



"For the Benefit, Care
and Assistance..."

How America fails to keep its health care promise

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Dear Reader,

It's a common misconception that Native Americans get “free” health care. Yet the responsibility to provide health care — among other core tenets — to Native Americans throughout the country is deeply rooted in United States history. The stories in this year's edition of the Native News Honors Project show the steep, continuing cost of that care, as well as the enduring efforts to improve it.

The phrase “for the benefit, care and assistance...” is written into the United States' agreements with sovereign Indian tribes. These words might seem cynical in 2017, nearly 100 years after they were written in the Snyder Act of 1921, the piece of legislation that eventually led to the creation of the Indian Health Service in 1955. It was a promise made law that to this day faces hurdles in funding, staffing and infrastructure.

This spring, Native News teams waded into the murky details of health care policy and pushed the

notoriously tight-lipped Indian Health Service for answers. Teams traveled to all seven of the tribal reservations in Montana to find out how well the IHS is meeting the promise made so long ago.

We found that IHS is budgeted to spend about \$4,000 per patient, half of the national average. The amount is touted as part of an efficient system, but overwhelmingly, patients feel underserved. IHS sites see high staff turnover, long wait times, geographic isolation, cultural misunderstandings and significant health disparities among Native Americans compared to national averages.

Although the IHS system is run by passionate, community-driven people, the system itself falters and succeeds inconsistently throughout the state. On Fort Peck, veterans promised health care by both IHS and the VA find access harder to secure, not easier. On the Rocky Boy's reservation, an infrastructure crisis puts reliable access to water out of reach.

Elsewhere, communities are asking new questions about how to solve old problems. Northern Chey-

enne leaders clash over whether to focus on diabetes prevention or treat its severest symptoms. On the Blackfeet reservation, prescriptions meant to ease the opiate crisis may be spawning a different problem.

Native Americans across Montana confront the systems that let them down and take matters into their own hands. On the Flathead reservation, a tribally run program aims to temper the challenges of mental health care in a place where nobody's anonymous. In Crow Agency, an intrepid administrator works to revitalize long-term care close to home.

Systemic changes have brought hope to others. Increased insurance enrollment due to Medicaid expansion has let urban Native Americans get access to previously inaccessible health care, while on Fort Belknap, it has led to increased resources for the community, not just enrollees.

The price of health care in Indian Country can be measured on several scales. The cost is historic, it's deep, and for most, it is under performing.

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If you have comments about the project, we'd like to hear from you. Email us at jason.begay@umontana.edu or jeremy.lurgio@umontana.edu or write to Native News Honors Project, School of Journalism, University of Montana, 32 Campus Drive, Missoula, MT 59812.

Cover photo by Derek Minemyer

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Thrown a Lifeline

How Medicaid is rebuilding health care on Fort Belknap

Story: Lucy Tompkins

Photos: Adam McCaw



Jean and Donald Bear dress their twins, Hazel and Kale, for the day. When Jean Bear learned she was having twins, doctors referred her to a hospital in Billings six hours away. She signed up for Medicaid, which covered the travel, lodging and treatment costs of her prenatal care.

When Jean Bear found out she was pregnant, she did what all women in Hays, Montana must do: She drove 82 miles across the Fort Belknap Indian Reservation to the nearest hospital with prenatal care and delivery services for her first checkup.

Her route took her past Fort Belknap's Indian Health Service, the facility created to provide health care to the reservation's tribal residents, as mandated by treaties between tribes and the federal government. Fort Belknap IHS stopped delivering babies in the 1970s, so Bear continued 50 miles farther to Havre, where a doctor did an ultrasound and gave her the good news: She'd be giving birth to twins.

Having twins is considered high-risk, so Bear was referred even farther from home for care. She drove to Billings — six hours round trip — for monthly prenatal appointments. Because the Billings hospital is beyond the reservation's borders, Bear's treatments and travel costs weren't covered by IHS, which doesn't charge Native American patients for care. Without health insurance, Bear would have to pay out of pocket for her monthly appointments, travel and lodging in Billings. As her due date approached, she had to make the 336-mile trip every week.

To cover those costs, Bear signed up for Medicaid. Because IHS doesn't deliver babies on the reservation, all pregnant women are urged to enroll, as Medicaid reimburses for travel expenses and pays for all medical needs. Nearing her due date, Bear spent three weeks in Billings at a Ronald McDonald House and two nights in the hospital. She doesn't know how much these costs amounted to, because Medicaid covered them, but the average cost of one night in a hospital in Montana is \$1,284, according to the Kaiser Family Foundation. After always relying on IHS for her health care, and never getting the comprehensive treatment she needed, Bear realized how much freedom Medicaid granted her.

Far from her rural hometown of about 800 people, Bear gave birth to fraternal twins, Kale and Hazel. When Bear or her now 16-month-old twins need to see a doctor or a dentist, she doesn't bother with IHS. She drives her children to Helena for dentist appointments, nearly five hours away. With Medicaid, Bear has access to high-quality care off the reservation, freeing her from the constraints of IHS' tight budget.

"(Medicaid) gets you faster appointments, and you don't have to wait around for IHS to go to the board and read on it," Bear said. "I have really bad asthma, and all I have to do is call and make an appointment. I don't have to wait around for IHS to schedule me one."



Kermit Horn heads to the grocery store to buy a turkey for Easter lunch with his family. Horn is getting a new wheelchair with the help of the Fort Belknap Public Health Nursing Program..

Despite the federal government's treaty responsibility to provide Native American tribes with health care, services on the reservation have long been underfunded. When IHS doesn't have the resources for a certain procedure, a board of administrators decides if IHS will pay for the patient to receive treatment in a hospital off the reservation — known as contract care. In the past, only patients at risk of losing their lives or a limb were granted that permission, due to lack of funding.

Because IHS has always been the main source of health care on reservations, applying for insurance or Medicaid is foreign to many Native Americans. Some don't have access to a computer to sign up, and others think it's expensive. Some refuse to enroll on principle to hold the federal government accountable for its failure to comply with treaty-mandated responsibilities and promises.

After suffering through years of chronic underfunding, IHS has been thrown a lifeline. Both the Affordable Care Act and Montana's Medicaid expansion provide a new way for IHS to improve its services and increase its revenues. A patient covered by Medicaid allows IHS to bill the federal government for the services it already provides. Currently, the federal government reimburses 100 percent of those expenses. Before the Medicaid expansion, it reimbursed just 65 percent. On the Fort Belknap Indian

Reservation, those reimbursements have reached beyond the IHS facility and into the community, improving services and creating stronger preventative health programs.

Greg Smith, acting CEO of Fort Belknap's IHS facilities, said they are seeing more patients with third party coverage than ever before in its history. The amount of money collected from billing Medicaid, Medicare and private insurance has increased by 15 percent since 2015, he said. Those reimbursements have helped the hospital add more nursing positions and buy new medical equipment to replace antiquated, 20-year-old machines. They've also helped departments fund preventative health care services like the community gym.

Nationwide, third party billing at IHS has increased by \$240 million, about 26 percent, since the passage of the Indian Health Care Improvement Act, which is included in the ACA.

If the ACA and Medicaid expansion are repealed, that 15 percent budget increase, and the expanded health care options that kept Bear from going into debt to give birth, would go away.

In 2012, Montana had the highest rate of uninsured Native Americans in the country, at 40 percent,

according to a report by the National Indian Health Board and North Dakota State University. But since Montana's Medicaid expansion went into effect in 2015, nearly 10,000 Native American patients have gained coverage.

The expansion made Medicaid available for all adults with incomes up to 138 percent of the federal poverty level (\$16,394 for a single adult in 2017). Mark Trahan, an expert on Native American politics, said the expansion makes nearly every tribal member eligible for Medicaid.

"You're out of luck if contract care runs out of money, but if you have insurance, you get that care," Trahan said. "The main reason to do it is it's better for everybody. If more people are insured, the clinic will have more resources."

The benefits of third party billing spill beyond Fort Belknap's IHS hospital, down the road and into the Red Whip Gym. From the outside, the gym looks like a dilapidated, windowless warehouse. Inside, a colorfully painted entryway serves as a portal to a renovated fitness room, basketball court, pool and kitchen for serving after-school meals to kids.

Miles Werk, 26, sits behind the front desk and admits members between the fitness classes he teaches. He recently instated a \$1 daily entrance fee for kids, and \$2 for adults. In the after-school rush, kids who can't afford the fee pick up trash outside the gym or do a quick fitness exercise with Werk as a substitute for the money. He won't turn away a kid who shows up without a dollar, but he wants to teach them to care for the property and for their health.

After graduating from the University of Montana with a degree in health and human performance in 2012, Werk, now the Red Whip Gym recreational fitness and wellness coordinator, returned to Fort Belknap to improve the community gym and teach kids healthy habits.

Since his return, the gym, which also serves as a community center for wakes, funerals and events, has transformed. The basketball court, where college basketball games are held and groups of schoolchildren scrimmage after school, has new hardwood floors that replaced the former tile floors from the 1970s.

There's new exercise equipment: stair steppers, rowing machines, bikes, dumbbells. The pool has a new lining, which replaced the chipping paint that used to float around and clog the filtration system.

A brand new wooden sauna steams poolside.

"People come in and are amazed by the change," Werk said.

When Werk wants to improve a part of the gym, he has to lobby the tribal government for funds. But



Miles Werk, the recreational fitness and wellness coordinator at the Red Whip Gym, instructs professional boxer and MMA fighter Delane Lamere on proper power clean form and technique.

lately, he has another source of revenue: Fort Belknap's Public Health Nursing Program.

The program comprises of eight nurses who do immunizations, home visits, community education, school screenings and more throughout the reservation. Their department is part of the IHS hospital, but it is tribally run. When a patient covered by Medicaid comes to them for treatment, the program can bill for a 100 percent reimbursement.

The program's manager, Kathleen Adams, said they use Medicaid reimbursements to boost the budget and fund new health equipment like wheelchairs, crutches and gym equipment. In its first contribution to the Red Whip Gym, Adams' program, along with two local diabetes programs, allocated \$14,000. Adams said it can purchase equipment as long as it improves someone's health.

As a focal point for the community, the improvements to the gym have far-reaching impacts. Werk said more young adults have been taking advantage of the renovated gym, and it dramatically expanded fitness options for kids who don't get enough physical activity in school. In a place where diabetes rates are more than twice that of non-Native people in Montana, access to a gym and fitness equipment is

particularly important.

In addition to its contributions to the gym, the Public Health Nursing Program funds medical equipment for people throughout the community. The program uses Medicaid reimbursements to help those who don't qualify for Medicaid but can't afford the medical equipment they need.

Kermit Horn is one such patient. Horn uses a wheelchair, as his legs are paralyzed from having polio as a child. For years, he swung himself along using crutches, but when his doctor warned him of the damage it would do to his shoulders, he switched to a wheelchair. Getting around since then hasn't been easy, as the reservation isn't required to comply with Americans with Disabilities Act requirements, and many buildings aren't wheelchair-accessible. He can maneuver over small curbs while holding a door open for himself and isn't uncomfortable calling the police on someone who parked so close to a doorway that he can't squeeze by in his chair.

Horn's monthly disability check for \$1,400 makes him ineligible for Medicaid. When his wheelchair started to tear in the seat and the back, Horn went to IHS to apply for a new one through Medicare. They denied his request, saying the chair wasn't in bad



Above: Bear feeds her children while celebrating her 30th birthday at her home in Hays. Her pregnancy with her twins was considered high-risk, and she was able to sign up for Medicaid to help cover the costs of care. Below: Horn's legs are paralyzed due to polio. He has had to reinforce the seat of his wheelchair with leather straps. Medicare rejected his application for a new one, so the Public Health Nursing Program helped him, thanks to additional revenue from third party billing.

enough shape.

"The seat is about ready to come through," Horn said, gesturing to the visible rips beside his hips.

He improvised a temporary fix.

"I took it upon myself," he said. "You see this leather strap? Like you find on the saddle of a horse. I cut four strips and I put them underneath my seat so it wouldn't completely tear off."

Without the leather straps, Horn says his seat would have ripped through a long time ago. When Medicare rejected his request for a new chair, the Public Health Nursing Program stepped in and ordered him a new one. It's on its way. Medicaid reimbursements augmented the program's budget enough to free up money that can be used to help more people like Horn.

"Without them, a lot of people would be hurting," Horn said.

Despite the benefits of enrolling in Medicaid, many Native Americans who are eligible for coverage remain uninsured. One reason for this could be a misunderstanding about the role of IHS, which was created to provide health care for Native Americans but doesn't constitute health insurance.

Of the roughly 70,000 Native Americans eligible for reduced-cost or free coverage in Montana, only about 17,000 have signed up. Another roughly 22,000 appear to have private insurance through their employers, according to an analysis of state and federal enrollment records by the Billings Gazette in September 2016.

For some, refusing health coverage is a conscious sacrifice with a political message.

Avis Spencer has worked for the environmental health department in Fort Belknap Agency for eight years. She chooses not to purchase the tribe's employer insurance to hold the federal government accountable for its trust responsibility to provide Native Americans with health care. Health care, housing and education were promised to tribes in exchange for huge swaths of their land, and Spencer doesn't want that to be forgotten.

"I believe in holding them accountable for that, so I rely on Indian Health Service for my care," Spencer said. "Good or bad, it's there, and a lot of people nationwide don't have that to fall back on."

Spencer's choice to forgo health coverage hasn't been a problem for her, she said, knocking her knuckles on a nearby table, because she hasn't had serious medical issues that IHS can't treat. But management of IHS funds has disappointed her, and she compared the hospital to a walk-in clinic, without physical therapy, a well-child clinic for schoolkids or regular screenings for young men.

She suggested that rather than continue providing substandard services, IHS funds be given to the tribe to help every member register for health insurance.

“If you can’t provide health care, then give us the money and we can get our own health insurance, rather than just being here and providing jobs,” Spencer said, adding that the jobs are helpful for tribal members, but most providers come from outside the reservation.

Of three permanent health providers and a handful of contracted providers at the IHS facility, only one is from the reservation.

Other people who remain uninsured have simpler reasons. In March, a new program launched to help register people on the reservation for Medicaid. Theresa Sullivan, the outreach worker for Hays and Lodgepole, visits homes and attends community events to find the people who have slipped through the cracks, she said.

So far, she’s helped 13 people sign up. The biggest barriers she’s seen are a lack of internet access and a misunderstanding about the benefits of insurance. Until Montana expanded Medicaid and the ACA required employers like the tribal government to provide health insurance, IHS was the main option for health care on the reservation.

“They don’t have an email, so in order for me to even enroll them I have to make them an email,” Sullivan said. “Or use my own, I guess.”

In a few instances, people haven’t wanted to create an email account, so they trust Sullivan to use her own. At a workshop for young mothers in the Kills at Night Recreation Center in Hays, Sullivan made her rounds with a notebook and pen. Various speakers educated new or soon-to-be mothers about breastfeeding, nutrition and other caretaking practices.

Sullivan spoke to each woman between speakers to share the benefits of Medicaid and to enroll the uninsured. She recorded each mother’s contact information on her note pad. She knew nearly everyone present, as is the case in such small towns.

Though Sullivan’s job is to spread the word about Medicaid and the benefits of health coverage, she remains uninsured. The insurance provided by her employer, the tribe, is too expensive for her to afford, but she’s not eligible for Medicaid as a one-person family with a decent income. She relies on IHS.

“I can’t claim my dog,” she said, giggling. Still, she’s happy to be helping other families enroll.

“A lot of these people are low-income, and I’m sure if I really scrimped I could afford insurance,” she said. “But I like it. I’m glad that they can have better health care. Especially for the kids, because they really need it.”

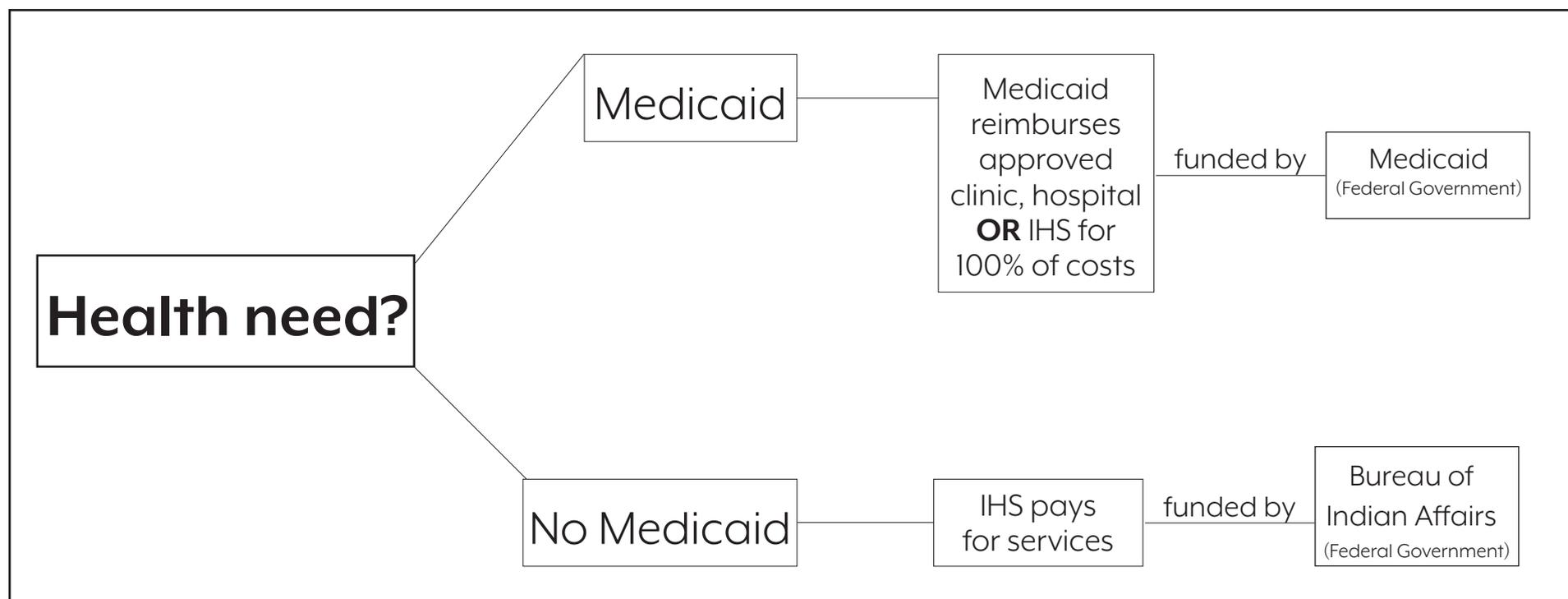
Widespread complaints about IHS are often followed by a sympathetic concession: For how little money it has to work with, the care it provides could be worse.

Though IHS funding saw some increases under the Obama administration, tribal leaders aren’t expecting the same treatment from President Donald Trump. But as long as the ACA isn’t repealed and Medicaid expansion continues to exist in Montana, IHS has a way to build its own revenues without relying on Congress. Third-party billing gives IHS the freedom to bill the government for funds they’d otherwise never see, for procedures they’d otherwise provide at no cost.

The revenue possibilities, if all eligible Native Americans enrolled for coverage, would be drastic. While the Fort Belknap IHS hospital has already begun to benefit from newly insured patients, that growth won’t continue if insured patients prefer to seek care outside the reservation. For Bear and her twins, it makes more sense to drive the extra miles for better care than to wait for approval or rejection from IHS, which has limited funds.

But Tribal President Mark Azure argues that people should always come to IHS first so that the facility can build itself up little by little. By encouraging people to make IHS their primary provider, Azure hopes that one day the facility will have a physical therapist again, and more resources for behavioral health so that in time, his people will get the best quality care.

“I believe that we are creatures of habit, and the ability to take an hour off from work and walk over here,” Azure said, pointing out his window to the IHS hospital, “rather than take a whole day and drive to Billings if you don’t have to — whether it’s snowing, raining, whatever the case — we’re gonna start coming back to this thing, and eventually it’ll all pay off.”



Smith, the acting CEO of Fort Belknap's IHS facilities, echoed this sentiment.

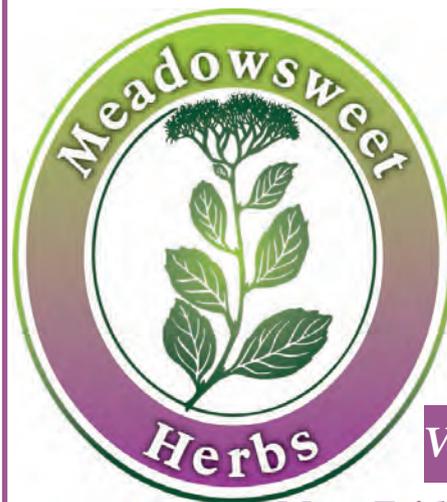
"The bottom line is, as you can tell, we're fairly isolated," Smith said. "And the reality is most people, at some point in time, are going to, just for convenience, come here."

For Bear, quality currently outweighs convenience.

In Montana's remote northcentral plains, Fort Belknap residents have more health care options than ever before. But with the ACA on President Donald Trump's chopping block, and Medicaid expansion at risk, that freedom and access to quality care could disappear. A complete ACA repeal, according to experts, would regress IHS to the days when only patients at risk of losing their lives or a limb were sent to a hospital outside the reservation.

In her 10 years working for tribal health, Assistant Director Tammy Rider has seen the difference insurance makes. Those who have Medicaid or insurance from the tribe have elevated their health care, and they have options and more control over their own health. But for those who haven't, or can't afford to, IHS continues to be their only hope. Unless IHS reaps the benefits of Medicaid reimbursement and helps tribal members enroll for insurance, health care on the reservation will remain inadequate, trapping tribal members indefinitely with second-rate care.

"For the ones who can't enroll," Rider said, "they're just stagnant." ♦



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Prescribing Uncertainty

Blackfeet look to controversial solutions to drug problem

Story: Noah Rott

Photos: Reed Klass



Leland Thomas knew he hit rock bottom when he nearly lost his life from liver failure after lifelong drug and alcohol abuse. Thomas repeatedly used the IHS services available in Browning to get clean. He now leads Narcotics Anonymous meetings and is pursuing a certification to be an addiction counselor.



Dawn Douglas-Holt, a recovering drug addict, speaks to community members during a discussion panel on community drug abuse.

The cycle was simple. And cruel.

When they stopped using pain pills, they'd need meth to feel better.

When they stopped using meth, they'd need pain pills.

Kimberly Hoyt and her husband couldn't stop shaking. Then they couldn't stop sweating. They were in a revolving door of withdrawal symptoms.

Among the low points was a car wreck on the state road from Great Falls to Browning in 2009. To treat their injuries, a doctor in Great Falls prescribed hydromorphone, a highly addictive painkiller. They shot up most of it in the hospital parking lot.

One morning, a few months later, they couldn't get out of bed. The couple rolled over to look at one another. Enough was enough.

They went to Blackfeet Community Hospital, the Indian Health Service facility on the Blackfeet Indian Reservation. Doctors said they detected enough opioids in their blood to

kill them. Behavioral Health decided to send them to a treatment center in Kalispell called Pathways, but only one at a time. Kimberly went first.

She was crying in pain, and the withdrawals were causing her to vomit by the time she arrived. The doctor who assisted her ended up sticking by her for years, walking her through a treatment that replaced her addiction with other, increasingly weaker drugs. Hoyt remains grateful to him to this day.

"He was telling me about this new medicine that came out in the state of Montana, and that's Suboxone," she said.

Suboxone is a buprenorphine-based drug used in medication-assisted treatment. The drug, if administered carefully, alleviates the symptoms of withdrawals and can allow patients to wean off even the most addictive drugs, according to the Substance Abuse and Mental Health Services Administration.

However, these prescription drugs are regulated differ-

ently. First-year doctors can only prescribe Suboxone to 30 patients at a time. They can apply to SAMHSA, which would increase that patient cap to as many as 275 patients.

For Hoyt's doctor, she was number 27 of 30.

It worked. Hoyt spent two weeks at the treatment center and her pain subsided. Her doctor sent her home with a Suboxone prescription. Then it was her husband's turn. His was prescription number 30.

The doctor regularly decreased the dosage of Hoyt's prescription until eventually, she and her husband no longer suffered withdrawals. They will be seven years sober in October, Hoyt said.

About 300 people from the Blackfeet reservation receive Suboxone from two clinics in Cut Bank and Great Falls alone. However, Suboxone is controversial. The prescription drug is itself potentially addictive. A Blackfeet Community Health Assessment released this spring cited it as the latest illicit drug to gain a foothold in the community.

Blackfeet Law Enforcement Services say it's the most common drug sold on the street, becoming as prevalent as meth and other pain pills.

Communities like Browning are divided on both the proven benefits and the proven health concerns of Suboxone. The Blackfeet IHS Service Unit neither stocks the drug nor has a doctor who can prescribe it, but it still contracts patients to buprenorphine clinics off the reservation. Citizen groups are taking to the streets to break the silence and advocate for new, culturally based programs.

Today, people still seek advice from Hoyt, now 41, and she shares her story with them.

"It's hard, but it can be done," she said. "As long as that person is strong enough to do it, and as long as that person has support. A person can get free from drugs and Suboxone. That's how I did it."

Even some of Hoyt's friends speak openly against Suboxone, concerned about its widespread abuse.

Her friend John Dog Monroe, who used drugs with her in the past, said that Suboxone gave him worse withdrawals than meth. Like Hoyt, he too overcame his addiction and is now raising a family. He got clean in jail. He said that even though he knows Suboxone helps people, there are others who abuse it.

Suboxone combines buprenorphine — a narcotic painkiller used to treat narcotic addiction — with the anti-opiate naloxone, which reverses the effects of opioids. Some studies show that Suboxone has successfully weaned half of its clinical patients off opioids and improved quality of life for its users, preventing relapse. This specific concoction is essential for Suboxone to work.

Dr. William Reiter has prescribed buprenorphine in Montana for 15 years. He is the medical director for the Helena Indian Alliance and Northern Winds Recovery Center in Browning. Reiter is concerned that the abuse rates for drugs like buprenorphine could increase because without naloxone, it can be used intravenously to achieve an opioid-like high.

There are fewer than 30 medication-assisted treatment doctors in the state, which means there are thousands of patients without access to medication-assisted treatment. That leads to desperate addicts who seek out Suboxone illegally, Reiter said. Medicaid covers Suboxone, but out-of-pocket, a monthly supply could cost up to \$350.

"Patients come in that don't have insurance coverage and beg for Subutex (a brand name for buprenorphine)," Reiter said. "It can be hard to resist that. And many of the people that are drug-seeking are Academy Award-winning actors."

The noticeable difference between Hoyt and others who wind up addicted to the medication is the relationship she had with her doctor. Assessing patients for addiction and keeping them on track takes a great deal of time and face-to-face interaction with doctors.

Hoyt and her husband used Suboxone for two years, with the doctor checking in every few weeks. This monitoring was key; missing a dose could cause withdrawal symptoms and cravings for other drugs. There is also a constant

threat of relapse and possible overdose.

"He kept saying that you need to stay on this, or next time you won't have a chance. It would kill you," she said. "He would pay attention to us. He'd talk to us almost like a counselor would."

The doctor called Hoyt regularly and randomly to demand pill counts. He was making sure she and her husband were using their drugs appropriately and not diverting them to other people. They were also subject to random drug tests.

These are common practices in diversion prevention. The reality, Reiter said, is that some medication-assisted treatment clinics do not monitor patients as well as others.

"If every patient in Browning that was using Suboxone on the street could make a doctor's appointment, get their stuff in order, get their prescription and have Medicaid pay for it, obviously, they'd do that," he said. "But there is a severe limitation to access of care."

There is no detox center on the Blackfeet reservation, only limited-capacity treatment centers.

Before John Dog Monroe went to jail, he knocked on the door of the tribally run Crystal Creek Lodge in Browning, which is partially funded by the Indian Health Service. He asked for help, but the 20-bed facility mainly focuses on alcohol treatment. Employees turned him away.

He was forced to turn to the primary health care provider for the reservation, the Blackfeet Service Unit of IHS. He was only admitted after threatening self-harm.

Blackfeet Community Hospital and a clinic in Heart Butte are intended to serve over 7,000 tribal members on a 1.5-million-acre reservation.

IHS claims on its website to be "efficient with resources provided by Congress," spending only \$4,000 per person per year, about half the national average for health care. That doesn't necessarily translate to good care if you ask any resident of Browning.

Blackfeet Business Council Member Timothy Davis worked for IHS for most of his career and said the drug problem is one of the most important facing the reservation and state.

"It's not endemic just to us. It's not an Indian issue," he said. "IHS doesn't have the resources to build a treatment facility, a medical detox facility here. The nurses, the psychologists, the social workers. The cost is prohibitive."

Like many reservations, substance abuse is a priority on the Blackfeet reservation. Suboxone is just the latest of those prescriptions to arrive, and while it has helped people recover, Davis understands that replacing one drug with another has challenges.

Earlier this year, the Washington state-based addiction medicine company Ideal Option opened a clinic in Cut

Bank. It's now the closest place to the Blackfeet reservation that will fill a Suboxone prescription. It's also just one of five locations in Montana and the only one not found in a larger city.

Ideal Option CEO Dr. Jeff Allgaier said that Cut Bank was chosen so that patients from the reservation would not have to drive all the way to Great Falls for treatment. When the clinic opened, it was met with some concern from the Blackfeet community.

"In the past, we have heard that there have been 'pill-mills' that don't hold patients accountable," Allgaier said. "I think there are some misconceptions about what we do."

He is aware that a few patients at the clinic could be illegally selling their prescriptions back on the reservation. He thinks that those individuals give the clinic an unfair reputation.

"You're never going to be 100 percent. It only takes one person selling for the police to extrapolate that to an entire population," he said. "It's difficult because we want to show that this is not a bad medication if it's responsibly prescribed and if patients are held accountable. That's critical."

Ideal Option has a diversion plan in place. The program's policy states that pill counts can be enforced, and that patients diverting their prescription through selling or sharing are subject to treatment termination.

The Blackfeet IHS Unit said it does not contract patients to the Ideal Option clinic, according to the Billings area IHS office. They declined further comment.

Due to the severity of abuse in the area, Allgaier said that a new program and additional staff for the Great Falls and Cut Bank clinics will conduct observed urine drug testing and full-body searches for track marks, which indicate intravenous abuse. The unfortunate side of that, he said, is that the invasion of privacy may deter patients from seeking help.

Still, law enforcement is concerned about the hold that buprenorphine has on the Blackfeet reservation. According to Andrew Castillo, Blackfeet Law Enforcement Services Drug Agent, patients can get large buprenorphine prescriptions from these clinics, take their dose, give the rest to family and friends and never be held accountable. The problem, he said, is just as rampant in Cut Bank and Great Falls.

"For a high poverty rate, it's easy to make money selling what you get," he said.

Eight-milligram Suboxone strips sell for anywhere from \$40 to \$80 each, according to the community health survey.

Adding to the concern of Suboxone prescriptions is the use of telemedicine technology. Patients have the opportunity to communicate with doctors in Washington from Ideal Option clinics via video conference for treatment. Sometimes, those doctors will change. Given the close contact she kept with her doctor throughout her treatment, Hoyt said this isn't enough.

Allgaier said it's just like any other doctor visit. Patients will typically visit every two weeks, when routine checkups and paperwork are conducted by staff. Since it only recently opened, Cut Bank Ideal Option is the only clinic without a



Terrance LaFromboise helped found the Silent Warriors Coalition, a group of community members concerned about drug abuse on the Blackfeet reservation. The Silent Warriors often host prayer walks during which they drum and sing in the neighborhoods of known drug dealers.

full-time physician on staff.

“The only difference is that instead of seeing a doctor in person, you’re seeing them over a HIPPA compliance video conference. It works well,” he said. “It’s not controversial anymore in the medical field. It’s politically controversial and it’s emotionally controversial.”

Allgaier said he is open to working with the reservation on creating plans to reduce illegal selling and abuse.

Wary of the paradox of using drugs to combat drugs, community members are uniting in hopes of inspiring a new, cultural and community-based solution.

The Browning Middle School gym filled on a Thursday evening. Grandmothers, mothers, and children shared snacks and filed into fold-out chairs. About 50 people were in attendance, with noticeably few men. After a short introduction by Director of Blackfeet Tribal Health Rosemary

Cree Medicine, the lights dimmed and the digital projector flashed onto an inflated movie screen.

The 2016 FBI-produced film “Chasing the Dragon” documented the lives of Americans addicted to prescription drugs and the lengths they went to to get high. Some overdosed, some went to jail. Every terrible facet of drug use was front and center. The audience winced when the film depicted a woman using gutter water to shoot up heroin.

After the film, a panel of seven local health and mental health professionals, including Reiter, took a seat at the head table to lead a discussion about drug abuse.

Browning resident Dawn Douglas-Holt, 56, sat unassumingly behind the panel members, out of the audience’s sight. She had spoken to groups before, but never one of this size.

Holt hid her head in her hands, knowing that she was about to be called to speak. She stood up with an embarrassed smile and took the microphone, brushing her bangs aside to look out over the gym. Children scuttled up and

down the wooden bleachers behind her. Their guardians leaned in to listen.

“I’m a recovering addict,” she said quickly. “I’ve been sober for 15 months. I started doing meth over 30 years ago, so I’ve been fighting a demon for a very long time.”

Holt’s story was like many addicts. Her addictions progressed from one drug to another, eventually leading to meth. She traced her addiction back to childhood trauma, which caused the need to alleviate pain. That addiction harmed the people around her.

“My children had to feed themselves, get themselves up to go to school,” she said. “I let them know I loved cocaine more than them. I was very mean. I didn’t care because I needed to be high and stay high.”

Since 2010, her addiction only got worse. It took her five visits to treatment centers and four visits to mental health services before she could stop relapsing. Now she leads Narcotics Anonymous meetings and speaks out to the community about recovery.

"I just praise my Creator every chance I get for giving me a second chance, third chance, fourth chance — I don't even know what chance I'm on," she said. "But I'm here. And I'm here to help in any way I can, thank you."

She sat down beside the panel, to applause.

Mary Ellen LaFromboise, director of Blackfeet Tribe Child and Family Services, suggested that families put children first. Her service has over 200 children and infants suffering from behavioral problems. Everyone has a sad story, something tough in their lives to deal with, she said.

"But we're resilient also, aren't we?" she asked the crowd. "How'd we end up lasting this long as a people if we didn't have some resilience, some strength?"

LaFromboise suggested challenging the medical community to find an alternative to prescription drugs. Moving forward, she asked the audience to practice tough love and to speak out. Otherwise, she said, the next film will be about the Blackfeet Nation.

Reiter took the microphone to ask the audience to keep an open mind about medication assisted treatment, receiving some applause of approval and some skepticism.

In the fall of 2016, LaFromboise's grandson, Terrance LaFromboise, 27, organized groups to march through neighborhoods where known drug dealers and addicts lived.

He would sing and drum as a few dozen of the Silent Warriors Coalition marched behind him, holding homemade signs saying "Stop Killing Our Kids" and "Just Stop." Men, women and children held hands and prayed.

They marched in Babb, East Glacier and Heart Butte —covering all the areas on and around the reservation where they felt prayers needed to be heard.

John Dog Monroe, a founding Silent Warrior, said grandmothers and children walked out of houses to join them in some neighborhoods. In others, people peered out nervously.

"Kids are seeing this out there. Kids are thinking this is okay. Right now, in this community, you got grandchildren using with their grandparents," he said. "You can turn your life around. I got a couple of felonies on my record. I was a hardcore drug addict. You can't tell me it's not doable."

Leland Thomas would agree.

At his pastel-pink house, the 53-year-old discussed recovering from meth addiction without medication-assisted treatment.

Thomas, used the services offered in Browning to save his life. He consistently went to Crystal Creek Lodge and other treatment centers in the region. Like Monroe, the most important one he found was in jail.

"People didn't want to help me. But when you jump on that sober wagon and people start seeing that you're trying to help yourself, then they will help you. You just got to seek them," he said.

He was sober for almost four years until he relapsed in



Blackfeet community members gather at Browning Middle School for a screening of the FBI-produced documentary film "Chasing the Dragon." The film featured the graphic stories of ex-opioid addicts and called for community action to overcome opioid abuse.

February. His parole officer called it strike one, but Thomas is confident he'll never use again.

He occupies his time with behavioral health classes at Blackfeet Community College, where he is excelling. He recently married, is improving his painting skills and gets out to fish as much as he can. Traditional sweat lodge ceremonies are also a favorite of his.

He knows that in a few years, he'll be a drug counsel-

or helping, people that were just like him. He already has brought friends to, and led, Narcotics Anonymous meetings alongside Douglas-Holt at the IHS hospital meeting room.

"Everyone has a mission here on Earth," he said. "We're put on this planet for a reason. For me, I think it's to help people, to help other addicts try to break them free from it." ♦



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Care at Capacity

Crow tribe revives long-term care but faces roadblocks

Story: Olga Kreimer

Photos: Olivia Vanni



Thomas Larson Medicinehorse, 78, makes his way out of his home in Crow Agency to go to a physical therapy appointment 20 minutes away in Hardin. Many Crow reservation residents are forced to drive to Hardin or Billings for medical appointments due to the loss of surgery and OBGYN clinics at the Crow/Northern Cheyenne Hospital.



TroyLnn Shotgunn, right, and her father, Kenneth Beartusk, left, play bingo at the Awe Kualawaache Care Center on the Crow Reservation. The center offers activities for its residents, including trips to the Sheridan Rodeo and the Crow Fair.



According to Shotgunn, when Awe Kualawaache Care Center was under outside management, it was a "little bit more strict." The residents were required to get up at 7 a.m., which was hard for her due to her arthritis.

When TroyLnn Shotgunn was 48

years old, she decided to give the nursing home a try.

It was more than a decade after rheumatoid arthritis forced her to leave her teaching job. Managing her health at her home had proven too difficult. Four times that year, Shotgunn ended up in the emergency room, immobilized and in pain while her medication lay forgotten in a drawer.

The second time, a doctor — recognizing a pattern — told her she might as well put a gun to her head.

"You're supposed to take prednisone daily," Shotgunn said. "When you drop it, you're just asking for a heart attack or a stroke."

She was scared. No one had explained it before. She vowed to take her medicine more regularly, but after every hospital visit she felt better, and within a couple of weeks she'd be off the regimen again.

Shotgunn's mother, who together with Shotgunn's son took care of her as the disease increasingly limited her mobility over the years, convinced her to try a nursing home.

The suggestion was alarming. Nursing homes were for the infirm, the elderly. They weren't for people her age.

After her fourth ER visit, Shotgunn made the short move to Awe Kualawaache Care Center in Crow Agency. The Crow/Northern Cheyenne Hospital, where the ambulance dropped her off so often that year, is visible from its windows.

"I thought I'd gain strength and go home," Shotgunn said. She gave herself a year to get her rheumatoid arthritis under control and to make it back home to her family. But after a year, she still wasn't strong enough to go back to Busby. "RA had just taken over and taken a toll on me," she said. "I thought it was just to throw their parents off where they don't want to take care of them, but it's not like that," Shotgunn said. "Sometimes, they need more one-on-one care."

Shotgunn is only 51 — but an even younger resident was staying at the home this spring.

Awe Kualawaache is the only nursing home on the Crow Indian Reservation. It also serves the neighboring Northern Cheyenne. In 2014, after more than a decade of contracted management by a Billings-based company called Health Management Systems, the Crow tribe took over nursing home operations directly.

Locals say the home is in better hands now. Its finances are in better shape, without relying on the tribal subsidy that supported it since its opening. Scores on annual state assessments of nursing facilities have improved. More of the staff is Native American now, which residents say makes them feel more at home.

Staff say that every resident at the center is covered by Medicaid, a joint federal and state program that helps with medical costs for low-income people. That's different than Medicare, which pays medical expenses for people older than 65 or with certain disabilities but doesn't cover basic long-term care in a nursing home. Medicare will only cover skilled nursing care.

As a skilled nursing facility, Awe Kualawaache is eligible for Medicare, but the center does not currently offer the therapy services required to bill the program, which includes speech, occupational and physical therapy.

For years, the center struggled to stay afloat on notoriously low Medicaid reimbursements. Now, the staff maps out the possibilities for expansion.

Administrator Carla Catolster worked at the center under the previous management as the only tribal member in the management staff. That experience, she said, convinced her that "somebody that sits in that chair needs to be from here." She wants the center to be a refuge for its employees as much as for its residents.

She sees it as a calling, not just a job.

"These are our people," she said. "We want to be able to do this for our people."

Catolster is a Crow tribal member. Lesa Evers, a DPHHS Tribal Relations Manager and tribal liaison for Indian Health Service, said that is important.

"That's a really big deal, to be able to have one of your members running a major part of your health service," Evers said.

It's also unusual. Awe Kualawaache is one of only two nursing homes in the state run by tribes, rather than contracted to outside management companies. The other is in Browning, on the Blackfeet reservation. IHS, which provides a range of medical services on five of Montana's seven reservations, does not provide long-term care.

The transition to tribal management happened under the 1993 Indian Self Determination Act, a federal law that authorizes tribes to take over given parts of their administration from the federal government. The Confederated Salish and Kootenai Tribes on the Flathead reservation and the Chippewa Cree on the Rocky Boy's reservation have used the program to fully administer their own tribal health programs.

The Crow tribe has owned Awe Kualawaache since it opened in 1998. However, Health Management Systems managed the site until 2014.

Todd Wilson, former director of the Crow Tribal Health Department, said the tribe was paying the Billings firm up



Carla Catolster, the Awe Kualawaache care center administrator, has spent the last three years making a handful of changes to the center. “No one wants to be here in a nursing home,” said Catolster. “But if they’re going to be here, I hope they enjoy it.”

to \$25,000 a month for management services and to fill in budget gaps, and the administration was interested in less financially draining options. Health Management Systems President Karl Rude explained that Medicaid reimbursements simply didn’t cover all the costs, making continued management untenable.

Awe Kualawaache was the company’s last tribal contract, according to Rude. He said the frequent turnover of board members, who are appointed by the tribal chairman, made it difficult to maintain support for unpopular cost-saving measures, like layoffs.

In 2014, with a re-negotiation coming up, both the firm and tribal management were ready to end their contract.

By that time, Catolster said, the situation at Awe Kualawaache had deteriorated. The home, with 40 beds, was nowhere near capacity, and the center prepared letters instructing residents to move to other facilities after an annual state survey found multiple violations.

“They were getting tagged for pharmacy, medical visits weren’t getting done in a timely manner, nutritionists weren’t coming,” Catolster said.

Catolster was no longer the administrator by then. After working at the home since 2004, she was fired in 2013 after what she describes as years of employee rivalry and favoritism.

She had been the first Crow tribal member to successfully complete her nursing home administrator license and be promoted to the top role at the tribe’s nursing home. But now she let her license expire.

In 2014, the Awe Kualawaache board called Catolster back into action. Health Management Systems was gone, along with most of the management staff. She would have to rebuild nearly from scratch.

Drawing from her experience working in every department over the last decade, Catolster slowly got the center back up to speed, doing the billing and payroll herself in the beginning. Since the number of residents was low, revenue from Medicaid reimbursements covered just the payroll. Some vendors’ bills and the center’s tax obligations took a backseat for a time. The tribe was still contributing a monthly sum, which helped. Eventually, Medicaid approved an increase in per-patient, per-day reimbursement, which allowed the center to stop taking tribal funds.

Gradually, the center welcomed more residents. It paid the taxes owed and hired a full staff. These days, staff turnover — a major problem in rural medical facilities — is lower.

“Before, we had an orientation every month or every couple weeks,” Catolster said. “Now,” she paused, “we haven’t had one for a couple months.”

More of the staff is Native American these days, too. Catolster estimated 45 employees at the center, and she could think of only three who were not Native American. That’s a change she believes helps residents and staff alike.

As a resident, Evelyn Hogan-Bear Ground feels the difference. She’s related to several staff members at Awe Kualawaache. Hogan-Bear Ground moved to the center after a stint at the Heritage Living Center in Ashland, just east of the Northern Cheyenne reservation.

“I wanted to be with my own people,” she said. Here, the staff is “like family.”

About half of the center’s residents are Northern Cheyenne, like Shotgun. She remembers the stricter days under the previous management and said she prefers the staff now. The Native American staff is more understanding and more lenient, she said. They have a good sense of humor. They chat and laugh with the residents.

“White people just do their job. They don’t add humor into it,” she said. She gets along with some anyway, but sometimes, “I just zip it and get what they’re gonna give me and get out.”

Awe Kualawaache Activities Director Yolanda Turnsplenty moved back to the Crow reservation last June after 25 years in Florida. At afternoon bingo, Turnsplenty joked with the residents pulling up chairs and rolling their wheelchairs around tables in the dining room. A television set was on mute in a corner, but all eyes are on cardboard game cards and Turnsplenty once the game starts.

Turnsplenty loudly announced the numbers to the room while also signing them for a resident at her table. Turnsplenty is working on opening her own graphic design business, but in the meantime she completed Certified Nursing Assistant training in November so that she could do more at the center.

Creating a nurturing home for residents is a priority for Catolster. Shotgun appreciates the outings to shopping trips and summer rodeo visits, which keep residents connected to community life outside the home. Catolster prioritizes not just social activities or visits from a hairstylist every couple of weeks, but also staff mindfulness.

She remembered breaking up a loud argument between two employees one day, asking them, “You don’t go to somebody else’s home and fight, do you?” They said no, of course not. “This is their home. Their home,” Catolster emphasized. “We work in their home.”

But like any success story, this one has snags. One is universal: There just aren’t enough nurses. “There’s always a nurses’ shortage,” Catolster said. “It’s just a national problem. There aren’t enough nurses in the world.”

With the current nursing staff, Director of Nursing Jácinta Walks said that the center is about at capacity for residents. They have plenty of space; out of 40 available beds, 17 are empty. But the current resident-to-nurse ratio is already “pushing it,” Walks said. More patients, without additional



Patti Medicinehorse, right, and Donald Güss, left, help Thomas Larson Medicinehorse, center, stand up. Thomas Larson Medicinehorse has Parkinson's disease and suffered a stroke a few years ago, which he would not have survived without his wife's medical training.

nurses, would spread the care too thin. And more nurses are hard to come by.

The American Association of Colleges of Nursing estimates more than one million job openings nationwide by 2022. On the reservation, those problems are even more pronounced. Awe Kualawaache is in Crow Agency, a rural town of fewer than 2,000 people.

"A lot of times, when there's somebody certified, IHS gets them," Catolster said. She gestured out of the window in the vague direction of the neighboring hospital. "They get our nurses, they get our CNAs."

IHS has better benefits, Catolster explained. It's a more attractive package for employees in this rural corner of the state. Even IHS is perpetually understaffed, with high staff turnover and insufficient funding.

It's a Catch-22. With more staff, Catolster could expand the center's offerings to include rehab therapies, which are covered by Medicare and could bring in more patients and more funding. But to receive Medicare funds, she needs to have staff that's trained in billing the program, which is more complicated than Medicaid.

Catolster is working on a contract with a company that specializes in bringing therapy services to rural areas, and she's already trained three CNAs to assist in rehab. She hopes expanding the center's services can help people stay closer to home.

Currently, many tribal members from the reservation end up in nursing homes in Billings to be near dialysis care, which is unavailable on the Crow reservation, Catolster said.

The typical length of a round trip between Awe Kualawaache and the clinic in Billings where residents get their treatment is about two hours. Since residents go in a group van, they have to wait until everybody is finished before turning back to Crow Agency. It's a long trip and a long day. Some patients prefer to live farther away from the reservation instead of traveling that distance several times a week.

Local dialysis, assisted living and a home health program are part of the staff's long-term vision. But more immediate problems require attention first.

"The building is old. Things are falling down," said Catolster. Among them, her office ceiling, which was leaking for years and collapsed during heavy rains while she was out of town for a family emergency.

She has been borrowing computers while the office, gutted to its insulation, remains under construction. She wants to put in a new call light system, new bathtubs, new wheelchair lifts. She has already replaced the old manual beds with electric ones and started to improve the glitchy computer system, which was interfering with billing and payroll.

Catolster realizes that nursing homes are a last resort for people and for their families. Like Shotgunn, people want to stay in their homes, and families want to take care of their

relatives.

"It's hard to admit that you can't take care of mom anymore," Catolster said.

Medicaid is also invested in helping people stay out of long-term facilities. However, help with home care is hard to come by, and without help, many end up in Shotgunn's position.

That's the paradox that frustrates Patti Medicinehorse, a paramedic with Big Horn County Ambulance who cited community paramedicine as an answer to fill the gap between care at home, which families aren't always equipped to handle, and inpatient care at a nursing facility.

Community paramedicine, she explained, is a program in which paramedics would be trained to offer a broader array of health services to rural residents. Big Horn County already has five employees with the necessary training; only funding is missing.

This is personal for Medicinehorse. She takes care of her husband, a Crow Sun Dance Chief who has Parkinson's disease. Medicinehorse credits her medical training for her ability to provide the care he needs full-time, but those without trained family members or extra help are often forced to look elsewhere.

Non-medical support, like Meals on Wheels and free meals at the Senior Citizens' Center, provide community and a point of access to social services when needed, but regular medical help like the kind that could have helped Shotgunn is unavailable.

A year after she moved to Awe Kualawaache to try it for a week, Shotgunn finally decided to decorate her room to make the center feel like home. Now, Shotgunn's walls are covered in paintings by her grandson, photos of her grandchildren and a completed puzzle by her best friend in the home, who passed away last year. The bubblegum pink vanity and wardrobe match her brightly coordinated outfits, down to her socks and her Crocs.

Shotgunn's father moved in a few months ago, too. It was weird at first, she said, especially when her dad would come to her room and tell her she should be up already on mornings when her arthritis kept her in bed. But eventually, "it just got to be normal."

Shotgunn still misses home, especially going outside at night when everything is still and peaceful. Here, the doors are locked after 10 p.m., but it's not the same anyway, with trains and semis on the nearby highway interrupting the night.

"I miss listening to the quiet town of Busby," Shotgunn said. But her dad is down the hall, and her grandkids smile down from the wall. She thinks she might go back to Busby one day with the help of her son and daughter, who she thinks could get training in how to help her get around.

If she were in Busby, she might sit out at night, listening to the quiet outside her door. But for now, this is home. ♦

Reaching Out

A conversation on mental health evolves on the Flathead

Story: Courtney Brockman

Photos: Sydney MacDonald



JaNessa Taylor drives herself to Polson High School most days. Her clinical depression makes getting out of bed difficult and sometimes results in absences.



Megan Inmee, 26, and her nephew brainstorm ideas to combat suicide and mental illness on the Flathead Indian Reservation. Inmee lost her father to suicide in February. "I'm hoping after all this happens, tribal health makes changes so everybody can get the help they need," Inmee said.

She never thought to seek out mental health services before. Not even when she started losing family members.

Megan Inmee didn't know anyone in her family who had been to a therapist. It was a foreign concept, though it seemed one or two relatives died every year.

The 26-year-old from the Flathead Indian Reservation didn't even know how to initiate an appointment with a mental health specialist. Then she lost her father. It was suicide and she knew she needed to get help.

"I wasn't really open with it until it happened," Inmee said. "I was like, 'Oh man, I need to start talking.'"

Her boyfriend finally convinced her to go to Confederated Salish and Kootenai Tribal Health Clinic for counseling, because it had helped him a lot after he experienced his own tragedy.

However, she could only get in for an appointment through a family friend. When she tried to set up counseling for her 6-year-old daughter through Sunburst Mental Health Services in Polson, she did not receive a call back for nearly three weeks, a sign to Inmee that the facility placed mental health as a low priority.

After all, Inmee couldn't recall ever having to wait for a dental appointment. She was shocked that there was a wait at all for a mental health appointment.

"It should be the opposite," Inmee said. "I should have to wait a week or two because it's your teeth. It's important, but not as important."

Inmee's father was one of 10 people who have died from suicide since October on the Flathead reservation.

Inmee recognized that mental health needs, if unrecognized and untreated, can end in fatalities.

Montana has remained in the top five states with the highest suicide rate for nearly 40 years, and the Montana Native American population is especially vulnerable, with about 28 deaths per 100,000 people, as compared to 13 per 100,000 for the U.S. population. Native American youth in Montana die from suicide at a rate five times higher than other groups between ages 11 to 24 statewide, according to data from the Centers for Disease Control and Prevention and the Montana Department of Public Health and Human Services.

However, mental health services in reservation communities are scarce. And like Inmee, people are hesitant to seek out the services that are available.

The state addressed this by increasing suicide prevention programs. In April, both houses of the Montana Legislature endorsed House Bill 590, which would use \$1 million for suicide prevention, especially for Native American youth.

Additionally, eight tribes and five urban Indian health organizations formed a Montana Youth Suicide Coalition to engage tribal health leaders, the Montana DPHHS, elders, veterans, health professionals and young people. The coalition published the Montana Native Youth Suicide Reduction Strategic Plan in January with funding from the Montana public health department.

According to the state health department, approximately 90 percent of suicide fatalities have at least one major psychiatric disorder.

Yet on the Flathead reservation, dedicated mental health facilities are limited. Patients in need of emergency assistance must wait at a facility in Polson, which has eight beds, until they can go to Missoula or Kalispell, and only if those places aren't already full.

For now, Confederated Salish and Kootenai Tribal Health provides most of the mental health services on the reservation in a limited capacity.

Once used as a hospital by the Sisters of Charity in the 1950s, the Tribal Health clinic in St. Ignatius sits between a large red barn and the Mission Church.

In 1993, the Confederated Salish and Kootenai Tribes formally assumed management of health services from Indian Health Service by invoking Public Law 638, a federal law that allows tribes to take over programs previously managed by federal agencies. Tribal Health today is funded by grants, federally contracted money and billing for services. It is available to enrolled members or descendants.

In 2014, the Salish and Kootenai Tribal Council declared the health and wellness of the people as a top priority. Anna Whiting-Sorrell, regional head of Tribal Health and the author of the suicide reduction strategic plan, took that declaration seriously.

Whiting-Sorrell's mission is to integrate medical care with mental health care.

"When someone hurts themselves, it is a medical emergency," Whiting-Sorrell said. "If someone is suicidal, it's a medical emergency. It's not a flaw in their character."

On a whiteboard in Whiting-Sorrell's office is a simple mantra scrawled in marker: "Being in a good way." Whiting-Sorrell said they must look at people holistically; physically, spiritually, emotionally and especially mentally.

“In the end, if you don’t feel good about yourself and want to take care of yourself, it doesn’t matter what the current issue of the day is,” Whiting-Sorrell said. “We have to figure out what do we do to build that in our people, that they want to feel well.”

Everyone at Tribal Health is trained on Question Persuade, Refer, a national training program that focuses on the best method for patients who might be suicidal. If the response to, “Would you like to see someone?” is “Yes,” Tribal Health either personally introduce the patient to a counselor or directly reach out to make referrals.

Down the hall from the medical wing, Behavioral Health is staffed with two clinical psychologists and about one dozen licensed clinical social workers and addiction counselors.

The head of Behavioral Health, neuropsychologist Jera Stewart, knows well the history of the community, its families and issues.

Stewart wrote three grants in her first five months at Tribal Health and brought in \$1.5 million, mostly used for suicide and domestic abuse prevention initiatives.

Stewart also documented the correlation between people seeking out mental health services with changes in the community, such as when people got a settlement or when diabetes spiked. She found that holidays and powwows tend to keep community members grounded and give them more hope.

“So when there’s something in the community that happens historically, whether it’s in behavioral health or just something happening out there, it does make a difference in how people feel or how people cope,” Stewart said.

According to the 2010 census, non-Natives outnumber Native Americans 2-to-1 on the reservation. Stewart said everyone, tribal or not, must be taken care of, because everyone is tied together. If one person is not well, it ripples out.

However, when trauma does happen within the community, Whiting-Sorrell said it is difficult to stop and actually grieve. In the heart of the Tribal Health building is a smudge room, where cedar and sweetgrass are burned, for taking a break. Whiting-Sorrell said it is for the healers there to “be in a good way.”

“I just know that you got to take care of the people who work here,” Whiting-Sorrell said. “You never really know what is going to hurt you.”

When JaNessa Taylor, 16 saw a friend post on Snapchat that he couldn’t do it anymore, depressed that he couldn’t play soccer on the varsity team, she



Annesha Anderson helps her daughter JaNessa put on makeup before school. JaNessa was diagnosed with clinical depression a year ago and says she couldn’t get out of bed most days without the help of her mom.

knew she had to reach out. She messaged him some encouragement and told him to just keep working at it. He saved that message.

JaNessa herself had been in his shoes just a year ago. It was winter, February, and she knew something was wrong when she could no longer look in the mirror.

She didn’t feel like the happy, straight-A 15-year-old everyone thought she was. Instead, she was overwhelmed by the sadness she felt for sneaking out to hang out with her boyfriend and, in her eyes, disappointing her community.

“It devastated them to the point I was devastated that I did it,” she said.

Even her normal outlet, playing soccer, couldn’t help. She documented her depression in an English essay.

“My shoes were gray and with every step, seemed to fade into a deep dark black,” her essay begins.

At one point, JaNessa asked her mom to sign her up for therapy, but changed her mind because she was embarrassed and scared.

She attempted suicide a week later.

JaNessa’s mom, Annesha Anderson, was in the middle of writing a senior thesis on suicide for her nursing degree at the time. Anderson lost her brother to suicide six years earlier, and a poem written in scratchy handwriting, “Miles’ Remem-

brance,” hangs among the family photos in the dining room. She said she had no idea her daughter was also in such a dark place.

“You think it’s not going to be your child,” Anderson said. “Nobody wants to say it, that that’s going to be my child.”

JaNessa spent five days in the emergency room. At one point, the mental health worker said JaNessa could go home, but Anderson fought to keep her in the hospital longer to receive intensive therapy.

Anderson’s background allowed her to advocate for JaNessa, but not everyone is that lucky.

As a nurse and Obstetrician manager for St. Luke Hospital in Ronan, Anderson sees a lot of people come into the ER during the climax of a mental health crisis or after a suicide attempt. The mental health worker who is on call at the time determines if a patient can go home.

“Sometimes we’re holding on to these patients on the floor and by that time, their crisis is over, and then they deem them not harmful to themselves, and then they send them home without getting them appropriate care,” Anderson said. “And so, it can be a couple days. Which is really unfortunate.”

JaNessa now receives medication and regularly sees a therapist at Tribal Health.



Tribal Health services holds a community conversation in response to eight recent suicides on the Flathead reservation.

Rosemary Epperson, JaNessa's therapist, is a licensed clinical social worker and one of six clinicians at Tribal Health.

Each morning, behavioral health specialists meet with the medical clinic to go over a list of people who may need counseling later and make sure clinicians are available at certain times to refer patients. Walk-in appointments are also available.

Epperson said many reach out for services, but few actually show up. JaNessa thinks people do not seek out help because of the stigma.

"It's like people walk around with these walls built around them and when someone cracks it's like, 'Oh, his wall's cracked, that's not good,'" JaNessa said.

Epperson said people instead self-medicate through hard drugs. Patients disappear from therapy. The suicide hotline receives up to 12 calls a week. Like JaNessa, many patients wait until they have to go to the ER for a mental health emergency. If someone does not end up in the ER, they may go to jail.

"People are very, very scared to come to Tribal Health," Epperson said. "It's a really small town, and with the tribal element, there's a lot of tight families and people who are just related and close to each other, and they're really scared of gossiping."

Sometimes elders are hesitant to come in because they may view medicine with suspicion.

Epperson also sees Native American men as the most difficult to get through the door.

"I've been told, 'Look, I came down here three times and made three different appointments, but turned around in the parking lot because I was raised to believe an Indian man who's being strong should never do something like this,'" Epperson said.

A few miles down the road, Patty Stevens, 57, takes a different approach to mental health issues.

Stevens, whose only rule is "don't knock the second time you visit," is a tribal council representative. She runs a horse camp for kids, a moccasin-making circle and other cultural events that bring people together.

"We're just doing good, positive behavior," Stevens said. "And I think there's something to that. I think it's a way of healing."

Firmly against a Band-Aid approach to problems within the community, Stevens has tried to educate herself and others on suicide prevention by attending training and spreading the word. She also talks to her grandson about his struggles with

depression to understand more.

Her grandson explained it as feeling like the worst day of his life seven days a week. Although he struggled with low self-esteem and eating disorders, he never thought about suicide until his dad killed himself.

Stevens thinks a lot of depression is linked to low self-esteem, so she focuses on training younger people.

"We got to take better care of our kids so they don't get themselves into those kinds of situations," Stevens said.

Through a Unity Leadership ministry, Stevens and her husband, Willie, work to help young people recognize someone in trouble and allow them to talk about what is going on in their lives.

Stevens opens up her house as a safe place for people to talk or to get clean, even if they don't necessarily have conversations about their struggles. She also engages with people on Facebook who post suicidal thoughts and privately messages them.

Stevens' grandson told her that suicide attempts are the result of a buildup to the moment, not just the result of an instant thought.

"I thought if you could spend so much more time building the self-esteem or the 'I'm worthy' kind of stuff in people, then it won't ever get to that," Stevens said.

Megan Inmee sat in the back of the Tribal Fitness Center in St. Ignatius, surrounded by her mother, her brother and his two sons, behind a semi-circle of about 80 people.

Food covered a table. Everyone bowed their heads as someone asked the Creator to watch over the assembly, announcing: "We are all one family." Tribal Health mental health professionals stood by in blue t-shirts to help people who might want counseling.

Patty Stevens sewed beads onto a moccasin. Anna Whiting-Sorrell wandered among the crowd. Everyone was gathered for a community conversation to address the recent suicide cluster on the reservation.

During the conversation, the facilitator read over the suicide reduction strategic plan. She told everyone to break into groups and "make the vision real."

Potential solutions appeared on sheets the groups wrote on: make people feel accepted, have safe places where people don't feel isolated, bring people back to their roots, reach out to elders and hold positive activities for children.

Inmee agrees with holding more activities for

young people. She wants younger generations to know that it is okay to get help, so they don't feel lonely or that they can't talk about things. She especially wants grieving families to come together.

She said that even a brief "I know how you feel," can help.

Inmee and her family now must move forward, but her hope is that Tribal Health will be more consistent in holding community conversations and activities, improving their response time and advertising their mental health services more, not just as a response to a suicide cluster. She wants more people to show up to the events and hopes there will be change.

Whiting-Sorrell, amazed at the number of people who showed up for the community discussion, said Tribal Health will not need to hold a similar conversation. She hoped the strategies brought up in the workshop will last long term.

JaNessa Taylor talks about how she has grown as a person in her essay:

"I wanted to try on some new shoes, and I was now in the right place at the right time with all the help I needed."

After her suicide attempt, JaNessa opened up to her soccer teammates and to her boss at Hallmark about what happened. Her relationship with her mother has also grown stronger. JaNessa said she would "step right on it" if she saw any symptoms in her siblings, who all sat on the couch ready for school when the ambulance came to get her that day last winter.

But she would like to see more conversations happening. Although people post on Facebook about suicide attempts, they don't necessarily talk about it, especially in schools. And their symptoms do not change.

"Sometimes they could think they are reaching out or having a conversation in the hopes of getting help, but in reality it could be hurting them," said Brandy Couture, program manager at the Center for Prevention and Wellness at the Salish Kootenai College.

JaNessa thinks holding assemblies over mental health would help. She said now that just having someone to talk to about mental health is more relieving than medication.

"It's like getting your hair cut at a salon," JaNessa said. "Everybody needs to get their hair cut. I see it like that, just the same. You need to get your hair cut, and you need somebody you can talk to. I don't know why it's such a rare thing."◇



Flathead community members gather to socialize and make moccasins at Patty Stevens' home. Stevens, describes her home as a safe haven. "I think you can heal or be well if you're just doing things that are part of your culture and being around other people that are happy," Stevens said.



Driven to Dialysis

Northern Cheyenne community clashes over diabetes care

Story: Nick Callahan

Photos: Derek Minemyer



Jay D Old Mouse has to walk 50 feet unassisted before he can receive approval from IHS for a second prosthetic leg. "I'm going to get on it because I want that leg," Old Mouse said. "That's the only thing holding me back is can I make 50 feet?"



Tribal President Jace Killsback speaks to Jay D Old Mouse about the differences between what Northern Cheyenne dialysis patients want, and what the tribal council sees as a realistic investment in diabetes prevention on the reservation.



Old Mouse learned to make and play the Northern Cheyenne flute from his elders. He plays on ceremonial occasions.

It's almost idyllic;

the modest, sky blue home that stands on the side of a hill, watching the highway run into the horizon. Behind Jay D Old Mouse's house are empty horse corrals. There has been no sign of horses grazing the land, or running the hills in months.

Extending from his front door is a makeshift wheelchair ramp constructed of loose boards and covered with a long rubber mat. The ramp leads directly to his truck.

Inside, Old Mouse navigated the narrow hallways of his small house with his wheelchair, weaving between his living room and his kitchen. He wheeled himself to the threshold of his bathroom, demonstrating how the tight quarters don't fit his wheelchair. He climbed out of the chair, clenching the bathroom doorway, showing how he squeezes into the shower.

"When I lost my first leg, simple tasks were a challenge. Cut your leg off and just see," Old Mouse said. "And to lose the other one becomes a double challenge."

Old Mouse was diagnosed with diabetes at 28 years old, and has been coping with the disease for more than two decades. It's a condition in which patients and doctors try to avoid the worst case scenarios, of which there are plenty. In 2016, he found himself in one of those worst case scenarios. Twice.

In March, the doctor said they had to take his leg.

In September, they had to take the other one.

Diabetes has long been an epidemic on Indian reservations, with Native Americans having the highest

rate of type II diabetes in the United States. It's a well-known problem. It's also well-known that diabetes is preventable, and its symptoms curable, by instilling major lifestyle changes. However, because the Indian Health Service is a medical care organization, most of its funding has been focused on treating symptoms of the disease after it's been contracted.

But tribes like the Northern Cheyenne, in southeastern Montana, are debating the best methods to fight the disease. It's a conversation that can be seen in two competing tribal proposals. One is a tribal dialysis center, which would treat patients with varying levels of kidney damage, another diabetic worst case scenario; the other is a community gym, touted as a strategic maneuver to help instill active lifestyles in an effort to prevent diabetes.

Some say the proposed gym would have more value in the long-run, as a dialysis center would passively condone the spread of diabetes. However, patients say a tribal dialysis center is desperately needed. It is literally a life sustaining necessity.

"Looking at the generation coming up, where we have high rates of obesity already and diabetes in our children, we don't want to be setting them up to fail, but that's what we're doing," said Jace Killsback, Northern Cheyenne tribal president. "I can serve 30 dialysis patients, or I can serve 300 youth, or 3,000 residents here for a nice community and fitness center that would also address dialysis prevention."

The story of type II diabetes, a version of the disease

that is contracted later in life, in Indian Country is not new. Prevalence of diabetes is highest among Native Americans with a rate of 15.9 percent, according to the American Diabetes Association. This is more than double that of whites.

The disease, in which the body stops properly burning sugars digested in carbohydrates, can yield a number of symptoms and health ailments as those sugars build up within the body's systems over time. Symptoms range from mild, dizziness, frequent urination, to severe, including blindness and kidney failure.

However, diabetes is unique in that patients often have the ability to treat it into remission. It's a continuous battle in which patients must consistently monitor diet to maintain blood sugar levels, regularly take the prescribed medications and live an active lifestyle.

Yet, most reservations are rural and considered "food deserts," where fresh produce is expensive and scarce. Patients must rely on a crowded and underfunded IHS system, and community development focuses on essential projects, which usually doesn't include gyms or outdoor recreation facilities.

About 44 percent of the Northern Cheyenne population is younger than 20 years old, according to the United States Census Bureau. With such a large youth population to consider, Killsback is taking aim at the long-term outlook of diabetes.

He estimates it would take about \$700,000 to build a dialysis center in Lame Deer. If the tribe were to make an investment of that magnitude, Killsback said he wants to make the greatest impact possible.

Building a fitness center would leave those 30 dialysis patients in dire straits. It's a difficult decision and

Killsback knows it. But, after decades living on the reservation, he also knows the effects of diabetes.

It began with black spots on his feet, then the ulcers appeared. Old Mouse's legs eventually became infected and had to be amputated, or he likely would have died, he said.

After the ulcers appeared on his foot, Old Mouse saw a doctor in Billings that suggested stem cell treatment on his feet, to regrow the skin. But IHS denied the treatment three times, each time calling it experimental treatment, Old Mouse said. He still wonders if the treatment could have saved his legs, had IHS approved it.

"Let's try it, maybe I could've still had my legs. Maybe it would've worked and I lost them anyway, but at least try," Old Mouse said. "Don't just deny it. They're not God."

IHS paid \$19,000 for a prosthetic for his left side. He's still waiting for a right one to match, and he's hoping IHS will pay for that one as well. If so, IHS will spend nearly \$40,000 for both of Old Mouse's prosthetics,

IHS has a budget of about \$4,000 per person per year. The national average spent by health care on patients is twice that, at \$8,000 per person per year. While IHS broadly touts its efficiency with such limited resources, efficiency doesn't always translate to quality care.

After the infection in Old Mouse's legs, his doctor told him his kidneys were functioning at about 15 percent. They are failing, and fast. Old Mouse is in a pre-dialysis stage, and he hasn't come to terms with it yet.

"I'm still in good spirits about my legs, but not in good spirits about dialysis," Old Mouse said. "Dialysis is a game changer."

There are currently 30 people on Northern Cheyenne who need dialysis, up from 18 in 2010.

Type II diabetes is the leading cause for kidney failure in the United States. High blood sugar over time diminishes the kidneys' ability to filter and clean the blood. The most common form of dialysis is hemodialysis, in which a patient goes to a clinic and is hooked up to a machine. Blood is lead via catheter out of the body and into the machine, which acts as the kidney and filters the blood before another catheter leads it back into the body.

About half of all diabetes patients experience some form of nerve damage, according to the American Diabetes Association. Nerve damage in the feet can be especially problematic. It can cause loss of feeling in the feet, which makes it harder to detect sores that can easily become infected. In 2010, there were 73,000 lower limb amputations in diagnosed diabetes patients over the age of 20, according to the American Diabetes Association.

Dialysis patients on Northern Cheyenne must commute more than 100 miles to Billings three times a week



Jay Red Woman is a home dialysis patient living in Ashland, just outside of the Northern Cheyenne reservation. He says home dialysis is liberating for him because he is able to dialyze while he sleeps.

for treatment. The commute can take its toll.

It's just before sunrise, and Winslow Whitecrane is already in his driveway waiting for his ride. It's Thursday morning, his day for dialysis.

He doesn't dawdle.

"The van pulls up, honks and waits five minutes," Whitecrane said. "If you're not out in five minutes, you get left."

Normally, Whitecrane takes the IHS-provided van to Billings. It picks him up and drops him off at his house in Ashland.

The car makes its way toward Lame Deer to pick up another dialysis patient.

Elrena Whitedirt makes her way out of her home toward the car. She has a canvas bag atop her shoulder filled with blankets, water and food. She's come prepared for a long day.

"We kind of give each other support to make the trip easier, because me and him always end up getting stuck way in the back of the van," Whitedirt said.

Whitedirt and Winslow are two of the 30 people from Northern Cheyenne who make the commute.

Whitedirt said the disdain for the commute is universal among the patients.

Outside the capitol building in Lame Deer a fire burned with mounds of firewood next to it. The fire

burned for Rock Red Cherries, a tribal chief who had died recently. Killsback said the fire will burn for 2 days so Red Cherries' spirit can find its way.

Red Cherries was a dialysis patient that made the same commute as Whitecrane and Whitedirt. But the drive wore on him, and he stopped making the trip.

"He could've just kept going. He would've been still alive today. And there's a lot of them that happened to," Whitedirt said. "They all quit going. And they're gone now."

Dialysis patients don't have the luxury of missing a day of treatment or taking a day off. It is literally life or death.

"We have to go no matter what," Whitedirt said. "No matter what kind of condition it is. We have to go to dialysis."

While the drive can be physically taxing, those on dialysis who take IHS transportation pay little out of pocket. IHS provides the ride and meals at the end of the day.

Diabetes has proven to be a substantial financial burden on a system that is already financially strained. According to the Department of Health and Human Services, people diagnosed with diabetes have medical costs that are more than double that of a person without diabetes, on average.

End stage renal disease is one of the largest drivers of



Erena Whitedirt has suffered from hereditary kidney failure for 23 years. She usually leaves home around 8 a.m. and doesn't get home until 5 p.m.

Medicare costs, according to the National Indian Health Board. In 2009, one patient on dialysis cost Medicare approximately \$80,000 a year. Reducing the number of patients on dialysis could greatly reduce the burden on both Medicare and IHS.

The U.S. Government established IHS to provide health care to Native Americans in exchange for the land claimed by the federal government. In efforts to combat the diabetes epidemic sweeping Indian reservations, Congress established the Special Diabetes Program for Indians in the Balanced Budget Act of 1997. At the time, Congress allocated \$30 million to fund the program per year. That figure has since increased to \$150 million.

Tammy Roundstone, director of wellness at North-

ern Cheyenne Tribal Health, a tribally run health clinic, oversees the special diabetes program funding and works with community members with diabetes. She said much of her job, and the job of the community, is about prevention of and education about diabetes.

"I'm not just pushing prevention," Roundstone said. "I am prevention,"

But she is limited in what she can do in her role at Tribal Health. The facility does not have a doctor on staff, so they have to rely entirely on diagnosis information from the IHS clinic in Lame Deer.

Once a patient is diagnosed, Roundstone steps in to help. She does her best to provide the patient with a sound nutrition and prevention plan, though some don't follow through with it. Roundstone said some people lose the will to help themselves, and once that occurs, there isn't much she can do.

Other patients mistake their long-term treatments

for cures.

"They stop at McDonalds — which is bad for chronic kidney disease — on the way over, and they stop at McDonalds on the way back. One bun has so much nitrate in it, it throws off their whole dialysis," Roundstone said. "A lot of them are aware of that. They've already lost that concept of 'I want to help myself.'"

An alternative to dialysis and the commute to Billings is peritoneal dialysis, also known as home dialysis. Instead of traveling to a dialysis clinic and hooking up to a machine, peritoneal dialysis can be done in a patient's home.

Jay Red Woman, 51, is one of only three home dialysis patients on Northern Cheyenne. Red Woman initially traveled to Billings three times a week, but he couldn't do it anymore after two months.

"Every other day, Tuesday, Thursday, Saturday, we'd get up three o'clock in the morning. Alarm would go off



Killsback, right, says basketball is the favorite local pastime on the reservation. He wants to invest tribal resources into diabetes prevention through cultural and lifestyle changes.

like clockwork and get to Billings at about five-thirty in the morning. Get there to that clinic and get in there and I'd be all groggy and they'd hook me up. Over three-and-a-half hours I was on there," Red Woman said.

Red Woman found out about home dialysis from a nurse, and it immediately piqued his interest.

Vicki Armistead, a registered nurse and training coordinator at Dialysis Center Inc., said home dialysis has been around for a long time, but became popular in the 1960s.

The system works by attaching a catheter to the patient's abdomen, then using the peritoneum as a filter and solution to clean the blood.

Armistead said a full cycle can take eight to 10 hours to complete. The time required is one of the drawbacks for patients. But Armistead said many patients use it in their sleep.

Armistead said home dialysis offers several benefits

to patients beyond convenience.

"Peritoneal is more like natural kidney function," Armistead said. "They don't have the ups and downs. It also eliminates the need to be near a dialysis clinic at all times.

"I have more freedom and mobility," Red Woman said. "I can go camping. I just hang up my bag and dwell for an hour. It's such a relief."

With only one prosthetic leg, Old Mouse can't do everything he wants. In March, he was waiting for the opportunity to prove he could walk 50 feet with a walker and his one prosthetic. In late April, he managed that 50 feet, earning a prescription for his second leg.

"I want to walk outside, mow my lawn and feed my horses," Old Mouse said. His son currently takes care of

the lawn. Old Mouse gave away his horses shortly after his first amputation.

Old Mouse said he will be about 80 percent normal, with his second prosthetic. But as dialysis looms, that's something he's struggling with more.

Old Mouse wants a dialysis center in Lane Deer. Like others, Old Mouse views dialysis as a "death sentence" and he's worried about the toll the long commute will have on every facet of his life.

But for now, Old Mouse is focused on being home and making improvements to his house. He's making an addition, fitting himself with a larger bathroom to accommodate a wheelchair.

Losing his legs wasn't something he ever expected, but in the year since he lost them, Old Mouse is adjusting to everyday life, and has come to peace with his legs.

"I'm alright with losing my legs," Old Mouse said. "I have to be."◇

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Twice Promised

Two federal programs fall short for Fort Peck's veterans

Story: Rehana Asmi

Photos: Parker Seibold



Mitchell Headdress gets into a van that takes him to his appointment at the Veterans Affairs clinic in Miles City. He is one of many veterans on the Fort Peck Indian Reservation who take advantage of the tribally run transportation program.



Wes Headdress, director of Veterans Affairs for the Fort Peck tribes, sells raffle tickets at a fundraiser on March 22, 2017. The annual event raises money to help pay for veterans' transportation and lodging when they travel off the reservation for medical care.

Something was wrong.

It wasn't just his father's health issues, which were troubling on their own. It was all the moving parts: the miles to get there, the bureaucracy of trying to schedule a proper doctor's appointment.

Wes Headdress, an Army veteran who served a tour in Iraq during his 2001-2005 service years, helps others wade through the Indian Health Service and Veterans Affairs programs. He makes sure the veterans on the Fort Peck Indian Reservation can get to their appointments and that doctors and hospitals make the proper reimbursements.

But this time, it was his father, Mitchell Headdress, who is also a veteran. Wes fielded phone calls about his father's health, dealing with the IHS clinic and coordinating with the Fort Peck Warrior Center where his father was staying.

Then he felt like it went wrong. The local clinic, run by IHS, turned Mitchell Headdress away after a perfunctory checkup. They told him his symptoms weren't serious and suggested he go to a medical center 2 ½ hours away, to the VA clinic.

"He needs immediate care and (IHS) told him that it's not an emergency," Wes Headdress said, shaking his head. "They said you need to follow up with your VA medical provider, which is in Miles City, so that's

the latest problem I've had dealing with that garbage."

The hand-off was more frustrating considering Headdress' unique position. The father and son, like most of Wes Headdress' clients, have been promised twice over that they'd be covered. As members of a recognized Native American tribe, the federal government has agreed to provide them health care in historic treaties. Then in exchange for their military service, VA provides medical benefits and assistance.

American Indians and Alaska Natives serve in the military at a higher rate per capita than any other race, according to a 2012 Veterans Affairs Report.

However, despite falling under the protection of these two federal programs, Native American veterans often end up volleyed between the agencies, which are separated by hundreds of miles.

In 2010, the VA and IHS signed a Memorandum of Understanding to better coordinate health care between the two systems for Native American veterans. Taking effect in 2012, the agreement allowed IHS and other tribal health programs to bill the VA for direct care.

Between 2012 and 2015, the VA reimbursed IHS and tribal health programs \$16.1 million for direct care. Both the VA and IHS have been experimenting with telemedicine, a way to virtually connect rural patients in their clinics to doctors in other cities.

The IHS also plans to expand the partnership in 2017 to improve its pharmacy program and the way Native American veterans can be reimbursed for their medication on a national level, according to a statement published by Mary L. Smith, principal deputy director of IHS.

The lack of IHS resources continues to be a problem on the Fort Peck reservation, which has two clinics: the Chief Redstone in Wolf Point and Verne E. Gibbs in Poplar, about 20 miles apart. Clinics deal mostly with outpatient services, such as dental, labs, nursing, pharmacy prescriptions and preventative care. The reservation lacks a full-blown IHS hospital.

Therefore, it's not uncommon that IHS refers patients to off-reservation centers if it can't provide the needed service. If a patient needs a service that the IHS clinics cannot provide, they may be referred out to a partnered hospital off the reservation or one of the smaller community hospitals in Wolf Point and Poplar. However, not everyone can be referred out, and the prioritization usually comes down to what is known as a "life or limb" policy.

Lana Engelke has worked at the Verne E. Gibbs Health Center in Poplar for over 20 years as a nurse and as part of the electronic records team. The Fort Peck Service Unit is unique because of how far they are from tertiary care and other hospitals.

"It's always got to be in our mind how far we are from hospitals," Engelke said.

But even the nearby community hospitals in Wolf Point and Poplar are limited, since they're just as rural. When Engelke first started working on the reservation in 1997, IHS had just started billing more services to Medicare, Medicaid and later the VA, allowing them to let those reimbursements free up IHS funding for other projects.

IHS as a whole is handicapped due to its lack of funding. In 2017, the proposed national budget for IHS was \$6.6 billion to cover about 2 million American Indians and Alaska Natives. In comparison, the 2017 proposed budget for VA health care services was \$65 billion to cover over 6 million veterans.

Being a veteran who is eligible for care from the VA is a "double-edged sword," Wes Headdress said, as they can be passed along to VA outpatient clinics in Glasgow, Miles City or Billings where the patient, if eligible for VA medical benefits, is also promised access to appointments and medical services.

"It's really tough for us veterans to tell the IHS that we are (veterans). They automatically assume, 'Well that's your health care provider,'" Wes Headdress said. "We can use both, so why not take advantage of the one that's here rather than traveling two hours one way and two hours back?"

Mitchell Headdress, 69, lounged on a chair in the corner of the wooden porch of the Fort Peck Warrior Center. Above him, a sign read "Veterans Honoring



Wes Headdress, left, and Mitchell Headdress recount their experiences navigating health care between IHS and the VA as Native American veterans on the Fort Peck reservation.

Veterans.” Headdress leaned back against the wall, taking in the fresh air. He’d get bored inside the house all day. There’s no TV or radio unless his granddaughter comes by to show him her newfangled tablet. He checked his black flip phone resting on the porch railing and then looked out toward the gravel driveway.

He was keeping an eye out for a nondescript silver van owned by the tribal Veterans Affairs office. He had a doctor’s appointment in Miles City, about 2½ hours away from his home in Poplar. He had gone to the emergency room earlier that week for some possible kidney issues, but he was told to follow up with his provider.

He served in the Vietnam war, and he’s eligible for VA medical benefits, so that meant one of the VA clinics off the reservation.

It was almost 11 a.m. when Monica Campbell drove up in one of the two tribal VA vans. Campbell usually does secretarial and administration work at the tribal VA with Wes Headdress, but she helps out with transportation when she can. She doesn’t mind the driving, she said. It gets her out of the office.

Headdress raised a hand and waved to Campbell, but he didn’t stand up from his chair. He asked if it was alright to have a smoke before they set off. Campbell

nodded, still standing in the driveway. She lit a cigarette of her own, digging the toes of her shoes into the gravel while the two chatted. She’s not a veteran, but she’s raised two sons who joined the military.

Headdress’ appointment was at 1:30 p.m. “I don’t even know where the place is,” he confessed. He had been living in Page, Arizona and came back to his hometown to take care of his health. Until recently, before being diagnosed with diabetes and having open-heart surgery in Billings, he claimed to be healthy. He’s never had to use the VA system in Montana.

Campbell told him not to worry and put out her cigarette. She knew where the clinic was.

With about 147,000 square miles, Montana is one of the largest “catchment areas” in Veterans Affairs, said Mike Garcia, the public affairs officer at Fort Harrison Veterans Affairs Medical Center near Helena. Veterans Affairs manages 17 outpatient clinics, hospitals and facilities across the state.

Even with a less dense rural population, it can become a challenge to manage all the clinics over a large area, Garcia said. That’s why partnership with other



Mitchell Headdress grabs his bag of medication before traveling to Miles City for an appointment at the VA clinic.



Wes Headdress brings his basketball team together for a half-time huddle during the Poplar Youth Basketball Tournament. Headdress acts as a leader in the community, not only as the tribal VA director, but also as a basketball referee and a coach for his son Devon's team.

health providers becomes so important.

The closest VA clinic to the Fort Peck reservation is in Glasgow, about an hour away, but it's a satellite clinic with fewer services. Most veterans end up going to Miles City, 2 ½ hours away. If a veteran from Fort Peck needs surgery, they'll have to travel a bit farther to a full medical center, maybe five hours to Billings, or seven hours to the VA Medical Center in Fort Harrison.

Both legislators and directors of IHS and Veterans Affairs need to seek out the Native American perspective if they want to develop future programs that address health care for tribal veterans, especially in rural Montana, Wes Headdress said. A lot of problems that plague rural veterans are the same for veterans who live on reservations, he added, but there are also unique issues.

"Get our input on it," he said. "Don't just go by what you hear we need. Let us tell you what we need."

The VA has created programs to fill the coverage

gaps and reach out to rural patients. However, even those are mired in bureaucratic rules and haven't benefitted Native American veterans enough, Wes Headdress said. The Choice Program, for instance, just didn't work on Fort Peck.

The Choice Program is a 2014 congressional initiative designed as part of the Veterans Access, Accountability and Choice Act. The act made sure veterans could receive care at non-VA clinics if they were more than 40 miles away from a VA clinic or couldn't see a doctor within 30 days. The program received \$10 billion and a time limit: three years or until the money is spent.

It was a good concept, Garcia said, but rural Montana proved to be a tough host. For one, the language in the Choice Program doesn't specify if the clinic has the services a patient needs. So if a veteran were 39 miles away from the Glasgow VA clinic and needed to see a specialized doctor, such as a cardiologist, they'd

still be ineligible for the Choice Program.

The program is also run through contracts managed by Health Net Federal Services, instead of Veterans Affairs, in Montana. In theory, Garcia said this was a way to promote the expansion of partnered providers to get more care to veterans in rural areas. It didn't work as well as promised.

For veterans on the Fort Peck Indian Reservation, Montana's most isolated, the cost is only magnified by distance and the lack of resources.

"You're paying out of pocket whether you like it or not," Wes Headdress said, since programs like Choice often disregard time and distance when it comes to getting to appointments off the reservation.

The Choice Program had good intentions but didn't braid together the capabilities of both IHS and Veterans Affairs strongly enough. Tribes still need to rely on fundraising, nonprofits and other programs to fill in the gaps.



Mitchell Headdress smokes a cigarette on the front porch of the Fort Peck Warriors Center as he waits for his ride to an appointment at the VA in Miles City. He doesn't have a television or radio, so he spends much of his time sitting outside or reading.

Recently, Wes Headdress set up a fundraising raffle at the tribal office building in Poplar. Members of the community trickled in, buying tiny blue raffle tickets and eyeing the possible prizes: a 50-inch TV, a Playstation 4 with the newest Call of Duty game and some Beats speakers.

By 2 p.m. the tribal VA had raised almost \$4,500, an even better haul than last year. This money would go towards paying for motel rooms and transportation for veterans traveling to their doctors' appointments under the Choice Program.

Lance Elliot Fourstar, 41, has a deep, rumbling voice

and the quiet confidence that comes from being over six feet tall. He joined the military in May 1997, working on medical equipment. He knew he qualified for VA medical benefits, because he helped many veterans apply for their benefits when he worked as a case management technician for the Fort Peck Warriors Center.

Veterans are usually eligible for medical benefits if they have served in active duty and received any honorable discharge or had a service-related injury. In Montana, there are about 74,000 veterans eligible for VA benefits, but only about 47,000 are enrolled, according to a 2017 VA report.

Fourstar said the role of a warrior is one of the highest honors in the community, and when a veteran returns from service, they're usually expected to take on

some sort of leadership position.

"We don't owe it to the United States of America to serve," he said. "But we do anyways, in disproportional amounts, because of what's been passed on through generations, as our roles as warriors. We're supposed to protect and provide for our community."

Fourstar has no interest in using the VA clinics. He tried applying for his medical benefits in the past, but there was always some issue — his application would get lost on the way to Glasgow, or something would be wrong on his form. He didn't think it was worth pursuing if he would just get lost in the system again, especially when he could use the IHS facilities as a member of the tribe.

Fourstar stopped working at the Warriors Center in

December after he caught pneumonia and felt himself burning out. His background wasn't in social work, but he brought his own life experience to help relate to the veterans who came in for help.

The Fort Peck Warriors Center is run by the Fort Peck Housing Authority with a grant from Veterans Affairs. Robin Bighorn, director of the housing authority, oversees the three dry houses while Gilana Rivkin coordinates the program. Bighorn said it can be a challenging program to operate.

Many of the veterans he and his outreach team talk to aren't sold on the idea of a curfew and dry house. They're used to their freedom. These temporary houses also only have single rooms, so they can't house families.

"It's very difficult to get the veterans to come in," Bighorn said. "But those that are willing to utilize the houses, they're doing good."

The Fort Peck Warriors Center works alongside other tribal health programs so residents like Mitch can receive home visits from the Tribal Health Diabetes Program. Before his appointment in Miles City, Mitch and Wes sat around the kitchen table while Michelle Aguilar and Morgan Martell set up shop to check Mitch's blood sugar and blood pressure.

Home visits are a distinct element of the program, since not every patient can make it to the tribal health office that's annexed to the IHS clinic. Martell said they also help refill water coolers and do pharmacy pickups from the IHS clinic.

"One good thing about veterans is, in some places, they take care of you," Mitch Headdress said, sitting in his chair on the porch of the Fort Peck Warriors Center. "The tribes are trying to take care of their people, but it's the money." Funding keeps getting cut and he wonders what future generations will have to deal with.

He wore his sunglasses this time, hoping for the sky to clear up. The wind blew the ash from his cigarette onto the floor. He doesn't harbor any faith in IHS.

"You have to be dead before they do anything to you," he said.

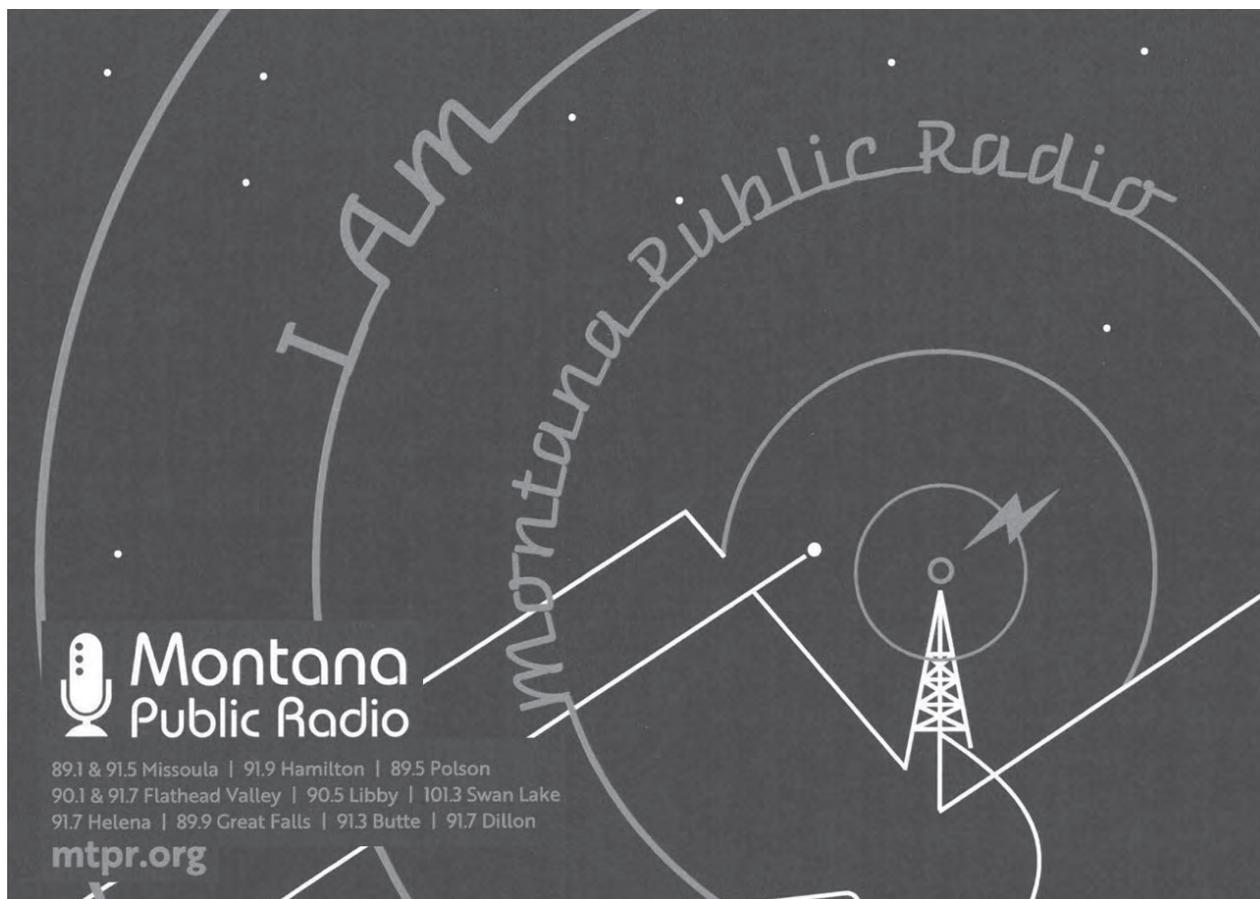
But even the VA system can be frustrating. It turned out Mitch Headdress' appointment wasn't until the next Thursday. It had been a wasted trip to Miles City.

"I thought maybe I could get some help," he said. "But it didn't work out."

Mitch Headdress returned to Miles City the following week for his checkup with a VA doctor. He felt like they spent more time on him, and overall, it was a better experience. He was referred by his doctor to come back to Miles City to see a specialist, something like a urologist, he said, in June. Then, hopefully, he'll know what's wrong. ♦



As a veteran and leader in the community, Lance Fourstar helped organize and lead community members in a walk protesting the Keystone XL pipeline on March 26, 2017.



Untapped Water

Rocky Boy's struggles for adequate infrastructure

Story: Abby Lynes

Photos: Chelsea Culp



Steel pipes sit in a field above the Tiber Reservoir, also known as Lake Elwell. To date, 21 miles of pipeline have been completed of the approximately 54 miles needed to reach Rocky Boy's Indian Reservation.



Ira Moreno inspects the water from his well. He says his well might be a little rusty, but he prefers that over the Rocky Boy's water system. "Those guys up there are always on a boil order," Moreno said.



Shalee Russette, project manager for the Rocky Boy's/North Central Montana Regional Water System Project, stands beside a 60-foot long trench box that protects employees working on the pipeline.

Every day since December,

Leana Wright wakes up and boils a large pot of water on her stove. She drags it to the bathroom and sets it on a stool near the bathtub. She dips in a loofa, and rubs out a soapy lather. Then, she washes her face and body.

She has to be quick or the water will get cold.

It has been months since she's been able to take a shower in her home. It's a mundane ritual turned romanticized luxury: to put her hands under the warm water spray and wash her hands and face.

Wright has lived in an aging trailer just up the road from Rocky Boy Agency for 10 years. At least once every year, she loses access to water and has to repair pipes below her trailer. It needs new insulation and a hot water heater.

Part of the problem is the old pipes. But part of it is shaping up to be a community issue.

Wright was one of more than 2,500 people to lose access to clean drinking water this past winter when the reservation's water system faced its worst break yet, and the loss of water pressure damaged her house's old, fragile pipes.

Infrastructure on Rocky Boy's Indian Reservation is in dire need of an upgrade. Aging pipelines continuously fail to deliver water to old, overcrowded homes, leaving varying sections of the reservation without clean drinking water several times a year. On top of that, efforts to build a pipeline to bring water from Lake Elwell have been blocked by funding issues and an embezzlement scandal.

From mid-December to early January this year, the Environmental Protection Agency issued a boil order

for the more than 2,500 people on the reservation water system, and Tribal Water Resources scrambled to deliver bottled water to its residents.

The Rocky Boy's community water system consists of about 700 homes, while 150 to 200 homes are on individual wells. Homes with wells weren't affected.

It was a cold winter, and rather than pay for the propane to heat their homes, a number of families vacated to spend the season with family and friends. Tribal officials said these families left without shutting off the main water lines into their vacant homes.

Many of the houses on the reservation are not energy efficient. The insulation in Wright's trailer has fallen apart.

"And it costs money — a lot of money — to fix it," she said.

Cold temperatures this winter, along with an aging water pipeline system, with low pressure caused pipes to freeze and crack, allowing contaminated groundwater to seep into pipelines.

While not an uncommon occurrence in central Montana, the effect was exacerbated by a low supply of source water in the small aquifers scattered across the reservation. This created low pressure in the water system making it easier for pipes to freeze and crack. This tends to affect clusters of homes at a time, either severely decreasing water pressure even more, or wiping out access to water entirely.

Residents on Rocky Boy's have been left without access to clean drinking water time and time again, and many people don't trust the tap water enough to drink it. Wright said that even when she does have water flowing in-home, it tends to have a chlorinated taste. Many people buy bottled water.

The Rocky Boy's reservation, home of the Chippewa Cree, looks like a severe drought has taken effect.

There are no green lawns on the reservation. Children don't run through sprinklers or swim in pools. The water supply is so low that people can get fined for watering their lawns in the summer. Filling up a pool could completely throw off a neighborhood's water system, because its storage tank wouldn't have enough time to replenish itself to deliver water to other houses.

There isn't enough source water to even have a car wash on Rocky Boy's.

Right now, water is drawn from aquifers across the reservation. It is cleaned and treated and then goes into a storage tank. There's one storage tank for each neighborhood. From there, it goes to people's homes. People who are on wells have either opted out of the community water system or have homes too far away to connect to any pipelines.

To fix the reservation's water issues, Tribal Water Resources Director Dustin White has been pushing to finish construction on a pipeline to bring water from Lake Elwell, also called Tiber Reservoir, about 50 miles west, to Rocky Boy's and surrounding communities in northcentral Montana. It would eliminate the water pressure problem and the water would taste better.

White has been working with tribal councilmen and the Chippewa Cree Construction Corp. to secure funding for the \$228 million project that would bring 30.9 million gallons of water per day over from Lake Elwell to Rocky Boy's.

At the rate at which the project is receiving funding, it won't get completed in Wright's lifetime. While tribal officials have managed to secure half of the funding for the project, it took 15 years. The funding



Above: Leana Wright experiences multiple pipe breaks every year. This past winter was particularly bad, she has been without hot water since December. To bathe, she boils her water in a single pot. “You’d be shocked at how little water we use. We know how to save water,” Wright said. Below: Wright boils a large pot of water and carries it to her bathroom every evening to bathe. She then mixes the boiled water with a pot of cooler water to get the right temperature. The bowl placed on top of the stool is strictly for rinsing. “It’s just like a shower,” Wright said.

mechanism has slowed due in part to a slew of embezzlement convictions. At the rate the funding is being allocated, and as costs continue to rise, White said the project won’t get full funding for another 70 years.

Once the project gets closer to completion, White will apply for grants through the Indian Health Service to upgrade the water system on the reservation itself and get more households who are now using wells on the community water system. Most people on wells don’t have them regularly tested, and water from the lake will be better than any well water, residents say.

At this point, about \$160 million is needed to complete the project.

However, in 2013, reports started to surface regarding misspent or missing grant money by the former chief executive officer of the Chippewa Cree Construction Corp., Tony Belcourt.

Federal officials temporarily halted construction of the project in 2013 after a string of allegations against Belcourt that he accepted bribes and kickbacks from consultants and contractors who were awarded federally funded contracts, including federal stimulus aid.

Belcourt was convicted in 2014. He was sentenced to 7½ years in prison and ordered to pay more than \$600,000 to the Chippewa Cree tribe and the IRS.

White and other employees at the company said they were in the dark about the whole thing. White said the tribe has implemented new policies to prevent it from happening again and is ready to move forward.

One thing is clear, though: Rocky Boy’s residents need water now, not in seven decades.

Leana Wright is one of many people who avoid drinking the tap water on the reservation. It’s not that she doesn’t trust it. The water just isn’t always available to her, and she dislikes how much it tastes of chlorine.

Tribal Water Resources must meet federal chlorine levels standards. Officials say those levels are where they should be. However, Wright said she can taste chlorine in the reservation tap water. Her husband’s socks turn a lighter shade of black in the washing machine, as if washed in bleach, she said.

She buys a lot of bottled water and is very cautious of the water that comes out of her faucets — when it comes out.

“A shower is a luxury,” she said. “Washing your clothes in your own home is a luxury.”

Water is only one component of a larger infrastructure problem on Rocky Boy’s. Many houses on the reservation come from Malmstrom Air Force base in Great Falls. The structures are old and not very energy efficient.

Additionally, the Chippewa Cree Housing Authority

has a list of more than 500 people who want low-rent homes.

Housing is only able to provide homes to about 10 families a year, according to Executive Director Ursula Russette.

Building a house independently is expensive which most residents can't afford. So most people either inherit their houses or wait their turn on the housing authority list. Wright was unusual e, in that she was able to buy her house.

Many people live in overcrowded houses. At one time, Wright had 12 people living in her then-three bedroom home.

It's common to have two to three families staying in one unit, Russette said. Housing could visit a home where two people live one day, and the next day, it wouldn't be unusual for another five people to be living there, she said.

Ira and Pearl Moreno also have a house full to the brim with six kids, one elderly grandfather and six cats. It's a five-bedroom, two-bathroom house they inherited.

The Morenos have been in their home for nine years, although they've only had access to drinking water, via a well, at their house for seven years. They had to negotiate with Housing and Tribal Water Resources for a few years before they could move in.

They initially got a well to save money. People on the community water system have to pay a monthly \$25 flat fee.

The Morenos also mistrust the community water system because of a contamination case in 2012, when someone broke into a water tank and contaminated the water with wooden boards, concrete and animal feces. Officials didn't discover the contamination for weeks.

However, even the Morenos' well water is visibly silty.

Sometimes, Ira Moreno will leave water in a plastic container overnight and there will be a residue the next day. The water leaves a layer of rust over his entire shower, and the Morenos have to use a special cleaner to get it off every three weeks.

Ira Moreno, who admits he hasn't tested or treated the well water, said it is drinkable. Still, the Morenos tend to rely on bottled water for drinking.

Obtaining the right to live in their house was a lengthy, exhausting ordeal. Though they love their home and have big aspirations for it, including building cabins and a dock on the lake, water is a major component that isn't working out for them.

If the Tiber Reservoir went through, though, the couple said they would consider getting on the community water system.

The only thing in the way of completing the Tiber Reservoir pipeline is funding. If the tribe had the funding it needed, the project could be completed in four years.

Russette is planning to go to Washington, D.C. this summer, along with mayors from other communities representing more than 30,000 people in the region that will receive water from the pipeline.

Sen. Jon Tester, D-Mont., said he has helped secure funding for the project in the past, and he'll continue to push for funding in the future.

"Access to safe, reliable drinking water is fundamental to the health of rural communities and Indian Country," he said.

Though it's not quite as bad as on the reservation, infrastructure is aging in communities throughout the region.

Russette went to Montana Tech of the University of Montana on a full-ride engineering scholarship specifically so she could come back to the reservation and work on the Tiber project for the Chippewa Cree Construction Corp.

Keely Barry, an engineer-in-training from a firm in Great Falls, also works on the project. The two hope to see Lake Elwell become tribal trust land.

Barry said she and Russette are working on the project to help improve the tribe's water system, which barely sustains everyone on the reservation even when it's running perfectly. They want everyone to have reliable access to clean drinking water on the reservation.

Neither wants people to have to spend money on bottled water or limit their intake because they're afraid to drink from the sinks in their own homes.

"No one should have to live like that," Berry said.◊



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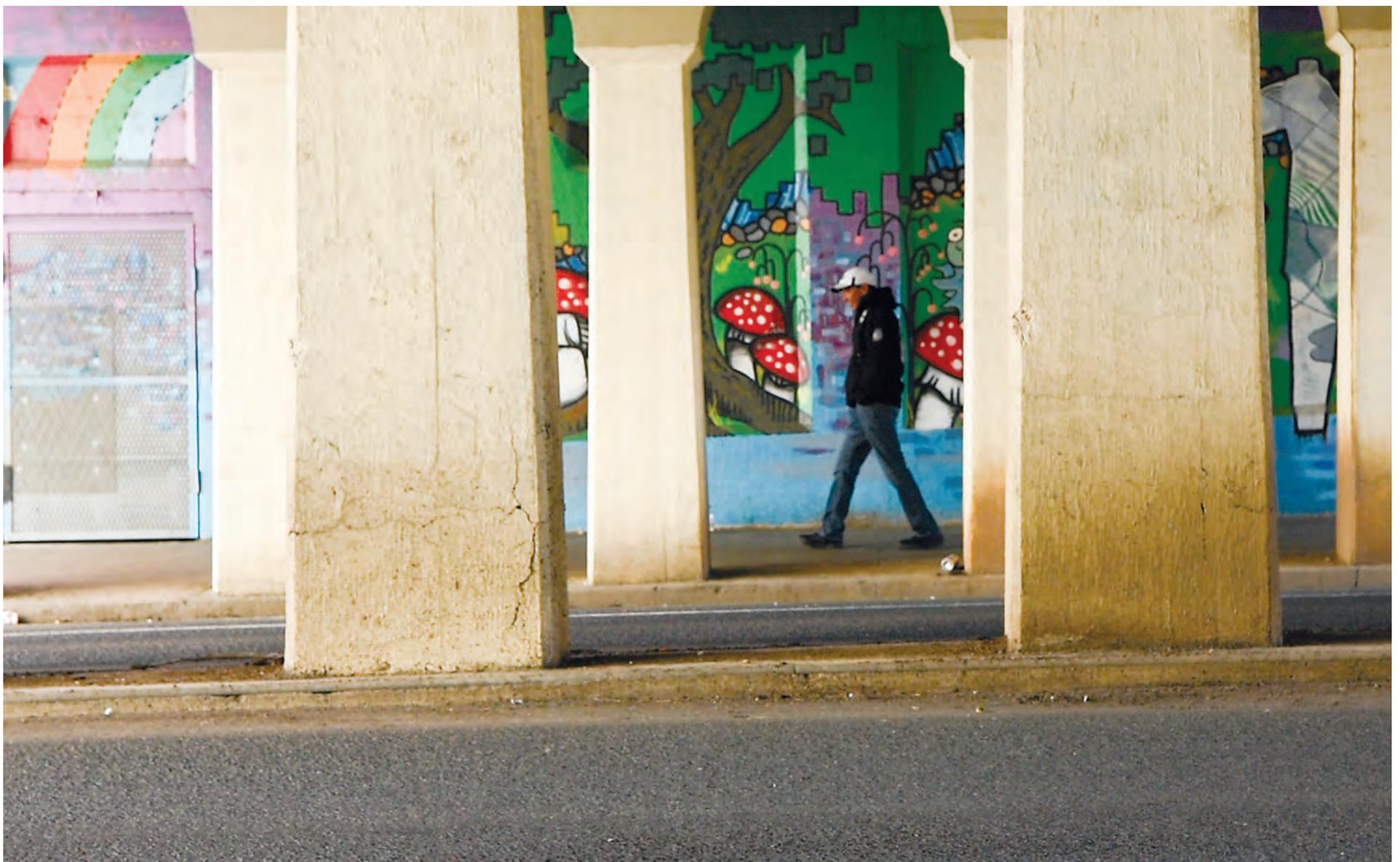
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Restoring Health

For urban Indians, Medicaid succeeds where IHS fails

Story: Zachariah Bryan

Photos: Jamie Drysdale



Accustomed to a fast-paced life as a professional in Washington, D.C. and Billings, Montana, Loren BirdRattler said a big challenge to living homeless was finding something to fill up his day.



Preparing his notes before testifying in Helena, BirdRattler admits that whenever he speaks before the Blackfeet Tribal Business Council in Browning, their first question often involves what color socks he's wearing.

It was Friday, the end of a busy week for Loren BirdRattler, Blackfeet Nation's agricultural resources manager. He was driving around the Blackfeet Indian Reservation in his banged-up 2001 Buick LeSabre. His attire stood in sharp contrast against the rugged terrain around him: A purple collared shirt with a matching purple patterned tie, pinstripe slacks, a black overcoat.

He was showing off the many projects he had gotten involved in since starting his new job in June 2016: a new water compact that he helped pass through tribal council vote in May, a conservation district, a noxious weed cleanup and plans to support Blackfeet farmers and producers. He also chairs the state Youth Suicide Prevention Commission, which recently helped pass a bill in the legislature that would allocate \$1 million to the cause.

This is where he's comfortable. He has a long resume with a smorgasbord of organizational development, policy and advocacy positions, taking him to Washington, D.C. and back. He lists positions with high profile organizations like the Smithsonian Institute, Department of Defense and, most recently, as inaugural executive director of Western Native Voice and Montana Native Vote.

Those last two positions ended four years ago. He became sick and then homeless, leaving a gap in his resume from 2013-2016. He picked up trash, bartended and slept on benches and in abandoned houses in Washington state, having fallen through the cracks of both the state and tribal health care systems in Montana.

He was rebuilding his life in Spokane, where he received health care through Washington's Medicaid

expansion, which Montana, at the time, had failed to pass itself.

It saved his life.

State officials believe that a little less than half of Montana's population of 70,000 Native Americans live in urban areas. Urban American Indians are described as the "invisible tribes," a group of people who are poorly understood, experience greater health disparities and are often ignored in the national conversation on American Indian health.

Treaty obligations require the federal government to fund health care for Native Americans, a responsibility that is fulfilled by the Indian Health Service. However, most of that money is concentrated on

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Loren BirdRattler is a regular at the Two Medicine Grill, just a stone's throw from his house in East Glacier on the Blackfeet Indian Reservation.

reservations. Less than 1 percent of the nation's IHS budget goes toward a smattering of Urban Indian health centers, \$44 million out of \$5.7 billion nationwide, according to the U.S. Department of Health and Human Services 2016 budget.

That scant funding comes in the form of grants and contracts, which often come with strings attached and specific parameters, such as diabetes or tobacco prevention programs. According to the Urban Indian Health Commission, there is no uniform national policy regarding Urban American Indian health care.

IHS does not focus on tribal members living in urban areas because those communities are not part of sovereign nations, said Aren Spark, government affairs director for the Seattle-based Urban Indian Health Institute.

"(It) is an easy out for them because then they don't have to spend as much money," Spark said. "That way you don't have to pay attention to all the Native people, which would be a much larger sum of money."

Just two out of the five urban Indian health centers in Montana have a clinic with limited primary care and other services, while the others act mostly as referral centers. Before Montana expanded its Medicaid program, many fell into a gap where they made too much money to qualify for Medicaid, and

made too little to afford the high premiums of private health insurance. It was common for urban Indians seeking treatment from IHS to drive back to the reservation.

BirdRattler opted out of health insurance when he was executive director of Western Native Voice in Billings. He figured he was healthy, he said, and if something ever arose, he could just drive to the IHS hospital on the Crow reservation.

In 2011, the same year he started working at Western Native Voice, he began a new medication prescribed by RiverStone Health, a Billings-based public health nonprofit, for a chronic illness he declined to disclose.

While the medication worked, he started developing side effects. Specifically, psychosis. It was gradual at first, enough for him to convince himself that nothing was wrong.

BirdRattler said he didn't let his growing inner struggles affect his work.

"I'm very meticulous about how things appear. I'm a perfectionist. I wanted perfect results. That drive (for my work) never stopped during that slow degradation," he said.

His problems persisted, culminating in spring

2013. He quit his position at Western Native Voice and went back home to the Blackfeet reservation.

He started having suicidal and homicidal thoughts.

"I justified in my mind that it was OK to take another life," he said. "There were times I felt I was ready to pick up a gun and begin to take people's lives."

One morning, he woke up and knew something wasn't right. He decided he needed to leave, before he actually hurt the people he loved the most: his friends, his family and his lover. He packed up his suitcase with three changes of clothes and his mother drove him to the train station. He was off to Spokane.

"I got on the train with no intention of ever coming back here, no intention of ever having ties with my family," he said. "That's how bad my state of mind was at the time."

It was a choice that saved his life, he said.

Washington passed Medicaid expansion three years before Montana did, and BirdRattler fit perfectly into its parameters.

With health insurance, BirdRattler was able to see a team of doctors in Spokane. They quickly identified that it was his medication causing the psychosis, and put him on a different medication. He worked with the providers on a plan to put him on the road to recovery. He had a whole team on his case: a physician, a physician's assistant, a pharmacist and a nutritionist. The experience was "eons ahead" of what he saw at IHS, which didn't have the resources to pay such close attention to his health.

His mind began to clear, he said, but it took time to heal fully.

"I think about those times and I often equate it to an LP record, when you put a scratch in it," he said. "Every time that needle comes around, it's going to hit that scratch. It takes a while to buff out those scratches, to not go back to where you were."

When the Affordable Care Act rolled out, it came with much promise and fanfare, and there was no shortage of initiatives targeting Native Americans for enrollment. Yet many Native Americans who are eligible for insurance in Montana remain uninsured.

Of the roughly 70,000 Native Americans eligible for reduced coverage in Montana, only about 17,000 have signed up. Another roughly 22,000 appear to have insurance through their employers, according to an analysis of state and federal employment records by the Billings Gazette in September, 2016.

Helena Indian Alliance, one of the two Urban Indian Health Centers in Montana that have a clinic, has been on the front lines. When the ACA marketplace first rolled out, Executive Director Tressie Smith said

there were a number of challenges: higher premiums, application glitches with the Affordable Care Act website and a long, complicated process.

Julie Burrows, enrollment coordinator, said it could take up to three visits, each two to three hours long, to guide a person through the process. And big enrollment events, no matter how well-advertised, proved to be ineffective, Smith said.

"Most of those were failures," she said. "What we really needed to do was target people and get one-on-one with them."

Medicaid expansion, which was enacted in 2015 after the state legislature passed the Health and Economic Livelihood Partnership, or HELP Act, has succeeded where the ACA private insurance marketplace faltered. So far, nearly 10,000 Native Americans have enrolled in Medicaid, and more sign up every day, according to a February report from the Montana Department of Health and Human Services.

Helena Indian Alliance has been an especially effective partner in the rollout. In 2011, when the organization first started tracking insurance numbers, 80 percent of their patients were uninsured, 9 percent had private insurance and almost 6 percent were on Medicaid.

In the first quarter of 2017, the numbers have changed dramatically: 39 percent of patients were uninsured, 17.6 percent had private insurance and 39 percent of patients had Medicaid. Overall, from 2015 to 2016, the clinic saw 25 percent more patients, which Smith largely attributed to Medicaid expansion.

"That's a big thing. Every one of those (people) matters," said Lesa Evers, tribal relations manager for the state Department of Health and Human Services. "Every one of those now have access to preventive care, to dental care, to eyeglass, to mental health and substance abuse services, this whole myriad of coverage they didn't have before."

Evers explained that Medicaid opens up a whole new world of options for Native Americans, many of whom aren't used to having private health insurance. Where before, if they went to IHS, they could be turned away if their health condition wasn't life threatening, now they can seek the treatment and operations they need. And if a patient needed care that couldn't be provided at an IHS facility, there were only so many dollars available to refer them to outside hospitals.

Having insurance could be critical in closing the life expectancy gap between Native Americans and other races, Evers said. According to a 2013 report, "The State of the State's Health," on average white men in Montana live 19 years longer than Native American men, and white women live 20 years longer than Native American women.

"That's a big deal," she said. "If we would've had



Lesa Evers, tribal relations manager at the Montana Department of Health and Human Services, says Medicaid could be a crucial step toward closing the 20-year life expectancy gap between Native Americans and Caucasians.

access to preventative care, if we understood what it is, if we knew what it meant to prolong life—to stopping disease or slowing disease — if we understood all that, maybe we wouldn't have this 20-year difference in lifespan," Evers said.

There will always be challenges in providing health insurance to Native Americans, she said. Health insurance is a new concept for most in Indian Country, and it's complicated, especially for a group of people who historically have received health care without having to worry about medical bills. There's a whole world of lingo that needs to be mastered: premiums, copays, deductibles and more.

"I think, for most people, it seemed out of reach, so they would just continue to use the limited services they have available to them," Evers said.

Lisa LaMere, 35, who lives in Billings, is a Chipewewa Cree descendant and qualifies for enrollment in the federally unrecognized Little Shell Chippewa Tribe. She has eight prescriptions. She uses them to treat a number of ailments: depression, anxiety, diabetes, high cholesterol, chronic heart burn and a kidney that has been losing function over the past year.

Before she qualified for Medicaid under Montana's HELP Act, she had to scramble this cocktail

of pills together in an unorthodox fashion. She got the majority of her medicine at the Billings Indian Health Board. But they didn't have everything, so she went to RiverStone Health to pick up two others through a discount program.

Sometimes, the Costco Pharmacy would be cheaper. Other times, she made the 90-mile trip to the Crow reservation IHS facility, but she didn't like the way they treated her. As an outsider, she felt unwelcome, like the staff expected her to seek treatment at her home reservation.

LaMere couldn't pick up all her prescriptions at the same time. They came on different days. If she missed a pickup, and didn't take certain medications for even a day, she experienced debilitating headaches.

Just talking about the process made her feel tired. LaMere is a working single mother of two, so taking hours, sometimes full days, off of work multiple times a month to pick up prescriptions or to see the doctor to get a new prescription, was unsustainable.

"I'm only 35 years old," she said, lamenting she was too young to have so many health problems. "To be on all those medications is a huge hassle to begin with, and then the time and energy it took to wait everywhere you go, any services that are for low income, you just have to wait for an extra long time."

Medicaid changed that. Now, LaMere can see her doctor and pick up her prescriptions all at the same



After spending almost two years living homeless on the streets of Spokane, Loren BirdRattler is back home with a roof over his head. Medicaid expansion in Washington helped BirdRattler get back on his feet again.

place, the Billings Clinic, which is right next to where she works. No more scavenger hunts for pills.

“I don’t know what I would do without Medicaid in my life,” she said. “I wouldn’t have the same level of life as I do now.”

Many Native American leaders and advocates were on the edge of their seats when Donald Trump was elected president and Republicans took over both houses of the Legislature. The administration has made it a top priority to repeal the Affordable Care Act, which would likely include cuts to Medicaid.

The House of Representatives failed to pass a replacement program, the American Health Care Act, in March. In late April, a new version of the act nar-

rowly passed the House, although experts are skeptical the bill has enough support in the Senate to follow suit.

“They don’t have the votes (to roll back Medicaid),” said Mark Trahan, an independent columnist who has been writing almost daily about the health care debate on his website Trahan Reports. “You see a lot of conservative states decide that the numbers worked out.

That includes Sen. Lisa Murkowski (R-Alaska), who said she would not vote for cutting down Medicaid expansion so long as state leaders still embraced it, despite her criticism of the ACA.

As for Montana, Sen. Steve Daines has said he supports cutting back Medicaid.

In this administration, nothing is safe, Trahan said. In March, he said he had heard rumors that Re-

publicans were already working on another attempt to repeal and replace ACA, and Indian health could be on the chopping block.

“They’re all in the target sights, the question is, can you get consensus? That’s the challenge now, they can’t get consensus,” Trahan said at the time, noting that the debate over healthcare has revealed deep divisions in the Republican party. Montana health care leaders are listening closely to the national debate, but at least for the time being, all they can do is keep operating like Medicaid expansion and other provisions of the Affordable Care Act are here to stay.

“I don’t think people should become paralyzed or stifle what they’re doing,” DPHHS Tribal Relations Manager Evers said. “We have it today. Let’s use it today, let’s continue like it’s going to stay in place for a while.”



After a successful career that took him across Montana and to Washington, D.C., Loren BirdRattler found himself on the streets of Spokane after suffering devastating side-effects from a medication he was taking for a chronic infection.

On Christmas Eve of 2015, BirdRattler returned to the Blackfeet reservation. He reconnected with his family, found old friends and helped his uncle out on the family ranch in Birch Creek.

He decided to stay.

In the spring of 2016, Verna Billedeaux, ex-officio member of the Natural Resources Conservation District, encouraged him to apply for the newly created agricultural resource manager position.

"I love his energy, love his passion, love his vision," she said over the phone.

So, he applied. He was interviewed and hired and he's been going 90 miles per hour ever since. Working a policy and organizational development job is like riding a bike, he said.

Thinking on it, BirdRattler said he likely would have never made it back to this kind of position, back

to his home, without that break in Spokane when he was able to receive insurance through Medicaid expansion. It was a slow climb up, he said, but he made it.

"To be patient was a hard lesson for me," he said. "To be patient and allow things to fall into place. I'm spiritual. I do have a relationship with the Creator, I knew the Creator had me on a path and that I just needed to be patient and things would manifest. And they did."

BirdRattler still visits Spokane every now and then. It's like a second home, he said. On a recent sunny April day, he clambered down a slope of rocks under the bridge overlooking the Spokane Falls. He found the spot where he had camped out so many times when he was homeless. He looked out onto the Spokane River, which, fueled by snow melt from a good winter, was higher than he had ever seen it.

The water was raging, constant, boiling foam white. Spray wetted the rocks and the litter where he had once slept.

He thought of other Urban Indian Americans, who perhaps didn't have the same resume and support system as he did.

"When you're really talking about the impacts (of Medicaid expansion) on urban Indians, they're profound," he said. "You're really talking about a population that's in this gray area, that doesn't get direct health care from Indian Health Service, that doesn't have access to health care on the reservation, that doesn't have access to health care off the reservation, in the urban areas where they reside.

"That is just egregious. I think as an industrial, advanced society, we can do a helluva lot better in coming up with solutions to raise them up and provide adequate health care for them."◇



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