

Montana's Urban Indians Face Health Care Barriers



By Carrie Tracy

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Executive Summary

Montana's health care providers and elected officials are closing their eyes to a health care crisis in our state. Montana's Indian people suffer elevated rates of disease, mortality, and infant mortality compared to people of other races. These health disparities are not unique to Montana; Indian people across the United States, like other people of color, suffer disparate levels of illness and mortality. These health disparities are not based on genetic differences or income levels; they are the result of racism on many levels. Such racism manifests itself in interpersonal encounters between patients and health care providers, institutional policies and practices that create barriers, and structural racism underlying health care institutions, our system of health coverage, and other factors outside the health care system.

Indian people in Montana have long confronted barriers that prevent them from accessing needed care. The Northwest Federation of Community Organizations conducted research to determine what these barriers are and how commonly people encounter them. Research staff conducted a review of data, articles, and research studies and conducted in-depth interviews with 46 Missoula residents. This research shows that barriers are both formidable and common.

Report Findings

- The considerable disparities in health outcomes and access to health care that Indian people in Missoula experience are the result of racism at many levels – interpersonal, institutional, and structural.
- Indian people in Missoula are prevented from getting needed care when providers and staff treat them with hostility, discrimination, and a lack of cultural competency resulting from interpersonal and institutional racism.
- Uninsurance, underinsurance, and underfunding of the Indian Health Service that prevents people from getting the care they need is a result of structural racism.
- Historical and contemporary racism inside and outside the health care professions create structural barriers to good health for Missoula's Indian people.

Recommendations

The report highlights best practices for addressing the multiple levels of racism that lead to health disparities.

Missoula's providers can address issues of interpersonal and institutional racism in their facilities by:

- Increasing the diversity of personnel, from the front desk to the examining room, to make their

facilities more welcoming to diverse clients and to increase the cultural competency of the staff.

- Training and holding accountable all staff to serve patients in a respectful and culturally competent manner.
- Developing quality assurance programs that hold doctors accountable to performance standards and track racial disparities in health care provision.
- Increasing health care providers' understanding of Native American traditional medical practices and ways to integrate these practices into Western medical treatment.

Missoula's health care providers and elected officials can address structural barriers that prevent people from accessing quality care by:

- Educating Indian people and health care providers about health coverage that is available to Indian people.
- Increasing funding for the Indian Health Service and other public health programs like Medicaid, which provide coverage for more Indian people in Missoula than do employer-based private coverage.

Introduction

Montana's health care providers and elected officials are closing their eyes to a health care crisis in our state. Montana's Indian people suffer elevated rates of disease, mortality, and infant mortality compared to people of other races. These health disparities are not unique to Montana; Indian people across the United States, like other people of color, suffer disparate levels of illness and mortality. These health disparities are not based on genetic differences or income levels; they are the result of racism on many levels. Such racism manifests itself in interpersonal encounters between patients and health care providers, institutional policies and practices that create barriers, and structural racism underlying health care institutions, our system of health coverage, and other factors outside the health care system.

Indian people are a significant part of Montana's urban and rural communities. Montana is home to 58,000 American Indians and Alaska Natives, 6.5 percent of the state's population.ⁱ There are seven reservations in Montana, all located in relatively rural areas. Many Native Americans live in Montana's urban areas; in total, about 8,500 American Indians and Alaska Natives live in Billings, Great Falls, Helena, Missoula, and Butte.ⁱⁱ

Indian people in Montana have long confronted barriers that prevent them from accessing needed care. The Northwest Federation of Community Organizations conducted research to determine what these barriers are and how commonly people encounter them. Research staff conducted a review of data, articles, and research studies and conducted in-depth interviews with 46 Missoula residents. This research shows that barriers are both formidable and common.

The first barrier to good health care is financial: too many American Indians and Alaska Native

people are uninsured. The resources available through the Indian Health Service are inadequate to cover all the people and services it is meant to cover. Many people, both health care providers and Native American people, do not understand what coverage is available through the Indian Health Service. Other barriers are cultural. Doctors and staff that do not understand cultural and spiritual beliefs of Indian patients cannot provide adequate care.

Finally, many urban Indians in Missoula report that they are treated badly based on their race when they try to access health care. Racism persists in Montana, and Indian people report that they face reactions ranging from discourtesy to outright hostility from health care providers and staff. This hostility inhibits Indian people from seeking care until health problems reach crisis point. Consequently, racism leads providers and staff to deny care to urban Indians in Missoula.

Methodology

Data and Literature Review

Research staff conducted a review of data, articles, and research studies on health disparities impacting American Indians and Alaska Natives in Montana and in the United States overall. This research can be grouped in three categories:

- Research detailing the scope of health disparities between Native American people and people of other races in Montana and in the United States.
- Research that identifies the causes of these disparities.
- Research that assesses proactive solutions.

Individual Surveys

The findings of this report are primarily derived from interviews of 46 Native American people living in Missoula, Montana. Interviewees completed a questionnaire with 36 questions, some of which were derived from the Commonwealth

Fund 2001 Health Care Quality Survey. The form included closed-ended questions and open-ended questions designed to surface information about respondents' experiences with health care, including:

- Existing health conditions
- Insurance status and sources of insurance
- Health care providers
- Racial composition of health care provider staff
- Cultural competency of health care providers
- Experiences with racial discrimination in the health care setting
- Satisfaction with health care providers
- Involvement in decisions about health care
- Race and gender preferences in providers
- Access to tests and treatment

Interviewees were recruited through community institutions including the Missoula Indian Center and the Missoula School District's Indian Education Program. The research team identified additional interviewees through the family and social networks of interviewees.

Focus Groups

The research team conducted two focus groups to obtain a more complete description of individual's experiences in accessing health care in Missoula. In total, 21 people participated in the two focus groups. All of the participants were women. The research team prepared a list of questions to guide the conversation and recorded participants' answers in writing. The questions included:

- How long have you lived in Missoula?
- Do you have health insurance?
- Where do you go for health care?
- Where have you gone in Missoula for health care?
- What have your experiences been with Missoula health care providers?

Key Informant Interviews

The research team interviewed nine key informants in the Missoula area to obtain a more complete picture of the barriers American Indians and Alaska Native people encounter in the health care setting. These key informants included four health care providers, staff at the Missoula Indian Center, service providers, and current and former health care facility executives.

Health Disparities

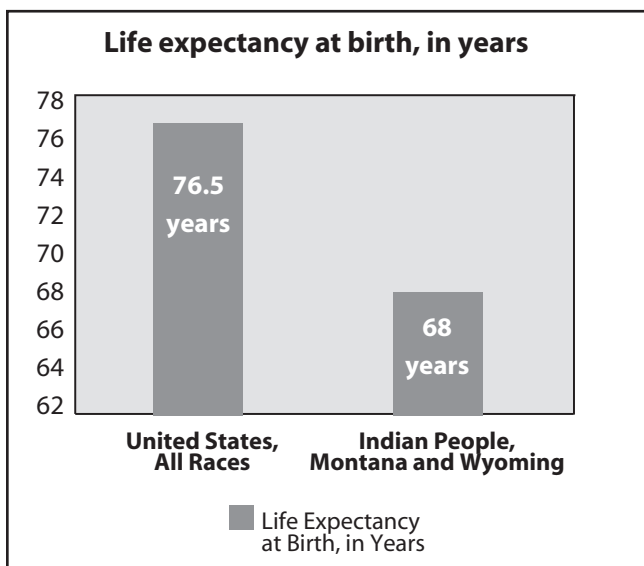
There is clear and undisputed evidence of disparities in health conditions and health outcomes related to race in the United States today. American Indians and Alaska Natives nationally have higher rates of many diseases and health conditions than do other Americans. For example, American Indians and Alaska Natives are twice as likely to have diabetes as white Americans.ⁱⁱⁱ American Indians and Alaska Natives nationally report higher rates of hypertension, diabetes, cardiovascular disease, and high blood cholesterol.^{iv} Rates of many diseases and health conditions are rising rapidly among American Indians and Alaska Natives, despite the many advances in medicine in the last century. Before World War II, diabetes was uncommon among American Indians and Alaska Natives; today almost 10 percent of American Indians and Alaska Natives have diabetes.^v

These higher rates of disease lead to higher mortality rates among American Indians and Alaska Natives. Not only are American Indians and Alaska Natives more likely to have diabetes; they also die of the disease at four times the rate for all U.S. racial and ethnic groups combined.^{xi} American Indians and Alaska Natives have much higher mortality rates for other diseases, including tuberculosis, cerebrovascular disease, gastrointestinal disorders, and pneumonia and influenza.^{vii}

These national trends are echoed in Montana. The life expectancy for Indian people living on reservations or in counties near reservations in the Indian Health Service (IHS) Billings service unit, which includes Montana, is only 68 years.^{xiii} The life expectancy for all people in the United States is 76.5, over 8 years greater.^{ix} And the infant mortality rate in Montana is higher for American Indians than for any other race.^x

Causes of racial disparities

Some people believe that racial disparities in health are a result of genetic differences between people of different races, or by socioeconomic status. This is not true. All human beings, regardless of race, share exclusively 99.9 percent of their DNA. The Human Genome Project has shown that the remaining .1 percent of genetic



material does not explain racial disparities in rates of disease.^{xi} And while health status is related to socioeconomic status for many reasons, including access to health care, environmental factors, workplace safety, and nutrition, this relationship does not explain all of the disparities; even when income, age, and education level are the same, people of color experience different health outcomes.

Racism impacts people’s health at many levels, from personal encounters with health care providers to systemic problems like lack of access to health coverage.

Patients encounter interpersonal racism that affects their health care when:

- front-desk staff make them feel unwelcome
- a provider chooses not to perform tests or recommend a course of care because of individual biases or stereotypes

Patients encounter institutional racism in the health care industry when:

- they are unable to access health care because of geographic or financial barriers
- they are unable to find a provider who will provide culturally appropriate care
- they are unable to find a Western medicine provider who can help them integrate traditional medical practices into their treatment

Structural racism impacts people’s health through:

- lack of access to good paying jobs with health benefits
- geographic or financial barriers to eating a healthy diet
- community design and segregation that leaves people of color living in unhealthy locations
- stress and other problems created by historical and current experiences with racism in all aspects of everyday life
- lack of access to high quality education

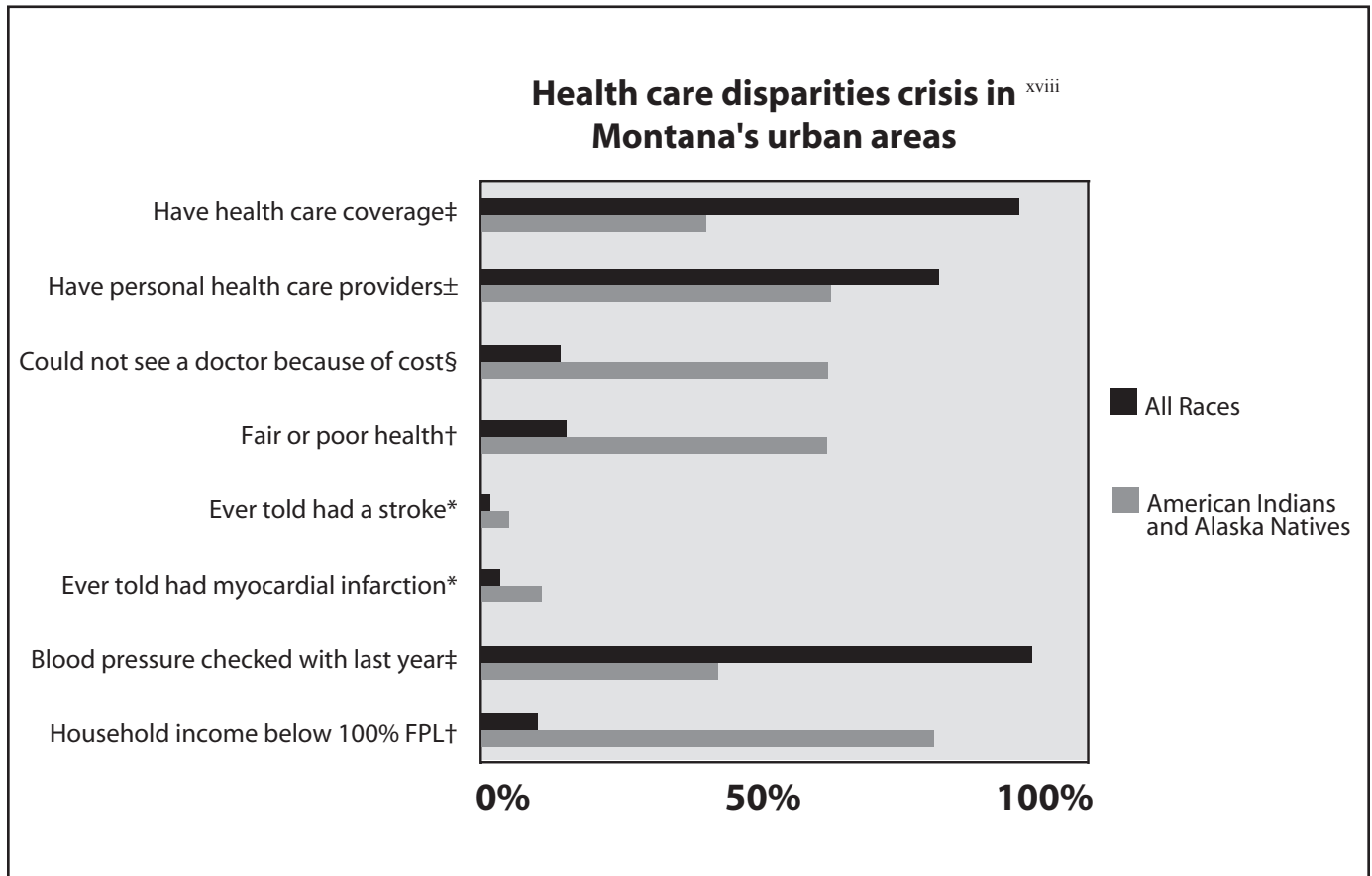
In its report “Broken Promises: Evaluating the Native American Health Care System,” the U.S. Commission on Civil Rights found that racism, racial bias, and the mistreatment of Native Americans cause health disparities.^{xii}

Montana’s Urban Indians in Poor Health

Any attempt to reduce health disparities must address the health needs of urban Indians. In 1955, more than 95 percent of Indian people lived on or near their home reservations.^{xiii} Today, almost 70 percent of American Indians and Alaska Natives live in urban areas.^{xiv} According to the 2000

census, 3,243 American Indians and Alaska Natives lived in Missoula.^{xv} Nearly one in four urban Indians living in an area served by an Urban Indian Health Organization (like Missoula’s Indian Center) lives in poverty.^{xvi} Poverty rates for urban Indians in Missoula are even higher – about 30 percent of Indian people living in Missoula live in poverty.^{xvii}

As the chart below shows, American Indians and Alaska Natives living in the five urban areas of Montana served by Urban Indian Health Organizations (Missoula, Billings, Butte, Great Falls, and Helena) suffer from serious disparities in access to health care and health conditions.





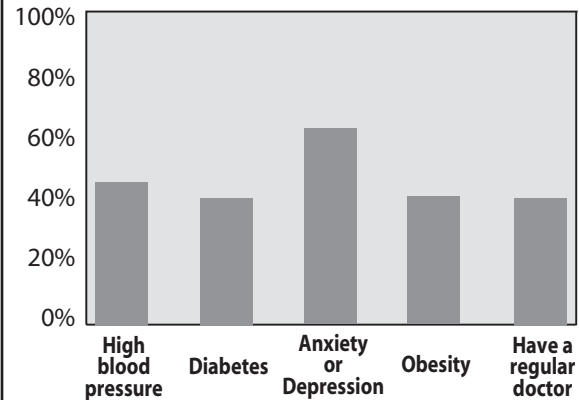
Peggy Cochran
Executive Director
Missoula Indian Center

Staff at the Missoula Indian Center do a lot of case management and outreach in order to get our clients to seek out preventive and primary care. Much of the problem consists of cultural issues. When you are from a reservation, you've grown up to know the reservation health care system. You know that you will be seeing Native American staff and doctors. It is intimidating to move to an urban area and walk into a facility where the providers are different than those you are accustomed to. It takes a lot of effort by our staff to get people to seek care in the Missoula health care system.

Missoula's health care providers need to have cultural training as part of their in-service trainings. In particular, doctors and nurses at emergency rooms need to learn about cultural issues. Sometimes Native Americans' shyness is construed by doctors as nonparticipation in their health care. For example, if a Native American does not look the doctor in the face or in the eyes, the doctor may assume that the patient is being difficult or non-cooperative, when the patient is in fact being respectful.

At the Missoula Indian Center we provide a state-certified chemical dependency program, referrals to health care or social service providers, mental health counseling, HIV counseling and testing, and limited assistance for urgent care, dental care, and optical care. If the IHS funding were cut, we would have to close our doors or dramatically cut services.

Missoula's Indian people report high rates of chronic disease but few have regular providers



A Closer Look at Disparities – Missoula Case Study

The health problems urban Indian people in Montana face is demonstrated in statistics on Missoula residents and in the results of our interviews with Missoulians. As these sources indicate, Indian people in Missoula have serious health problems but are not getting the care they need for these problems.

Missoula's American Indians and Alaska Native residents have very high rates of certain diseases. Forty-five percent of the people interviewed reported having high blood pressure. Thirty-nine percent have diabetes. Sixty-five percent have been diagnosed with anxiety or depression, and forty-five percent have been told by a doctor that they are obese. Despite these high rates of health problems, sixty percent of the people we interviewed said that they did not have a regular health care provider.

As a result, American Indians and Alaska Natives in Missoula are going without necessary treatment and critical preventive care. Only 37 percent of the people we spoke to had received a complete physical exam in the previous year. Twenty-six percent had not had a physical in over five years, and seven percent said that they had

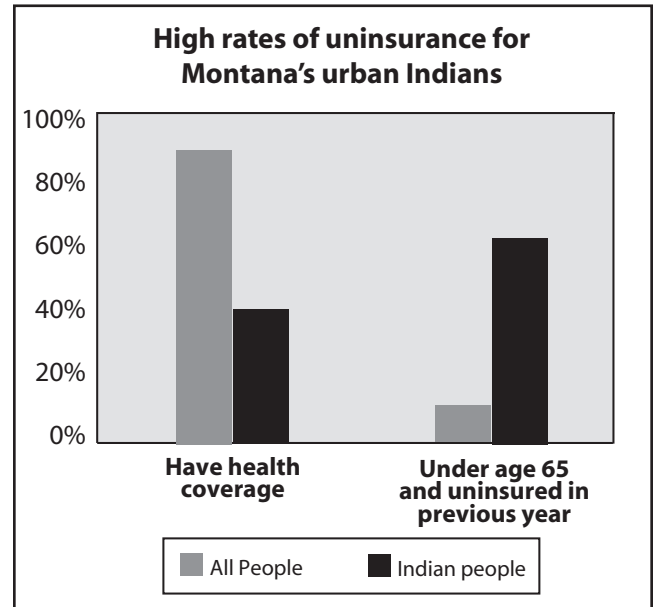
never had a complete physical exam. Only 47 percent of women reported receiving a pap test in the previous year; eight percent said that they had not had a pap test in more than five years, and 11 percent had never had one.

programs, while only six percent of white respondents relied on public coverage.^{xix} Eighty-three percent of white respondents were covered through employment or other coverage, while

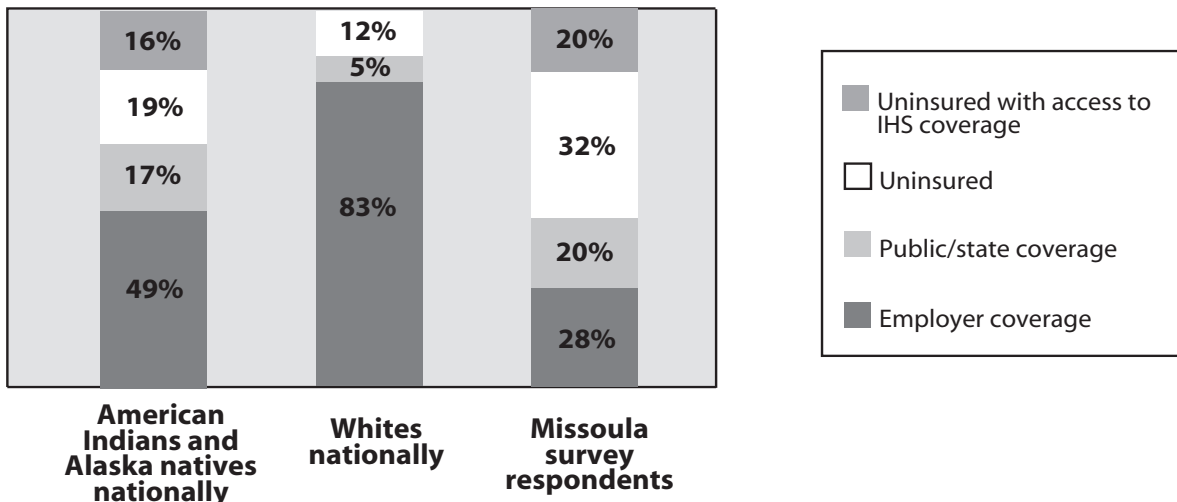
Uninsurance, Underinsurance, and Under-funding of Indian Health Service Keeps People from Receiving the Care They Need

Indian people in Missoula have high rates of uninsurance or underinsurance.

Nationally, American Indians and Alaska Natives are less likely to have health care coverage than people of most other races. A national survey conducted in 1997 and 1999 found that 17 percent of American Indians and Alaska Natives were covered through public health care



Indian people more likely to be uninsured or covered by public programs



I don't care what race my doctor is, but I think it would be better for Indian people if medical places had some staff who were people of color, especially staff like receptionists and schedulers. It is much less intimidating when you walk into a place like a hospital to see someone of your own color who has had the same experiences and can be more sympathetic about issues like these.

– Jane Curtis

only 49 percent of American Indians and Alaska Natives were.^{xx} Sixteen percent of American Indians and Alaska Natives reported that they were uninsured but had access to IHS coverage, and 19 percent were uninsured with no access to IHS coverage.^{xxi} Low-income American Indians and Alaska Native families were half as likely to have employer or other non-public coverage as low-income white families.^{xxii} As a result, American Indians and Alaska Natives reported greater problems accessing health care and lower utilization of health care than white respondents did.^{xxiii}

Urban Indian people in Montana are more likely to be uninsured than are other urban residents. In the five areas of Montana served by Urban Indian Health Organizations (UIHO), 42 percent of American Indians and Alaska Natives reported that they had health coverage, while 88 percent of all residents were covered.^{xxiv} Sixty-two percent of American Indians and Alaska Natives under the age of 65 reported that they had had no health insurance in the

previous year, while only 15 percent of all people reported that they had been uninsured in the past year.^{xxv}

Uninsurance rates were even higher among survey respondents. Fifty-four percent said they were uninsured. Twenty-nine percent of those with insurance said they were covered by Medicaid, and 13 percent said they were covered by Medicare. Forty percent of respondents said they received care through the Indian Health Services. Forty-four percent of respondents said that they go to Partnership Health Center for care, the community health center with which the Missoula Indian Center has contracted to provide care.

Even when respondents did have access to care, they did not always receive complete care. Thirty-seven percent of the people we interviewed said that they had not followed a provider's advice or treatment plan, have a recommended test, or see a referred doctor. Among these respondents, 67 percent said that the reason they did not follow the provider's advice was because they could not afford to do so.



Sandy Hirning

I have insurance through work but it doesn't cover much. Last year it paid for my first surgery for a diabetes-related problem. My joints were starting to freeze up. They would not do the surgery. My insurance paid for a lot but I ended up responsible for \$4,500 for the surgery. A few months after the surgery they sent me to collections because I could not pay it off.

My husband works in construction and was laid off for four months last year. We are behind on our mortgage and utility payments and it's hard to keep food in the house. My stepson is a teenager with a healthy appetite, and I am supposed to eat well to control my diabetes. The food bank runs out of food. Then I go to the clinic and they say I earn too much money!

I've run out of my anxiety medication but I would have to go see a doctor to get the prescription refilled and I can't afford to do that. I also have asthma. Sometimes I get the prescription but do not fill it right away because I can't afford to. When I need the

medication, I find that the prescription has expired and I can't afford to go to the doctor to get it renewed. About eight months ago my insurance through work decided not to cover my prescription for upper reflux unless I prove that I have it, but I can't afford the test.

I've had one bad experience with a doctor being rude to me because of my race. I went to see a white doctor I did not know because I had a bladder infection. She walked in the room and did a double take. She barely talked to me and avoided touching me. When she did speak she was very short with me. It made me so uncomfortable that I decided I would never go back to her. I couldn't pay her bill and she put me in collection. Later I had to see a general practitioner and she was the only doctor available that my insurance covered. I went to the office and paid my \$25 copay. The front desk person went in back and talked to the doctor and she refused to see me unless I paid in full first. I walked out sick without seeing her. My specialist then sent me to another doctor and I went to them not knowing if my insurance would cover it.

I've had diabetes for 29 years. It is very hard to control, and an insulin pump costs too much - \$5,000. The doctor told me that I was very close to having diabetes-related kidney disease. Lately every weekend I spend one day so sick I can hardly get out of bed because I am really nauseated and exhausted. I am afraid that means that I have kidney disease now but I'm afraid to find out, and I can't afford to go to the doctor to get tested. I have been thinking about giving up and getting declared disabled because it is so hard just to get through a day. Sometimes I think I would rather die than go through all this.

Kathy Reddies

Two years ago I was uninsured. I had an abnormal pap smear so I went to Partnership Health Center. They gave me a year's supply of estrogen pills and sent me home. A year later, I went back. This time I had coverage through Blue Cross. They started to give me the same treatment, until they found out I had insurance. They referred me to a specialist instead. It turned out I had cancer and had to have a hysterectomy. They delayed my treatment for over a year because I didn't have insurance. In those 15 months that they weren't treating my cancer I had continual bleeding. The estrogen made me bleed even more. By the time I went to the specialist my iron was so low that the doctor said they couldn't see how I could get out of bed. I was really anemic and bruised really badly. In general, I have been very dissatisfied with the care I have received at Partnership. I have had questions for my doctor that I have not asked because the doctor was in too much of a hurry to listen. The doctor is polite enough, but the nurse is very rude. I believe that I have been treated with disrespect both because of my lack of insurance and because of race.

Jane Curtis (pseudonym)

Two years ago, my daughter Sarah was living in Missoula because she was at the University. She was too old to be covered by our insurance, and she declined the school insurance – I don't know why she did that. I was in Great Falls when she called and told me she was sick and needed help but the hospital would not treat her. She had gone to St Patrick's Hospital a couple of times and they turned her away because she was uninsured. I drove to Missoula and went to the hospital with her. They told her to go to the reservation to get care. They had not asked us our race,

and our last name doesn't "sound Indian." They just assumed from looking at us that we were Indian. I am not enrolled Flathead, so going to the reservation was not an option. I got angry and kept asking the lady what they expected her to do. They suggested that she go to Partnerships but it was late at night and it was closed. Finally I said I have a checkbook, and then Sarah got to see a doctor. They gave her a prescription for an antibiotic and we filled it at the hospital, which was expensive. I made an appointment with an oral surgeon in town. They would not take a look at her until I assumed responsibility for the debt and gave them my Visa card. She had an impacted wisdom tooth and they ended up taking out all four.

I have an aunt who is very dark skinned and quiet. She stands in lines and twenty people will jump in line in front of her and she will not say a word. If you are a little dark skinned and wear "ethnic looking" jewelry like turquoise, people in the medical profession, banks, restaurants, assume that you are Indian. That assumption determines the type of care you get.

Survey respondents reported that they felt they were treated differently because they were uninsured or unable to pay for care.

Fifty-five percent of survey respondents said that a doctor or medical staff person judged them unfairly or treated them with disrespect because of their inability to pay for care or the type of health insurance they had.

Marie Smith (pseudonym)

I go to Partnerships for health care and I get coverage through the Indian Health Service. I feel like I am disrespected because of my coverage. The last time I got sick and went to the doctor, I felt that he did not really listen to me. He seemed to overlook what I was saying. He just looked at my throat really quickly and dismissed me with “It’s viral. In a few days you won’t be sick. Come back if you are.” I was sick for a month and a half. Being dismissed like that just makes me think, next time I get sick, that there’s no point in going to the doctor – it’ll just be like last time. It’s a waste of time and money to go to Partnerships. You have to wait so long to see someone that by the time they see you you’re not sick anymore.

Survey Responses

Sometimes before they ask about my insurance status I end up waiting for a while. Once they find out that I have insurance the process speeds up.

A person with health care insurance would have faster and better service.

My brother was in a bad car accident and was taken to St. Patrick’s Hospital. They discharged him with a broken neck because he had no insurance. Doctors at Community Medical Center were shocked that he was discharged in that condition and did a lot of stuff St. Pat’s didn’t do before sending him home. Craig Meyers

Indian Health Service funding cannot cover all urban Indian health care needs.

While many people believe that all American Indians and Alaska Natives receive free and comprehensive care through the IHS, this is not true. The federal government has a legal obligation to

provide health services to members of federally-recognized tribes, based on the Constitution, treaties, laws, Supreme Court decisions, and Executive Orders.^{xxvi} The IHS provides primary care services and some specialty services without charge to 1.5 million American Indians and Alaska Natives through clinics and hospitals on or near reservations.^{xxvii} But another 2.6 million American Indians and Alaska Natives are not served at all by the IHS. Some of these 2.6 million are not eligible because they are not enrolled in or descended from members of federally recognized tribes. Others do not live close enough to IHS facilities to access services.^{xxviii}

Urban Indian Health Organizations (UIHO) serve an estimated 150,000 Native Americans, or six percent of the American Indians and Alaska Native population, even though 25 percent of American Indians and Alaska Natives live in areas served by UIHOs.^{xxix} Montana has five cities served by UIHOs: Missoula, Billings, Great Falls, Helena, and Butte. The IHS allocated only about one percent of its annual appropriations for urban programs between 1979 and 2004.^{xxx}

IHS-funded clinics and UIHOs do not have enough funding to meet all of the health care needs of the people they do cover. In 2003, the IHS had a budget of \$2.9 billion. One study in 2002 found that the IHS would need an additional \$1.8 billion to provide everyone who uses the IHS’s services with benefits equivalent to those provided by the Federal Employee Benefits Plan.

Instead of increasing funding to meet this need, President Bush’s 2007 budget (released in early 2006) proposed cutting \$33 million from the Indian Health Services budget, eliminating funding for the 34 UIHOs around the country.^{xxxiii} This proposal would have eliminated the funding, about \$4 million, for Montana’s five UIHOs, which serve up to 7,000 patients each year.^{xxxiv}

The budget proposal assumed that these 7,000 patients would turn instead to community health centers, which are federally-funded clinics



Tina Snell

Even though I work full time I do not have insurance because I can't afford the insurance available through my work. My kids have no insurance, either. Last year, my son injured his leg playing football. At the time he and my husband were going to Ft. Belknap, 300 miles from here, so he had an x-ray at the reservation health facility. They want to see him again in three months to see how it has healed, but it will be very difficult to get him there again.

Because we do not live on the reservation, the only care I can get paid for through the reservation is my prescriptions. I can pick them up at St. Ignatius Hospital for free but it is a 49 mile drive from here. When I was screened at the Indian Center last year they told me that I am in the beginning stages of diabetes but I can't afford follow-up tests.

I used to go to Partnerships but I never felt like I was getting the proper treatment. It felt like going to the clinic on the reservation. There you make an appointment but then wait around for hours to be seen. The doctors are rushed because they're volunteering their time. I'm afraid that if I go to Partnerships for my fibromyalgia and IBS I would not get the same care as I would if I had insurance and could see the specialists who understand those problems. I have to see a specialist for my fibromyalgia. I have not seen her in a year because I don't have insurance to cover it, and that is very scary.

that provide primary and preventive health care services to underserved populations. Missoula's Indian Health Center contracts with a community health center, Partnership Health Center, to provide care to urban Indians in Missoula. Community health centers, which receive federal funds through the Department of Health and Human Services, are also chronically under-funded. Asking these safety-net providers to absorb additional patients without additional funding is unrealistic. Congress rejected the President's proposal and continued funding the UIHOs. Many advocates expect the White House to propose these cuts again when the 2008 budget proposal is released in early 2007.

Indian People in Montana Do Not Have Adequate Access to Effective Mental Health Care and Substance Abuse Counseling

American Indians and Alaska Natives are at higher risk for mental health disorders than other races in the United States, but they have much more limited access to mental health services.^{xxxv} The most pressing mental health issues for American Indians and Alaska Natives today are substance abuse, depression, anxiety, violence, and suicide. But there are only 101 mental health professionals available per 100,000 American Indians and Alaska Natives, compared with 173 mental health personnel per 100,000 whites.^{xxxvi} The consequences of this gap are dire; the suicide rate for American Indians and Alaska Native youth is twice that of youth their age in the general population.^{xxxvii} Montana ranks third in the nation for annual suicide deaths.^{xxxviii}

Montana is seventh in the nation for rate of deaths in which alcohol is a cause.^{xxxix} Montana's alcohol-related automobile accident fatality rate is fifth in the nation.^{xl} And the need for alcohol treatment in Montana is unmet – while Montana ranked seventh in the nation in one measure of need for alcohol treatment, it ranked 32nd in a measure of the rate of alcohol treatment clients.^{xli}



Marquetta (Kitty) Felix
Outreach Worker/Case Manager
Missoula Indian Center

Many urban Indian people do not know what Indian Health Service care they are eligible for. According to federal regulations, when you leave the reservation, you should be covered for 6 months by contract care paid for by the reservation health budget. A lot of times people don't know that so they are not tapping into that service. A lot of students don't know that they are eligible for contract care services for the duration of their studies if they move from their home reservation to Missoula to study. The procedure you go through to get approval for services varies from reservation to reservation. Knowing what services you're eligible for is one thing. Accessing the services you're eligible for is another thing. Sometimes I when I advocated for a student to get care covered through contract care, I was told that there was no money left, or that the service doesn't fall within the reservation's priorities. Some reservations ask students to come home over the summer to get preventive care and services that can wait. When people aren't eligible for contract care, the Missoula Indian Center may be able to help.

Provider and Staff Confusion About Indian Health Service and Coverage Prevents People From Getting Care They Need

Many people said that they had difficulty accessing care because providers and staff did not understand what services are covered by the Indian Health Service. They also found that providers and staff did not understand the process for accessing IHS coverage. Some reported that they were turned away or told to go to a reservation for care. Others reported that they were treated with disrespect or made to wait for care because they were covered by IHS.

Some of the people interviewed also said that they felt that some of the disrespectful treatment they experienced from staff at health care facilities originated in a mistaken belief that Native American people have better access to health care than other people in the United States because of the Indian Health Service.

Survey Responses

I felt that I was treated with disrespect because of my race and ability to pay for care when I went to see a doctor and was told that I should just drive up to Ronan (a city on the Flathead Reservation) and see the doctor there. The staff members in hospitals and at Partnership don't seem to know what Indian Health Service is, and that causes long waits and short visits with the doctor.

Providers' Lack of Understanding of Cultural Issues Prevent Indians from Getting Needed Care

Providers and staff at Missoula's health care facilities do not understand key aspects of Indian culture and these misunderstandings prevent Indians from getting the care they need

Many survey respondents do not feel that Missoula's providers are able to treat them in a culturally appropriate manner. Eighty-one percent of respondents said that none of the staff or providers at the facility they usually go to for care are of their own race and ethnicity. Forty-seven percent of respondents said that their doctor does not understand their background and values.

This cultural competency gap results in serious communication problems between providers and their Native American patients. Less than half of respondents (49 percent) said that their doctor listens to everything they have to say.

Only 57 percent said that their doctor involves them in decisions about their care as much as they want to be involved. Thirty-eight percent said that they had had questions about their care or treatment that they wanted to discuss with their provider but did not.

One result of providers' failure to listen to patients and engage them in treatment decisions, patients report, is that they do not always follow their doctor's advice. Thirty-three percent of respondents who have failed to follow a doctor's advice or treatment plan, get a recommended test, or see a doctor, did so because they disagreed with the doctor. Another 17 percent of respondents failed to take advice because they did not understand it.

Survey Respondents Indicate Missoula Providers Need Improvement on Key Indicators of Cultural Competency

	YES	NO
Have you had questions about your care or treatment that you wanted to discuss with your provider but did not?	38	62
Does your doctor understand your background and values?	53	47
Are there staff or providers at your regular care facility that are of your race or ethnicity?	19	81
Does your doctor listen to everything you have to say?	53	47

Survey Response

My sister and I were seeing the same doctor at Partnership. She put both of us on glucophage, a medication. We both told her that we didn't want to take it because it caused us pain. She told each of us that she had never heard another patient tell her that. She didn't listen to anything you said. I quit taking it. Every time you saw her she wouldn't talk to you doctor to patient. You just had to take care of yourself.
Lauretta Brown

Focus Group story

I took my son to the dentist because he needed care. We have Medicaid coverage. My son was being seen by the dentist when I started to worry that we would miss the bus home. The buses in Missoula are not always convenient, and I was afraid that the appointment would take so long that we'd miss the last bus. The receptionist seemed to ignore me so I asked again. The receptionist rudely told me that I would have to ask the nurse. I explained that I just needed to know in case I had to call for someone to pick us up if the busses were no longer running. The receptionist left the room and after some time returned to her desk but didn't say anything to me. So I asked again. The receptionist again left the room, without saying anything to me, and returned with a woman who I guessed was the nurse.

The woman sternly told me to stop "harassing the receptionist with questions." I explained why I wanted the information and was told to "just sit down and wait." By the time the dentist finally finished working on my son the busses had stopped running. The dentist came out with the nurse but not with my son. I asked the receptionist if I could use the phone to call a family member to come and pick us up. The dentist then asked me who would be caring for the

child at home. I said I would. He then asked what my "qualifications" were to take care of a child who had had such dental work done. I explained that I have five children and felt that I am well qualified to take care of my children.

I felt threatened and asked for my son. The dentist told me to "calm down." I asked why they were doing this to me and the dentist said that they didn't think I was capable of caring for my son. On the verge of panic, I demanded that they get my child because I could hear him crying. The dentist said that if I didn't settle down they would call the police and child protective services to take the child. My brother then entered the office and the situation quickly changed as the nurse got my son and we were finally able to leave.

I don't believe this would have happened if I were not Native American, so I asked IPA for help. When they talked to the dentist he went straight to defensive mode and told them that his wife had "grown up on the Blackfeet reservation" and that "they've treated many Indians and have never had a problem." I think these stereotypical beliefs and individual prejudices need to be changed and that this could be done through ongoing training that addresses the issue. I also feel that health care providers who act this way should be held accountable for their behaviors and actions. This experience has taught me never to go alone to clinics or hospitals, and to be certain that I always have a "witness" with me. We need to feel confident that complaints will be taken seriously. My experience has been that the Indians are not believed when accusing or confronting non-Indians. Everyone assumes we are lying or that we have imagined things. People like this dentist need to stop lumping all Indians together and stop being so judgmental.



Marquetta (Kitty) Felix
Outreach Worker/Case Manager
Missoula Indian Center

I help Indian people who come to the Indian Center get health care by referring them to providers and authorizing their care with Indian Health Service coverage. I have seen my clients struggle with cultural barriers at some of the providers' offices in town. Indian people can be very shy. Our clients tend to be modest and gentle in their approach, and sometimes very soft-spoken so you have to get real close to hear them. Your approach to them has to be gentle, too.

Once I sent a client to Partnership for care. I faxed the authorization or sent it with him – I don't remember which. I don't know exactly what happened, but he sat and waited for four hours. No one offered him any help or asked if he needed anything for all that time. I brought it to the attention of the staff there.

Recently I referred a client to NowCare, an urgent care facility that we have a contract with. She had an oozing breast lump and had been putting off getting any care. I sent her to the urgent care facility because it seemed like she needed immediate attention. Her husband went with her to NowCare. Afterward, he told me that the person at the desk talked about his wife's health problem in front of other patients, and sent her away saying that they don't cover female care. Her husband had been trying for a while to get her to go to the doctor, and as soon as she did look what happened. Luckily he was with her and convinced her to come back and tell me what happened – I think that she would have just gone home and never followed up because she was so upset by what the staff person said to her. I sent them to another urgent care facility we did not have an agreement with and they took care of her and she is signed up for follow-up care.

I complained to the person's supervisor and the supervisor said her employee would never have done that. She was going to take the employee at her word and decided not to follow up on my complaint.

Focus Group story

My brother stayed at St. Patrick's Hospital when he was dying of liver disease. For many Plains tribes, it is tradition to surround the sick and dying with family. Family members will stay throughout the illness up to the actual time of death. They will visit, speak of "old times," pray, and may even share a last meal with the family member, even if the loved one is unaware of their presence.

My family remained with my brother and when visiting hours were over, we stayed in the various waiting rooms throughout the hospital because we could not afford to get motel rooms. Hospital staff got hospital security to ask us to leave and when we said we wanted to stay near my brother, the nurse called local police who then threatened arrest if we didn't leave. They also told us we could not park in the parking lot overnight.

We also had to endure negative and insinuating comments from some hospital staff. Some providing care made assumptions that the ailing man had "probably drank himself to this state – they all do" and other comments such as "you'd think these people would know better." Additionally, we felt that some nurses offered little compassion. It almost seemed as though they did not want to touch my brother.

The hospital should allow for more than one family member to stay with a loved one. I wish the hospital policies reflected that different cultures do things differently. We are not asking that hospitals change their rules but that they be willing to be flexible. The way we were treated made it seem as though we were being unreasonable by wanting to be with our loved one as he left this world. We were not being disruptive. People sat by his bedside and spoke in low voices, but we were made to feel as though we were creating a terrible disruption. The experience was terrible and I will do all I can to never have to use the facility again.



Gail Gilman, RN
Community Medical Center

I work in the rehab department, where we care for people who have had traumatic injuries.

We try to be attentive to our patient's cultural and spiritual needs. We have people of many cultures in this area, including Hmong people, Hutterite people, and Indian people from many tribes. There are some aspects of Indian culture that providers have to understand to provide good care. For example, I have learned to expect that when a Native American patient comes in to our department they will have a lot of people come with them. While other patients might have just one or two close family members visiting, an Indian patient will have their whole family around to support them. Sometimes our staff has different expectations than these visitors have. Late at night when we think it is time for our patients to settle down and for visitors to go home, our Indian patients still have visitors, with children running around and family keeping the patient company. We might ask visitors to quiet down at times, but we try very hard to make sure that our department is a place where this custom is welcomed. We also have patients from Hutterite communities nearby whose whole families come to support them as well. This emotional and spiritual support is an important part of a patient's recovery. It also helps to have family members present a lot to learn to help with a patient's care, because our patients have long recovery processes. I think we do a good job of facilitating family visits, but I do not know if all facilities do the same.

Historical and Contemporary Racism Affect Indian People's Ability to Access Care

Historical racism in the health care system and personal experiences with racism in health care have left Montana's Indian people with a legacy of distrust of the medical profession.

J.T.

Once when I was living on our reservation I split my lip open on barbed wire and needed stitches. I went to the clinic there and the doctor who treated me thought it was a waste to use anesthetic. I had to have it stitched without any painkiller. After he was done, he told me "now you know what a fish feels like." I have also gotten care at Partnership Health Center but have been very dissatisfied with my care there. In the past, I have felt that doctors and medical staff have treated me with disrespect both because I have Indian Health Service coverage and because of my race. Besides my experience getting my lip stitched, looks and glares from the staff make me feel unwelcome. If I had a choice, I would rather be treated by a doctor who was Native American.

Racism and Stereotypes Continue to Impact the Delivery of Health Care in Missoula Today

Forty-two percent of respondents said that a family member or friend of theirs had been treated unfairly when seeking medical care specifically because of race.

Survey Responses

Clara LaRoque

I have two adult daughters, Sissy and Jean, who are disabled and require constant care. Since I am 86 and cannot take care of them like I used to, I rely on personal care assistants. The agency I work with now is good, but I had trouble with an agency in the past. I wanted to work with a new agency, but every time I called the office they told me the person I needed to talk to was out. She would never return my calls. One day I called and they told me she was out. My daughter, who has a different last name, was visiting and she called a few minutes later and the person who was “out” took her call.

They told me my daughters were not eligible for their services because of some law. We were thinking that we would have to put Sissy and Jean in a home because I could not take care of them by myself. Then I explained the problem to a case-worker who was helping us and she looked into it. She found out that there was no law that made my daughters ineligible. We got signed up for services, and since then I have had no problems like that with the agencies.

My husband has back pains and the doctor said that he was just getting old. I think they thought we wanted pain medicine when he didn't.

Because my dad is an alcoholic they treated him as if was just “another drunk Indian.”

The dentists and nurses seemed to treat me differently by ignoring me. By observing how they treated others made me see how oppressed I am.

Doctor and/or staff assume that I am uneducated, lacking information and/or they don't trust my judgment.

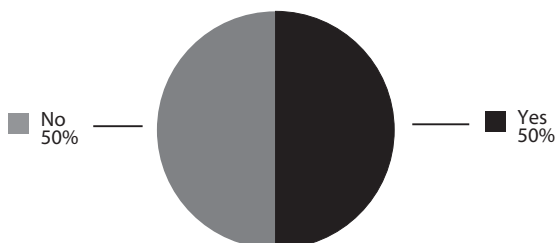
They talk about me as if I were not there.

LOOKS. GLARES.

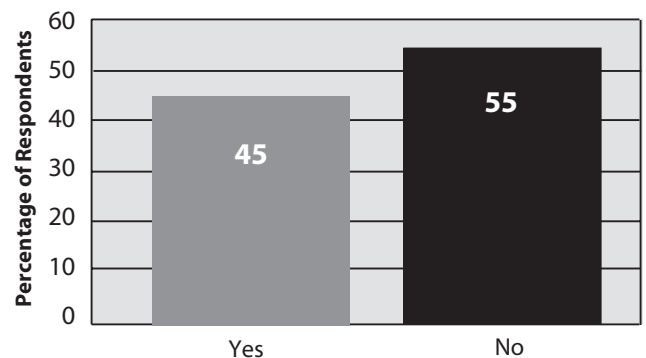
Half of respondents reported that they believe they would get better care if they belonged to another race or ethnic group.

Forty-five percent of respondents said that they have felt that a doctor or medical staff judged them unfairly or treated them with disrespect because of race.

Half of respondents believe that they would have received better care if they belonged to another race or ethnic group



Almost half of respondents felt medical staff judged them unfairly or treated them with disrespect because of race





Sue Harn

Usually I go to Partnerships, but I have had to go to the emergency room at times. Because I have so many health problems, I prefer to see one doctor regularly, so I do not have to keep explaining my story. I had been seeing one doctor for a while, but he traveled a lot so I was unable to see him for almost a year. The last time I went to see him, he acted suspicious about not having seen me for so long. I tried to show him a rash that began as a spider bite, but he would not even look at it. I had questions to ask him about another health problem that was really worrying me, but I was so frustrated by his ignoring me that I forgot to bring it up.

I had a very bad experience the last time I went to the emergency room. I went because I was in a great deal of pain and had run out of painkillers. They served three other people who did not seem to be in such dire need of help as I was while I sat and waited. They just kept me sitting there and from time to time they would ask “so how’s the pain now?” I waited for 45 minutes. Now I think they were calling the other hospitals to see if I had gone there first. A friend had driven me there because I could not drive in such pain, and she became angry. When she confronted the doctor, he let it slip that he did not believe I was in pain – he thought I was just there to get drugs because my blood pressure was so low. I told him that I was controlling my blood pressure by meditating. I have been dealing with chronic pain for so long that I have had to learn ways to get by, and I have learned to use meditation to control the pain and my blood pressure. When I told him that, the doctor said, “uh huh.” So I stopped meditating and let my blood pressure rise, then got it back under control. The doctor watched, and then he believed me.

The only way I can make sense of it is that they have prejudiced ideas about people who look like me. I hate having to prove myself every time. They say other Indians go into the emergency room to try to get drugs, but a lot more white people do and they don’t assume that every white person going into the emergency room is faking the pain to get drugs. It’s frustrating that I’m the one who gets the sideways looks.

Recommendations

1. Increase diversity of qualified staff, from the front desk to the examining room.

Eighty-one of the people who participated in the survey said that the place they regularly go to for health care has no Indian people on staff. Many people we spoke to also said that they felt comfortable going to the Missoula Indian Center because the staff and clients of the Center are Native American and are able to address health issues in a culturally appropriate way. Missoula’s health care providers should recruit diverse qualified staff members for all positions, and make their workplaces welcoming and supporting to a diverse staff.

2. Prioritize serving all patients in a respectful and culturally competent manner.

Native American people in Montana have lived with the state’s legacy of racism in all settings.

Health care providers must overcome these experiences and staff biases to ensure that health care settings are welcoming to Native American patients.

Facilities should:

- Train staff in all departments in cultural competency. Staff should receive this training before their first interaction with patients and annually thereafter.
- Train all staff members using MPA's Dismantling Racism curriculum. Missoula's Police Department has used this training program, which addresses the roots of racism within the community and the individual.
- Train employees to treat all patients with respect and incorporate these expectations in performance standards to which employees are held accountable.

3. Track racial disparities in health care provision.

Alaska's Southcentral Foundation, which provides health care to Native Americans and Alaska Natives in Anchorage, has developed a quality assurance program that holds doctors accountable to performance standards. The system tracks each doctor's percentage of patients who have had immunizations, mammograms, Pap tests, lipid checks, and other screenings and tests, and each doctor is presented monthly with a report. Alongside the doctor's statistics is the clinic average and state and national averages where available. The reports also show the number and age of patients who have received certain services. By tracking how well doctors provide these preventive health care services, Southcentral is able to ensure that patients receive the care they need and reduce catastrophic care costs. Missoula's health care providers, including Partnership Health Center, should institute a similar quality assurance program and include data on race, to track how well they are caring for diverse patients and make changes in their programs to ensure that they are meeting the needs of the community.

4. Educate Indian people and health care providers about health coverage options.

Health care providers and patients are confused by the complex health care coverage system and do not

know what coverage is available to Native American Montanans. This prevents people from accessing the care they need. Montana's tribal leaders, UIHO staff, and health care providers could work together to prepare materials explaining what coverage is available to Montana's urban Indian people. Providers and staff at health care facilities in Missoula should receive training about the coverage options, and this information should be made available to Missoula's Native American community members.

5. Increase access to Native American traditional medical practices.

Montana's Indian people have traditional medical practices that are effective and many Indian people prefer these treatments to Western medical treatments. Traditional practitioners have had great success treating alcoholism and other health problems that are a serious concern for Native American people in the state. Missoula's health care providers should be educated about traditional medical practices of Montana's Indian people and how to integrate these traditional practices with Western medicine.

6. Increase funding for the Indian Health Care Service and other Public Health Programs.

The employment-based health coverage system leaves many gaps for American Indians and Alaska Natives. Nationally, American Indians and Alaska Natives are much more likely to be uninsured and to rely on public health programs and the Indian Health Service for health coverage. The Indian Health Service and public programs like Medicaid are crucial to ensuring that Montana's Indian people have access to health care. The Federal government should fulfill its commitment to providing health care to Native Americans by funding the Indian Health Service at a level that provides all of the care that is needed. Montana should expand Medicaid coverage to all recipients allowed under federal law and use state funds to cover people who are currently excluded.

References

- i US Census 2004 American Community Survey Data Profile Highlights: Montana.
- ii CDC Behavioral Risk Factor Surveillance System (BRFSS) data, analysis by the Urban Indian Health Institute.
- iii *Atlas of Heart Disease and Stroke among American Indians and Alaska Natives 2005*, Centers for Disease Control and Prevention, p. 30. (Hereinafter cited as Atlas of Heart Disease and Stroke).
- iv Youlian Liao, MD, et al., *REACH 2010 Surveillance for Health Status in Minority Communities --- United States, 2001–2002*, Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, August 2004.
- v *Atlas of Heart Disease and Stroke*. In Montana, 13 percent of American Indians report that they have diabetes.
- vi *Ibid.*
- vii Regional Differences in Indian Health, 2000-2001, Indian Health Service, July 2002.
- viii *Ibid.*
- ix *Ibid.*
- x *Racial/Ethnic Disparities in Infant Mortality - United States, 1995–2002, Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, June 2005.
- xi Francis S. Collins, “What we do and don’t know about ‘race,’ ‘ethnicity’, genetics and health at the dawn of the genome era.” *Nature Genetics* 36, S13 - S15 (2004) Published online: 26 October 2004; | doi:10.1038/ng1436.
- xii *Broken Promises: Evaluating the Native American Health Care System*, U.S. Commission on Civil Rights, September 2004, p. 32. (Hereinafter cited as Broken Promises).
- xiii Bonnie Duran, DrPH, “American Indian/Alaska Native Health Policy,” *American Journal of Public Health* 758, May 2005, Vol 95, No. 5.
- xiv *The Health Status of Urban American Indians and Alaska Natives, An Analysis of Select Vital Records and Census Data Sources*, Urban Indian Health Institute, March 2004.
- xv Census 2000 Demographic Profile Highlights: Selected Population Group: American Indian and Alaska Native alone or in combination with one or more other races.
- xvi *Ibid.*
- xvii *Ibid.*
- xviii CDC Behavioral Risk Factor Surveillance System (BRFSS) data, analysis by Urban Indian Health Institute.
* Data only available from 1996-2003
† Data only available from 1993-2003
‡ Data only available from 1991-2000
§ Data only available from 1991-2003
± Data only available from 2000-2003
- xix Steven Zuckerman, PhD, et al., “Health Service Access Use and Insurance Coverage Among American Indians and Alaska Natives and whites: what Role does the Indian Health Services Play” *American Journal of Public Health*, Vol 94, No. 1, 53-59, January 2004. (Hereinafter cited as Health Service Access Use).
- xx *Ibid.*
- xxi *Ibid.*
- xxii *Ibid.*
- xxiii *Ibid.*
- xxiv CDC Behavioral Risk Factor Surveillance System (BRFSS) data, analysis by Urban Indian Health Institute.
- xxv *Ibid.*
- xxvi Indian Health Services Introduction, http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/IHSintro.asp
- xxvii *Health Service Access Use*.
- xxviii *Health Service Access Use*.
- xxix *Broken Promises*, p. 67
- xxx *Ibid*, p. 68.
- xxxi Marsh Lillie-Blanton, DrPH and Yvette Robideau, MD, MPH, Editorial, “Understanding and Addressing the Health Care Needs of American Indians and Alaska Natives,” *American Journal of Public Health*, Vol 95, No. 5, May 2005.
- xxxii Indian Health Service. FEHP Disparity Index.
“Urban American Indian health centers against Bush proposal,” *Missoulian*, February 22, 2006.
- xxxiii *Ibid.*
- xxxiv *Broken Promises*, p. 11.
- xxxv *Ibid*, p. 13.
- xxxvi *Ibid*, p. 13. The study considered youth of 14 to 24 years of age.
- xxxvii Montana Department of Public Health and Human Services.
- xxxviii William McAuliffe, et al., *An Integrated Substance Abuse Treatment Needs Assessment for Montana, Final Report*, North Charles Research and Planning Group, September 2001, p. IV-15.
- xl *Ibid*, p. IV- 20.
- xli *Ibid*, p. IV-23.

Montana's Urban Indians Face Health Care Barriers

About the organizations releasing this report



Northwest Federation of Community Organizations (NWFCO) is a regional federation of four statewide, community-based social and economic justice organizations located in the states of Idaho, Montana, Oregon, and Washington: Idaho Community Action Network (ICAN), Montana People's Action (MPA), Oregon Action (OA), and Washington Community Action Network (formerly Washington Citizen Action). Collectively, these organizations engage in community organizing and coalition building in 14 rural and major metropolitan areas, including the Northwest's largest cities (Seattle and Portland) and the largest cities in Montana and Idaho. 1265 South Main Street Suite #305, Seattle, WA 98144, Voice: (206) 568-5400, Fax: (206) 568-5444, Web: <http://www.nwfc.org>



Founded in 1982, Montana People's Action (MPA) is a statewide economic justice organization with over 6,000 member families in Billings, Bozeman and Missoula. For over two decades MPA has been the primary voice for low- and working-income Montanans around the issues of housing, access to credit and banking services, access to health care, economic development policy, and income security.



Organized as an MPA chapter in 1997, Indian People's Action (IPA) builds the voice of urban Native Americans while working for systematic change to alter the balance of power. With over 350 members in Billings, Butte and Missoula, IPA builds strength in numbers through direct action strategies to impact policies in local and state government, the public school system, law enforcement, and various state and local agencies.