the non-Federal matching fund requirement.

Discussion

The close alignment of system of care values and principles with many Tribal values and beliefs empowers a Tribal system of care to include the Tribal community in its planning efforts. System of care grant requirements such as providing culturally competent services that best meet the community to be served, creating ways to ensure family-driven and youth-guided care, consistently evaluating the factors related to child and family progress, and developing a social marketing plan that helps the community understand the meaning of a system of care are all opportunities for a more culturally and

[7] A logic model is a process to articulate the theory of change underlying systems of care for children and families. It is a tool for describing theories and beliefs about how and why service systems are expected to produce particular results.

linguistically appropriate and inclusive planning model. Authentic community involvement in all levels of planning not only gives family voice to the process, but can clarify community needs and wants, and helps to determine which elements of the system of care should be sustained after the Federal grant ends.

The Tribal system of care communities stressed that adherence to the cultural strengths of Tribal values becomes the screen through which all services and fund-seeking decisions must pass. Within this framework, the written sustainability plan can clarify financing priorities, outline steps to be accomplished toward each financing priority area, list timelines for the completion of tasks, designate key leadership roles and responsibilities, and detail benchmarks to monitor progress toward long-term sustainability of the Tribal system of care.

Political Entities and Sustainability

Findings

The willingness of those who hold the power and authority to make funding decisions has tremendous influence on the financial sustainability of the Tribal systems of care. The AI/AN systems of care described the ways in which their sustainability efforts were impacted by government agencies at the Federal, State, Tribal, and county levels.

Each Tribal system of care community described making significant investments of time to increase the government funding sources' knowledge about why system of care services are needed and why Tribal-driven services increase community access and produce better outcomes. This work included providing education about Tribal culture, Tribal needs, Tribal sovereignty, and the Tribal approach to child and family services. The Tribal systems of care became expert in ways to generate political and policy-level support for their systems of care through education and relationship building.

Tribal–State relationships varied by State, often for historical reasons, and community representatives reported the value of developing partnerships with key State officials and administrators. Many community representatives participated in State and county planning meetings to make Tribal needs known, but pointed out that Tribal staff time was limited and travel to State or county planning meetings was time consuming.

Tribal system of care communities also provided numerous examples of their efforts to monitor and influence State health planning initiatives, such as social marketing efforts to draw policy attention to Tribal family needs. A further complication is that several of the Tribal system of care service areas encompass multiple States, resulting in a multilayered process of developing relationships with State administrators and the need to understand multiple State child-serving initiatives.

Many community representatives discussed the impact of Tribal politics on their sustainability planning efforts. Some communities reported that frequent elections of Tribal government officials were disruptive to sustainability planning; the Tribal election process can occur as frequently as every 2 years, and the system of care staff had to repeatedly provide orientation about the transformative meaning of "systems of care" to prospective, or newly elected, leadership. Community representatives also discussed the impact of turnover in key Tribal government positions that lead to a shift in priorities for the Tribe or Tribal organization. Community representatives emphasized that Tribal elections sometimes caused rules to change overnight.

Discussion

Support from those with power and influence over funding decisions is critical for the sustainability of any system of care, but the Tribal systems of care have the additional task of educating funding sources about their culture and approach to Tribal services. Tribal systems of care spend a significant

amount of time explaining what services and supports work for Tribal families, developing ways to document the benefits of their service array, and negotiating strategic alliances that support the sustainability of their systems of care.

In order to sustain financially, the Tribal system of care communities must advance each of these areas. For example, although each Tribal community is aware of what mix of clinical and cultural supports works best for it, there remains a need to better articulate how the cultural supports may help advance the clinical interventions, or how clinical and/or medical interventions may help open the door for increased understanding of the stabilizing role of cultural supports. Also, Tribal academicians, researchers, and evaluators are interested in better describing the benefits of a Tribal service array, but many struggle with how to describe the intersection of the different world views represented by clinical and traditional services. And, while Tribal communities are experienced in developing tactical alliances, the ultimate accomplishment of turning allied support into actual contract dollars remains a challenge.

Developing Sustainable Services

Findings

The Tribal system of care communities described their efforts to build an array of services that best responded to the behavioral health needs of their community. Their inherent knowledge of all things Tribal (social and cultural lifestyles, spiritual beliefs, values, communication styles, and resources) offered a cultural advantage in designing services to match the local need. In general, not only do the program names of many Tribal systems of care reflect the AI/AN value of honoring children and youth, but their arrays of services reflect that their culture is the foundation of their services.

Some of the communities addressed an ongoing workforce shortage in Tribal behavioral health by investing in training and credentialing programs for staff to increase the quality of care and to provide career advancement steps for paraprofessional staff. In addition, several Tribal communities were successful in marketing their training program to the State, which resulted in modification of State provider standards to enable the certified, Tribal paraprofessionals to meet requirements for third-party reimbursement.

These successful partnerships between the Tribal systems of care and State governments resulted in training and education programs that met State credentialing requirements as well as the cultural service needs of Tribal communities. Many Tribal systems of care encouraged partnership with the State from the beginning of the curriculum development to ensure that any obstacles to becoming a State licensed provider of behavioral health services were readily addressed and resolved.

Community representatives described successful partnerships with Tribal community colleges and universities to develop and provide training. One community representative noted that while higher education strengths lie in providing an academic foundation to behavioral health knowledge, such a setting may not always be as successful for teaching the practical skills needed by staff to provide mental health services. Given the urgent situations of many Tribal youth, some communities felt that Tribal system of care staff needed on-the-ground clinical skills more than academic theory.

The Tribal communities developed a range of approaches to address the role of culture as part of the assessment and treatment planning process, including

- relying on local cultural advisors to guide the development of the services;
- developing extensive cultural assessment protocols based on the local definition of wellness;
- developing treatment goals to include both a clinical and cultural assessment;
- setting the pace and location of the "treatment" according to local culture and individualized needs;
- developing Tribal behavioral health training that benefited both the Tribal practitioner and non-Native clinical supervisor;
- incorporating traditional practices into the "treatment" plan that were individualized according to particular Tribal beliefs and family requests.

Many of the Tribal communities discussed their struggles with determining whether and how to seek financial support for traditional practices. Traditional practices can be defined in many different ways and are an important cultural link to the healing process. In general, the Tribal systems of care expressed concern that seeking financial support for traditional practices might result in requirements for adhering to licensing and accreditation standards.

Tribal community representatives suggested various solutions, which included

- developing a line item in their system of care budgets for broadly defined cultural supports, which might include traditional practices;
- including references to traditional practices within their system of care coordinator certification process;
- cross-walking the "treatment" goals of Tribal traditional practices with their clinical outcome counterparts.

Whether a treatment approach was referred to as a traditional practice or not, many felt that promoting culturally competent service provision was just as important to the sustainability of their system of care as securing financial resources.

In addition, several communities discussed the impact of the large infusion of Federal system of care grant dollars on their program design. Although the Federal support enabled the community to pay detailed attention to all elements of Tribal service provision, a few communities advised that too much program growth too quickly could diminish the quality of service provision. That is, the addition of staff without program underpinnings in place (e.g., a full orientation to the system of care framework, training on system of care service expectations, and an understanding of how the service array links to outcome measures) could mean that the newly hired staff were not able to work effectively as a team of system of care providers. Therefore, some community representatives recommended building slowly and expanding services only to the extent that quality service provision could be assured.

Discussion

Tribal systems of care are challenged by building services that can be sustained beyond the Federal grant. This requires that the system of care leadership maintain a balance between cultural and clinical knowledge, address workforce recruitment and training needs, provide effective supervision and oversight, and develop meaningful ways to measure outcomes related to the full range of their services. Training and education costs are critical for workforce readiness, and supervision supports could be an important element of workforce retention. Another program cost is Tribal administrative time, essential for building

relationships and educate funding sources on the value of Tribal-driven services.

Strengthening Infrastructure

Findings

Each of the Tribal system of care communities was at a different point on the continuum of infrastructure development. Those that were part of a Tribal primary health care organization often had a reasonably strong infrastructure in place (e.g., computerized care management documentation, an information technology department for computer trouble shooting, a fully staffed finance and billing office). Tribal systems of care that were not attached to a health care system often had to build their organizational infrastructure from the ground up. This was complicated by their remote locations, which hindered their ability to recruit and hire staff to support their infrastructure development.

The communities discussed how the lack of local and well organized culture-based services contributed to the disproportionate numbers of American Indians and Alaska Natives in juvenile justice, foster care, child welfare, and behavioral health systems. Most Tribal communities are rich in culture, but poor in financial resources. When funding for services is received in such high need communities, the immediate focus is on delivering services to the community. Strengthening the service system infrastructure often takes a back seat to mobilizing services to meet the community need.

One community representative suggested that Tribal communities should take the time to build a solid administrative and financial infrastructure, one that is designed for growth. Another community representative reported that hiring or contracting with a public accountant to review the Tribal system of care's accounting system, billing capacity, and fund oversight was an essential step in building such infrastructure.

Community representatives discussed other aspects of their organizational infrastructure that affected their system of care, including the following:

Internet. The remote locations of many of the Tribal systems of care have sporadic Internet connectivity. This was mentioned as affecting electronic billing capability and diminishing their ability to comply with State contract performance standards, such as those mandating a maximum time period between when the service was provided and when the data was input into State databases. One community that increased its use of electronic communication found that many members of its Tribal Council were unfamiliar with the technology, so that training had to be provided to improve the Council members' comfort and skill with computer technology.

Office space. Office space is extremely scarce for many Tribal communities, as is housing for newly recruited staff. Due to a lack of available office space, several communities reported having uncomfortable working conditions or offices scattered across several locations, creating a barrier in staff unity. To address the lack of space, some communities received office space from school districts to provide school-based services. Other communities built their own facilities. Building office facilities, which also served as community centers, was a large part of promoting program sustainability for these systems of care.

Billing infrastructure. Tribal billing capacity is critical for many financial sustainability plans, but many finance staff in smaller Tribal organizations have a narrowly defined responsibility of meeting payroll and billing a grant funding source on a once-a-month basis. Thus, establishing a complex, third-party billing system can require a huge investment of resources. Technical assistance from State representatives was helpful for some to better understand their billing processes and reduce future billing errors. Others reported facing the challenges of insufficient financial software or keeping up with

necessary software upgrades to meet the changing requirements of payers. On the other hand, those that were part of a large Tribal health care organization reported being able to tap into existing billing infrastructures, making the transition to billing for mental health services less challenging.

Staff transformation. Some community representatives discussed the challenge of transitioning Tribal direct service staff from a long history of working within a grant funding environment, with no uniform expectation for a specific number of direct service hours per week, to a billable service hour model. The billable hour model requires that each staff person work within specific weekly service expectations that include an established goal of a certain number of billable service hours. Transitioning staff into billable hour performance expectations was successful when the Tribal organizations turned the billable hour expectation into a visible team effort that emphasized increased service to the community.

Discussion

Many Tribal organizations have made important advances in strengthening their organizational infrastructure as part of sustainability planning. Consultation with financial oversight and grants management advisors has been helpful and has resulted in a list of action steps to achieve a stronger infrastructure. Many Tribal systems of care have gained much support and advice from peer-to-peer learning opportunities. Establishing relationships with State funding sources and State contracts offices has been useful in better understanding data requirements and billing processes. Tribal systems of care have gained additional insight by exploring a State or national accreditation process that provides a list of action steps to prepare for accreditation. Continuous awareness of integrating cultural norms into the infrastructure development is critical.

Developing a process for continuous quality improvement (CQI) is another important step toward financial sustainability. Unless a CQI process is institutionalized within the Tribal organization—especially in communities where the need for services is great and the environment may frequently be crisis driven—it can be easy to lose sight of the sustainability plan. Institutionalizing a CQI process requires the formal allocation of responsibility for quality improvement to a person or team with the power and authority to transform and improve services and financing opportunities. It is helpful for this person or team to have experience in managing in a changing environment.

Role of Data in Financial Sustainability

Findings

The Tribal system of care representatives discussed general concerns about data collection that reflected the historical mistrust held by many Tribes. Tribal hesitation about data collection, ownership, and analysis is based on the historical misuse and abuse of Tribal data by some non-Tribal researchers. However, many community representatives also recognized the importance of tracking service use information as part of financial reporting. The system of care funding legislation requires grant community participation in a national evaluation of system of care implementation; some Tribal communities have used this involvement as a springboard to further develop their own local evaluation efforts. Community representatives emphasized the importance of Tribal "ownership" of, and a voice in, the data collection and analysis processes to ensure a cultural interpretation of the data.

Discussion participants also reported the need to improve Tribal data systems. Community representatives from one community stressed the usefulness of having information on the number of clients served, the number of services rendered to each client, the types of services rendered, and client characteristics. Another community representative stated that program evaluation cannot

occur without data and benchmarks. Tribal strategic planning and system of care coordination is hindered when basic service information is not available across the child-serving systems.

Coordination between State reporting systems and Tribal databases was also reported as a challenge. One community discussed the double challenge of using an outdated data tracking system within the Tribal organization, but also having to enter data into a complex State database. Technical assistance from the State regarding the State databases proved helpful for one community, but another community discussed the need for increased Tribal advocacy and input into State decisions about technology upgrades and electronic reporting requirements.

Tribal–State partnerships in improving data technology were often successful. A State discussant described efforts to help Tribal organizations in obtaining technology grants to upgrade computer equipment and to increase the Internet speed for remote Tribal locations, enabling reports and data for billing to be transmitted quickly. In this win–win situation, the State's motivation was to facilitate Tribal access to Medicaid billing and data tracking, and the Tribal organization gained a multipurpose technology upgrade.

While data collection was reported as being a time-consuming requirement for the Tribal system of care, it was also considered essential for justifying the need for staff positions, revamping program foci, securing additional funding sources, negotiating changes with the State for provider qualifications, focusing staff training on emerging community needs, and promoting social marketing endeavors.

Discussion

The system of care national evaluation process is challenging to some Tribal communities. However, the communities acknowledged advancements in the use of data for sustainability planning, program planning, and organizational change. The ability to have program managers and evaluators on staff who became trained and experienced with system and client outcome indicators, sustainability assessment measures, and other aspects of data use was recognized as valuable.

Although Tribes and Tribal organizations hold a historical distrust of data requirements, the system of care evaluation effort provides an opportunity for Tribal communities to build knowledge and adapt the data requirements in ways that best support local needs. Tribal systems of care are at different places on the continuum of data use, but the ability to develop data-based arguments for funding of Tribal services is essential for long-term sustainability planning.

Assessing and Mobilizing Funding Sources

Findings

Tribal community representatives expressed frustration with the scarcity of available funding sources for their communities. The shortage of funding for Tribal communities is partly due to regional economies, confusion about which government entity is responsible for Tribal services and omission of Tribal services from funding applications. One community representative mentioned the practice of some States and counties of including Tribal statistics in their overall statement of need in State and/or county grant applications, but to provide little funding to Tribal service providers.

There is a substantial lack of available funding in rural and remote Tribal locations. One community reported it had three experienced grant writers on staff, but the community lacked any funding opportunities to pursue, especially those that would support the youth-guided and family-driven values of a system of care. In another instance, upon the Tribe's receipt of the system of care grant funding, the county within which the Tribe resided stopped providing all previous funding to the Tribal community and would not re-establish the financial support once the CMHS grant funding ended, despite system of care staff efforts. Communities were also challenged in finding grants with sufficient indirect cost funding to support program administration needs.

To further complicate fund-seeking efforts, some of the Tribal system of care communities encompass service areas that are part of more than one State. In these situations, multi-State political and economic environments affect the systems of care, requiring that Tribal communities become knowledgeable about multiple States' children's initiatives, Medicaid regulations, provider standards, and credentialing requirements.

Matching Funds Requirement

The Federal system of care funding requires that the grant community must make non-Federal contributions toward program costs. Meeting the Federal cost-sharing requirement (informally referred to as the match requirement) is consistently one of the greatest challenges for the Tribal systems of care. Although the requirement encourages local investment in the system of care by other child-serving systems, Tribal communities represent some of the most impoverished areas of the country. One community reported that there were not enough financial resources in the area to meet the match requirements. Another community addressed this issue by joining a coalition of Tribes to negotiate with the Federal Government to have the requirements waived for the poorest counties in the country.

Communities stressed the importance of understanding what can and cannot be used toward the match requirement under the Federal cost-sharing guidelines. Although eligible Tribes and Tribal organizations receiving funds under the Self-Determination and Education Assistance Act are exempt from the restriction prohibiting the use of Federal funds as match, they must ensure that the funds received under this Act are not being used as Federal match by other components of the Tribal organization or Tribal government.[8]

Those community representatives who reported having the most success with meeting the match requirements had long-term relationships with State or county funding sources; the State or county cash grants were their match, or cost-sharing, dollars. Most communities reported meeting the cost-sharing requirements by assigning a cash value to in-kind contributions. However, searching for and documenting in-kind contributions was a labor-intensive process that pulled time away from direct services.

Discussion

The Tribal, State, and regional economic environments that surround the Tribal system of care have a direct impact on its ability to locate and access funding support. The fund-seeking challenge is greatly exacerbated because many of the Tribal systems of care are located in the most economically depressed regions in the country. The shortage of available funding sources makes it even more important for the Tribal system of care communities to avoid "chasing" dollars as they become available. Instead, time spent in developing a sound strategic plan and a logic model delineating the community's theory of change would be well spent.

[8] Tribes receiving funds under the Self-Determination and Education Assistance Act (PL 93-638, as amended) are exempt from the restriction that prohibits the use of those Federal funds as match as long as the funds are not being used as match for other funding sources.

Analysis and identification of funding sources that meet the Tribal vision as well as the funding source vision is a business-smart, strategic process. This fund-seeking process should be focused by the community's strategic plan for sustainability that includes a well-thought-out theory of how the local community will change from "service as usual" to a new framework of a Tribal system of care. Additional development of strong financial and contract reporting systems will not only help build well-organized and effective services, but will result in setting the stage for replication of best service and infrastructure practices.

Determining the Cost of Services

Findings

A fundamental step in sustainability planning is to determine the true cost of service provision. One community's representatives reported that they determined the actual cost of their services through the use of time and cost studies. Using a time study form, each administrative and direct service staff person tracked how he/she spent each work day over a specified period of time (e.g., 2 weeks). The time study approach categorizes typical activities and requires staff to record the amount of time spent in each type of activity. Using this foundation of information, the actual cost of various services (including time spent completing client paperwork, administrative costs, supervision costs, transportation, etc.) was calculated. With this information in hand, the Tribal system of care could then negotiate payment rates with funding sources.

Discussion

Tribal programs that develop a budget or negotiate a contract without a full determination of the actual cost of their service provision are fiscally vulnerable and always in a disadvantageous position during contract negotiations. Determining an accurate cost of services is especially critical for culture-based services because this type of service usually involves a longer process for cultural engagement and usually requires an expanded amount of time to render service. Time studies can help determine the length of time used for culture-engagement strategies, and the amount of time needed for each step of culture-based treatment. Tribal communities can then negotiate cost-based rates for the full range of Tribal services (e.g., clinical and cultural assessments, community health aide services, behavioral health care, case management), which is critical.

States are interested in ways to reduce the high cost of some State services and increase their effectiveness. Negotiating with States for Tribal service contracts is more effective if Tribal organizations know the cost of their services and can demonstrate that their approach to service provision will not only be less costly to the State, but will likely result in better outcomes.

Medicaid as a Funding Source

Findings

An essential part of many of the Tribal system of care sustainability plans included exploration of a partnership with Medicaid (the largest payer in the country for behavioral health services). The Medicaid structure, designed as a shared expense between the Federal and State governments for State plan-approved Medicaid services also includes a special provision for Tribal partnerships.

This provision is related to the Federal share of the Medicaid service cost, which is referred to as the

Federal Medical Assistance Percentage (FMAP).[9] Several community representatives reported that they spent significant amounts of time meeting with State officials to explain the potential benefits of Tribal–State partnerships and to negotiate access to reimbursement rates through this special provision in the Indian Health Care Improvement Act, through federally qualified health center rates, or through changes in provider standards that better support Tribal-driven services.

The exploration of Medicaid access had many starting places, depending on the organizational structure and infrastructure capacity of the Tribal system of care. For example, Tribal communities that did not already have a national or State license or accreditation status as a behavioral health provider first pursued the steps to become licensed or accredited—a necessary step toward being able to bill Medicaid for eligible services. Most of these communities realized that in addition to further development of their behavioral health policies and procedures, they also needed to focus attention on developing their third-party billing capacity. Some communities became knowledgeable about Medicaid enrollment standards and explored ways to co-locate Medicaid enrollment staff in Tribal community locations.

The potential relationship between traditional services and Medicaid reimbursement were addressed in a variety of ways. Traditional services could be classified as behavior management or rehabilitation services in some State Medicaid Plans that recognized the value of selected traditional practices as part of the service array. One Tribal community employed a licensed counselor as a clinical staff supervisor who provided cultural services as part of the treatment plan. Some communities addressed the use of traditional approaches as part of treatment in their training and certification curriculum.

Careful analysis of the State Medicaid reimbursement rates and behavioral health billing categories was important in Tribal community service planning, as was the financial calculation of the number of billable hours per week per staff person. Some Tribal communities conducted a crosswalk of the planned Tribal system of care's services with Medicaid behavioral health billing categories to determine categorical alignment. Some Tribal communities worked closely with State Medicaid staff and other Medicaid providers to explore and submit State Plan Amendments to increase Tribal access to Medicaid services. If amendments were not possible, continued collaboration with the State Medicaid office sometimes led to regulatory changes (e.g., easing of duplicate paperwork) that facilitated a Tribal system of care's involvement as Medicaid providers of services.

Challenge areas included unsuccessful access to the State's behavioral health managed care system and, hence, unsuccessful access to Medicaid. Some communities were not able to access Medicaid services because they did not have licensed staff or did not offer any billable services at their current stage of service development. Some communities were unaware that transportation is a service that may be eligible for Medicaid reimbursement. This is unfortunate because transportation is a significant cost in Tribal services due to limited community member vehicle ownership, the long geographic distances to reach services, and the lack of financial resources for fuel.

[9] The FMAP rate is based on the State per capita income, thus varying from State to State; the State share of Medicaid service costs range from 50 percent to 85 percent. A Congressional provision of the Indian Health Care Improvement Act established a match rate of 100 percent Federal dollars and zero State dollars for Medicaid services offered through the Indian Health Service (IHS), Public Law 93-638 Tribes, or Public Law 93-638 Tribal organizations. In addition, the Tribal services must be provided through a tribally owned/leased and operated facility that is on the official IHS facility list. If all the requirements are met, this FMAP option can result in cost savings to States and is one of the reasons that Tribal systems of care explore Medicaid as a resource for eligible services.

Discussion

The historical funding resources for Tribal behavioral health services, primarily Indian Health Service and Bureau of Indian Affairs, remain too meager to fully address the growing disparities and behavioral health needs of local Tribal communities. Tribal system of care communities recognize that they must search for additional financial support, and Medicaid is prominent in most of the Tribal sustainability plans. Key to pursuing Medicaid service coverage are several factors: the ability of the Tribal organization or Tribal government to develop a working relationship with State Medicaid officials; the design and efficacy of the Tribal service array; the ability to recruit (or develop) a licensed workforce; and the capacity of the Tribal infrastructure to effectively support a third-party billing mechanism.

Developing and Sustaining Key State Partnerships

Findings

The majority of the community representatives spoke about the value of establishing a working relationship with a key State administrator that later became an important part of their sustainability efforts. The Tribal communities used a variety of approaches to build relationships with State administrators, but common to their approaches was conducting Tribal–State meetings to educate each other on mutual needs and priority areas and provide information about the connection between a cultural foundation to service and improved outcomes. One community's strategy was to include representatives from the county on its Tribal advisory board to increase their exposure to Tribal needs.

Some community representatives stressed the need to start relationship-building with the State as early as possible, as it could take years to get into the State system and, ultimately, into the State budget. Often, the State contact person became a "champion" for Tribal services—that is, someone who advocated within the State system for the value of Tribal services.

The State contacts that were developed also provided insight into the inner workings of State system priorities and data systems, which proved invaluable to several Tribal systems of care. For example, some State contacts provided training on how to negotiate a maze of county program requirements and reporting forms. One State champion provided assistance in understanding how to reduce the error rate in Medicaid billing. Another was helpful in advocating for changes in minimum provider qualifications for case managers and care coordinators.

The State champions were valued because they understood sovereignty rights, valued the Tribal expertise regarding providing services to Tribal communities, and understood how Tribal services could benefit the State. However, some community representatives observed that the development of positive relationships with representatives of their States' agencies was challenged by State personnel lack of knowledge about Tribal sovereignty and historical trauma, lack of trust between the Tribe and the State, and staff turnover within partnering agencies and representatives.

Discussion

Developing working relationships with key State partners can be helpful for Tribal communities that are trying to expand their funding sources. Tribes and Tribal organizations that pay particular attention to Tribal members disproportionately using high-cost State services can then develop a data-driven argument for Tribal service contracts. That is, if the number of Tribal youth in high-cost State services (e.g., juvenile corrections, non-Native foster care, residential treatment) continues to be out of proportion to the percentage of Tribal youth in the overall State population, the Tribal organizations can build their argument that placement of Tribal youth in mainstream institutions is not only ineffective, but very costly to

the State. Relationship building with State partners, combined with demonstration of the effectiveness of Tribal services, can result in service contracts for Tribal systems of care.

Implications for Long-Term Financial Sustainability

Examination of the financial sustainability efforts of the 15 American Indian and Alaska Native (AI/AN) system of care communities has resulted in information that will be useful to Tribal service planners, Tribal finance administrators, and system of care funding sources. It is clear that Tribal sovereignty and Tribal political structures (including Urban Indian structures) have a significant impact on financing.

Other factors impact sustainability. Historical trauma can affect the ability of the Tribal community to come together for productive sustainability planning, as well as impact how much Tribes want to develop a working relationship with the State or county. Tribal infrastructures (e.g., computer technology, finance and billing systems, and human resources) are critical to implementation of sustainability plans, but are under-developed in some Tribal communities. Determining the true cost of Tribal and culturally based services is challenging but possible. Matching fund requirements (non-Federal cost sharing) remain a significant challenge in Tribal system of care communities that have limited resources.

Implications of the study's findings for next steps include the need for finance-focused training and technical assistance, broader dissemination of best practices, and the importance of peer-to-peer learning opportunities on a range of topics such as accreditation, Tribal–State agreements, Medicaid negotiations, third-party billing systems, and other finance-related topics.

The AI/AN system of care communities have made significant contributions to the field of cultural competence through their community-engagement strategies, cultural and clinical assessments, culturally based treatment plans, and culturally based services. This report summarizes the Tribal contributions to the field of sustaining systems of care through examples of Tribal infrastructure development, Tribal–fund source relationship building, and a range of approaches that lead to financing for culturally based services.

Successful planning for long-term financial sustainability

- is a strategic process that starts early;
- is facilitated by proactive leadership;
- builds on a strong and stable infrastructure;
- ensures that the system of care theory of change is integrated into fund development plans;
- builds collaborative relationships with national and local Tribal resources.

The development of financial relationships that meet serious Tribal community needs can benefit from quality cross-cultural communication; respect for Tribal self-determination; understanding of mutual financial needs, opportunities, and restrictions; data-driven and anecdotal understanding of the urgency of Tribal community needs; and a commitment to decrease reliance on ineffective service systems that are not working for Tribal families.

Following are recommendations for each of the financing and sustainability subject areas discussed in this report.

Recommendations for Financing and Sustainability in American Indian and Alaska Native System of Care Communities

Planning for Sustainability

- Begin planning for long-term financial sustainability on the first day of the system of care grant (or even before actually receiving the grant), taking care to build planning on the foundation of local cultural strengths.
- Create a sustainability planning team that includes key decision makers (e.g., Tribal elected officials or Tribal administrators who have the authority to make the needed changes, Tribal program planners, and Tribal finance staff).
- Ensure active involvement of Tribal youth and family members at the planning table, and examine and resolve the cultural basis of any resistance to their active leadership.
- Use the system of care grant requirements categories as a guide to developing a framework for Tribal planning efforts.
- Review the Tribal Constitution, Tribal Codes, or the Tribal organizational mission statement for compatibility with key system of care principles; use the constitution, codes, or mission statement as the mechanisms through which the system of care transformation goals can be met.
- Determine the readiness of the local Tribal offices and Tribal programs to understand and willingly adhere to system of care values and principles. If needed, develop a system of care orientation for Tribal members that explains a system of care in simple terms; use local cultural concepts as examples.
- Work with Tribal leadership to examine Tribal financial capacities and resources for long-term sustainability strategies.
- Determine ways to incorporate the system of care sustainability plan into the broader Tribal financial planning; if barriers exist, discuss with Tribal leadership ways to create a cohesive system of care team across Tribal programs, Tribal offices, and other Tribal resources.
- Discuss how local Tribal values and beliefs fit with a logic model concept and/or contribute to the description of the Tribal theory of change.
- Use a logic model-planning tool that best fits the Tribal community to combine all needs assessment and service design information into a sustainability plan; update the plan annually and make sure the plan is tied into the timeframe of the overall Tribal planning process.

Interacting With Political Entities Regarding Financing

- Determine who makes funding decisions within the Federal, State, Tribal, and county governments; determine how funding decisions are made within these entities.
- Assign a point person, or join a Tribal coalition, to follow the development of State legislative health policy and/or State administration regulatory processes for proactive planning.
- Stay alert to the annual or bi-annual Tribal, State, and county budget-building processes and make sure decision makers are aware of system of care operational and non-Federal match needs.
- Build an educative relationship with Tribal elected officials, key State Legislators, and other local policymakers, taking care to stay in contact on a regular basis throughout the year and not just during a financial crisis.
- Build alliances with Tribal elected officials, Tribal service administrators, and/or Tribal governing boards; negotiate inclusion of the Tribal system of care as a standing agenda item on the Tribal governing board agenda and

provide ongoing updates on the system of care transformation and child and family improvements.

- Meet with candidates for Tribal elected offices and orient them to the system of care approach to services, the meaning of system of care transformation, and budget needs.
- Develop a data-driven argument for the need for Tribal system of care funding, emphasizing human and financial cost-savings by redeploying funds from high-cost State services that tend to be less effective to lower-cost Tribal services that tend to be more effective.
- Develop a cultural competence argument for Tribal services, linking culturally competent service provision with increased access to services and improved child and family service outcomes.
- Develop a Tribal–State workgroup to examine the over-representation of Tribal people in child welfare, juvenile justice and education, and to propose solutions for the elimination of disparities.
- Participate in Tribal, State, and county planning meetings and present Tribal behavioral health needs and cost-effective services that meet those needs; request statutory or fund-shifting changes to support the Tribal system of care.
- Develop and/or participate in a Tribal–State Medicaid workgroup and develop working relationships with Tribal Medicaid liaisons.

Developing Sustainable Services

- Conduct a planning retreat or process to convene with key community stakeholders to determine a local definition of wellness and to describe how Tribal traditional culture and other cultural influences impact access, services provision, and service outcomes.
- Design a cultural approach to services (individualized for each family) that includes strengths-based language; a cultural assessment component of the clinical assessment; treatment goal setting that includes attention to the role of culture in wellness; treatment benchmarks that include cultural strengths; and outcome measures that show how attention to culture can improve treatment outcomes.
- Review traditional practices used in the community for healing and stabilization purposes and review the therapeutic aspects of traditional practices (e.g., some traditional practices may help resolve grief); cross-walk these therapeutic practices with State-approved behavioral health billing categories.
- Meet with State representatives to discuss Tribal services and any changes that are needed in provider qualifications (e.g., expanding Targeted Case Management to include a provision for Tribal providers, modifying State educational requirements for becoming a licensed Tribal behavioral health provider).
- Develop a staff-training curriculum based on local Tribal values and local Tribal service design to advance staff service skills and credentials; meet with the State credentialing board for licensed behavioral health providers to discuss the Tribal curriculum concept to ensure that the State licensing board will approve the Tribal curriculum.
- Partner with Tribal colleges and the State credentialing program to implement a Tribal system of care training and education program.
- Develop a training plan for program managers, clinical supervisors, and other program management staff to ensure their knowledge is current regarding managing change in complex environments, staff supervision, staff development, contract oversight, and financing strategies.

Strengthening Infrastructure

- Conduct a scan of infrastructure needs by reviewing the list of system of care grant requirements and any fundraising goals to determine if the Tribal program has appropriate
  - physical buildings and adequate service locations;
  - space for individual and family services that meet privacy requirements;

- group space for community activities;
- office furnishings that reflect professionalism and offer family comfort;
- clinical tools and equipment for service provision;
- cultural tools and equipment for service provision;
- adequate computer hardware for communication, reporting, and training;
- functional computer software that meets day-to-day communication and reporting needs, including data tracking and accounting needs;
- consistently available computer technology staff for trouble shooting and repair;
- personnel policies and procedures, job descriptions, and salary scales;
- policies and procedures for services, grants management, and fiscal controls;
- billing manuals.

- Consider hiring a Certified Public Accountant to review current financial systems and to make recommendations for improvement and further development.
- Develop and implement infrastructure development plan that supports service growth and includes actions steps and timelines; ensure that it is framed within the broader context of a Tribal logic model or theory of change.
- Assess the feasibility of becoming a State-licensed or nationally accredited organization by reviewing the accreditation options, examining the fit with the Tribal belief system, determining the overall benefits and drawbacks to licensing and/or accreditation, determining whether the cost of pursuing accreditation is feasible, and determining whether the Tribal system of care has administrative staff available to lead the accreditation team.
- Upgrade billing and data reporting software after determining if the purchase of new software is cost effective when compared to the volume of Tribal data processing needs.
- Implement third-party billing capacity, including the training and supervision needed to transition from grants management to a third-party billing system.
- Overcome Tribal staff resistance to increased documentation requirements by using Tribal supervisors for professional modeling, oversight and helping Tribal staff understand the relationship between third-party billing, budget, and increased services for the community.
- Conduct computer skill development training for Tribal Council or Tribal governing board members for increased communication and access to resources.
- Conduct a site visit to another Tribal system of care that has successfully implemented a sustainability strategy, for a peer-to-peer learning opportunity.
- Work with Tribal administrators to ensure that all internal systems (e.g., fiscal, technology, management, human resources, training) interlock, maintain close communication with each other, and share a common goal of advancing the Tribal system of care.

Using Data in Financial Sustainability Planning

- Discuss with Tribal leadership any concerns or questions about data use and clarify the Tribal stance on data collection, data analysis, and data ownership.
- Provide orientation on Tribal system of care data use for Tribal elected officials, Tribal governing board members, and Tribal administrators; link data use examples to client progress, program planning, fund development, and contract negotiations; and emphasize ways that Tribal data use can support Tribal self-determination and data-driven decision making.
- Discuss Tribal capacity for, and affiliated costs of, a sustained data collection and data analysis process and allocate resources for implementation.
- Develop data-driven arguments to support inclusion of Tribal services in fund opportunity

language and regulatory changes to funding processes (e.g., ways to increase Tribal access to Medicaid reimbursement of services).

- Determine the role of Tribal data in program evaluation, sustainability planning, and contract reporting.
- Visit a Tribal system of care that has been successful in using data for a peer-to-peer learning opportunity.
- Analyze aggregate data to demonstrate youth and family improvements and related human and financial savings.
- Identify existing Tribal and non-Tribal data sources that may be useful for the sustainability planning process.
- Advocate that State technology decisions related to data transmission requirements must be consistent with the technology capacities of Tribal communities.

Assessing and Mobilizing Funding Sources

- Conduct a financial environmental scan and list all funding sources in the State or region that support Tribal children and youth; determine which funding sources the Tribal system of care is not accessing, and list the reasons why the system of care has not been able to access these sources.
- As part of building a case for funding, compare the percentage of the Tribal youth population in the State with the percentage of Tribal youth in State or county services (e.g., juvenile justice, child welfare, residential treatment).
- Develop data-driven funding arguments by determining the monthly (or yearly) cost of State, county, and private institutional care and comparing these costs to the cost of Tribal services.
- Imbed the Tribal system of care sustainability plan into all aspects of the Tribe or Tribal organization's overall fund development and business operations.
- Write a business plan for the system of care.
- Follow the development of behavioral health policy in Indian Health Service (IHS) and the State legislature, or any State regulatory discussion of existing behavioral health policy; participate in State planning meetings as much as possible to track and influence evolving State initiatives and ensure that Tribal needs are included in legislative language.
- Develop an accreditation team to assess the organization's ability to complete required steps toward State behavior health licensure and/or national behavioral health accreditation.
- Explore the financial feasibility of out-of-the-box financing ideas such as developing a business arm of the non-profit corporation.
- Clarify what can and cannot be used as match under the Federal cost-sharing guidelines, with particular attention to understanding the exemption for eligible Tribes and Tribal organizations, which allows use of certain Federal funds as match.
- Develop annual goals for in-kind contributions and local non-Federal cash contributions; monitor all match goals on a monthly or quarterly basis.
- Create a list of potential in-kind contributions (e.g., space donations, pro bono consultation) and non-Federal cash resources (e.g., State grants, private foundation grants).
- Develop processes to document in-kind contributions and the assignment of cash value to contributions.

Determining the Cost of Services

- Determine if the Tribe or Tribal organization is currently using, or has previously used, a cost study process; if necessary, seek advice from a cost-study-experienced Tribal organization or an Indian health planning board.
- Determine a timeframe to implement a cost study.
- Provide an orientation of cost study expectations for Tribal administration, governing board, and staff.

- Determine the actual service and administrative costs of the full range of Tribal behavioral health and support services, including the costs for administrative and supervisory time, staff training, transportation, home visits, and traditional practices (i.e., conduct a cost study).
- Ensure that cost formulas address the costs of delivering services in remote Tribal areas, including time spent in cultural translation of services; computer technology development and computer training (especially related to cultural application of service); rural Internet challenges; cultural-based telemedicine consultation; and off-site supervision due to the geographic range of Tribal service locations.

Determining the Feasibility of Medicaid as a Funding Source

- Work closely with the Tribal government or Tribal organization to determine the percentage of the local Tribal population that is eligible for and enrolled in Medicaid services.
- Meet with Tribal administrators or the Tribal governing board to discuss any community perception that participation in the Medicaid program would result in loss of IHS benefits; consider a public community meeting to clarify any confusion.
- Consider negotiating the co-location of State Medicaid enrollment staff at the Tribal location.
- Review Tribal services, including traditional practices, for compatibility with Medicaid behavioral health billing categories.
- Consider including access to Medicaid funding as part of the Tribal sustainability plan and outline the steps to becoming a State Medicaid provider.
- Develop a close and ongoing working relationship with the State Medicaid office to increase Tribal access to information about Tribal enrollment strategies, provider standards, eligible services, and billing process.
- Meet with State Medicaid and Tribal health representatives to determine if the 100% Federal Medical Assistance Percentage (FMAP) option is being fully utilized.
- Meet with State Medicaid representatives to discuss the development of a Tribal services section in the State's provider billing manual.
- Join a coalition of Tribes in the State to explore a waiver to the State Medicaid Plan to support Tribal services and system of care partnerships.

Developing and Sustaining Key State Partnerships

- Invest in educating State officials and State funding source administrators about the Tribal system of care.
- Recognize that there may be steep cultural learning curves for Tribal and State representatives about their respective service systems.
- Develop relationships with Tribal champions within State government (e.g., non-Tribal State administrators who acknowledge the value of Tribal services) and provide them with information on how Tribal-operated services can result in positive service outcomes.
- Ensure that the Tribal organization has the right person at the right table; for example, send a Tribal staff person with decision-making responsibility to a Tribal–State meeting if decision-making authority is needed.
- Recognize the multiple influences on the development of positive Tribal–State relationships, including historical trauma and key staff turnover at the State and in the Tribe.
- Recognize that both States and Tribes are concerned about the financial cost of ineffective services and the resulting human cost to both the Tribe and the State.

APPENDIX A. Understanding the Challenge: The Cultural Framework

Although the system of care principles and Tribal belief systems are very much aligned, Tribal systems of care continue to face unparalleled challenges in developing and implementing financing strategies for sustainability. This is due to many reasons, including the lack of knowledge by potential funding sources, such as States, of the advantages of working with Tribes, the impact of Tribal–State history on the willingness and ability to pursue financial partnerships, and the lack of financial resources in remote Tribal communities. Adding to the complexity of the challenge is

- the history of confusing and contradictory Federal policies about support for Tribal services;
- the meaning of sovereign status of federally recognized Tribes as it relates to financing;
- the financial options of Tribes that are recognized by States but lack Federal recognition;
- the role of Tribal self-determination and the financial implications of Tribal assumption of services that were previously provided by Federal agencies.

All of these challenges are further deepened by a lack of cross-cultural and cross-system problem solving when partnership barriers arise. The result are complicated jurisdictional and policy conditions that exist between Tribes, Federal, and State governments with many implications for financial strategic planning. Negotiation for financial partnership must often start with the education of Federal, State, or private funding sources about the relationship between a cultural foundation to services and improved outcomes; the impact of Tribal sovereignty on financial partnerships; and the values and decision-making processes of Tribal governments, Urban Indian organizations, and Tribal nonprofit organizational structures.

Mental health services for the American Indian and Alaska Native (AI/AN) population are widely documented as inadequate to provide for the needs of the people. There are a number of reasons for the shortage of services: the annual Federal budget for the Indian Health Service (IHS) is under-funded by an estimated 40–60 percent of the need for care; only 7 percent of the IHS budget is allocated for mental health services; a large percentage of AI/AN people live in remote rural areas where behavioral health services are not routinely available; and Medicaid and other third party payers often exclude Tribal providers from participation in mental health networks, do not purchase the types of services offered by Tribal health providers, or Tribal providers are unable to employ the types of clinical providers necessary to render billable services.

These disparities combined with the economic conditions in Indian country result in a disproportionate representation of the AI/AN population in social service programs, juvenile and adult detention facilities, and treatment facilities for mental health and substance abuse problems. Thus, the impact on Federal- and State-funded programs is also disproportionate to the population. Statistics demonstrate that

mainstream efforts to address health, social and economic issues in Indian country are ineffective in addressing the root causes of these problems. State government programs, particularly in States with large Native American populations, are recognizing these costs and have become interested in partnering with Tribal organizations for community based service delivery.

Tribal Entities in the United States

American Indian and Alaska Native people have long demonstrated a high level of resilience and have retained, or re-established, the traditions and beliefs that serve as their cultural core. Hundreds of Tribes continue to thrive and remain culturally and politically unique in the United States. Each Tribal group is organized according to historical and cultural influences (e.g., Tribe, Band, Nation, Pueblo, Village, community, corporation). The Federal Government holds special trust obligations towards Tribal members to provide basic social, medical, and educational services. The statutes and treaties under which Tribal communities are organized have a direct influence on their financial sustainability options.

Recognition Status

More than 560 federally recognized Tribes exist in the United States. Federally recognized Tribes hold a government-to-government relationship with the Federal Government. Nearly one-half of the federally recognized Tribes are in Alaska.

Tribes with Federal recognition status are legal sovereign nations. Federally recognized Tribes are rare and distinctive as they function as independent nations within the nation of the United States. Therefore, a unique legal and political relationship exists between the Federal Government and Indian Tribes. (Similarly, a special legal relationship exists between the Federal Government and Alaska Native Corporations.) This relationship is grounded in the U.S. Constitution, treaties, statutes, U.S. Supreme Court decisions, and Federal laws and regulations. The relationship between the Federal Government and Tribes is also grounded in political, legal, moral, and ethical principles. It is important to note that the relationship is not based upon race, but is a government-to-government relationship.

The U.S. Department of Health and Human Services (DHHS) has a formal consultation policy with Tribes. Consultation with AI/AN Tribes must occur to the extent practicable and permitted by law before any action is taken that will significantly affect the Tribes. In short, any DHHS policy requires consultation with Tribes before action by the Federal Government is taken if the policy substantially and directly affects one or more AI/AN Tribes; the relationship between the Federal Government and Tribes; or the distribution of power and responsibilities between the Federal Government and Tribes.

The legal and political power of sovereignty is deep. As sovereign nations, Tribal governments have the right to hold elections, determine their own citizenship, and consult directly with the Federal Government on policy, regulations, legislation, and funding. Tribal governments can also create and enforce laws to govern their Tribal members. Tribal laws can be stricter or more lenient than State laws, but they are not subservient to State law. State laws cannot be

applied to a Tribe if the laws interfere with the right of a Tribe to make its own laws protecting the health and welfare of its citizens, or if they would interfere with any Federal interest. Tribal district courts and supreme courts can be established to administer justice in criminal, civil, and juvenile matters. Tribal tax commissions, economic development corporations, environmental protection agencies, public works, and gaming commissions are other examples of entities that may be part of a Tribal government structure.

In addition to the federally recognized Tribes, there are 245 Tribes whose lands and rights are recognized solely by the State. A State-recognized Tribe is an Indian Tribe that does not have a recognized relationship with the Federal Government through historic treaty, Congressional act, or administrative process, but is recognized as a Tribe by the government of the State in which members reside or are historically based. A lack of Federal recognition limits the capacity of State recognized Tribes to fully govern themselves, seek compensation for previous loss of land, or be eligible for certain Federal benefits and funds designated for federally recognized Tribes. Many State-recognized Tribes are seeking formal Federal recognition.

Another important segment of the Tribal population is the Urban Indian community. 'Urban Indians' is a term used to describe American Indians and Alaska Natives, or descendents of American Indians and Alaska Natives, who have moved from their Tribes to cities or urban areas, either voluntarily or through forced Federal Government relocation programs.[1] Poverty and lack of economic opportunities also contribute to the movement of Tribal people from reservations to cities or urban areas. More than 60 percent of all Tribal people in the United States now live in cities or urban areas and they remain part of the congressionally mandated trust responsibility.

Regardless of Federal or State recognition, or Urban Indian status, each Tribal community reflects a distinct culture, belief system and, often, Native language. Despite these differences, common across all Tribal people is a deeply ingrained sense of respect and honor for their children (as illustrated by the names selected for their systems of care). Many Tribal systems of care program names reflect the Tribe's special recognition of children and youth and the principal role that culture plays as the foundation of their services.

American Indians and Alaska Natives live within the complex and overlapping worlds of Tribal, State, and Federal Governments—each of these entities has unique laws, manners of conducting business, and interpretation of sovereignty. The relationships between Tribes and the Federal Government, and Tribes and the State in which they are located, are constantly evolving. The role of Federal trust responsibility, sovereign Tribal governments, interpretation of Tribal and State laws, the Urban Indian relationship with urban and Tribal services, and the overall changing needs of Tribal communities add to this changing environment. All of these are key factors affecting the financial relationships and collaboration between Federal, State, County,

[1] National Council of Urban Indian Health (2007). *Fact Sheet*. Retrieved January 2008 from http://www.ncuih.org/Fact%20Sheet.pdf

and other funding sources and Tribal communities.

Impact of Federal Policies

Federal Government policies related to Tribal affairs have fluctuated from open warfare to later attempts to assimilate Tribal people into mainstream society, from termination of Tribal rights to later restoration of Tribal rights, and from attempts to limit Tribal government to later compliance with Tribal government self-determination. These inconsistencies have created a legacy of policy confusion that continues to affect Tribal–Federal and Tribal–State relationships and financing strategies today.

A strength of the Tribal financing picture is the Indian Self-Determination Act (Public Law 93-638), which gives authority to Tribal governments to assume the budget and operations of programs and services that had been previously carried out by the Federal Government. This not only supports Tribal self-determination, but also reflects support for culturally competent practices and community ownership. The Indian Self-Determination Act provides the legal framework for federally recognized Tribes and Tribal organizations to assume the budget and operations of services previously provided by the Federal Bureau of Indian Affairs or the IHS. A Tribe or Tribal organization that enters into a 638 agreement with the Federal Government is referred to as a "Tribal 638 organization" in this report.

Importance of Sustainability

Shediac-Rizkallah and Bone suggest three reasons why program sustainability is important.[2] First, if a program ends while there is still a need for services, rates of people with untreated needs may regress to pre-intervention levels. This is important when considering rural AI/AN communities, which likely have limited mental health agencies and may depend heavily on the contributions of each agency.[3] Second, programs often incur significant start-up costs in human, technical, and monetary resources, only to have funds removed before a program has reached its fullest potential. This is especially relevant to Tribes that may have no health care infrastructure at program start-up resulting in a need to design an unfamiliar program, implement major computer technology upgrades, develop a third-party billing structure, or provide additional training for staff who are cultural experts but do not meet the higher education requirements established by State or national accreditation bodies. Third, program sustainability promotes community investment in future community programs and lack of sustainability may lead to community confusion toward future programs. Community support is essential to the existence and persistence of Tribal community mental health programs due to the collectivistic orientation of AI/AN communities.

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[2] Shediac-Rizkallah, M. C. & Bone, L. R. (1998). Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice, and policy. *Health Education Research*, *13*, 87–108.

[3] Jim, N. (2004). The morning God comes dancing: Culturally competent mental health and HIV services. In Nebelkopf, E. & Phillips, M., (Ed.), *Healing and mental health for Native Americans*. New York: Altamira Press.

Interest in the topic of system of care sustainability has reached new peaks in the past few years. Several studies have been developed to examine aspects of system of care sustainability. In their work, *The Sustainability of Systems of Care for Children's Mental Health*, Stroul and Manteuffel discuss the sustainability study undertaken by the National Evaluation Team.[4] The development of the Web-based survey included an examination of the various definitions of sustainability. Emphasized was the acknowledgement that adopting the system of care approach for the long term requires a "sea change" in policy, clinical practice, and administration of children's mental health systems and maintenance of all of these elements of systems of care in the face of budgetary challenges and changing political environments. The University of South Florida Research and Training Center, in partnership with the National Technical Assistance Center for Children's Mental Health at Georgetown University, the Human Service Collaborative of Washington, DC, and Family Support Systems, Inc., of Arizona, initiated a study titled "Financing Strategies and Structures to Support Effective Systems of Care." The goal of the study is to develop a better understanding of the critical financing structures and strategies that support systems of care. Seven critical financing strategies are being examined and a series of guides have been developed. None of these studies is focused specifically on AI/AN financing. Although the findings of these studies provide a framework of sustainability issues relevant to any system of care community, none of the studies address in detail the cultural, political, and economic issues that are specific to AI/AN communities and that have a direct impact on their long term sustainability.

The cultural importance of program sustainability must not be ignored. Sustainability of community mental health programs within Tribal communities is especially important to empower and avoid re-victimization. Lucidly expressing this point, one leader of a Tribal community-based substance abuse prevention and intervention program stated,

> We have a responsibility to our program recipients. They've had so may losses in their lives, and [if we] come in for a year or two or three and give them hope, only to have the program go away, we've just caused another loss and further hopelessness in their lives.[5]

The 400 years of persecution, genocide, and forced assimilation experienced by Native Americans have led many to experience a perception of great loss leading to anxiety and depression or anger and avoidance.[6] These psychological consequences have been termed "historical trauma." It is hypothesized that program sustainability can function to combat such trauma by empowering Tribal communities to decrease reliance on outside support and

[4] Stroul, B.A., Manteuffel, B.A. (2007). The Sustainability of Systems of Care for Children's Mental Health: Lessons Learned. *Journal of Behavioral Health Services & Research.*

[5] Noe, T., Fleming, C., & Manson, S. (2004). Reducing substance abuse in American Indian and Alaska Native communities: The Healthy Nations Initiative. In Nebelkopf, E. & Phillips, M., (Ed.), *Healing and mental health for Native Americans*. New York: Altamira Press.

[6] Whitbeck, L. B., Adams, G. W., Hoyt, D. R., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology, 33*, 119–130.

foster a sense of pride in being able to care for their own community.

Factors Affecting Sustainability

Program sustainability at every level can be impacted by the effectiveness of critical sustainability factors. Mancini and Marek have developed seven key elements critical for program sustainability: (1) competent leadership to develop a program's vision and provide staff training; (2) effective collaboration with community members and key stakeholders; (3) understanding of community needs and resources; (4) program results demonstration; (5) strategic funding; (6) staff involvement and commitment to sustainability; and (7) program responsiveness to a community's changing needs.[7] While it is clear that many variables interact to affect sustainability, underlying each of these components is the need to understand the culture of a population served. For example, effective collaboration with Tribal community members will be facilitated through a program leader's ability to integrate Tribal culture into the development of a program's vision. Further, program response and results demonstrated within an AI/AN community hinges on a programs' ability to provide culturally competent care.[8] Finally, obtaining long-term financial support requires knowledge of the resources both within Tribal communities and outside of the Tribal community. Following are brief discussions of key sustainability factors known to affect program sustainability among Tribal programs.

[7] Mancini, J. A., & Marek, L. I. (2004). Sustaining community based programs: Examination of relationships between sustainability factors and program results. *Family Relations, 53*, 339–347.

[8] LaFromboise, T. (1988). American Indian mental health policy. *American Psychologists, 43*, 388–397.

Economic and Political Environments

In 2000, the AI/AN poverty rate was 26 percent, twice the national rate and greater than that of any other ethnic group.[9] Socioeconomic conditions vary from Tribe-to-Tribe and in different regions of the country. Some Tribal system of care communities report unemployment rates as high as 80 percent in the local Tribal population. The Center for Disease Control also mentions geographic isolation, cultural barriers, and economic conditions as barriers that contribute to poorer health outcomes.[10] Other studies have focused on Tribal income increases associated with the legalization and institution of casino gambling for the effects on aspects of American Indian well-being, including the effects on poverty levels, medical care, and risk-taking behavior, all of which are indirectly associated with health status.[11] The political environment of Tribes and Tribal organizations is complicated; sovereign nation status, and the Alaska Native Claims Settlement Act (1971) which promised 44 million acres and $1 billion to Alaska Natives, are examples of the unique aspects of the AI/AN political environment.

[9] Centers for Disease Control and Prevention. (2003).Surveillance for health behaviors of American Indians and Alaska Natives: Finding from the behavioral risk factor surveillance system, 1997-2000. *Morbidity and Mortality Weekly Report. 52*, 1. Retrieved January 20, 2008 from http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5207a1.htm

[10] Rural Assistance Center (2008). Tribal health frequently asked questions. Retrieved January 5, 2008 from http://www.raconline.org/info_guides/tribal/tribalhealthfaq.php

[11] Taylor, J. B., Kalt, J. P. (2005). *Cabazon, The Indian Gaming Regulatory Act, and the Socioeconomic Consequences of American Indian Governmental Gaming–A Ten-Year Review. American Indians on Reservations: A Databook of Socioeconomic Change between the 1990 and 2000 Censuses*. Cambridge, MA: The Harvard Project on American Indian Economic Development.

The Harvard Project on American Indian Economic Development, at Harvard University's John F. Kennedy School of Government, aims to understand and foster the conditions under which sustained, self-determined social and economic development are achieved among American Indian nations. At the heart of the Harvard Project research program is the systematic, comparative study of social and economic development on American Indian reservations. Relevant for the Tribal system of care communities are their key research findings:

- *Sovereignty Matters***.** When Native nations make their own decisions about what development approaches to take, they consistently out-perform external decision makers—on matters as diverse as governmental form, natural resource management, economic development, health care, and social service provision.
- *Institutions Matter***.** For development to take hold, assertions of sovereignty must be backed by capable institutions of governance. Nations do this as they adopt stable decision rules, establish fair and independent mechanisms for dispute resolution, and separate politics from day-to-day business and program management.
- *Culture Matters*. Successful economies stand on the shoulders of legitimate, culturally grounded institutions of self-government. Indigenous societies are diverse; each nation must equip itself with a governing structure, economic system, policies, and procedures that fit its own contemporary culture.
- *Leadership Matters*. Nation building requires leaders who introduce new knowledge and experiences, challenge assumptions, and propose change. Such leaders, whether elected, community, or spiritual, convince people that things can be different and inspire them to take action.

The Native Nations Institute is an outgrowth of the Harvard Project on American Indian Economic Development and serves as a self-determination, development, and self-governance resource to Indigenous nations. For more than 15 years, the Harvard Project and the Native Nations Institute researchers have worked systematically to understand the conditions under which sustained economic development can be successful on American Indian reservations in the United States and among First Nations in Canada. These findings indicate that, while a number of things contribute to initiating and sustaining reservation economic development, five are particularly important:

- **Practical Sovereignty (genuine decision-making power)**

  Native nations that have been willing and able to assert self-governing power over their affairs and resources have significantly increased their chances of sustainable economic development.

- **Capable Governance (effective governing institutions and practices)**

  Sovereignty is not enough to produce economic growth unless those rights and powers are exercised effectively; the chances of sustainable development rise as Native nations put in place effective, nonpoliticized, dispute-resolution mechanisms that can shut down opportunistic behavior by politicians, place buffers between day-to-day business management and political decisions or interference and build capable bureaucracies.

- **Cultural Match (fit between governing institutions and political culture)**

  Effective Trial governing institutions require legitimacy with the people whose future is at state, rooted in the fit between the formal institutions of governance and the indigenous conceptions of how authority should be organized and exercised.

- **Strategic Orientation (decision making that takes strategic considerations into account)**

  Successful Native nations tend to approach development not as a quick fix for poverty but as a means of building a society that works, considering long-term priorities and concerns as well as assets and opportunities, and bring strategic criteria to bear on development decisions.

- **Leadership (individuals and groups who recognize that fundamental change may be necessary, and who can envision a different future and persuade the community to join them)**

  Successful Native nations have some group or set of individuals who recognize the need for fundamental change in a way things are done; they have a vision of a future of assertive, capable, effective self-determination and self-governance, and can bring the community along with them in building that future.

In addition to these findings, gaining community consensus on the approach to Tribal system of care sustainability can be complicated. Tribal systems of care often operate within multiple governing structures that must work together in sustainability planning. The Tribal governing structure may have frequent elections of Tribal officials that result in leadership turnover and starts and stops in sustainability planning. All of the variables discussed, exacerbated by health disparities, affect the AI/AN sustainability planning process.

Planning

Planning and infrastructure development assistance has been available for years to some Tribal communities through the Federal Infrastructure Development for Children's Mental Health Systems in AI/AN Communities Initiative, more commonly known as the Circle of Care Initiative. Available through a competitive application process, the Circle of Care Initiative supports AI/AN communities with funding and technical assistance to plan, design, and assess the feasibility of a culturally respectful mental health system of care. The Circle of Care Initiative provides 3-year grants to State and federally recognized Tribes, Urban Indian organizations, Tribal colleges and Tribal universities. Successful applicants gain community planning tools and resources to design a holistic, community-based system of care to support mental health and wellness for their children, youth and families. Nearly half of the Tribal system of care communities had previously received a Circle of Care planning grant that enabled them to conduct an in-depth analysis of the existing infrastructure of the local child-serving system to identify policy, service gaps and potential resources, and to facilitate culturally respectful strategic planning activities. Also important to the Circle of Care planning process is community-wide engagement, development of Tribal logic models, and development of a local evaluation process.

Partnerships

Tribal leader hesitancy to develop State or Federal partnerships is often based in historic distrust. Broken treaty agreements, conflicts over land or water rights, and the removal of Tribal children from their homes to be raised in non-Indian boarding schools or non-Indian foster care homes are just some of the reasons for Tribal partnership hesitancy.

State motivation to pursue partnerships with Tribes and Tribal organizations has generally been reliant on the personal interest of a few State representatives. However, the system of care movement, combined with increased national interest in addressing racial health disparities and the lack of culturally competent services, has sparked more interest at the State level for Tribal-State partnerships. States are searching for methods that could more effectively address high cost institutional and residential treatment services that are utilized when behavioral health needs are not met in the community. Thus, some States are exploring ways to engage more Tribal organizations as partners in behavioral health services. Transformation of State organizational structures, with increased support for culturally competent practices and a re-examination of the use of evidence-based practices, are all opportunities to develop new partnerships with Tribes and Tribal organizations. Conversely, Tribal systems of care may be able to access previously untapped State revenue sources, and influence current and future State policy to better address Tribal needs. For example, Tribal–State partnerships can not only be beneficial to Tribal communities but can improve the health of State budgets as the high cost of institutionalized care is transferred to lower cost and more effective Tribal systems of care services.

Jurisdictional confusion and misinformation about Tribal needs also complicate communication and partnership building. Some State administrators erroneously believe that Tribal needs are being met by the Indian Health Service (IHS), when only 55 percent of American Indians and Alaska Natives rely on the IHS or Tribal-operated clinics or hospitals for care. Further, the IHS budget meets less than 60 percent of the national Tribal needs, and less than 5 percent of the Tribal mental health needs.[12]

Tribal–State partnerships are also challenged by growing State requirements that tie evidence-based practices (EBPs) to State behavioral health contracts.[13] Tribal systems of care are concerned that EBPs are not normed on Tribal populations and might not be easily transferable or appropriate for use with Tribal populations, yet growing numbers of State and Federal contracts require the use of EBPs. In addition, the cost of training for manualized EBPs is often too costly for many Tribal communities. However, growing interest in the fields of cultural adaptation of EBPs and support for practice-based evidence approaches (which include field-driven practices and traditional practices) has opened new opportunities for financing discussions between Tribes and States.

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[12] Gone, J. P. (2004). Mental Health Services for Native Americans in the 21st Century United States. *Professional Psychology: Research and Practice, 35*(1), 10–18.

[13] For the purpose of this report, the term 'evidence-based practices' is used to define interventions and approaches shown to be effective through rigorous research. This term is synonymous with the term 'evidence-based treatment.'

Infrastructure

Many Tribes have both a traditional Tribal leadership structure and a "business council" governing structure. The Tribal business council structure usually involves a formal election process. Each Tribe determines its frequency of Tribal elections (which can occur as often as every 2 years). Election of "business" council members is not a historic Native tradition; rather, the Federal Government mandated it. Tribal elections can result in the re-setting of Tribal priorities and funding strategies. Ensuring that Tribal council candidates and Tribal elected officials understand the framework and purpose of a system of care for children and families is critical because Tribal-elected officials are politically powerful and play a critical role in both short and long-term sustainability plans.

The national field of behavioral health rests on a foundation of formal licenses, credentials, and program accreditation—all critical components of sustainability, especially if the sustainability plan includes third-party billing for behavioral health services.

Another factor that can complicate sustainability plans is AI/AN preference in hiring practices. Part of Tribal self-determination policy, Tribes and Tribal organizations are legally sanctioned to have AI/AN preference in hiring practices through Tribal exemption to Title VII of the Civil Rights Act (1964). AI/AN preference in hiring is not only allowable, but often a policy and mission for Tribal organizations that support the Nation Building concept.[14] AI/AN preference in hiring is an important part of Tribal self-determination, but may conflict with contract requirements for licensed and credentialed staff.

Staffing

AI/AN mental health counselors are more likely to provide culturally competent services to Native children, youth and families because they share a cultural affinity. As such, hiring Native staff will promote sustainability by increasing staff integration and involvement in the program.[15] However, AI/AN mental health community programs often have great difficulty finding credentialed service providers who are AI/AN. For example, the IHS behavioral health programs employ approximately two psychiatrists and four psychologists per 100,000 people for the 1.5 million Native people currently eligible for IHS funded services, in contrast to general U.S. availability of 14 psychiatrists and 28 psychologists per 100,000 people.[16]

Providing funding to support the higher education of Tribal community members is one strategy used to address this challenge. Promoting the accreditation of AI/AN mental health service providers allows a community to become self reliant in the provision of mental health care and is posited to promote the sustainability of mental health programs.

In a study involving 401 American Indian youths and 188 American Indian providers,

[14] Nation Building refers to the process of constructing or structuring a nation using the power of the State (in this case, the term "State" refers to the Tribe).

[15] Mancini, J. A., & Marek, L. I. (2004). Sustaining community based programs: Examination of relationships between sustainability factors and program results. *Family Relations, 53*, 339–347.

[16] West, J., Kohout, J., Pion, G. M., Wicherski, M. M., Vandivort-Warren, R. E., Palmiter, M. L. , et al. (2000). Mental health practitioners and trainees. In R.W. Manderscheid & M.J. Henderson (EDs.), *Mental health, United States, 2000*. Rockville, MD: U.S. Department of Health and Human Services

researchers found that providers were more likely to correctly identify the problems of American Indian youth and offer them, or refer them for, services when the provider was knowledgeable about mental health problems and available resources in the community.[17] These results suggest that to best assess the needs of American Indian youth, providers need to have both an understanding of the local culture and community resources, and a formal education in mental health service provision to provide the most culturally and clinically meaningful services. Effective treatment will in turn promote program sustainability.

Primarily due to the shortage of Master's- and Ph.D.-level Tribal behavioral health specialists, many Tribal systems of care hire non-Native professionals to serve in clinical supervisory or managerial positions. A frequent challenge to newly hired non-Native clinical supervisors is that they must recognize that the Tribal paraprofessionals hold the expert knowledge on Tribal community needs and cultural engagement strategies. Training in Tribal approaches and Tribal life ways can be a multiyear transition for the non-Native professional, however investment in training and supervision of non-Native staff is critical to prevent costly staff turnover. To address the immediacy of the mental health needs of the AI/AN population, many mental health programs have developed cultural competence training curriculums to teach non-Native providers about the culture of the AI/AN community in which they will be providing services.[18] Direct service supervisors can also serve as important role models for day-to-day sustainability practices, such as generating staff enthusiasm about the value of Tribal data for program planning, and ways to increase billing accuracy.

Financing

Long-term financial sustainability requires funding. Generally, the economic status of Tribal communities results in meager financial resources to draw upon and significant competition for limited Tribal funds. Although system of care funding and technical assistance resources have provided training on new approaches to the fund-development process, some Tribal communities are able to seize these opportunities, while the ability of others to maximize such opportunities has been compromised. There are many reasons why some Tribal communities are challenged in developing their financing capacity, which often include a lack of a comprehensive strategic plan to address the behavioral health needs of children, youth and families and the lack of an administrative and billing infrastructure. It also requires a commitment from Tribal administrative staff to build relationships with funding sources in order to gain access to budgets or grant cycles.

Even if a strategic plan, infrastructure, and consistent leadership is in place, the Tribal system of care can still be challenged by limited resources. Last, some Tribal organizations have difficulty in adopting a proactive approach

[17] Stiffman, A. R., Freedenthal, S., Dore, P., Ostmann, E., Osborne, V., & Silmere, H. (2006). The role of providers in mental health services offered to American-Indian Youth. *Psychiatric Services, 57,* 1185–1191.

[18] Nebelkopf, E., & King, J. (2004). A holistic system of care for Native Americans in the San Francisco Bay Area. In Nebelkopf, E. & Phillips, M., (Eds.), *Healing and mental health for Native Americans*. New York: Altamira Press.

which some feel is the result of generations of Federal paternalism, while others point to historical trauma.

American Indian/Alaska Native Medicaid Provisions

Medicaid is the largest payer for mental health services in the country. Medicaid services are a shared expense between the Federal Government and State governments. The Federal Government pays a percentage of the total payments for services which varies based on each State's per capita income. The Federal share, called the Federal Medical Assistance Percentage (FMAP) ranges between 50 percent and 85 percent of the total cost expended in the State.

Important to AI/AN financing is a special Congressional provision, embedded in the Indian Health Care Improvement Act, which established a match rate of 100 percent Federal dollars and zero dollars from States for Medicaid services offered through IHS, 638 Tribes, or 638 Tribal organizations. The 100 percent match rate was enacted because Congress did not want to burden States with what had been a Federal responsibility – the health care of AI/AN people. In addition, the 100 percent FMAP rate is specifically tied to the location of where the services are provided; services must be provided through a tribally owned / leased and operated facility that *must* be on the official IHS facility list.

Tribal 638 organizations (Tribe or Tribal organizations entering into a 638 agreement with the Federal Government) providing services at a location on the official IHS list are eligible to receive payments are the 100 percent FMAP rate, which means that

1. States do not have to pay a State match for services offered through these Tribal organizations because the Federal Government will pay for 100 percent of the service;
2. Tribal–State Medicaid partnerships can result in behavioral health services to Medicaid eligible and Medicaid enrolled Tribal people;
3. dollars that a State would normally pay as its part of the Medicaid matching fund could instead remain in the State general fund;
4. State general fund savings can be spent on other needs within the State instead of being spent for Medicaid match.

This arrangement is a significant win-win opportunity for both States and Tribes where Tribal organizations provide increased health services to Tribal youth and families at little or no cost to the State. Many State decision makers are not aware of this partnership opportunity and may often be suspicious of what appears to be a too-good-to-be-true situation. There are significant barriers to enrollment of American Indians and Alaska Natives in Medicaid and SCHIP, which has led State and Tribal policy experts to believe that the population is significantly under enrolled in these programs.[19]

If the AI/AN community is not part of a Tribal 638 organization, a financially successful alternative might be acquiring Federally Qualified Health Center (FQHC) status, which also allows for higher reimbursement rates.

[19] Langwell, K., Laschober, M., Melman, E. & Crelia, S. (2003). *American Indian and Alaska Native Eligibility and Enrollment in Medicaid, SCHIP, and Medicare Individual Case Studies for Ten States*. BearingPoint, Inc. and Westat, Inc.

FQHCs (and Rural Health Clinics) must be paid on a cost basis under Federal law. States have flexibility in determining the scope of ambulatory services covered under the FQHC model, which may include a variety of behavioral health services that can support a system of care grantee.

Match

All system of care communities are required to make contributions, also referred to as cost sharing, toward the system of care costs as outlined in the Federal authorizing legislation for systems of care (Title V, Part E section 565(b)(2) of the Public Health Services Act). The match requirement requires that the applicant entity will provide, directly or through donations from public or private entities, non-Federal contributions according to the below formula:

- For the first, second, and third fiscal years of the cooperative agreement (grant), the awardees must provide at least $1 for each $3 of Federal funds.
- For the fourth fiscal year, the awardees must provide a least $1 for each $1 of Federal funds.
- For the fifth and sixth fiscal years, the awardees must provide at least $2 for each $1 of Federal funds.

The purpose of match is to encourage local investment in the system of care by other child-serving systems, and as evidence of the potential of the initiative to sustain itself beyond the 6-year award period. Matching resources may be cash or in-kind, including facilities, equipment or services, and must be derived from non-Federal sources (e.g., State or sub-State non-Federal revenues, foundation grants).

Indian Tribes receiving funds under the Self-Determination and Education Assistance Act (PL 93-638, as amended) are exempt from the restriction of not using Federal sources as match. Although only in-kind donations and cash funds from non-Federal sources can be used as matching funds by non-Tribal system of care grantees, eligible Tribes and Tribal organizations may also use Federal funds as match under certain conditions.. Although Federal dollars are generally not permissible for use as “match” dollars, P.L. 638 enables Tribal organization to use Federal dollars assumed by Tribes through the 638 legislation as match dollars as long as the identified 638 dollars are not being used as Federal match by other components of the Tribal organization or Tribal government.

APPENDIX B. Purpose and Description of the Exploratory Description Study

Background and Purpose of Study

The Comprehensive Community Mental Health Services for Children and Their Families Program (referred to as the Child Mental Health Initiative [CMHI]), funded by the Center for Mental Health Services (CMHS) at the Substance Abuse and Mental Health Services Administration (SAMHSA), was initiated in 1992. The program was created to provide grants to States, communities, territories, and American Indian and Alaska Native (AI/AN) Tribes to develop systems of care to serve children and adolescents with, or at risk for, emotional disorders and their families.[20] A system of care is a coordinated network of community-based services and supports organized to meet the challenges of children and youth with serious mental health needs and their families. Families and youth work in partnership with public and private organizations to design mental health services and supports that are effective, that build on the strengths of individuals, and that address each person's cultural and linguistic needs. A system of care helps children, youth and families function better at home, in school, in the community and throughout life. Systems of care is an approach to services that recognizes the importance of family, school and community, and seeks to promote the full potential of every child and youth by addressing their physical, emotional, intellectual, cultural, and social needs.[21]

CMHI provides grants and cooperative agreements to States, counties, territories, American Indian Tribes, and Tribal organizations to improve and expand their systems of care to meet the needs of an estimated 4.5–6.3 million children with serious emotional disturbances and their families. The program was first authorized in FY1992 by section 561-565 of the Public Health Service Act, as amended.[22]

Since 1992, more than 125 communities have received Federal funding to support the creation of new systems of care; these communities represent all States and two U.S. territories. The core values of a system of care specify that services should be child-centered, family-focused, community-based, and culturally competent, all values long held by many Tribal communities as part of their ancient, traditional values and beliefs.

AI/AN communities entered the system of care movement in 1994 with the initial Federal grant award to the Restoration of K'e: The Navajo Nation Child Mental Health Project, located on the Navajo Reservation in New Mexico. The experiences of this initial Tribal venture into the realm of system of care reform helped to open the doors for Tribal communities that followed.

[20] For the purpose of this report, the terms "American Indian/Alaska Native," "Native American," "Indian," and "Tribal" are the same.

[21] http://systemsofcare.samhsa.gov/, retrieved March 25, 2008.

[22] http://systemsofcare.samhsa.gov/ResourceDir/Comprehensivehome.aspx, retrieved March 25, 2008.

Table B–1. American Indian and Alaska Native System of Care Grant Communities

System of Care	Population of Focus	State	Funding Period
Graduated Communities			
Restoration of K'e: The Navajo Nation Child Mental Health Project	Navajo Nation	New Mexico	1994–1999
Sacred Child Project	North Dakota Tribes	North Dakota	1997–2003
Kmihqitahasultipon ("We Remember") Project	Passamaquoddy Nation	Maine	1997–2003
With Eagles' Wings Project	Northern Arapaho and Shoshone Tribes	Wyoming	1998–2004
M'no Bmaadzid Endaad Program	Sault Ste. Marie Tribe of Chippewa Indians and Bay Mills Tribe of Chippewa Indians	Michigan	1998–2004
People Working Together Project	Yup'ik Eskimo and Athabascan Indians	Alaska	1999–2005
Nagi Kicopi–Calling the Spirit Back Project	Oglala Sioux Tribe	South Dakota	1999–2005
Ak-O-Nes Project	Northern California Tribes	California	2000–2006
Currently Funded Communities (at the time of the study)			
Choctaw Nation CARES Project	Choctaw Nation	Oklahoma	2002–2008
"Ch'eghutsen" A System of Care	Alaska Native Communities	Alaska	2002–2008
Urban Trails Project	Urban Indian Community	California	2003–2009
The Po'Ka Project (Blackfeet Children System of Care)	Blackfeet Nation	Montana	2005–2011
Tiwahe Wakan (Families as Sacred)	Yankton Sioux Tribe	South Dakota	2005–2011
Seven Generations System of Care	Urban Indian Community	California	2005–2011
Sewa Uusim Systems of Care	Pascua Yaqui Tribe	Arizona	2006–2012

(The 15 Tribal communities that have received system of care funding between 1994 and 2006 are presented in Table B–1, American Indian and Alaska Native Systems of Care.) These Tribal communities symbolize the broad diversity of Tribal people. Their languages and cultures are as diverse as their geographic locations, which include rural reservations, Urban Indian communities, and remote Alaska Native villages.

Building systems of care means initiating new partnerships based on family and youth involvement, cultural competence, and community-based principles. These new partnerships not only translate into novel approaches to services for families, but they often require new approaches in financing. Financing systems of care is a strategic endeavor that involves determining what funds will be used, how they will be used, and how they will be managed.[23] As systems of care vary in shape, size, and complexity, so do approaches to financing.

Purpose of Study

Representatives from the AI/AN systems of care have long been interested in organized discussions about financial sustainability

[23] Stroul, B. A. (2007). Issue brief 1: Effective strategies to finance a broad array of services and supports (RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub. #235-IB1). Tampa, FL: University of South Florida, Louis de la Parte Florida

challenges and strategies. Reports on aspects of sustainability became an important part of the bi-annual Tribal system of care community meetings, and special sustainability meetings allowed communities the forum in which to share information and concerns. In particular, the communities were interested in learning about financing approaches that their peer organizations found successful.

During these meetings, the Tribal system of care community representatives shared their common knowledge that Tribal financing is complex and impacted by cultural nuances. Community representatives also expressed frustration that most funding sources lack knowledge about Tribal needs and the win–win opportunities of Tribal–State financing partnerships. Tribal data were often lacking and funds-seeking was often based on demographic and anecdotal information. State funding formulas (e.g., formulas used for Block Grant dollars) include Tribal population data in the formulation, yet the vast majority of Tribal communities receive no direct Block Grant funding.

This led to the need for a special examination of the financing and sustainability of Tribal systems of care. The National Evaluation Team of the Comprehensive Community Mental Health Services for Children and Their Families Program designed this study to develop a better understanding of the financing opportunities and challenges experienced by Tribal systems of care in relation to program sustainability.

Mental Health Institute, Research and Training Center for Children's Mental Health.

Overview of Study

Determining how sustainability is defined for any system of care is as complex as describing the multiple aspects of each system of care. While the purpose of this study was to explore the financing strategies related to sustainability of the Tribal system of care communities, it is important to note that Tribal communities often define sustainability as more than just funding. Many Tribal communities measure sustainability by the ability of the system of care to transform the mindset of the entire community to care, support, and guide youth and families in a way that not only strengthens families and builds the cultural self, but also strengthens the overall Tribal collective. For the purpose of this study, sustainability is defined as the strengths and challenges of implementing financing strategies within Tribal systems of care.

This study provides an exploratory description of the unique financing opportunities and challenges experienced by Tribal system of care communities. The study team worked with the 15 Tribal system of care communities that were awarded system of care cooperative agreements between 1994 and 2006.

The objectives of the study are to

- develop a better understanding of the unique financing opportunities and challenges experienced by graduated and currently funded Tribal system of care grant communities;
- develop a better understanding of the factors that contribute to, or impede, the ability of Tribal system of care grant communities to sustain systems of care, both during the period in which the Federal cooperative agreements are in effect and after Federal

funding ends. Some of these factors may be related to the approaches used to develop and finance the systems of care, and some may be related to the larger economic, social and/or cultural, and political context in which the systems of care operate;

- provide information that will assist the Tribal system of care grant communities in making decisions regarding financing and sustaining systems of care over time;

- provide information that will assist in identifying ways to support more effectively the development and sustainability of systems of care in Tribal grant communities.

Study Design

This study is an exploratory qualitative description of the unique financing successes and challenges experienced by the graduated and currently funded Tribal systems of care grant communities for the provision of children's mental health services. While the study can be considered research, as it is an "investigation designed to develop or contribute to generalizable knowledge," it does not involve obtaining "information about living individuals" as defined by 45 CFR 46.102(f). During the discussions, personal information about the participants was not addressed.

Respect for AI/AN concerns about the research process was the overriding foundation for developing the study design and for the dissemination and use of study findings. A participatory approach to the study design and data collection process was essential; Tribal communities participated in the study design, and received periodic updates throughout the process. Tribal system of care project directors and key players also received an update about the study progress at each of the Tribal system of care meetings held in 2007.

The study team included a Native researcher as well as several non-Native researchers. The study team convened an advisory group of experts knowledgeable in financing strategies specifically relevant for Tribal communities to (1) provide guidance to the development of the guides that formed the broad framework for discussions with the Tribal system of care grant communities; and (2) provide guidance to the researchers. The study team selected members for their knowledge of financing strategies, their knowledge of infrastructures that support successful finance operations, and their experience with the challenges of meeting the required match requirements. Five people comprise the Tribal Finance Expert Advisory group:

- Chris Bragg, Director of Policy and Rate Review, Yukon-Kuskokwim Health Corporation in Bethel, Alaska (a graduated system of care community).
- Mike Crocker, Chief Financial Officer for the Puyallup Health Authority in Tacoma, Washington (a current SAMHSA Child and Adolescent State Infrastructure grantee).
- Gary Nunley, Director of Behavioral Health for the Choctaw Nation in Talihina, Oklahoma (a current system of care community).
- Vijay Ganju, Project Director for the Texas Mental Health Transformation in Austin, Texas, and former private consultant to the Yakama Nation in Washington (Mr. Ganju formerly was the Director of Center for Mental Health Quality and Accountability for the National Association of State Mental Health Program Directors Research Institute).

- Elizabeth Neptune, Managed Care Consultant for Indian Health Service (IHS) (Ms. Neptune formerly was the Principal Investigator and Project Director for the graduated Passamaquoddy Nation system of care in Princeton, Maine).

The study team involved representatives from currently funded Tribal system of care communities in providing feedback on the development of the discussion guides. The study team also sought input from representatives of the IHS and from the Harvard Project on American Indian Economic Development and its sister organization, Native Nations Institute for Leadership, Management, and Policy at the University of Arizona,[24] regarding the impact of local economic viability. Finally, the study team sought and received approval from the Macro International Institutional Review Board for all aspects of the study.

Procedures

The study team used unstructured topical guides to conduct telephone discussions—over a period of 4 months—with the project director, fiscal manager, and staff from the 15 system of care Tribal grant communities (see Appendix F, Discussion Guides). The guides contained broad thematic topics that included perspectives on sustainability; the economic, social, and political environment; infrastructure; services; and funding. Participants were asked to share the lessons they learned and offer advice to other Tribal communities that might consider applying for a system of care grant in the future.

Two note takers were in attendance during each teleconference to ensure the accuracy of the information captured. Their notes were compiled and organized, and all personal and location-identifying information was removed. The study team shared a summary of the discussion with each participant for his/her review and comment. Participants were invited to provide information they felt was missing from the notes and explain whether they felt that their system of care had been, or would be, sustained. The study team updated the notes per the participant's feedback.

Following these discussions, researchers conducted supplemental detailed conversations during site visits with five of the communities (see Appendix F for the Site Visit Discussion Guides). The study team selected the communities as those representing community characteristics posited to be important factors affecting sustainability efforts. The five communities selected encompassed several criteria:

- An Urban Indian community
- A community located in Alaska
- A community relying on IHS for behavioral health services
- A community with a strong Tribal–State relationship
- A former Circle of Care grant recipient
- A community located within a primary health care center
- A community with a strong Tribal College partnership

[24] The Harvard Project on American Indian Economic Development and the Native Nations Institute for Leadership, Management, and Policy at the University of Arizona work in partnership on research and outreach in service of Native nation self-determination. More information can be found at www.hks.harvard.edu/hpaied and at nni.arizona.edu

- A community with a strong emphasis on the integration of traditional practices
- A Tribal start-up nonprofit organization
- A Tribal 638 organization[25]

The on-site participants included the project director, fiscal manager, Tribal Board or Council representative, and State representatives, including mental health, child welfare, substance abuse, and/or Medicaid agencies. The latter were interviewed to explore the perspectives and roles of these agencies in the support and sustainability of the Tribal grant communities. State representatives participated either during face-to-face discussions or by telephone, depending upon the distance of the representative from the system of care community. One note taker recorded notes for all site visit discussions.

A Native researcher who is familiar with the Tribal system of care communities and is sensitive to the importance of conducting the discussions in a culturally competent manner facilitated the telephone and site visit discussions. All discussions were open-ended and informal in nature, and participants were encouraged to tell the "story" of their sustainability efforts and partnerships, while touching on the broad themes contained in the discussion guides. The on-site discussions with the State representatives followed the broad thematic topics outlined in the topical guide, but also provided an opportunity for the State participants to share their story of partnership development with Tribes and Tribal organizations.

[25] A provision that enables 638 Tribes and Tribal organizations to tap into higher Medicaid reimbursement rates. This is addressed in more detail later in this report.

Prior to each discussion, participants received information concerning the nature of the study, an informed consent, and a discussion guide. The facilitator reviewed the informed consent at the beginning of each call and participants were given the opportunity to ask questions. The study team did not begin discussions until they received a signed consent from each discussant.

Data Analysis

Because the telephone discussions were not interviews in which the respondents answered specific questions, the information obtained is not uniform across all 15 grant communities, but rather represents the information the respondents felt was the most important to share during the discussions. In order to analyze the telephone discussions qualitatively, the study team collaborated throughout the data collection process to isolate themes found in the telephone discussions as they related to financing successes, challenges, and lessons learned. Additional information gained from site visit discussions with project directors, fiscal managers, and Tribal Board or Council representatives was folded into the analysis. As this additional information continued to be added, the study team became confident of having reached a point of saturation in which existing themes were being strengthened but no new themes were identified. Such saturation adds confidence to the reliability of the themes identified. Discussions with State representatives were qualitatively analyzed separately, as this information was different from the other collected information. The study team again collaboratively identified themes in these discussions.

APPENDIX C. Findings From Discussions With Project Directors, Fiscal Managers and Tribal Board or Council Representatives

The American Indian/Alaska Native (AI/AN) system of care communities experienced a range of successes and challenges in their search for sustainability. Tribal strengths of resiliency and creativity resulted in the development of win-win opportunities that serve as best practice examples of cross-cultural sustainability partnerships. Challenges are deepened by the unique cultural and political status of Tribes and Tribal organizations, which are often not understood by those they sought as partners. The discussions revealed common themes among the 15 communities. Themes from the discussions related to the economic and political environment of the State, county, and Tribe; sustainability planning; partnerships with Tribal agencies, universities, Tribal colleges, and other Tribal systems of care; system and service infrastructure; staffing; and funding.

Economic and Political Environments

The economic and political environment of the State, county, directly influences the financial sustainability of any system of care and Tribe in which it exists. Because Tribal system of care communities are often located in some of the most impoverished areas of the United States, the impacts of local and regional economic conditions can be more severe. For example, one community reported that many clients do not have the funds to allow for transportation to services and some have limited access to a telephone. Another community's representatives shared that due to a lack of funding in their State to support behavioral health services, clients in remote locations are only able to receive community-based services once every two weeks. One system of care developed a list of resources for families to utilize in the event of a crisis; however, without a telephone, families are unable to access these potentially life saving resources. Well-intentioned plans made by the State or county were reported to have not produced the intended results when there was a lack of understanding of the economic resources and needs of the people.

One-quarter of the Tribes funded to develop a system of care encompass service areas that are part of more than one State. In these situations, multistate political and economic environments affect the systems of care. Tribal communities must become knowledgeable of current and planned State child-serving initiatives, State Medicaid regulations, State provider standards and approved services, and credentialing requirements for multiple States. Provider standards and approved services often differ between States, which adds to the level of complexity of Tribal sustainability planning.

State and County Economic and Political Environments

Several examples illustrating the impact of the State economy on Tribal services were provided during the discussions. In the State of Alaska, from a pure cash flow perspective, the available dollars to augment State funding for behavioral health services, through the Alaska Mental Health Trust Authority, is predicated on the

value of trust land assets and the price of oil. As such, in a good income year, there can be additional funding for mental health services; in a bad year, this additional funding is not available. At the county level in California, the statutory Mental Health Services Act (1994) imposed a 1 percent income tax on personal income in excess of $1 million to provide increased funding, personnel, and other resources for the county-based mental health system. Unfortunately, the phrase "Tribes and Tribal organizations" was not included in the legislative language, so distribution of dollars to support special populations is only possible if the need is included in each county mental health plan. As such, Tribal systems of care reported spending a great deal of time negotiating with county officials to be included within individual county mental health plans in order to receive part of the $683 million in additional dollars for California behavioral health needs (Fiscal Year 2006 projection).

While some the communities reported having good relationships with the State and county, others acknowledged that relationships were impeded by disregard of Tribal sovereignty and Tribal needs. For example, one community's discussants indicated that their State organized meetings with the Tribes to receive input on policy issues, but notes from the meetings were not kept; there was no record of Tribal recommendations yet the State could claim it had fulfilled its obligation by meeting with the Tribes. Some Tribal communities had difficulty obtaining funding from the local and State governments because funding allocations were prohibited from being distributed to programs that serve only a particular racial or ethnic group. Several communities reported that the State or county utilized American Indian population statistics in grant applications without directing services stemming from the grant funds toward the American Indian population. Another community participated in several meetings to express concern that the counties had no track record in providing culturally competent services, and Tribal systems of care had to negotiate to receive a share of the funding allocation.

One system of care community reported building a good relationship with the State as an outgrowth of the State's commitment to transformation of services. A statewide transformation advisory committee was established and a Tribally elected official was appointed chairperson by the Governor. Following a Tribal-led presentation to the entire governor-appointed transformation committee on Tribal–State relationship building, a Tribal–State work group was developed that opened the door to improved relationships between the Tribe and the State.

Respondents often reported that State and county budget cuts and policy changes affected the cash flow into Tribal systems of care. One community recounted that despite promises from the State agency assuring the system of care access to Medicaid for home-based services, the Legislature enacted a law prohibiting Tribes from receiving reimbursement for home-based services. Alternatively, one community was able to thwart a State budget cut that would have eliminated funding for Tribal services by preparing a summary of rural Tribal needs and disseminating it to every State committee member prior to the committee vote. For other communities, their consistent presence at

planning meetings at the State capital or within their county was critical in being able to access mental health funds. These communities stressed the importance of being alert to policy decision-making, taking advantage of one's right to participate in the government process, and educating policy makers about Tribal systems of care by making regular contact with these individuals. One community marketed the importance of their system of care by demonstrating to legislators the high cost of services used by Native Americans. One community participates in multiple State committees to ensure that the Tribal voice is heard.

Tribal Economic and Political Environments

Communities reported that IHS funding has been flat for the past decade while health care costs have increased significantly. Urban Indian organizations continuously stave off proposed Federal elimination of Urban Indian health care funding, despite the fact that nearly 60 percent of all Tribal people live in urban areas. It is also important to note that a property tax structure on Tribal lands is virtually nonexistent. This means that there is no tax base to support Tribal school budgets, or Tribal systems of care, although this has been a sustainability strategy used by mainstream counterparts. Communities reported that the lack of an economic base resulted in school districts strapped for money seeking support from the Tribal government. Tribal governance boards have to make difficult decisions in prioritizing program funding. One community shared that their Tribal Board had to decide between funding for medical services or mental health services, while another community reported budget deficits leading to the closure of many behavioral health programs. Because of competition for funding in a resource poor environment, many communities commented on the need to educate their Tribal Board on the importance of the system of care. Taking a unique approach to educating people about the improvements found in children who have participated in the system of care, one community developed a PowerPoint presentation, a video about Tribal wraparound services, and a Tribal system of care poster to hang in Tribal council member's offices. This education extends not only to Tribal Board members, but also to the Tribal community at large as the system of care presentations are given in the mall and at school family nights.

The impact of Tribal politics on local system of care sustainability planning can also be significant. Many communities reported Tribal elections to be disruptive, as newly elected leadership can result in turnover of key organizational positions, a shift in priorities for the Tribe, or loss of supportive Tribal board members. Respondents emphasized that outsiders need to understand that with Tribal elections, some rules can change overnight. One community reported that the main reason their system of care did not sustain was due to the impact of Tribal politics. Tribal system of care staff, therefore, must engage in a continuous effort of educating current and future candidates for elected positions within the Tribal decision-making structure to assure financial and political support for the system of care. A few community representatives reported seeking nonprofit status to avoid the impact of Tribal government policies and to start up their program quickly, however lack of Tribal status made fund seeking more difficult as many

sources set aside funds specifically for Tribal entities.

Planning

Many communities stressed that the importance of planning for sustainability cannot be underestimated and, if given the opportunity to begin again, they would begin planning for sustainability early in the funding cycle—perhaps even before receiving the grant. In fact, representative of those communities that did engage in planning activities prior to receiving funding reported being at an advantage and some were able to provide services in their first year of funding. Several of the Tribal systems of care discussed the struggle to break away from a nonproductive approach to planning that they feel was ingrained in Tribal communities through years of colonialism. This nonproductive approach to planning, for some, involved a mentality of waiting for others to provide support, rather than actively being involved in maximizing available resources. Within some Tribal communities, implementing the system of care was preceded by helping community members recognize the impact of colonialism and historical trauma on the Tribal community's ability to come together in productive ways. Further, one respondent added that prior to colonialism, Tribal people traditionally had to be well-organized and good planners in order to survive, and that planning is not a Western concept; rather it is a basic element to promote sustainability and should be utilized to strengthen AI/AN self-determination. Succinctly commenting on the importance of program sustainability, one respondent argued that there was little value in building a large system unless program sustainability was a goal. One community discussed how the system of care helped to facilitate this more productive approach to planning.

Several communities commented that the wraparound approach to mental health services has been a part of Tribal life ways for centuries. As such, planning for and implementing the system of care is a good fit with the cultural history of the people. One community commented that the system of care philosophy is the most important component to sustain as it represents a return to traditional Tribal life ways. Another community discussed a return to traditional decision-making processes by governing through reaching consensus amongst system of care staff, Tribal spiritual leaders, and advisory board members. This emphasis on a return to Tribal values and governance spread to the other agencies within this Tribal community.

The system of care framework boosted the coordinated planning efforts of Tribal communities. For example, some sought advice from youth and elders to ensure that their sustainability plans were grounded in the perpetuation of the cultural values and beliefs of their Tribal community. Respondents from the communities stressed that building a system of care on the foundation of Tribal beliefs and Tribal ownership is a tremendous transformation. One community stressed the importance of continuous planning to assure alignment with their vision for their system of care. Additionally, a few communities advised that too much program growth too quickly could diminish the quality of service provision; they recommend expanding services only to the extent that quality service provision can be assured. Still others suggested that communities seek out culturally competent technical

assistance for ideas about community planning approaches.

Some communities focused on ways to determine their true cost of service using time and cost studies. Other communities analyzed all of the fund sources that affect the Tribal youth and families in their State to determine the fund sources they currently access and those they need to pursue. Some communities began with visits to the State Medicaid office to determine what the provider and billing requirements were so they could then use a backward mapping process to establish their sustainability plan. Still other communities focused on ways to build evidence and cost bases for traditional practices they know to be the cultural glue to which treatment approaches can stick.

Circles of Care

Nearly half of the Tribal system of care communities had previously received Federal grants for the 3-year Circle of Care planning initiative, which supports federally recognized Tribes and Urban Indian communities with financial and technical assistance to plan, design, and assess the feasibility of a culturally respectful mental health system of care. One community commented that their Circle of Care grant was the first to advocate for the incorporation of traditional life ways into a mental health program. Communities reported that their participation in the Circle of Care planning initiative helped them understand the priorities of the system of care movement.

Supported by Circle of Care funding, Tribal communities engaged in a number of planning activities. To illustrate, one community combined needs assessment and financial strategy at a community picnic during which all participant were given equal amounts of Monopoly [play] money that they used to prioritize services and supports most important to them – literally voting with their money. Similarly, other system of care communities commented that the Circle of Care planning grant allowed for

- a clarification of their cultural definition of health and wellness;
- the development of strategies to infuse Tribal values, practices, and cultural supports into their system of care through practitioners, providers, and families;
- an assessment of needed mental health services;
- the gathering of necessary data to compete for other funding opportunities;
- the creation of resources to be utilized in their system of care, such as equine therapy for children.

The communities reported that the Circle of Care experience was invaluable in helping to assess the financial needs of their system of care.

Funding Timeline

Several communities commented that the Federal Government should consider providing additional years of funding in order to give programs with no existing infrastructure an equal chance of being able to sustain meaningful services. One community suggested that an additional year be added to the funding cycle for Tribal programs that did not previously receive a Circle of Care grant. Another community argued that 5 years barely allowed their Tribe the time to change its way of thinking. Some asserted that less money over

more years would permit the building of a better base and allow the necessary time for people to buy into the system of care program. Tribal systems of care spent much time educating funding sources about the cultural attributes of Tribal services; such education is necessary, but diverts time away from other aspects of sustainability planning.

Partnerships

Tribal system of care communities developed partnerships with a variety of Tribal, State, county, and Federal entities. Positive interagency collaboration facilitated referrals among agencies; however, developing and maintaining relationships when long distances separated partner agencies in remote or large geographic areas was a significant challenge. Partnerships allowed Tribal system of care communities to provide training to agencies on culturally competent service delivery, Tribal needs, the system of care philosophy, and/or the Tribal wraparound approach.

Developing partnerships with State, county, and Federal representatives was also essential to the success of many systems of care. For example, one community reported that the years invested in educating key State representatives ultimately resulted in a statewide transformation of behavioral health services. Another community developed partnerships by strategically including representatives from the county on their advisory board so as to promote the visibility of Tribal needs. However, a lack of understanding of Tribal sovereignty and historical trauma, a general lack of trust, and staff turnover within partnering agencies were challenges to be overcome.

The person selected as project director for the system of care is in a critical position to develop relationships, effect community change, and set the direction for the future. Several grant communities interviewed reported that their project director had relationships with the State that facilitated a positive outcome for the system of care. In most instances, the project director had held a State, county or community mental health center position during previous employment and therefore understood the government system, had relationships with key people in child serving agencies, and could communicate with high level government officials to advocate for the system of care. A few other Tribal communities recruited experienced, politically savvy people for their Boards – in one instance a long term Indian political activist – in order to secure knowledgeable people to advocate for their programs. One board member was so involved with the system of care that he worked with the staff to motivate them to develop sufficient billable hours to keep the program sustainable.

Partnerships with Tribal agencies. Partnership building within the Tribal community has unique challenges. Scarce employment opportunities in Tribal communities, ironically, can sometimes lead to feelings of suspicion toward the new Tribal system of care and can impede formal partnerships. In addition, some communities reported that the Federal resources that enable their system of care to recruit and hire licensed and credentialed staff and operate their clinical services within a clearly defined standard of care was threatening to other entities. Some communities reported, however, that once the system of care had established a

positive reputation, other agencies were more willing to develop partnerships.

Partnerships with schools. Several communities developed partnerships with both public and Tribal school systems. While some schools were very receptive to the system of care approach, others were less so. For example, one public school superintendent did not understand the system of care approach and believed there was no advantage or reason for the school district to collaborate. This superintendent was focused on the No Child Left Behind legislation and making sure his school district met academic performance standards. As such, he felt that schools were no place for social workers and had no time for system of care partnerships. Further, turnover in school administration and staff requires a constant introduction to the system of care work. On the other hand, another system of care provided one-on-one care in the classroom for children with special needs to demonstrate that their work was improving child outcomes. Once success was shown, the school district was willing to invest its own funding into the one-on-one workers. Successful school partnerships facilitated cultural approaches to care within the school systems.

Partnerships with other systems of care. Collaborations between Tribal systems of care and other systems of care promoted sustainability. For example, one community contracted with a graduated system of care for technical assistance to develop their sustainability plan. One community felt that being able to share ideas with other Tribal system of care communities allowed their system of care to flourish. Another community began as a part of a non-Tribal statewide system of care that was able to secure their own grant with support from the State when the State realized that they were not meeting the needs of American Indians. Another community reported that successful relationships with the State system of care were dependent upon the State recognizing the Tribal system of care as an equal partner. Other Tribal systems of care were able to share their approach through cultural competence trainings and contract negotiations with State child-serving systems.

Partnerships with Tribal colleges. Tribal efforts to invest in growing their own staff led to innovative partnerships with higher education for credentialing and other training needs, and partnerships with Tribal colleges and local universities were developed; communities then worked strategically to align State credentialing requirements with cultural approaches that worked best in Tribal communities. One college supported a Web site for mental health agencies to facilitate communication and provided training for system of care staff on topics related to Medicaid.

Partnerships with colleges and universities were not without challenges. For example, some university programs provided the academic foundation to knowledge relating to behavioral health theory, but were not able to develop the clinical skills needed to provide mental health services without an advanced degree. Although funding sources are usually pleased to see a university-Tribal partnership, deeper inspection to ensure that higher education can continually adapt to meet the evolving needs of the Tribal system of care "customer" is needed. Several Tribal colleges have been formal partners and the cultural compatibility between a Tribal system of care and the Tribal College facilitates the development of certificate programs that

meets the practical training and credentialing needs of the system of care. In one example, while the Tribal system of care leadership and Tribal community college worked to develop a training curriculum, the system of care simultaneously negotiated with the State to ensure that the curriculum was understood, valued, and sanctioned. Many Tribal systems of care develop the training curriculum in partnership with the State to ensure that any obstacles to becoming a Medicaid provider of behavioral health services are addressed and resolved.

Federal, State, and county champions. Tribal champions, described as individuals at the Federal, State, and/or county levels who provided support to Tribal systems of care, were an essential factor in the success of many systems of care. For example, one champion provided training on how to negotiate through a maze of county program requirements and forms. Another champion provided assistance in understanding how to reduce the error rate in Medicaid billing. Still another was essential in allowing for changes in minimum provider qualifications for case managers and care coordinators. Champions understood sovereignty rights, recognized the Tribe as having expertise in providing services to Tribal communities, and understood how Tribal services can benefit the overall State. Several States with large Native American populations established Tribal liaison units for Medicaid and other programs that facilitate the training and relationship building necessary to secure Tribal participation in programs.

Infrastructure

Each of the Tribal system of care communities are at different points on the continuum of infrastructure development. Those that are part of a Tribal health care organization often had an infrastructure in place (e.g., administration, documentation standards, computer systems, billing office) that facilitated rapid development of billable services. Other Tribal systems of care were start up programs that had to build their organizational infrastructure from the ground up, often further complicated by their remote locations. Additionally, local community needs in some Tribal locations are so dire that when funding is received, there is a focus on getting immediate services to the community, rather than on developing system infrastructure. As such, the financial infrastructure needs of the Tribal system of care can become secondary to direct service functions. However, it was recommended that future system of care communities focus attention towards infrastructure development to allow for continued growth and expansion.

Systems

Internet. The remote locations of many of the Tribal systems of care have sporadic Internet connectivity, which in turn, can affect electronic billing capability and negatively affect the ability to comply with State performance standards for data entry into State databases. Further, several Tribal communities related that they lack technology or have only “dinosaur” computers; one community which began to rely on electronic communication found that many members of the Tribal Council were unfamiliar with such technology and therefore the community provided training to improve the Council members technology skills.

Office space. Office space is extremely scarce for some communities, as is housing for newly recruited staff. Due to a lack of available office space, several communities reported having uncomfortable working conditions or offices scattered across several differing locations, creating a barrier to staff unity. To address the lack of space, some communities received office space from school districts to provide school based services. Two communities build their own facilities as part of their sustainability efforts; one community raised money, mostly through private foundations, to build a community center, while another developed an agreement with the Tribe to set aside rent payments for the construction of a system of care building.

Billing infrastructure. A billing infrastructure is critical to financial sustainability and the complexity of health care billing has grown dramatically in recent years with HIPAA, Federal program rules, compliance and quality assurance initiatives. Tribal programs have traditionally operated under government program structures and therefore have experience in billing the fund source for payments. Subsequently, managers and staff lack basic knowledge about the revenue cycle and must begin from scratch in developing systems and processes to accurately manage funds and bill for those services. Some Tribal staff learn finance and billing primarily through on-the-job experience.

Other essential elements required for successful billing include documentation for services that meet professional and payer standards, coding, and medical records management. Significant training is necessary for professional and technical staff to establish skills, and this is a challenge for organizations with limited resources in rural and remote areas.

Establishing a third-party billing system is a huge learning curve which many communities have underestimated. One community shared their experience of initially having their Medicaid reimbursement forms sent back to them with numerous errors. It was not until the community received technical assistance from State representatives that they were able to reconcile their billing processes and reduce future billing errors. Others reported facing challenges with insufficient financial software or in keeping up with needed software upgrades to meet the changing requirements of payers. On the other hand, communities that are part of large Tribal organizations reported being able to tap into existing billing infrastructures, making the transition to billing for mental health services less challenging.

Data tracking systems. Discussion participants reported that many Tribal programs need to increase the ability to develop data tracking systems. Inconsistent data prevents its use as part of service planning among some Tribal agencies. One community discussed the challenges both in using an outdated data tracking system and of entering data into complex State databases. Recognizing the importance of tracking service use data, other communities are beginning to develop or redesign databases to track services and outcome. One community stressed the importance of capturing the number of clients served, the number of services rendered to each client, the types of services rendered, and client characteristics. Receiving technical assistance from the State related to entering data into State data bases proved helpful for one community.

While data collection was reported as being a large effort, it was also essential to securing additional funding sources, negotiating changes with the State for provider qualifications, justifying the need for staff positions, focusing staff training in challenge areas, and promoting social marketing endeavors. One community recommends educating staff on the importance of data collection.

Traditional Services

Cultural beliefs, traditional practices and cultural services serve as the foundation for all of the Tribal systems of care. Traditional practices rendered in systems of care were individualized according to the particular Tribe and family requests, and included talking circles, story telling, sweat lodges, and other traditional practices that have meaning for that particular community. One community developed a list of cultural advisors, including leaders from the various faiths and traditional practices represented within the Tribe. Additionally, many communities offered Native language and cultural education to promote a revitalization of their culture. For example, communities created CDs to help teach the traditional language, purchased a traditional drum for ceremonies to involve youth, collaborated with the Tribal College to bring children to cultural events supported by the college, and organized weekly cultural activities in which the youth and families could participate. Such activities were considered important in empowering people and supporting their sense of cultural pride. Communities reported that often clients feel as though a piece of them is missing and reconnecting the client with their culture helps them to heal. One community reported that many families come to the system of care to receive traditional healing services and ceremonies because the system of care was the first mental health organization to offer such services within their Tribal community. In general, the Tribal systems of care grantees reported that the use of cultural and traditional beliefs as a foundation of counseling and other mental health supports was essential in services to Tribal communities.

Several communities reported that traditional practices were a natural fit with some of the system of care principles and the wrap-around approach to services served as a prime example. In addition, the system of care emphasis on a strength based approach to service also matches the Tribal system of care emphasis on supporting a sense of cultural pride as a treatment goal. The Tribal communities also emphasized the importance of strength based language and many used words, phrases or concepts from the local Native language as part of their system of care approach to treatment; however, for one community, their strengths based orientation presented a challenge in working with larger mental health structures which function from a deficit model. The cultural foundation of Tribal services reflects the cultural beliefs of Tribal communities. Many reported that promoting culturally competent service provision was just as important to the sustainability of their program as was securing financial resources.

Staffing

The recruitment, hiring, and retention of staff have been serious challenges for most of the Tribal systems of care. Tribal systems of care are located in some of the most rural and remote locations in the country, or may be located in

the core of an inner city. Each of these circumstances can create staff recruitment challenges. Tribal community members, expert in the local culture and key to increased community access to services, often do not meet the higher education degree requirements required for billing services. High staff turnover presents a challenge to system of care communities as continual recruitment of and training for new staff members requires both time and money, and may interrupt billing for services.

Communities developed unique methods of addressing the challenge of staff recruitment and retention, including

- utilizing Tribal resources to increase staff salaries;
- obtaining funding for staff though outside agencies;
- negotiating changes in provider qualification standards to allow services provided by paraprofessional staff to be paid through Medicaid;
- offering housing opportunities through partnerships with school districts;
- developing partnerships with local universities for internship field placement for students working on their Masters degree, thus enabling the hiring of these students following their graduation;
- integrating staff from pre-existing behavioral health programs into the system of care.

Communities not only faced challenges relating to high system of care staff turn over, but also to high staff turnover among partnering agencies. For example, one community commented that high staff turnover within collaborating agencies creates a need to continuously educate partner agencies in the importance of incorporating traditional ways into service provision. Such continual education can place a strain on system of care staff. It is important to note, however, that while some communities faced huge challenges in staff turnover, a few reported great success in staff retention. For example, one community has had only one staff member leave in 10 years. This community was careful to hire only individuals who would positively contribute to their staffing team and emphasized the need to train all new staff members. Staff retention promotes program sustainability because funding sources may assess the frequency of staff turnover. Further, one community stressed the importance of program sustainability to promote staff retention; staff members often left in the last year of the grant if it was unlikely that services would be sustained the following year.

Another workforce issue is the need for staff to address the role of culture as part of the assessment and treatment planning process. Tribal system of care staff understand the fundamental nature of culture as a life factor either because they themselves are life-long Tribal community members, or they were trained in the cultural assessment process. This is especially important for non-Tribal staff who often serves in a clinical supervisory role. One community reported facing challenges with non-Native clinical supervisors who wanted to provide therapy, rather than supervise and train Native staff; however, a non-Native clinician's cultural incompetence can impede therapeutic outcomes. For example, non-Native clinicians were reported to misinterpret their client's silence as acceptance into the culture. Another community reported that prior to receiving the

system of care grant, the cultural insensitivity and lack of linguistic competency of therapists caused misdiagnosis and lack of inclusion of family members within care planning. Tribal systems of care have addressed this critical workforce training need from several perspectives: cultural awareness and cultural intervention training, community training in Tribal mental health, and training related to licensing and accreditation requirements.

Additionally, it is important for non-Natives to realize that the assessment process can be viewed as cumbersome, intrusive, and time consuming. One community reported that parents might be unwilling to enroll their child into the system of care because they are wary of the stigma of the diagnosis. Other families become confused and believe that the assessment process is the therapy and fail to return for actual treatment services. One community reported that the assessment is not culturally appropriate as it is considered rude to ask personal and invasive questions in their culture. Another community reported that clients are unaware of what behavioral health services are and so when interviewers ask if the client has received any behavioral health services the client incorrectly reports no.

Tribal systems of care made groundbreaking approaches to training staff in cultural awareness and cultural interventions. Many started with developing a local definition of wellness with the input of elders and community members. One developed cultural assessment tools for their particular Tribal population and cultural diagnostic categories. Plans for intervention, support and treatment result from a melding of cultural and Western clinical approaches. System of care funding supports these critical innovations to training which ensure that treatment planning matches the culture of the community, thereby increasing the probability of improved outcomes. However, negotiations with other funding streams must occur for several reasons. Because training and experience are linked to State licensing or other accreditation bodies training curricula must be pre-approved. Although licensing and accreditation groups each affirm their support for culture competence, few have actually seen a Tribal training curriculum which has as its foundation a cultural definition of mental health, culture-based assessment and diagnostic categories, and culture-based treatment approaches. Negotiations usually take place with the State to ensure that the State values and sanctions the curriculum. Partnership with the State can help alleviate any obstacles to becoming a licensed provider of behavioral health services with billing capability.

As mentioned previously, several Tribal systems of care communities developed successful partnerships with Tribal community colleges or universities as a way to support staff training. Partnerships with higher education, and other internal training efforts, provide an avenue for Tribal systems of care to “grow their own” staff. Investing in staff development through training was a crucial step in long-term sustainability strategies. Some Tribal systems of care have successfully moved their community from 100 percent non-Tribal behavioral health staff, prior to the system of care funding, to 89 percent Tribal behavioral health staff post-system of care funding through investment in training and education. Other areas of training include dual certification in mental health and substance abuse. Overall, Tribal communities often

provided funding and/or flexible work schedules to allow staff members to obtain their credentials and licensures. In addition, Tribal supervisors were able to help translate staff training into practical application.

Training for Tribal staff in third-party billing requirements (primarily Medicaid) and establishing standards for service documentation was an essential component of sustainability planning for many of the Tribal systems of care. Several of the system of care communities first met with the State Medicaid office to learn about the provider requirements and billing standards. Communities reported needing to invest time in training staff on billing documentation for several reasons. For example, most Tribal services are funded through grants so many Tribal staff have never worked within an environment of billable services. In addition, billing for 15-minute increments of time was a new way of thinking. This was especially challenging because multiple levels of staff often require training in third-party billing procedures and clinical documentation, including financial administrators, direct service supervisors, and front line service providers. Three of the communities developed billable hour expectations for all direct service staff, which ranged from 50 percent to 65 percent of the workweek, drawing a clear relationship between their paycheck and hours of direct service provision. The billable hour expectations were less than those of a mainstream community mental health clinic primarily due to the travel involved with remote Tribal service locations, cultural expectation of a high percentage of home-based services, and the time involved in the cultural engagement process. Some of the system of care communities took care to ensure that the billable hour expectation was spread across the organization as a shared responsibility. One community found great success in turning the billable hour expectation into a visible team effort by charting billable expectations weekly in the staff room.

Communities addressed the challenge of staff retention in several ways but primarily focused on supervision and professional support as ways to address staff retention. One community shared that the staff workweek can be long and intense and can lead to staff burnout. To address this issue, the community developed a personnel policy that staff take time off each quarter to regroup and heal themselves.

Funding

The study team discussed with communities the disproportionate numbers of American Indians and Alaska Natives in juvenile justice, foster care, child welfare, and behavioral health systems. Despite these disproportionalities, communities reported having insufficient funding resources to address these needs. For one system of care community, just keeping the lights on in their office was a challenge. Another community reported having three experienced grant writers on staff but lacked funding opportunities that supported the youth- and family-driven values of a system of care. In one instance, upon the Tribal receipt of the system of care grant funding, the county stopped providing all previous county funding. Further, despite system of care staff efforts, the county would not reestablish their financial support of the system of care once the SAMHSA grant funding ended. One community stressed the importance of creating realistic goals to maximize sparse resources. Communities were

also challenged in finding grants with sufficient indirect cost funding to support program administration needs.

Despite these challenges, many communities also recounted success stories in accessing Federal, State, county, and private funding sources. Communities developed contracts with Juvenile Justice agencies, and school districts to receive funding for service provision to Tribal youth and training for the mainstream system staff as part of the continuum of care. Within school districts, staff worked to implement Individualized Education Plans (IEPs) and provide cultural competency trainings. Within juvenile detention facilities system of care service providers adapted child treatment protocols and provided training to correction facility staff to promote a more nurturing and supportive approach. These contracts supported culturally competent service provision. One community commented that the best way to promote sustainability is to access grant funding. The success of these collaborations was often dependent upon the contracting agency's willingness to work collaboratively with Tribal system of care staff. Many communities discussed struggles in gaining financial support for traditional services and communities used a variety of strategies to pay for cultural services, including the use of funding from various grants. Most important was the development of a line item in the Tribal system of care budget for traditional practices. Several suggested that fundraising and using donations could be a viable way to fund activities, such as traditional practices, for which there are no other funding resources.

Medicaid

Many of the Tribal sustainability plans included exploration of a partnership with Medicaid, the largest payer in the country for behavioral health services. For many communities, Medicaid reimbursement was an essential ingredient that allowed for the sustainability of services. Many of the Tribal systems of care spent a significant amount of time meeting with State officials to explain and gain access to higher Medicaid reimbursement rates through a special provision in the Indian Health Care Improvement Act.[26] Challenges hindering Medicaid use included a lack of program infrastructure and lack of qualified staff. Additionally, one community reported delayed approval of client Medicaid eligibility due to slow mail delivery within rural communities. Another system of care community, which operated within the Tribal health care organization, reported having little motivation to bill Medicaid for services as the revenue earned would go to the Tribal general fund and was not guaranteed to be infused back into the system of care. They advocated that all funding received from Medicaid through system of care service provision should go directly back into the system of care to encourage Medicaid billing and thus program sustainability. Although most communities reported facing minor challenges in Medicaid billing, communities reporting significant challenges—such as extremely limited or no access to Medicaid dollars—were less likely to sustain.

Developing a working relationship with State Medicaid representatives was helpful to several

[26] A special provision through the Indian Health Care Improvement Act allows 638 Tribes and Tribal organizations to tap into a higher Medicaid reimbursement.

communities as they negotiated changes to provider qualification requirements; however, such efforts by other communities were unsuccessful. Collaborative relationships with State Medicaid representatives opened doors for informal technical assistance on billable service options, such as transportation services. Additionally, State Medicaid representatives provided information on how to develop the written policies and procedures essential to becoming a Medicaid provider.

Many of the Tribal grant communities were able to bill Medicaid for services to children and families. Because many Native American communities are low income, children are often eligible for Medicaid. Several of the grant communities perform outreach and enrollment activities and assist families in completing Medicaid applications. All of the Tribal systems of care provide case management services, but very few Tribal grant communities were successful in getting Medicaid payment for that activity. One State made a rule change so that the grant community could bill for case management by changing the provider qualifications for Tribal providers.

A few State Medicaid agencies classified traditional services as behavior management or rehabilitation services, which enabled Tribal systems of care to be paid for cultural activities and healing ceremonies. Another grant community employed a licensed counselor as a clinical supervisor of mentors providing cultural services, and received approval from Medicaid to bill for those services. Those grant communities who were unsuccessful in billing Medicaid included several that could not access the behavioral health managed care system, and several do not have any licensed staff or do not render any billable services.

Match

Many communities reporting successes in meeting match requirements had pre-existing funding structures and grant sources prior to receiving a system of care grant. For one system of care, having a Circle of Care grant was essential in allowing them to meet match requirements as they argue that it takes a long time to become written into State agency budgets. Communities stressed the importance of understanding what can and cannot be used as match.

Communities reported several match sources:

- Tribal, county, and State funds
- volunteer time from elders, youth, staff, and others
- school, juvenile justice, and medical services
- 638 funding
- gaming revenue allocated for social service programs
- donations from the American Indian Relief Council
- Temporary Assistance for Needy Families (TANF) funding for office employees
- cultural activities (including donated equipment use and transportation)
- Tribal land donations

While Tribes have successfully developed a number of ways to meet match requirements, these processes are not without their challenges. While some stated that meeting the match requirements early on in the funding period was easy, meeting the increased match ratios

required later in the grant funding period became 'impossible' for others. For example, one community commented that the challenge of getting match is ongoing and that there are not enough resources in the area to meet the match requirements. Another community is addressing this issue by trying to develop a coalition of system of care grantees to negotiate with the Federal Government to have match requirements waived for the poorest counties in the country; they argue that such a provision would allow for the continuation of needed service provision. Meeting match requirements was reported to be time and labor intensive in that documentation requires all staff to be vigilant to match possibilities, and the value of the match may be difficult to assess.

Communities developed forms and spreadsheets to document and track match contributions. For example, one community developed triplicate match documentation so that the project director, accounting office, and donor would all have a copy of the match documentation. Another community reported using two different match documentation systems: one for match related to direct client service provision and one for documenting all other forms of match contributions. Protocols for utilization of match documentation included: assigning employees the responsibility of documenting all items given out to families; having staff carry the match documentation form wherever they go; having a centralized person manage all in-kind documentation; and assessing progress in meeting match goals on a quarterly, monthly, and/or annual basis.

A few communities cited difficulties in assigning a value to in-kind contributions. For example, one community expressed challenges in documenting their research to assess the reservation property values. Another community reported having difficulties in assigning costs to traditional healing services. For example, some cultural traditions suggest that it is inappropriate to pay for traditional healing services; however, lack of payment for services does not mean that traditional services are without value. One community rose to this challenge of assessing in-kind contributions by having donors estimate the values of the donated goods or services. Further, standardized estimates of average hourly wages based on type of work performed were developed by some Tribal systems of care to assign values to volunteer time.

APPENDIX D. Findings From Interviews With State Representatives

State representatives stressed the importance of creating and strengthening relationships between State and Tribal representatives, as well as acknowledging the power that Tribal–State partnerships can hold. Each party has much specialized knowledge to share that could benefit the other. Many representatives discussed their long-term professional relationship with Tribal leaders. The friendly relationships were mutually beneficial to both parties: State representatives gained personal insight into the strengths and needs of the daily world of Tribal communities, and Tribal leaders gained insight into the inner workings of State systems and the State decision-making processes. In one State, the Lt. Governor's willingness to develop personal relationships with the Tribes ultimately helped to persuade the Governor to sign government-to-government agreements with the Tribes.

State–Tribe relationship building can be affected negatively by a variety of sources. Tribal politics often results in a high turnover of Tribal staff, which affects the sustainability and nurturing of Tribal–State relationships. Lack of oversight or technical assistance from the State can be detrimental to relationship building because, as one State representative noted, if the State provides funding without technical assistance and the Tribal grantee struggles, the State can too easily blame the Tribal grantee for "failing" instead of assuming responsibility for the lack of technical assistance and oversight. In addition, some Tribal people are imbued with historical trauma, which broadens the lack of trust Tribal people have toward the States and impedes the development of Tribal–State relationships. Several State representatives discussed their struggle to break down barriers created by the lack of trust and reported hopefulness in eventually being able to develop a positive working relationship.

Transformation efforts in some States opened doors of communication so that communities could join the planning efforts. States'interest in inviting and engaging diverse and statewide communities provides an opportunity to influence State behavioral health policy for interested Tribal communities. State representatives discussed how they announce the opportunities available for Tribal communities to influence the direction of State planning. Methods included coordinating with the State Tribal Liaison or Tribal health boards to broadly advertise the State's "open door" policy with Tribes and Tribal organizations. States set up mechanisms to solicit Tribal input that included statewide coordinating committees, State planning committees, Tribal–State work groups, regularly scheduled meetings with Tribal-elected officials and Tribal health boards, and State public hearings on child and family issues. In one State, Tribes that were initially lumped into statewide hearings felt their needs were ignored; separate discussion forums, established solely for the Tribal voice, proved effective.

Despite the success of some, other State representatives reported great difficulty in getting Tribes to participate in State planning meetings, even if meeting announcements are

followed up with reminder calls. The limited numbers of behavioral health staff in many Tribes restricts the staff's ability to participate in State planning meetings. Meetings rarely are held in Tribal communities, so travel costs and time spent away from service provision also restrict Tribal participation. Some Tribal people who attend meetings are not in a position of power to influence people back home. State representatives also spoke of Tribal staff turnover as a hindrance to communication about key meetings.

State representatives revealed a wealth of structured processes and tools available to them to solicit Tribal participation in State planning meetings. Each State representative had a formal Tribal consultation policy in place within their department. In States, the Block Grants of the Social Security Act (Title IV-E funding) include a formal process for working with Tribes that can serve as a model for Tribal–State relations. Some States had a senior-level Tribal Liaison who serves as a direct conduit to Tribal leadership. Some States created Tribal–State boards for relationship building through legislative initiative. One State initiated an annual, 1-day summer institute to showcase Tribal behavioral health programs; registration fees were waived and the State provided stipends to those Tribal program staff who needed financial support to attend.

State governments have a range of methods available to them to assist Tribes' move forward in financial sustainability. The discussions with State representatives resulted in a list of approaches used by States to increase partnerships with Tribes and Tribal organizations:

- Commit time and resources to assist Tribes.
- Develop special training sessions and technical assistance for Tribes.
- Conduct monthly conference calls with Tribes.
- Develop flow charts on how to access State funding.
- Develop a Tribal section in the State billing manual.
- Provide technical assistance specifically on the State billing process for Tribal providers.
- Simplify the billing process and billing codes for Tribal services.
- Develop a State agency accreditation process for Tribes as an alternative to the costly national accreditation services.
- Assign a State liaison to work with Tribes on licensing and accreditation.
- Work with Tribes as they move through the accreditation process.
- Advocate for State funding of the Tribal services.
- Provide Title IV-E administrative funds to Tribes to support the development of 5-year plans.
- Review the licensing and provider certification portions of the State mental health plan and remove barriers for Tribal services.
- Work with Tribes to develop alternatives for provider qualifications.
- Institutionalize a licensed counselor trainee process to address Tribal workforce shortages and to promote Tribal career advancement.

Several State representatives discussed alternatives to State laws that act as barriers to Tribal service provision. If the law cannot be changed State managers can promote regulatory

changes instead, including recommending the certification of alternative providers, lessening the paperwork for documentation of service provision, and reaching parity in the payment of mental health and substance abuse services. One State representative discussed its transformation effort to move the State system from a long-standing position of "contract compliance" to that of "technical assistance and support."

State funding also plays a role in the advancement of technology but the technology decisions must be in sync with the technology capacities of underserved communities. For example, one State discussant described the State's effort to assist Tribal technology by obtaining technology grants to replace Tribal computer equipment and to expand the band width for remote Tribal locations for increased connectivity. These efforts developed to facilitate Medicaid billing, grant reporting, and data tracking. As such, these improvements are important in that success in these areas should promote program sustainability.

States have learned that standard contract language may not fit Tribal communities. For example, standard contractual clause in one State contracts required that the contractor must pay into the State workers compensation fund, but Tribes may have their own worker's compensation fund as a sovereign nation. Standard managed care contracts do not work in extremely remote Tribal areas where there either is not enough or no "care" to manage. Some States reported that their contracts are moving toward the accreditation of providers as a requirement. The cultural incompatibility of some accreditation standards, combined with the prohibitive cost of national accreditation, can place Tribal service providers in jeopardy.

State representatives further revealed their challenge areas, which included

- struggling to fully understand the challenges of the Tribal provider;
- realizing that State provider qualifications are often a mismatch with the available Tribal workforce;
- aligning certification and training requirements with State and Tribal needs;
- lacking a common definition and contractual expectations of collaboration;
- conflicting viewpoints between State data requirements and Tribal perspectives on data ownership and data submission.

Additionally, it was recommended that States be made more aware of 638 Medicaid funding mechanism and the advantages of Tribal–State Medicaid partnerships for the claiming of 100 percent Federal match for payments to IHS and Tribal 638 programs.

State representatives reported that Tribes render good services, but billing is not a priority for some. One State representative discussed their regulatory changes that decreased and broadened the number of billing categories for eligible Tribal services in an effort to increase Tribal access to Medicaid funding. State representatives were aware that Tribes need active training on accessing Medicaid and Title IV-E funding sources.

APPENDIX E. National Evaluation Sustainability Study Findings for Tribal System of Care Communities

The national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program initiated a study in 2002 to assess the ability of funded sites to sustain key components of their systems of care beyond the Federal grant period. The study involved a Web survey and telephone interviews with respondents from system of care communities funded in 1999–2000 and 2002–2003. Six of the communities that responded to the study were Tribal communities. Data were collected from four key respondents in each community, including the current or former project director, a key person responsible for children's mental health in the community, a family member, and a representative from another child-serving agency; 22 respondents from the six Tribal communities completed the survey. The survey was administered in late 2005 and continued through early 2006; for the communities funded in 1999–2000, this activity occurred during the final year of their grants. For the communities funded in 2002–2003, the activity occurred during the third year of their grants.

A range of general sustainability strategies were used to assess the ability of Tribal communities to sustain key components of their systems of care beyond the Federal grant period. (See Table E–1, General Strategies for Maintaining Tribal Communities' Systems of Care.) More than 90 percent of the respondents reported that the strategy most commonly used was cultivating strong interagency relationships. Communities were also likely to involve stakeholders (82 percent of respondents) and to provide training on the system of care approach (73 percent of respondents), generate political and policy-level support for the approach (73 percent of respondents), and establish a strong family organization (73 percent of respondents). The strategy reported as being used least was making policy/regulatory changes that support the system of care approach (48 percent of respondents).

The respondents also reported on the effectiveness of any strategies they reported using. The general strategies reported as being used by most respondents were rated as being at least moderately effective.[27] "Cultivating strong interagency relationships" was rated as being at least moderately effective (74 percent of respondents). Similarly, "involving stakeholders" was rated as being at least moderately effective (82 percent of respondents), and was rated very or completely effective by more than one-half of those respondents.

However, out of the five most frequently used strategies, two were rated as being very or completely effective by less than one-half of the respondents: "cultivating strong interagency relationships" and "generating political and policy-level support for the system of care approach." The strategy that seems to have been the least successful is "making policy/regulatory changes that support the system of care approach"; only 48 percent of the respondents reported that the strategy was used, and 46

[27] Rated as being "moderately effective," "very effective," or "completely effective."

Table E–1. General Strategies for Maintaining Tribal Communities' Systems of Care

General Strategies	Strategy Used?		If Used, Effectiveness of Strategy					
	N	% Used	N*	Not Effective	Somewhat Effective	Moderately Effective	Very Effective	Completely Effective
Cultivating strong interagency relationships	22	90.9%	19	0%	26.3%	26.3%	36.8%	10.5%
Involving stakeholders	22	81.8%	17	0%	17.7%	23.5%	41.2%	17.7%
Providing training on the system of care approach	22	72.7%	18	5.6%	22.2%	11.1%	38.9%	22.2%
Generating political and policy-level support for the system of care approach	22	72.7%	16	6.3%	18.8%	31.2%	31.2%	12.5%
Establishing a strong family organization	22	72.7%	17	5.9%	17.7%	23.5%	41.2%	11.8%
Mobilizing resources	22	68.2%	15	0%	46.7%	33.3%	13.3%	6.7%
Using evaluation/accountability results	22	63.6%	17	11.8%	17.7%	23.5%	35.3%	11.8%
Creating an advocacy base for the system of care approach	22	63.6%	15	6.7%	6.7%	33.3%	46.7%	6.7%
Infusing the system of care approach in the broader system	21	61.9%	16	12.5%	37.5%	37.5%	6.3%	6.3%
Creating a viable, ongoing focal point for system management	22	59.1%	15	13.3%	0%	33.3%	46.7%	6.7%
Making policy/regulatory changes that support the system of care approach	21	47.6%	13	23.1%	23.1%	30.8%	15.4%	7.7%

*The numbers in this column are not always consistent with the number indicated by the "% Used" because some respondents indicated a strategy was used but declined to rate its effectiveness; other times some respondents rated the effectiveness of a strategy that they had not indicated as being used.

percent of those respondents rated the strategy as having being relatively unsuccessful (i.e., "not" or "somewhat" effective).

Regarding specific financing strategies, respondents reported that the most frequently used strategy was "operating more efficiently through cutting costs" (83 percent of respondents). (See Table E–2, Financing Strategies for Maintaining Tribal Communities' Systems of Care.) "Leveraging funding sources" and "increasing the ability to obtain Medicaid reimbursement for services" were the next most frequently reported strategies (75 percent and 67 percent of respondents, respectively). "Administrative claiming" (that is, using available child welfare and Medicaid funds to cover administrative costs), "de-categorizing funding streams," "charging fees for services," and "creating new revenue by pursuing an activity unrelated to the system of care mission" were the strategies least used.

It is important to note that only two of the financial strategies were rated as being completely effective by any respondents: "increasing ability to obtain Medicaid reimbursement for services" and "obtaining new/increased foundation funds." Only one respondent rated each of those strategies as being completely effective. Even those strategies reported as being used most frequently were not rated highly. For example, "operating more efficiently" was rated as being moderately or very effective by 64 percent of the respondents; that is, this strategy that was

Table E–2. Financing Strategies for Maintaining Tribal Communities' Systems of Care

Financing Strategies	Strategy Used?		If Used, Effectiveness of Financing Strategy					
	N**	% Used	N	Not Effective	Somewhat Effective	Moderately Effective	Very Effective	Completely Effective
Operating more efficiently (i.e., cutting costs)	12	83.3%	11	0%	36.4%	45.5%	18.2%	0%
Leveraging funding sources (i.e., using new funding to draw down additional Federal, State, or local funds in the form of a "match")	12	75.0%	9	11.1%	22.2%	44.4%	22.2%	0%
Increasing ability to obtain Medicaid reimbursement for services	12	66.7%	10	20.0%	30.0%	40.0%	0%	10.0%
Obtaining grants	12	58.3%	9	33.3%	22.2%	22.2%	22.2%	0%
Redeploying/shifting funds from higher cost to lower cost services	12	58.3%	7	0%	14.3%	57.1%	28.6%	0%
Using in-kind space donation	12	58.3%	7	14.3%	14.3%	28.6%	42.9%	0%
Obtaining new/increased local funds	12	58.3%	7	28.6%	0%	28.6%	42.9%	0%
Creating partnerships with other (non-mental health) systems to obtain new/increased funding	12	50.0%	7	14.3%	28.6%	28.6%	28.6%	0%
Obtaining new/increased Federal funds	12	33.3%	6	50.0%	0%	33.3%	16.7%	0%
Fundraising	12	33.3%	6	33.3%	16.7%	16.7%	33.3%	0%
Reinvestment of money saved through redeploying funds or reductions in spending	12	25.0%	4	25.0%	25.0%	50.0%	0%	0%
Refinancing (i.e., using other sources of money to pay for existing services in order to free up money for other uses)	12	25.0%	7	42.9%	57.1%	0%	0%	0%
Coordinating categorical funds (i.e., using funds from a variety of agencies and funding streams to support specific programs/services)	12	25.0%	6	33.3%	16.7%	16.7%	33.3%	0%
Obtaining new/increased State funds	12	16.7%	4	50.0%	0%	25.0%	25.0%	0%
Obtaining new/increased private or corporate funds	12	16.7%	4	50.0%	0%	50.0%	0%	0%
Obtaining new/increased foundation funds	12	16.7%	5	60.0%	0%	20.0%	0%	20.0%
Pooling or blending funds from several agencies	12	16.7%	5	60.0%	20.0%	0%	20.0%	0%
Administrative claiming (i.e., using available child welfare and Medicaid funds to cover administrative costs)	12	8.3%	5	60.0%	20.0%	20.0%	0%	0%
Decategorizing funding streams	12	8.3%	5	60.0%	40.0%	0%	0%	0%
Charging fees for services	12	8.3%	6	50.0%	16.7%	16.7%	16.7%	0%
Creating new revenue by pursuing an activity unrelated to the system of care mission (e.g., rental income, charging parking fees, enterprises)	12	8.3%	5	60.0%	20.0%	20.0%	0%	0%

**Note that only 12 of the 22 survey respondents completed this section of the survey. The respondents providing information about financing strategies were primarily the project directors.

reported as being used by 83 percent of the respondents was rated as being no more than moderately effective by 82 percent of those respondents.[28]

The general strategies of "cultivating strong interagency relationships" and "involving stakeholders," which were reportedly used by most of the Tribal communities, seem to reflect Tribal cultural norms of community engagement and relationship building. In contrast, making policy or regulatory changes that support the system of care approach was reported as being one of the least-often used general strategy for sustainability (47.6 percent of respondents) and it was rated as no more than moderately effective by 77 percent of the respondents. This stands in contrast to the State representatives who mentioned policy or regulatory changes as strategies to increase resources for Tribal communities.

The finding that infusing the system of care approach into the broader system was one of the lesser used general sustainability strategies might reflect the struggle of some Tribal communities to broadly infuse the system of care philosophy throughout the full range of Tribal health service and economic development programs. Another general sustainability strategy reported as being used by relatively few respondents, "using evaluation/ accountability results," could reflect Tribal mistrust of data and lack of Tribal-developed data systems.

More than 80 percent of the respondents reported that cost cutting was used as a financing strategy, although 82 percent also indicated that the cost-cutting strategy was only somewhat or moderately effective. In addition, specific financing strategies of "leveraging funding sources" and "increasing ability to obtain Medicaid reimbursement for services" were reported to be used by 75 percent and 67 percent of respondents, respectively. Although leveraging funding sources and increasing ability to obtain Medicaid reimbursement for services were attempted, 78 percent of the respondents indicated that leveraging funding sources were no more than moderately effective. Regarding the ability to obtain Medicaid reimbursement for services, only 10 percent of the respondents felt this was a completely effective approach, and 90 percent of the respondents indicated that their ability to obtain Medicaid support was no more than moderately effective. These responses seem to be reflective of the void of financial resources in many Tribal communities and the struggle communities have in leveraging funding sources. The respondents indicated that they attempted various financial sustainability strategies with only moderate (or less) success. Turning to cost cutting as a last resort, especially in communities with limited financial resources, might further jeopardize long-term financial sustainability.

The specific financing strategies rated as least used and least effective for the respondents—"administrative claiming," "de-categorizing funding streams," "charging fees for services," and "creating new revenue by pursuing an activity unrelated to the system of care mission" (e.g., rental income, charging parking fees, enterprises)—seem to reflect the Tribal priority of focusing human resources on the immediate provision of services in high need communities rather than on building the infrastructure needed to sustain the provision of services. An

[28] Rated as being "not effective," "somewhat effective," or "moderately effective."

emphasis on services in Tribal communities with limited human capital may result in diverting energy from building infrastructure, integrating the system of care with Tribal economic development efforts, and moving to the next level of advanced financial planning.

APPENDIX F. Discussion Guides

TELEPHONE DISCUSSION GUIDE
PROJECT DIRECTOR AND FISCAL MANAGER

Site ID#:_____ **Date:**_____

Discussion Facilitator:_____

Notetaker:_____

A. TRIBAL COMMUNITY PERSPECTIVE ON SUSTAINING THE SYSTEM OF CARE

Topics

- Community's perspective on system of care long-term sustainability over the grant period
- Aspects of the system of care that are, and are not, working well
- Commitment and/or ability to sustain the system of care
- Planning process for sustainability

B. ECONOMIC, SOCIAL, AND POLITICAL ENVIRONMENT

Topics

- Impact of local, regional, or State economies
- Impact of social issues
- Impact of Tribal politics or Tribal government decisions about programs priorities

C. INFRASTRUCTURE

Topics

- Organizational and service delivery structure
- Organizational capacity challenges
- Interagency collaboration

D. SERVICE PROVISION

Topics

- Strategies for sustaining services (including traditional practices)
- Building system of care services, successes, and challenges

E. FUNDING

Topics

- Mobilizing funding
- Meeting the Federal match requirements
- Impact of support from State or local government, the community, or the political arena

F. LESSONS LEARNED

Topics

- Financing strategies
- Technical assistance or information that would be helpful
- Recommended changes in planning or implementing a system of care
- Advice for new sites

SITE VISIT DISCUSSION GUIDE
PROJECT DIRECTOR

Site ID#:_____ **Date:**_____

Discussion Facilitator:_____

Notetaker:_____

A. TRIBAL COMMUNITY PERSPECTIVE ON SUSTAINING THE SYSTEM OF CARE

1. What are/were your successes and challenges in gaining community support to sustain the system of care?

2. Does/did your community have a local community "champion" for the system of care effort that has improved your ability to mobilize resources? Please discuss.

B. FACTORS AFFECTING SUSTAINABILITY

Collaboration and Coordination

3. Please describe your collaborative efforts among the programs within your Tribal organization or with other Tribal organizations.

Tribal – State Relationships

4. What is/was the Tribe or Tribal organization's relationship with the State and did/does it help or hinder sustainability planning for your system of care?

5. Has/did your organization established a relationship with any of the following State, county, or Federal agencies to support your system of care? Why or why not?

- Mental health
- Substance abuse
- Child welfare
- Juvenile Justice
- Medicaid
- SCHIP
- Indian Health Service
- Other

6. What strategies do/did you used to build these relationships? Please describe how these relationships impacted your ability to implement and sustain your system of care.

7. Do/did any of the State or county agencies have Tribal liaisons? If yes, please describe your relationships with the Tribal liaisons and how they do/did help or hinder financing and sustainability of your system of care.

8. Does/did your State have a Mental Health Transformation State Incentive Grant, or is/was the State engaged in activities to restructure the delivery system for behavioral health services? If yes, is/was your Tribe an active participant in these efforts? If not, why?

9. Does/did your State mental health or Medicaid agency have any formal process to interact with the Tribes? If yes, are/were you involved in this process?

10. Is/was building support for your system of care with members of the State Legislature part of your strategy? If yes, what impact do/did these relationships had on financing and sustainability of your system of care?

Tribal Governance

11. What strategies do/did you use to engage Tribal council members and increase their investment in the implementation and sustainability of your system of care?

12. Does/did turnover in your Tribal council or governing body impact your financial sustainability planning? Do/did you think there is/was anything you could do to lessen the impact of changes in your Tribal council or governing body membership?

Recruitment and Retention of Staff

13. Does/did your system of care community have successes and/or challenges in recruitment and retention of staff?

14. If you have/had success in recruitment and retention of staff, what are/were the effective strategies?

15. If you have/had challenges, what factors affected your recruitment and retention of staff? Are there specific positions that are/were particularly difficult to recruit or retain?

C. SERVICE PROVISION

16. What role does/did Tribal traditional beliefs and traditional practices play in your service system development? Were/are there any challenges in integrating traditional practices into your system of care?

17. What are/were the greatest service gaps in your system of care and how has funding (or lack thereof) affected the array of services you offer or would like to offer?

18. Are/were there licensing or accreditation requirements necessary to receive payment from State or other fund sources? Describe the successes and challenges in meeting these requirements.

Graduated Sites

19. Were you able to build or access the system of care required services during the Federal grant period? Please describe the successes and challenges in building service capacity.

20. If services declined after Federal funding was no longer available, what types of services were reduced or eliminated and what factors affected the decision to make the changes?

D. FUNDING

Medicaid

21. Do/did Medicaid services have to be provided or supervised by credentialed staff? If yes, how was this process designed?

22. Does/did Medicaid pay for behavioral health services that you would like to offer but do/did not, or do/did you offer services not covered by Medicaid? If yes, what are/were the barriers to accessing this fund source and what do/did you need to do to achieve payment for these services?

State Child Health Insurance (SCHIP)

23. Is/was your organization able to enroll as a provider in the SCHIP Program? If no, please explain why you are/were unable to enroll as a provider (for example, you cannot join the provider network, are not part of the managed care network, etc.).

24. If you are/were an SCHIP provider, does/did the program cover the behavioral health services you offer?

25. Do/did you provide behavioral health services that are not eligible for payment? Please describe these services and why you think they are/were not reimbursed.

Medicaid and SCHIP Eligibility

26. Does/did your organization conduct Medicaid or SCHIP outreach and enrollment for children? Does/did your organization receive funds from Medicaid (or SCHIP) in payment for your outreach and enrollment activities?

27. If you don't/didn't perform these activities directly, do/did you have an arrangement for the State or county to conduct outreach and enrollment at your Tribal location?

28. What factors affect/affected Medicaid and SCHIP eligibility of children? For example:

- Families do/did not complete application process
- Families lack interest in applying for government programs
- Children are/were not financially eligible
- Families do/did not re-apply when eligibility ends
- Other

Match Funds

29. Did the matching fund requirement for the system of care grant influence the amount of grant funds you requested? Please explain.

30. Did you receive any training on Federal match fund requirements? If yes, at what point during your Federal grant period? Who provided the training?

31. How did you meet, or how do you plan to meet, the increased match over the grant period? What was your original planned source of match over the grant period? Did the actual matching funds you acquired over the grant period correspond with your original matching fund plan?

32. Did meeting with other Tribal system of care sites at conferences help you with new ideas for sources of matching funds?

Flex Funds

33. Are/were you able to maintain a pool of flexible funds during, and after, the grant period? Please describe any successes and challenges you have/had regarding flexible funds and the source of these funds.

34. How are/were your flexible funds used? Can you list some examples of expenditures from the most common use to the unusual, one time type of use?

E. LESSONS LEARNED

35. What did you learn about collaboration with other agencies, such as schools, non-Tribal providers and government agencies?

36. Are there aspects of the system of care that will be/were difficult to maintain when the Federal funding cycle is complete?

Graduated Sites

37. Were the sustainability plans you developed during the system of care adequate to meet the financial needs of the program when the Federal grant cycle ended?

38. If you were previously a Circle of Care grantee, in what ways was that experience helpful in obtaining a system of care grant? Do you think your Circle of Care experience contributes/contributed to your long-term sustainability after the Federal system of care grant ends/ended?

SITE VISIT DISCUSSION GUIDE
FISCAL MANAGER

Site ID#:_____ **Date:**_____

Discussion Facilitator:_____

Notetaker:_____

FUNDING

1. What is/was your role and responsibilities as Fiscal Manager for the system of care grant?

2. What are/were your successes and challenges in developing and/or maintaining financial strategies to sustain the system of care?

3. Did you receive any training specifically related to the system of care requirements for match funding and/or strategies for sustainability? If yes, please describe your training experiences.

4. What funding strategies are being used/have been used or have been tried to support and maintain the system of care in your community? Please discuss.

    - Cultivating county-level interagency relationships
    - Partnering with Tribal organizations for joint funding applications
    - Facilitating discussion with State governor, State mental health commissioner, and/or other State division leadership
    - Facilitating discussion with State legislative leadership
    - Facilitating discussion with U.S. Congressional leadership
    - Obtaining grants
    - Obtaining new/increased State funds
    - Obtaining new/increased Federal funds
    - Obtaining new/increased local funds
    - Obtaining new/increased private or corporate funds
    - Obtaining new/increased Tribal funds
    - Fundraising Using evaluation outcome data
    - Beginning or increasing Medicaid or State Child Health Insurance (SCHIP) billing
    - Using child welfare or Medicaid funds for administrative costs
    - Beginning or increasing insurance billing
    - Charging fees
    - Using in-kind donations
    - Creating or diverting revenue from Tribal businesses
    - Obtaining licensing or certification
    - Other

Medicaid

5. Do/did you receive Medicaid payment:

At the Indian Health Service (IHS) encounter rate? Yes _____ No _____
At the FQHC rate? Yes _____ No _____
At the State behavioral health fee schedule? Yes _____ No _____
At managed care negotiated rates? Yes _____ No _____
For some services at one rate and other services at a different rate? Yes _____ No _____
If yes, which services are paid at which rates?

6. If you do/did not receive Medicaid payment for services, what are/were the barriers? Some examples of barriers may include:

- Lack of required license
- Lack of required certification
- Lack of billing capacity to submit claims
- Lack of computer technology for billing
- Lack of staff capacity (e.g., time, knowledge of Medicaid policy)
- Inadequate clinical documentation
- Do not provide the level of services required
- Cannot join managed care network
- Medicaid pays only State entities for services
- Other

7. Does/did your organization receive funds from Medicaid for administrative activities (for example, arranging transportation, making health care referrals, training, etc.)?

State Child Health Insurance (SCHIP)

8. If you are/were enrolled in the SCHIP, how are/were you reimbursed for services?

For an SCHIP Medicaid expansion:
At the IHS encounter rate? Yes _____ No _____
At the FQHC rate? Yes _____ No _____
At the State behavioral health fee schedule? Yes _____ No _____
At managed care negotiated rates? Yes _____ No _____
Other?

For a stand-alone SCHIP program:
At the program fee schedule? Yes _____ No _____
At managed care rates? Yes _____ No _____
Other?

Match Funds

9. How did you meet or how do you plan to meet the increased match over the grant period? What was your original planned source of match over the grant period? Did the actual matching funds you acquired over the grant period correspond with your originally proposed matching fund plan?

10. How did or how has your match fund sources changed over time?

11. Did meeting with other Tribal system of care sites at conferences help you with new ideas for sources of matching funds?
12. What percentage (estimate) of your match is/was cash and what percentage (estimate) of your match were in-kind services?

13. What types of in-kind contributions do you/did you use (for example, meeting space, food donations, transportation vehicles, clinical supervision services, etc.)? How do/did you translate your in-kind services into cash equivalents?

14. What process do/did you use for documentation of match? Did you develop or adapt a form to document your match funds?

Flex Funds

15. Where you able to maintain a pool of flexible funds during, and after, the grant period? Please describe any successes and challenges you had regarding flex funds and the source of these funds.

16. How are/were your flexible funds used? Can you list expenditures from the most common use to the unusual, one time type of use?

17. Do you have any financing advice you would like to offer to other Tribal system of care sites based on your experiences?

SITE VISIT DISCUSSION GUIDE
GOVERNING BOARD REPRESENTATIVE

Site ID#:_____ **Date:**_____

Discussion Facilitator:_____

Notetaker:_____

A. TRIBAL GOVERNING STRUCTURE

1. Please describe the structure of your Tribal governing body.

2. What is the relationship between your Tribal governing body and the system of care advisory board?

B. SYSTEM OF CARE

3. Did the Tribal governing body have any involvement in the development of the Circle of Care and/or the system of care grant? If yes, please explain. If no, how did you learn about the system of care grant?

4. What role has the Tribal governing body had in the development and ongoing decision making regarding the system of care?

5. How is the Tribal governing body kept informed about the system of care?

C. SUSTAINABILITY

6. How do Tribal finances impact your system of care financial sustainability plans?

7. Are there any larger social issues of concern to the Tribal governing body that may impact financing and sustainability of your system of care community and the system of care philosophy?

8. What has been the role of the Tribal governing body in developing collaboration with State agencies and other partners needed for sustainability of system of care

9. What has been the Tribal governing body's involvement in strategic planning for sustainability of the system of care?

10. What is the Tribal governing body's vision regarding sustainability of the system of care after the Federal grant is no longer available?

TELEPHONE AND SITE VISIT DISCUSSION GUIDE
STATE AGENCY REPRESENTATIVE

Site ID#:_____ **Date:**_____

Discussion Facilitator:_____

Notetaker:_____

A. SYSTEM OF CARE SUPPORT

1. What is your involvement with the Tribal system of care grantee in your State?

   - Provided formal letter of support for grant application
   - Provide funding for Tribal organization
   - Partner in service delivery
   - Organization has Tribal liaison
   - Organization provides training
   - Organization provides technical support
   - Organization provides licensing or accreditation
   - Other (please describe)

2. What is your involvement with any other system of care grantees in your State?

   - Provided formal letter of support for grant application
   - Provide funding for system of care
   - Partner in service delivery
   - Organization has system of care liaison
   - Organization provides training
   - Organization provides technical support
   - Organization provides licensing or accreditation
   - Other (please describe)

3. Does your State have a Mental Health Transformation State Incentive Grant?
   If yes, how have you engaged Tribes and Tribal organizations in the activities of the transformation grant? Please describe.

4. If your State does not have a transformation grant, is your State currently pursuing or planning any activities to restructure the delivery of behavioral health services? If yes, how have you engaged Tribes and Tribal organizations in your planning activities? Please describe.

5. Does your agency have any formal process for working with Tribes and Tribal organizations? Please describe.

B. FUNDING

6. Please describe funding that is available for behavioral health and family support services being provided in systems of care.

7. Are there any barriers to Tribes and Tribal organizations in accessing these sources of funding?

8. Does your State provide Mental Health Block grant funds directly to Tribal organizations? If yes, please describe the relationship of the State mental health agency to the Tribal programs receiving these funds. If no, are there other arrangements?

9. Does your State Medicaid program reimburse Tribes and Tribal organizations for the provision of behavioral health services? If yes, please describe the Medicaid reimbursement method.

    a. The IHS encounter rate

    b. The FQHC rate? Yes _____ No _____

    c. The State behavioral health fee schedule? Yes _____ No _____

    d. The managed care negotiated rates? Yes ____ No _____

    e. Payment for some services at one rate and other services at a different rate? If yes, which services are paid at which rates?

10. Please describe the behavioral health services that are reimbursed to IHS and 638 Tribal organizations at the IHS encounter rates.

11. Do you limit payment of the IHS rate for the above services to certain health care professionals? If yes, which professionals? (please check all that apply)

- Psychiatrist
- Psychologist
- Psychiatric nurses
- Physician Assistant
- Licensed clinical social worker
- Marital and Family Therapist
- Licensed counselors
- Para-professionals
- Clinical associates
- Behavioral health aides
- Other _____

12. Does your State purchase behavioral health services for Medicaid under a Federal waiver? If yes, please describe briefly how the services are purchased.

13. If you answered yes to #12

    a. Are American Indian and Alaska Native Medicaid clients required to participate under the purchasing arrangement in order to receive behavioral health services? Yes _____ No _____

    b. Can an American Indian or Alaska Native client continue to access services from a Tribal health provider? Yes ____ No _____

    c. Are Tribal providers included in the purchasing network for your waiver? Yes _____ No _____

    d. How are Tribal health providers reimbursed for services under your waiver? Please describe.

14. Are Tribal health providers included in the provider network of your State Child Health Insurance Program? Yes ____ No ____. If yes, how are they paid for services?

15. Does your State provide Medicaid administrative funds to Tribes and Tribal organizations for outreach, enrollment and other activities to facilitate use of the Medicaid Program?

16. Does your Medicaid program purchase case management or care coordination services for children receiving behavioral health services? If yes, please describe the conditions for payment and if Tribes and Tribal organizations have access to this payment source.

17. Can you suggest any strategies that could be implemented with the Tribes or Tribal organizations to help them sustain the Tribal system of care in your State?

For more information, contact:

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