Overcoming the Distance:
New Mexico Tribal Behavioral and Mental Health Response to the COVID-19 Pandemic

Prepared By:
Philip Essienyi, MPH & Marina Zambrotta, MD

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I. EXECUTIVE SUMMARY

While the COVID-19 pandemic has been first and foremost a physical health crisis, it has also fueled a major mental and behavioral health crisis within the Native American community. Nonetheless, through collaborations with not-for-profit organizations, academic institutions, and government agencies, Native Americans have been working passionately and diligently (within the constraints imposed by COVID-19) to deliver mental and behavioral healthcare services for New Mexico tribal populations.

Our research project thus represents an important effort in identifying Indigenous challenges and innovations in delivering behavioral and mental health care during COVID-19. Specifically, we sought to identify what worked, for whom, and under what circumstances and how their successes can be shared with and replicated in other New Mexico Native American communities.

One of the main findings, and one that has been reinforced by COVID-19, is that mental and behavioral healthcare requires culturally-grounded solutions that are community-based and community-driven, as well as strong collaborations between Native American providers, tribal leadership, and government entities.

We also found that in the face of abject resource scarcity, it is the creativity, dedication, and resilience of providers (at both tribal behavioral and mental health programs and the Indian Health Service) that is lighting the path of recovery in Indigenous mental health.

So, although COVID-19 has brought enormous challenges to care delivery, there is opportunity in this crisis that should not be wasted by the New Mexico Native American behavioral and mental health community. Hence, we recommend using COVID-19 as a catalyst to invest in sustainable solutions to longstanding barriers to accessible behavioral and mental healthcare for Native Americans in New Mexico. Specifically, we recommend the following:

1. Improve availability of services by enhancing broadband access and bolstering the behavioral and mental health workforce, including direct providers and case management.
2. Improve affordability of services by expanding awareness and uptake of public insurance and safety net programs.
3. Improve acceptability of services by partnering with tribal schools, engaging in community outreach, and increasing the number of native providers.

4. Improve accessibility of services by building on-call mobile response teams and hotlines for coordinated crisis response in tribal communities.
5. Improve collaboration among tribal behavioral and mental health providers across the state of New Mexico by appointing a Native American Liaison in the NM Behavioral Health Services Department.

It is our hope that this report will serve as a guiding tool for all those so passionately invested and intimately engaged in improving mental health outcomes throughout the Native American community in New Mexico. Your hope and resilience are inspiring.

II. INTRODUCTION

Pre-Existing Disparities in Behavioral and Mental Health

American Indians and Alaskan Natives face significant health disparities when compared to the general US population.[1] This is especially apparent in behavioral and mental health, with adjusted death rates from alcoholism (520% greater) and suicide (60% greater) compared to overall death rates in the United States.[1]

The COVID-19 pandemic has disproportionately impacted American Indian communities, therefore further exacerbating the pre-existing health disparities across Indian Country.[2] A study by the Center for Disease Control (CDC) noted a cumulative incidence of COVID-19 cases among AI/AN individuals was 3.5 times that among non-Hispanic whites.[2]

The state of New Mexico is home to 23 tribal nations (Figure 1). According to the 2020 Census, American Indians and Alaska Natives make up more than 10% of the state's population.[3] New Mexico's tribal nations were significantly impacted by COVID-19. In May 2020 Navajo Nation (which spans across parts of Arizona, New Mexico, and southern Utah) surpassed New York State for the highest per capita coronavirus infection rate in the US.[4] At one point during the pandemic, Native Americans made up nearly 60% of all COVID-19 cases in the state of New Mexico with alarming hospital admittance and fatality rates.

Figure 1: Tribal Nations in New Mexico

COVID-19 Increased Prevalence of Behavioral and Mental Health Conditions

Many studies have documented the impact of the COVID-19 pandemic on behavioral and mental health.[5] The pandemic led to a spike in risk factors for mental health, including social isolation, unemployment, overall feelings of insecurity and instability, and grief associated with the death of loved ones. This was observed in many of the Indigenous communities in this report, as they reported an increased prevalence of

anxiety and depression, increased suicide cases, increased substance use, and increased incidence of domestic violence since the start of the pandemic. COVID-19 social distancing measures presented barriers to access to behavioral and mental healthcare for these conditions including closure of both inpatient and outpatient treatment facilities, inability to get an in-person appointment with a provider, and fear of leaving the home due to the possibility of contracting the virus.

Previous Work by Harvard Nation Building Course

Previous research by the Harvard University Native American Program (HUNAP) and the New Mexico Indian Affairs Department (NM IAD) in the Spring of 2020 assessed suicide prevention and postvention in Indigenous communities across New Mexico. Prior to the pandemic, all rural counties in New Mexico were designated as Behavioral Health Professional Shortage Areas (BHPSAs) by the US Department of Health and Human Services.[6] Of the limited number of behavioral health providers in the state of New Mexico, only 2% are Indigenous. This report, "Bolstering the Behavioral Health Workforce", provided specific recommendations to the NM IAD regarding provider workforce development and sustainability in four major categories:

1. Recruitment of Tribal citizens to behavioral health training programs.
2. Behavioral health training programs located in Tribal communities.
3. Financial and professional incentives for behavioral practice in Tribal communities.
4. Access to teleservices including tele-behavioral health services and tele-supervision for behavioral health providers.

The recommendations in this 2020 report form the foundation for our continued research on access to behavioral and mental healthcare. The fourth category of recommendation, access to teleservices, is especially important in light of the COVID-19 pandemic. Telemedicine was the world's response to increasing healthcare access during the COVID-19 pandemic. This presented a particular challenge for the state of New Mexico in that as many as 80% of individuals residing on tribal lands in New Mexico did not have internet services coming into the pandemic.[7]

In the words of a primary care provider from the Indian Health Service Gallup Service Unit, "***The ability to respond to a crisis is only as good as the baseline infrastructure.***" The pre-pandemic combination of increased prevalence of behavioral and mental health conditions, a severe shortage of providers, and a lack of broadband connectivity comprised a fragile baseline infrastructure that was put to the ultimate test by the COVID-19 pandemic. However, as you will see in this report, it is in these times

of crisis that showcase the incredible strength, perseverance, collaboration, and innovation of tribal communities, which has been the cornerstone of survival and prosperity of Indigenous people for thousands of years.

III. PROJECT AIMS AND DEFINITIONS

Project Aims

The goal of this research is to document New Mexico Tribal Nations' responses to the COVID-19 pandemic with a specific focus on **access to behavioral and mental healthcare**. We will present the barriers to access, innovations among tribal communities to overcome these barriers during COVID-19, and recommendations to improve access moving forward beyond the pandemic.

Before discussing our research approach, findings, and recommendations, it is critical to define the scope of 1. Behavioral Health and Mental Health and 2. Healthcare Access.

What is Behavioral and Mental Health?

Figure 2 demonstrates the distinction between behavioral health and mental health. Behavioral health encompasses behavior and habits and includes conditions such as substance use, eating disorders, gambling, and other addictions. Behavioral health is directly linked to mental health. Mental health encompasses emotional, psychological, and social well-being and includes conditions such as stress, anxiety, depression, and mood disorders. This distinction is important in the context of access because in some organizations, such as the Indian Health Service (IHS), the funding streams allotted for behavioral health and mental health are separate. Behavioral health and mental health combine with physical health to achieve wellness of the body and mind.

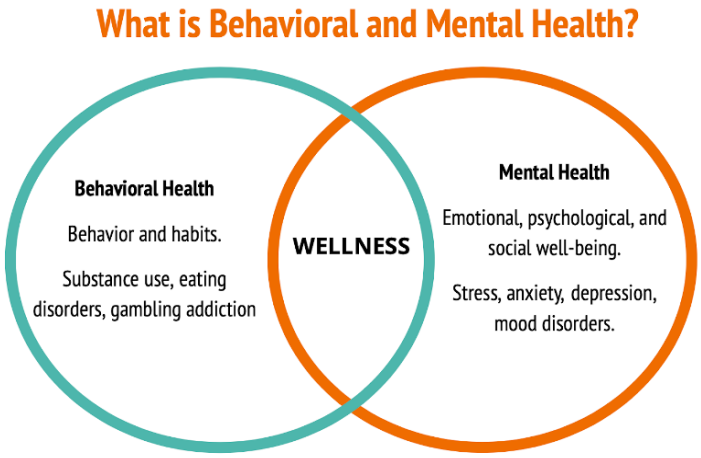


Figure 2: The Distinction Between Behavioral Health and Mental Health

The Four Dimensions of Healthcare Access

The World Health Organization (WHO) concept of universal healthcare access provides a useful lens through which we can define access to healthcare.[8] According to the WHO, healthcare access has the following four dimensions: Availability, Affordability, Acceptability, and Accessibility, which are described in Figure 3. In the context of this report, availability includes that of providers (both in-person and virtual) as well as internet technology. Affordability includes insurance coverage, such as Medicaid, as well as utility costs that would allow for telemedicine services such as costs of electricity, internet, and cell phone usage. Acceptability in the Native American context includes traditional approaches to behavioral and mental healthcare as well as cultural competency of providers, including the ability to find providers that speak the various native languages of Indigenous people. Accessibility encompasses transportation to in-person services, which is especially important in a rural state such as New Mexico.

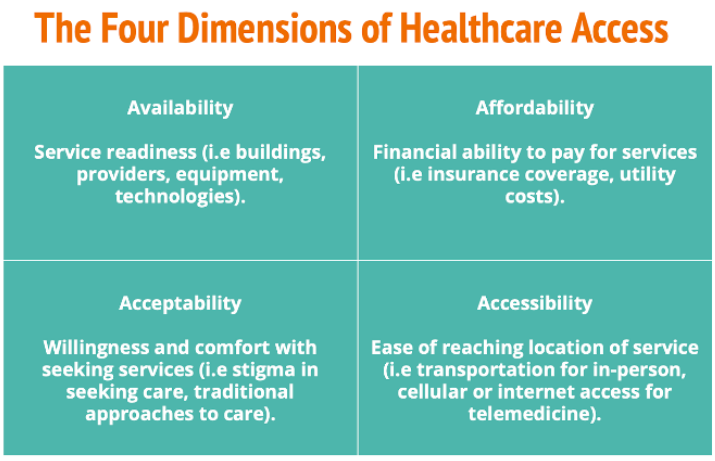


Figure 3: The Four Dimensions of Healthcare Access

This report will assess the barriers to the four dimensions of access to behavioral and mental health services for children, teenagers, adults, and elders of the Indigenous communities of New Mexico.

IV. RESEARCH APPROACH

We are honored to have had the opportunity to work with the New Mexico Indian Affairs Department (NM IAD) on this important project. The vision of the NM IAD is: ***Tribal nations, tribal communities and Indigenous people are happy, healthy and prosperous and that traditional ways of life are honored, valued and respected*.** It was important that our final report captured both the vision of the NM IAD as well as the voice of the Indigenous people that the IAD serves. This is why, throughout our report, direct quotes are used when possible. We also respect the opinions, the stories, and the challenges of the tribal representatives and providers who we interviewed. While we are grateful for the incredible work they do every day and their willingness to share it with us, the names of our interviewees will be anonymous in our final report.

Research Approach

The research was conducted primarily through a series of interviews which comprised ten case studies. Table 1 shows the ten case studies that were conducted virtually via the Zoom meeting platform from March to April 2021. The offices and programs that served as case studies were chosen to reflect diversity in tribal communities, geographic areas, and organizations. Organizations included a tribal government, Indian Health Service facilities, and tribally run behavioral and mental health clinics. Interviewees included tribal government officials, direct providers (including psychiatrists, primary care physicians, psychologists and social workers), as well as administrative officers (operations managers and coordinators). Interviews were one hour in length. An interview guide (Appendix 1) was used to structure the conversation around the four dimensions of access to behavioral and mental health services.

Case Studies

The research team consolidated each interview into a one page summary that included Pre-COVID-19, During COVID-19, Challenges and Goals/Opportunities. We then reviewed all of the case studies to identify common barriers and highlight innovations. The next section will outline the common barriers to behavioral and mental health access, organized according to the four dimensions of access.

Table 1: Case Studies

Case Study Interview	Tribal Nations Represented
Circle of Life Behavioral Health Network of Eight Northern Indian Pueblos Council	Nambe Pueblo Picuris Pueblo Pojoaque Pueblo San Ildefonso Pueblo Ohkay Owingeh Tesuque Pueblo Santa Clara Pueblo Taos Pueblo
Indian Health Service (IHS) Acoma-Laguna-Canoncito*	Acoma Pueblo and Navajo community of Tohajillee
Indian Health Service Gallup Service Unit	Navajo Nation
Indian Health Service Shiprock Service Unit	Navajo Nation
Indian Health Service Mescalero*	Mescalero Apache Tribe
Kewa Family Wellness Center (FWC)	Kewa Pueblo (formerly Santo Domingo Pueblo)
Mescalero Prevention Program (PP)	Mescalero Apache Tribe
Navajo Nation Office of the President and Vice President (OPVP)	Navajo Nation
San Felipe Pueblo	San Felipe Pueblo
State of New Mexico Behavioral Health Collaborative (NM BHC)	All tribal and nontribal individuals in the New Mexico

*IHS Acoma and IHS Mescalero, while they are two separate service units, were interviewed during the same Zoom interview session.

V. BARRIERS TO HEALTHCARE ACCESS

After reviewing barriers to access that were common across the case studies, we categorized these barriers into one of the four dimensions of access to care (Figure 3). This section will outline the common barriers to availability, affordability, acceptability, and accessibility. Each of the four access dimensions is followed by a table (Tables 2-5) summarizing the barriers to access, the voices of the community describing these barriers, and the innovations by the community to overcome these barriers.

Barriers to Availability

Barriers to availability of care were the most common and most significant barriers described by the communities in the case studies. The two most outstanding barriers to availability of mental and behavioral health care were limited broadband connectivity and a shortage of providers.

Limited Broadband

As referenced in the introduction, prior to the COVID-19 pandemic, up to 80% of individuals residing on tribal lands in New Mexico did not have access to reliable internet services. In March of 2020, when the United States moved a majority of healthcare services to telehealth, in many tribal communities, **"*video telehealth was not an option*".** Because of this limitation, most communities began providing strictly telephonic services.

Innovations to overcome limited broadband access were multiple. First, many tribal governments received funding from the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) which included provisions, such as new cellular towers, for increasing telehealth and tele-education during the pandemic.

Through the CARES Act, San Felipe Pueblo was able to obtain mobile cellular towers on wheels (mobile COWs). These towers were placed around the community to enhance broadband access. The primary motivation for these towers was for virtual education rather than telemedicine. Once these towers were in place, it was common to see ***"Whole families sitting in cars next to COWs to get their children educated."***

In multiple case studies, internet access was better at the site of the care facility than it was in more remote areas where patients lived. Towards the later part of the pandemic, broadband in some areas was strong enough to support telemedicine with video capabilities. In these situations, facilities would set up a socially distanced room at the behavioral or mental health center with a computer and camera. The patient would then come into the clinic and use a private room with internet access/telehealth capability to have a telemedicine visit with a provider who was, most often, in another room in the same building using a different computer/camera set up.

Provider Shortage

Shortage of providers in Indigenous communities was an overarching theme in all ten case studies. Whenever interviewees were asked if they could change one thing to improve behavioral and mental health care in their community, increasing the number of providers came up the most (Table 7). Due to the limited number of providers, those providers that are available have extremely busy schedules as was noted by the team at IHS Shiprock, **"*We have 4 therapists but there is enough work for 10 therapists. The patients suffer, as there is not enough time for them to get individualized attention*."**

While increasing the number of licensed providers on Indigenous reservations is the ultimate long-term goal, in the interim, Native American communities have been creative in finding solutions to fill the provider gap.

Tribal nations with adequate broadband to support telehealth capabilities have partnered with the University of New Mexico to provide remote telehealth services. Pre-pandemic, UNM was able to provide four hours per week of pediatric and adult psychiatry services to the patients of IHS Mescalero to augment the in-person services offered by the full-time in-person providers. This telehealth service continued throughout the pandemic, with patients coming into the IHS hospital offices to utilize the internet for virtual appointments with UNM behavioral and mental health providers.

Another approach to plugging the provider gap is through training the community. The Navajo Public Health Team has pioneered Youth Mental Health First Aid Trainings which teach trainees to "Ask, Listen, Give Reassurance, Encourage Help, and Encourage Self Help". Prior to COVID-19, this eight-hour training was publicized using flyers and school outreach and was held in-person. The training was on hold from March 2020 until August 2020. However, they did resume in August 2020 in a virtual format, which has been successful.

While these trainings do not increase the number of licensed professional providers, they do raise awareness of warning signs of people in need of services so that care from a licensed provider can be arranged.

Case Management Shortage

Not only is there a shortage of in-person providers, but oftentimes, providers are compelled to add case management roles to busy clinical duties. In the words of one IHS provider, **"*I start my second job after I see patients*"**, referring to the hours of care coordination and patient follow-up that they do after a day's worth of patient visits.

At this particular IHS location, the case management position has been vacant for two and a half years. As a result, patients ***"fall through the cracks"*** as the primary providers do not have time for patient outreach to ensure individuals stay engaged with care. Another IHS provider at a different location expressed the same concerns, ***"It gets so busy that if a patient doesn't show up and they don't hear anything, they (the providers) assume all is okay, and move onto the next patient on the list."***

During COVID-19, at the former IHS location, a nursing assistant was loaned to the behavioral and mental health department. She was trained to work as a case manager for 10 months, which proved beneficial to the providers. However, this nursing assistant was then re-allocated to vaccine administration, leaving the case manager position vacant.

Table 2: Availability Barriers and Innovations

Barrier to Availability	**Voices from the Community**	**Innovations**
Limited Broadband	For many tribal communities, "*video telehealth was not an option*." *"Whole families sitting in cars next to COWs (Cellular towers On Wheels) to get their children educated.*" -San Felipe Pueblo	CARES ACT Funding In-office use of internet by patients Mobile Cellular towers On Wheels (COWS)
Provider Shortage	"*We have 4 therapists but there is enough work for 10 therapists. The patients suffer, as there is not enough time for them to get individualized attention*." - IHS Shiprock	Teleservices with UNM Providers Peer-to-Peer Support Mental Health First Aid Training
Case Management Shortage	"*I start my second job after I see patients*" We need someone to call patients and "*keep them from falling through cracks*" - IHS Provider	Training a nursing assistant to be a case manager

Barriers to Affordability

Historically, more American Indians and Alaska Natives (AI/AN) lack health insurance coverage relative to the general population. This, in effect, has led to low utilization of mental and behavioral services by AI/ANs. However, within the context of COVID-19, the main barrier to affordability was awareness and uptake of state and federal insurance programs such as Medicaid.

In the words of a representative from the Human Services Department (HSD), ***"It took a lot of coordinated effort of eligibility determiners and education and outreach via phone to encourage Native Americans to sign up for Medicaid or health insurance."***

Table 3: Affordability Barriers and Innovations

Barrier to Affordability	**Voices from the Community**	**Innovations**
Awareness and Uptake of Public programs to help Offset Cost	*"We have never denied someone services if they need them.* *Money should not determine healthcare."* - Circle of Life Behavioral Health Network *"Medicaid enrollment almost doubled during the pandemic."*- Human Services Department *"It took a lot of coordinated effort of eligibility determiners and education and outreach via phone to encourage Native Americans to sign up for Medicaid or health insurance. The education portion of the outreach explained how to use network services such as telehealth, navigating provider networks, and applying for benefits."* - Human Services Department	Training intake coordinators to assist patients in signing up for Medicaid

Barriers to Acceptability

It can be argued that this dimension of access is the most important. If individuals are not willing to engage or accept care, then it does not matter how many providers are available, how affordable the care is, or how one will access the services. The first and most critical step is accepting care for behavioral and mental health conditions.

Stigma in Seeking Care

There is widespread stigma around seeking care for behavioral and mental health conditions. Although pervasive in most societies, this mental health stigma is especially pronounced in many Indigenous communities where ***"Issues that don't bleed"*** are not as important and talk about life-threatening mental health conditions is avoided, ***"We don't talk about suicide on the Navajo Nation."***

At IHS Shiprock, mental health services are located in a part of the building distinct from other healthcare services. Sometimes patients feel ashamed to be seen walking to get

care from the distinctly separate mental health facility. Because of the separation in physical location, mental health providers expressed that they, too, feel separate from the providers in other parts of the hospital.

Notably, the providers at IHS Shiprock observed a decrease in stigma during COVID-19, saying, ***"The pandemic has made our clinic more visible***." This was observed in other tribal communities as well. The levels of anxiety, depression, and grief associated with the pandemic were so widespread that COVID-19 in a way normalized mental health conditions and made them easier to talk about.

The Navajo Nation actively organized virtual forums to openly talk about issues relating to mental health. The Navajo Nation Office of the President and Vice President Division of Behavioral Health Services piloted "Hozho Mondays" starting in March 2021. "Hozho" is a Navajo word meaning balance, beauty, and harmony. Every Monday evening a one hour virtual session would be held via Zoom and broadcast to the Navajo community. Hundreds of participants would attend the live session and thousands of additional people would watch the recorded session on the Navajo Nation Facebook site after the event. Each session had a theme, for example, "Positive Thinking: I am able to manage my feelings in a healthy way." In addition to having Navajo providers and tribal leaders discuss the week's mental health awareness theme, participants also had the option to use the Zoom chat to ask questions or request help such as ***"I need somebody right now."*** In these cases, trained providers would then be able to provide telephonic outreach to those asking for help in real-time.

Another way to decrease the stigma associated with behavioral and mental health conditions is to educate the community about the importance of this topic at an early age. Some tribal communities have recognized the benefit of early engagement and have developed partnerships with tribal schools. San Felipe Pueblo has launched Project Venture, which is a youth driven program to strengthen resilience and cultural values. The Mescalero Apache Tribe has developed a youth council that creates programs for their peers on substance use and drunk driving. Circle of Life has a childhood advisory committee that, in response to COVID-19, created a book about mental health struggles during the pandemic and distributed this to the larger community.

Limited Traditional Approaches to Care

One of the requests from the community during the Hozho Monday sessions on Navajo Nation was the option for traditional approaches to care for behavioral and mental health issues. The desire for traditional approaches to care, instead of or in combination with Western medicine, is shared across all tribal nations we interviewed. While most IHS facilities have a medicine man on site to provide traditional approaches, these in-person services were significantly impacted by COVID-19. IHS Gallup noted that ***"Early on in the pandemic, our office of Native Medicine closed and has still not reopened."***

Traditional approaches to care are woven into the services provided at Circle of Life in

the form of beading classes and Native Arts classes for individuals in residential treatment. The Mescalero Prevention Program incorporates recognition of the tribe's cultural identity into all of its community behavioral and mental health interventions, ***"All the grants we work with have a traditional component."***

Shortage of Culturally Competent Providers

As mentioned in the introduction to this report, only 2% of behavioral health providers in New Mexico are Indigenous. That means that a majority of providers may not have the degree of cultural competency necessary to provide optimal care for their patients. This is critical, as noted by the Mescalero behavioral health team, *as a* provider without cultural competency can become ***"harmful instead of helpful"*** to the community.

An important aspect of providing culturally competent care is the provider's ability to speak the native language or have access to a translator who can speak the preferred language of the patient. In the words of a Navajo tribal representative, ***"Sometimes you need to say things in Navajo to make it more profound."***

This is especially important for the elderly and in communities where there are a large portion of people who speak the native language. In San Felipe Pueblo, upwards of 80% of individuals on the reservation speak the native language. This presented an extra barrier to the attempt to provide telephonic or telemedicine services during COVID-19, as the providers were unable to access translators over the phone.

In addition to increasing the number of Indigenous providers as outlined in the 2020 HUNAP report *Bolstering the Behavioral Health Workforce*, some tribal nations have adapted evidence-based practices for behavioral and mental health interventions in tribal communities. After a series of unfortunate cases where a non-tribal Fire and Rescue team could not locate people in need on tribal lands, Mescalero Apache Tribe provided community members to support the Fire & Rescue in navigating the community.

Table 4: Acceptability Barriers and Innovations

Barrier to Availability	Voices from the Community	Innovations
Stigma in Seeking Care	*"We don't talk about suicide on the Navajo Nation."* - Navajo OPVP *"Issues that don't bleed" are not important.* - San Felipe Pueblo *"Asking for help and seeking help is the biggest barrier."*- Mescalero Apache Tribe	*"The pandemic has made our clinic more visible"* - Shiprock IHS Navajo Hozho Mondays - Navajo OPVP
Limited Traditional Approaches	*"Early on in the pandemic, our office of Native Medicine closed and as still not reopened"* -IHS Gallup	*" All the grants we work with have a traditional component."* - Mescalero Apache Tribe
Shortage of Cultural Competent Providers	*A provider without cultural competency can become "harmful instead of helpful" to the community* - Mescalero Apache Tribe *"Sometimes you need to say things in Navajo to make it more profound."*- Navajo OPVP	Addition of Native Emergency Response providers to Fire and Rescue Team

Barriers to Accessibility

Native American communities are generally located in remote, geographically isolated areas that make it difficult for providers to deliver care and for tribal members to access care when they need it. During interviews, providers identified transportation, access to technology, and emergency crisis response as the salient accessibility challenges.

Absence of Reliable Transportation

The sparse availability of public or private transportation to bring patients to their appointments as well as emergency transportation was a recurring theme in interviews. In the pre-COVID era, Circle of Life recognized the lack of transportation as a major contributor to the number of "no shows" at the facility. Implementation of a transportation service in the form of an unmarked van that would pick people up from their homes and bring them to the facility ***"dropped the no show rate from 25% to 3%"***. Providers stated that the problem of transportation was further compounded when patients had to

travel long distances to access higher-level residential treatment and/or specialist services outside their reservations or outside New Mexico. However, COVID-19 (to some extent) addressed this transportation problem temporarily for patients who could afford to switch to telephonic care.

Cost of Telephones and Poor Network Services

For many Native Americans, the means to buy a telephone and pay for call time is a financial challenge. Additionally, the remote location of many reservations means that network service is consistently poor. Time and again, we heard that this problem made it difficult to provide telephonic care and/or follow-up with patients during the pandemic. In the words of a director at the Kewa Family Wellness Center "***we can't do video sessions, we barely have phone services in the village***". Unsurprisingly, providers acknowledged that lots of patients were lost to follow-up when COVID-19 hit.

Limited Emergency Crisis Intervention Resources

Crisis lines that are available 24 hours a day, 7 days a week, 365 days a year to accept mental health emergency calls is an essential component of a modern mental and behavioral health crisis system. While Navajo Nation has 22 helplines for individuals and family members facing mental and/or substance use disorders, a large number of Native American communities do not have this capability. For Kewa Family Wellness Center, the cost of having a 24-hour on-site clinician for crisis response in the pueblo is prohibitively expensive and remains a longstanding barrier in having a comprehensive behavioral health crisis system. However, facilities such as the Kewa Center are filling the existing gaps by building an "on-call" mobile crisis team who can be dispatched to anywhere, anytime, and to anyone in need in the community.

Table 5: Accessibility Barriers and Innovations

Barrier to Accessibility	Voices from the Community	Innovations
Transportation to mental and behavioral healthcare provider	*"A transporter dropped our no show rate from 25% to 3%."* - Circle of Life	Paid transporters (pre-COVID) to ferry patients in unmarked vehicle (Circle of Life)
Access to technology (telephonic, telemedicine, electricity)	*"Even though individuals had cell phones, when a provider would call for a phone visit, it would often go straight to voicemail because they didn't have service in their home."* - Gallup IHS	Used CDC Grant funding to buy patients cell phones and pay for minutes if they continued to engage in care (Circle of Life)

VI. SNAPSHOT OF BARRIERS & INDIGENOUS INNOVATIONS

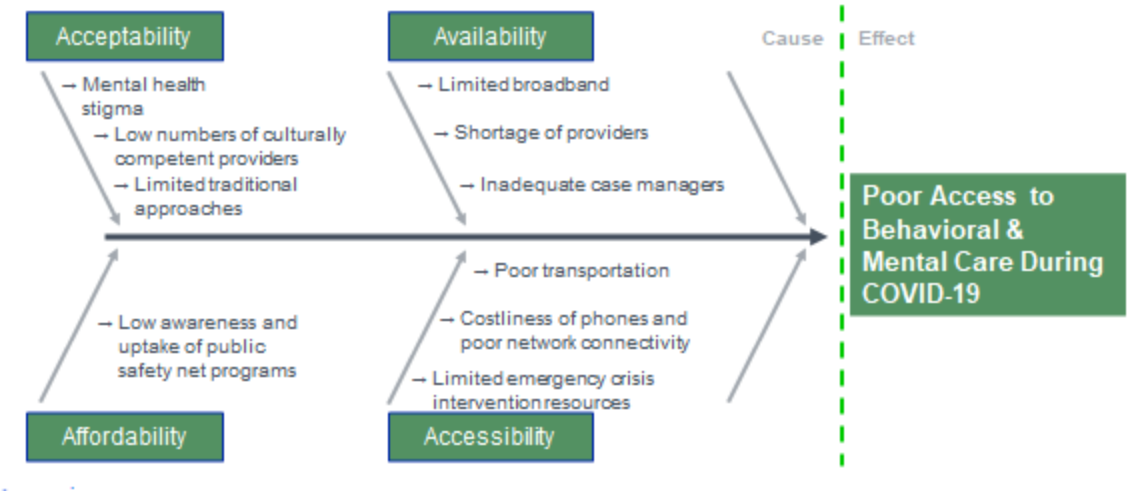


Figure 4: Barriers to Accessing Mental and Behavioral Care During COVID-19

Table 6: Snapshot of Innovations to Overcome Barriers to Mental and Behavioral Healthcare Access During COVID-19 Pandemic

SNAPSHOT OF INNOVATIONS

Facility/Organization	Availability	Affordability	Acceptability	Accessibility
Circle of Life	Community outreach on Facebook with prizes and gift baskets	Trained intake coordinators to enroll patients in Medicaid	Created youth and children's advisory councils. Working with children to write a book on COVID-19 experiences	Provided transportation to bring patients to in-person visits
San Felipe Pueblo	Mobile COWS to boost internet connection. Provided an office with computer/camera for patients to do telehealth		Started Social zooms in the evenings to encourage intergenerational bonding	Implementing an electronic health record (EHR) system that is shared among local provider
IHS Shiprock	Sought training on telehealth and bought cameras using own funds			
IHS Mescalero	Trained a nursing assistant to serve as a case manager			
Kewa Family Wellness Center	Provided telephonic services from home			Using a grant to build an on-call mobile response team.
Mescalero Prevention Program	Funds a Youth Council that creates media campaigns on various social topics		Incorporates a traditional element to every single grant it operates	
Navajo Nation OPVP	Virtual community mental health awareness forums on Facebook (Hozho Mondays)			Planning long-term for a centralized call center
Navajo Nation IHS	Providers purchased their own HIPAA compliant virtual platform for high-risk patients		Offers mental health first aid with a traditional component. Does focus groups with medicine men association	
NM HSD	Initiated a peer support program	Expanded people who could determine presumption eligibility for Medicaid		

At the conclusion of each interview, the interviewees were asked the same question by the research team “If you had a magic wand to improve access to behavioral and mental health care for your community, what is the one thing you would change?” The answers to this question are listed below in Table 7. Direct quotes from the interviewees are included when available.

Table 7: “If you had a magic wand to improve access to behavioral and mental health care for your community, what is the one thing you would change?”

Case Study	**Response to:** **“If you had a magic wand....what is the one thing you would change?”**
Circle of Life	*“More therapists, case managers, and transporters!”* *“Take out the money piece, let’s get people the services they need. Money should not determine healthcare.”* *“Community based after-school programs. Making behavioral health easy to get.”*
IHS Acoma	Support from leadership, administration seeing the importance of behavioral and mental health
IHS Gallup	Increasing broadband, ability of providers to do telehealth
IHS Shiprock	*“More providers.”* *“Improve communication and listen to each other.”* *“Enhancing collaboration with the medical side of the hospital.”*
IHS Mescalero	More community outreach and networking with different agencies
Kewa FWC	*“For access to be easier than it is to currently get alcohol or drugs.”* *“Telehealth needs to be more advanced.”*
Mescalero PP	“*To have an adequate number of providers on the reservation.”*
Navajo Nation OPVP	Centralized crisis response call center, training youth to be crisis counselors, more traditional practitioners
San Felipe	Internet access, listening to the community and having community representatives in positions of authority
NM BHC	*“We need to increase the number of people who can recognize a crisis and respond.”* *“Workforce sustainability.”*

VII. RECOMMENDATIONS

Based on the major themes described in our case studies above, our recommendations for improving access to healthcare in each of the four dimensions of access are detailed below. A comprehensive list of recommendations can be found in the next section. Each recommendation will include rationale and action steps to be taken.

Recommendations to Improve Availability

Improve Broadband Connectivity

Rationale
Improving broadband across tribal nations in New Mexico is a critical step in increasing availability of behavioral and mental health services. Increasing internet access at clinics and hospitals will allow organizations to engage in video telemedicine services. Increasing internet access in homes will enable patients to be able to engage in telehealth and removes the need for transportation, which can be a significant barrier in rural New Mexico. It will expand the available pool of licensed providers, as tribal reservations will be able to take advantage of partnerships with larger organizations, such as UNM, and have UNM providers stream in for telemedicine visits. Broadband at provider locations will also facilitate virtual collaboration efforts, as described in section VIII.

Short-term Actions

1. Encourage providers to apply for FCC Funding. The Federal Communications Commission (FCC) set-up Round 2 of the COVID-19 Telehealth Program to support healthcare providers by providing telecommunications services, information services, and connected devices necessary to enable telehealth. While Round 2 ended on May 6th, 2021, tribal communities should be on the look-out for Round 3 of Funding Applications.
2. Build awareness of and encourage tribal members to apply for FCC funding through the FCC Emergency Broadband Benefit program. The program will provide a discount of up to $75 per month towards broadband service for households on Tribal lands. The program will also provide discounts on a laptop, desktop computer, or tablet. Eligible households will be able to enroll in the program from May 12, 2021.

Increase Behavioral and Mental Health Providers

Rationale
As mentioned in the introduction, all rural counties in New Mexico are designated as Behavioral Health Professional Shortage Areas by the US Department of Health and Human Services. The shortage and sustainability of providers is one of the most significant barriers to access as identified in our case studies. Currently, the behavioral and mental health providers are overworked with a combination of clinical duties and a high burden of administrative tasks, and their patients suffer because of this.

Short-term Action

1. Increase the number of people in the community who can recognize and respond to a crisis by offering mental health first aid training programs for teachers, school staff and administrators, all hospital staff and administrators, as well as tribal governments. While there are commercial mental health first aid programs available, it is important that the training program be adapted by each tribal community to reflect their traditional culture and values. The mental health first aid training offered by Navajo Nation Division of Behavioral and Mental Health Services can serve as a model for other tribal communities.

Medium-term Action

1. Increase broadband and telehealth capabilities as described above. Once telemedicine is established, partner with direct providers at larger organizations, such as UNM, who can provide remote telehealth visits.

Long-term Action

1. Please reference the 2020 HUNAP Report *Bolstering the Behavioral Health Workforce* for detailed recommendations for increasing Behavioral and Mental Health Providers in New Mexico, including recruitment of tribal citizens to behavioral health training programs, behavioral health training programs located in tribal communities, and financial and professional incentives for behavioral practice in tribal communities.

Increase Case Management

Case managers can serve two critical functions in the behavioral and mental healthcare setting. 1. Dedicated time to patient outreach so that individuals stay engaged in care and are not lost to follow-up. This offloads administrative tasks from direct providers and opens providers to see more patients in direct care. 2. Expertise with assisting patients in taking advantage of tribal and state programs to improve access to care such as signing up for Medicaid or enrolling in programs that offset the financial cost of services such as electricity, internet, and phone subsidies.

Short-term Action

1. *Allocate funding and fill positions for case managers in tribal behavioral and mental health organizations as well as Indian Health Service facilities.*

Recommendations to Improve Affordability

Increase Awareness and Uptake of Medicaid and Safety-Net Programs

Rationale
Poverty and lack of insurance remains a barrier in accessing behavioral healthcare services. However, oftentimes, poor awareness of state resources (Medicaid and safety net programs) combined with complexities of navigating these resources, prevent Native Americans from utilizing these resources. As noted by a provider at Kewa Family Wellness Center Access *"**currently it is far easier for someone to get alcohol or meth than to get access to these resources. A 2-minute walk or less and you can find meth or alcohol, 24 hours a day***."

Short-term Action

1. New Mexico's Human Services Department (HSD) should sustain the COVID-19-related coordinated effort by eligibility determiners and the Native American Liaison to encourage Native Americans to sign up for Medicaid or health insurance. Targeted education and outreach should be made towards counties such as Union, Harding, and Edy, which have some of the lowest rates of Medicaid enrollment of Native Americans as a percentage of the Native American population.
2. Tribally run programs should foster a practice of training and positioning all intake coordinators to help all patients enroll in Medicaid and other publicly funded insurance programs.

Medium-term Action

1. HSD and the Indian Affairs Department (IAD) should jointly create a Native American Liaison position. Potentially, this Liaison could be employed at HSD and housed in IAD, and would work with Dr. Neal Bowen (Director of NM HSD Behavioral Health Services Division) on Native American behavioral health issues. Part of the Liaison's job would be to build targeted education and outreach campaigns to boost awareness and uptake of Medicaid and other public health insurance programs.

Recommendations to Improve Acceptability

Increase Early Engagement and Mental Health Awareness in Schools

Rationale
The earlier that mental and behavioral health awareness can be introduced in a child's life, the more that it can be accepted and acknowledged, therefore decreasing the stigma associated with mental and behavioral health disorders. Multiple tribal nations in our interviews had started programs to partner with schools in order to introduce some form of mental health curriculum to children in tribal communities. It is important to note that the formation and success of these partnerships is largely dependent on school

leadership- if school leaders do not see this as an important aspect of a child's education, these programs can be met with resistance. With the enhanced awareness and importance of mental health generated by the pandemic, the COVID-19 recovery era presents an ideal open window in which to begin collaboration with tribal school leaders. San Felipe Pueblo and Mescalero Apache Tribe have both developed successful school outreach models in their communities.

Short-term Action

1. On a tribal level, tribal representatives should facilitate meetings between educational leaders (at elementary, middle and high schools) and mental and behavioral health providers in the community. Leaders should review what, if any, mental and behavioral health exposure is currently available for the children and teenagers of the community (i.e youth council, afterschool programs, etc.). When possible, efforts should be taken to ensure mental and behavioral health programming for children and young adults is youth driven and incorporates cultural values.

Increase Community Outreach

Rationale

When it comes to mental and behavioral health, it is important to give the community what they need. Since every community has different needs, interventions should be designed and implemented after conducting informal or formal needs assessments of tribal members. A needs assessment can be in the form of a virtual forum, as was done with Hozho Mondays on Navajo Nation. Through this virtual forum, the community voiced a request for traditional practices, stories of survival from community members, as well as a desire for virtual group therapy. The San Felipe Pueblo Circles of Care program performs needs assessments via surveys to children, teachers, and parents in the school setting. San Felipe Pueblo describes this strategy as a ***"community based participatory research approach"*** and notes the importance of building rapport and trust with schools and the community.

Short-term Action

1. *Tribal representatives should perform needs assessments of their communities and design data driven interventions based on those results. This can be through a survey that is distributed to community members (either paper or electronic) or through focus groups with community members. Funding for data-driven, community based mental and behavioral interventions is available through UNM and Substance Abuse and Mental Health Services Administration (SAMHSA). This is especially important as we move into the post-COVID era, as the needs of a given tribal community at this time may be different from what they were in the pre-COVID era.*

Traditional Medicine and Cultural Competency

Rationale
Based on our interviews with tribal providers and representatives, individuals are more likely to seek treatment and engage in care if therapy includes a traditional component. In the needs assessment performed by Navajo Nation in the form of Hozho Mondays, traditional services for mental health was the one of the most common requests from the Navajo community. Successful mental health awareness programs in Mescalero, San Felipe, and Circle of Life have all incorporated traditional teaching in their outreach.

Short-term Action

1. In engaging in the formation of school partnerships and community outreach as described above, ensure all interventions are designed to incorporate traditional components.

Short-term Action

1. Indian Health Service service units should make every effort to resume in-person offerings of traditional services at their locations. This includes re-opening of offices where traditional providers work as well as informing primary care providers that the services have resumed and encouraging referrals to traditional medicine.

Short-term Action

1. Invite direct providers in the area to be involved in designing school outreach programs and community outreach initiatives above. This is particularly important for non-native providers, as the opportunity for non-native providers to engage with the community will enhance their cultural competency when it comes to providing mental and behavioral health services.

Long-term Action

1. As discussed in *Bolstering the Behavioral Health Workforce and in the previous recommendations above*, efforts should be initiated to expand the number of native providers in New Mexico.

Recommendations to Improve Accessibility

Telehealth

Rationale
In what has been an upside to the COVID-19 pandemic, telehealth has eliminated some of the transportation and distance issues that limited access to mental and behavioral services in Native American communities. The acceleration in use of telehealth was made possible by the many waivers granted by federal and state authorities during the pandemic. Since the underlying accessibility (transportation and distance) issues will remain even after the pandemic has ended, telehealth will need to be promoted--where

it makes sense to do so-- to ensure Native American communities continue to have better access to mental and behavioral healthcare.

Short-term Actions

1. New Mexico should make permanent the relevant telehealth waivers that have led to increased buy-in and utilization of telehealth during COVID-19. These waivers include reimbursement for audio-only phone services and the designation of the patient's home as an eligible originating site.
2. As mentioned above, Native American behavioral and mental health programs should seek funding from FCC COVID-19 Telehealth Program to acquire telecommunications services, information services, and devices necessary to provide critical connected care services.

Improve Emergency Crisis Response

Rationale

COVID-19 has led to an uptick in risk factors for mental and behavioral health issues and derivative emergencies. However, not all Native American communities have the resources to operate a fully-staffed crisis hotline or call center or yet a 24/7 Crisis Mobile Team Response. Thus, there's a need for other innovative ways to improve behavioral health-related crisis response.

Short-term Action

1. Native American behavioral health organizations should seek grant funding to create an on-call mobile crisis team response that can be dispatched to the location of the individual in crisis. Such a mobile crisis response system should comprise a two-person behavioral health team, including a clinician, accompanied by Emergency Medical Services (EMS)-where it exists. This could help fill the gap in providing a fully-fledged crisis response within the community. For instance, the Kewa Family wellness center is using the Tribal Behavioral Health Native Connections Suicide Prevention Grant to build an on-call mobile response team within the Pueblo.

Medium-term Action

1. New Mexico should partner the Native American community-such as the Navajo Nation- in aligning efforts to consolidate multiple crisis hotlines into a single number and/ or build awareness of such a resource.

VIII. COLLABORATION AND COVID-19

A major theme throughout our case studies was collaboration. Throughout the pandemic, both intra-tribal and inter-tribal collaboration increased as Native American tribes and healthcare organizations realized the need to work together for the safety and health of their people. In the words of Kewa Pueblo, the **"*Main thing that COVID taught us was to work together."***

Inter-tribal collaboration forms the foundation of the Circle of Life Behavioral Health Network, a program of the Eight Northern Indian Pueblos Council, Inc. Within this council, there is a sense of "***You're not my pueblo but I want you to be well."*** During the pandemic, the degree of collaboration was favorable, with representatives at Circle of Life noting **"*Every time we've asked for help, someone has been there to help*."** They also relayed that behavioral health organizations outside of their network were generous in notifying them of funding opportunities often saying, "***Hey, there's this funding available, are you aware of this?*"**

As the largest tribal nation in New Mexico, Navajo Nation is spread out among New Mexico, Arizona, and southern Utah. Due to the nation's geographic size and many tribal members, organizations within the Navajo Nation often work in silos. In speaking with the Navajo Nation Office of the President and Vice President, collaboration improved in response to COVID-19, **"*Since COVID we have had better collaboration and we hope that this will be sustained.*"**

The one case study that was an outlier to the observed increase in collaborative efforts was Mescalero Behavioral Health. A few years ago, Mescalero was experiencing a cluster of suicides on the reservation and they reached out to Navajo Nation for help asking, **"*How are our Navajo Partners addressing suicide response?*"** Prior to COVID-19, Mescalero was very actively engaged in in-person collaboration in Albuquerque with the University of New Mexico, the National Indian Health Board, as well as the Southwest Tobacco Tribal Coalition. Unfortunately, due to travel restrictions and the limited internet connectivity on the Mescalero reservation, this collaboration was lost during COVID-19 and they are looking forward to resuming these partnerships.

The observations of pre-COVID-19 inter-tribal collaboration, during COVID-19 increased collaboration, and real-time collaboration on our Zoom calls demonstrated the benefit of collaborative efforts when it comes to improving behavioral and mental healthcare access. This led us to the question of, how can we formalize and sustain this collaboration among providers?

Recommendations to Improve Collaboration

Collaboration Hubs

Rationale

From the Behavioral Health Collaborative to the Native American Suicide Prevention Advisory Council, there's no shortage of collaboration platforms for the New Mexico Native American behavioral and mental health community. Nevertheless, the degree and frequency of real-time knowledge sharing that was observed during this project, lends credence to the fact that more creative opportunities exist for Native Americans to exchange best-practices and learn how other tribes and nations are approaching similar issues.

Short-term Action

1. Carve out an additional access point for collaboration within the newly established NM Tribal Behavioral Health Providers Association. This could be an online forum (Zoom) purposely dedicated to exchanging solutions on pertinent issues in mental and behavioral healthcare delivery

Long-term Actions

1. Create a collaboration hub to provide the necessary knowledge, tools, and sustainable research-based strategies for use by Native American tribes, pueblos, and nations to improve access to behavioral and mental health services. This effort should be driven by Native American community with support from the state of New Mexico, University of New Mexico, and the Indian Health Board.
2. Pair Native American communities that are delivering innovative programs or raising the bar in improving access to behavioral and mental healthcare services with tribes that are looking for novel ideas.

Post-pandemic Technology Partnerships

Rationale
Although broadband and reimbursement issues remain obstacles to the adoption of telehealth when the COVID-19 public health emergency is over, there's reason to believe that telehealth(video and telephone) will remain an essential part of delivering mental and behavioral health for the foreseeable future. To optimize the benefits of telehealth, Native American providers that are new to telehealth would need to build partnerships to learn evidenced based strategies in the use of telehealth.

Short-term Action
1. Partner the National American Indian and Alaska Native Mental Health Technology Transfer Center (MHTTC) to discover innovations and build telehealth capacity.

Long-term Action
1. Leverage the experience of Canadian First Nations' Tribes Digital Health Initiative to build a mental health data collection infrastructure. This could help Indigenous communities in New Mexico to collect and control their own relevant health data as well as support access to real-time data on the impact of future pandemics.

Dedicated Native American Support at Behavioral Health Services Department

Rationale
Currently, the Behavioral Health Services Department within the New Mexico Human Services Department (HSD) lacks a liaison dedicated to Native American behavioral and mental health issues. While all Native American human services issues fall within the remit of the incumbent Native American liaison at HSD, the urgency of addressing behavioral health issues within the Native American community warrants a Native American liaison at the Behavioral Health Services Department. Such a liaison will ensure that Native American behavioral health issues receive the needed attention and priority at the Behavioral Health Services Department.

Medium-term Action
1. HSD and IAD should work to find a permanent Native American liaison at the Behavioral Health Services Department. There could be potential for the current policy analyst at IAD focusing on behavioral health issues to be used to fill that gap.

IX. LIST OF RECOMMENDATIONS

1. **Recommendations to Improve Availability**

   1.1 Improve Broadband Connectivity
   1.2 Increase Behavioral and Mental Health Providers
   1.3 Increase Case Management

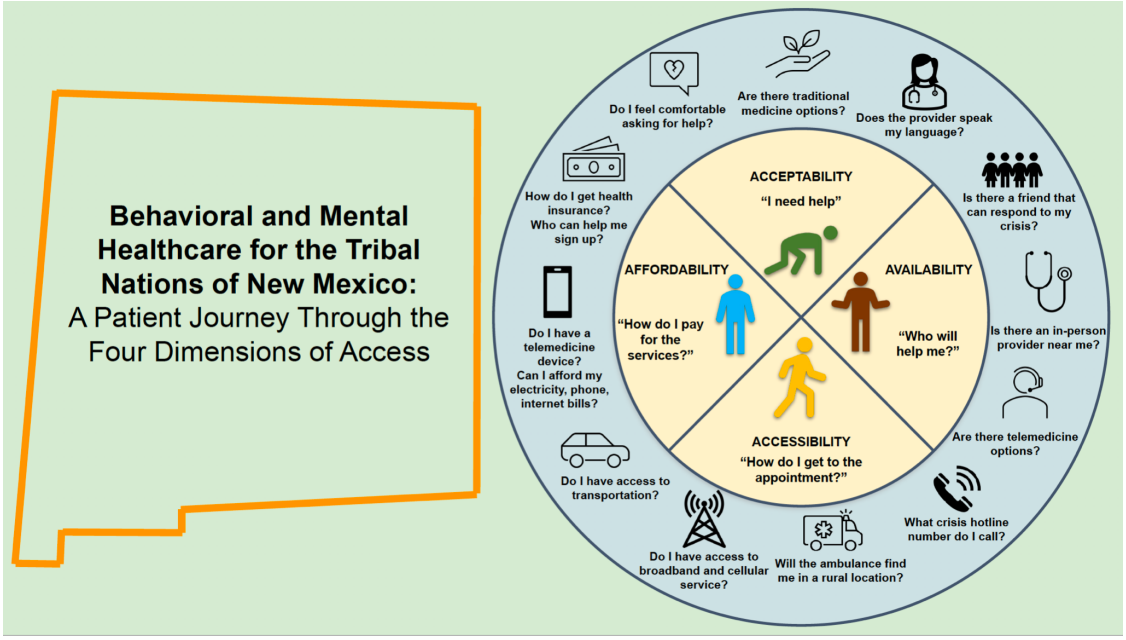
2. **Recommendations to Improve Affordability**
   2.1 Increase Awareness and Uptake of Medicaid and Safety-Net Programs

3. **Recommendations to Improve Acceptability**
   2.1 Increase Early Engagement and Mental Health Awareness in Schools
   2.2 Increase Community Outreach
   2.3 Incorporate Traditional Medicine and Promote Cultural Competency

4. **Recommendations to Improve Accessibility**
   4.1 Improve and Sustain Telehealth
   4.2 Improve Emergency Crisis Response

5. **Recommendations to Improve Collaboration**
   5.1 Develop Collaboration Hubs
   5.2 Develop Post-pandemic Technology Partnerships
   5.3 Appoint Dedicated Native American Liaison at the Behavioral Health Services Departments

X. PATIENT JOURNEY INFOGRAPHIC



XI. FINAL PROJECT REFLECTIONS

"Thank you for doing the report because that's like having a seat at the table and just even being able to speak about it is a release." - IHS Provider

Reflection from Philip Essienyi, MPH
Nation Building II Student, Harvard Kennedy School

My belief about the state of healthcare access in the U.S. was a positive one when I started this project. However, over the course of this project, I've gained a better perspective of access issues than I had ever anticipated. As someone new to Native American issues, I will admit that I was initially apprehensive that this research effort would miss out on capturing the true voice of patients and the realities on the ground in Native American communities, given that it was to be conducted entirely online. To my surprise, I've thoroughly enjoyed the diverse set of Native voices and experiences that were shared during interviews. What I've discovered about the historical and current challenges of the Native American community is vast and I remain ever impressed by the tireless dedication of all the providers who I was fortunate to meet during the interviews. Notably, I'm inspired by IHS providers, who in the face of overwhelming resource scarcity, continue to find ingenious ways to deliver mental and behavioral healthcare for communities with an unwavering commitment. I am thankful for this look forward to modelling that kind of commitment in the next chapter of my work in global health.

Reflection from Marina Zambrotta, MD

Nation Building II Student, Harvard Graduate School of Education
Internal Medicine Physician, Brigham and Women's Hospital, Boston, MA

As a non-native physician preparing to practice as a full-time primary care physician at IHS Shiprock in the fall of 2021, this report has given me knowledge to be a more culturally competent doctor for the people of Navajo Nation. Coming into this project, I was aware of some of the barriers to behavioral and mental healthcare for Indian Country. Having volunteered at IHS Shiprock in February of 2020 (prior to COVID-19) I became familiar with the limited broadband and cell phone service in the hospital. I cared for many patients that requested traditional services from the hospital's medicine man, to the point where it was difficult to find an available appointment with him. I experienced the benefit of the elders having an in-person Navajo translator for their doctor's visits. I was honored when an older Navajo woman offered me a pocket-sized beautiful piece of her hand-made weaving. One day, I had to escort a patient to the hospital's mental health clinic and I did not know where the clinic was located - a prime example of the disconnect between the primary care providers and the mental health care providers as described in our IHS Shiprock case study. The tribal representatives and providers that I virtually met during the creation of this report have given me a window into the lives of my future patients -- I can now see the challenges they may face when they don't have transportation to get to an appointment, when they don't have electricity or refrigeration to store the insulin that I prescribed for diabetes, when they don't feel comfortable speaking to me about their anxiety or depression, either because it's not spoken about in their culture or because they feel that I, as a non-native, won't understand or won't be able to offer them traditional treatment options. I will keep all of these stories and experiences close to my mind and heart as I prepare for the next step in my career and I am incredibly grateful to have had this opportunity to learn from the tribal nations of New Mexico.

XII. ACKNOWLEDGEMENTS

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Harvard University Nation Building II Course including Professor Eric Henson and our Nation Building II Colleagues for generous feedback and support.

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XIV. APPENDIX

Appendix 1: Case Study Interview Guide

Case Study Interview Guide

1. Generally, what do you think about the mental and behavioural healthcare services your program offers within your community?
   1.1. What are the strengths of the services you offer?
   1.2. Where is there room for improvement in the services you offer?

2. How does a tribal member get an appointment with a behavioral health provider at your location? Can you walk me through the process?
   2.1. What is the average waiting time for an appointment at your location?
   2.2. What are the most common conditions that you provide treatment for?
   2.3. What is the current staffing at your program? (i.e adult providers, child/adolescent providers, providers with MAT waiver)
   2.4. If you cannot provide the services needed for a particular individual, where is that person referred to?

3. In your experience, what are the largest challenges faced by individuals to access behavioral health services at your location? For example:
   3.1. Availability- availability of appointments, healthcare providers, resources
   3.2. Affordability- Cost of travel or lack of transportation, cost of healthcare services, cost of medicine, lack of health insurance, priorities (food over health)
   3.3. Accessibility- Transport availability or cost, distance to travel, phone or internet access, access to residential treatment facilities
   3.4. Acceptability- cultural competence, stigma of mental and behavioral health treatment

4. How has COVID-19 impacted your ability to provide behavioral health services?
   4.1. How have you adapted to provide services during the pandemic? (For example, telemedicine visits, virtual support groups, etc)
   4.2. What challenges have you faced in adapting your services to be socially and physically distanced during the pandemic?
   4.3. How would you describe the internet access at your location?
   4.4. How would you describe the internet access for the majority of individuals that you treat? Are there resources available to help people get wifi access?
   4.5 Based on your experience with COVID-19, what long term adjustments do you anticipate in the delivery of behavioral health services for your program?

5. How do you think these challenges that you have mentioned could be resolved?
   5.1 Is there anything being done currently to overcome these challenges? (For example, increased funding for hiring more providers or provider training, increased funding for internet/telemedicine capability)
   5.2 What is the current funding model? (i.e billing for service provision and receiving revenue or is the program pursuing federal, state, other grant opportunities?)

6. If you had a magic wand to improve access to behavioral and mental health care for your community, what is the one thing you would change?