April 07, 2003

United States Senate
Committee on Indian Affairs
Washington, D.C. 20510-6450

Dear Indian Select Committee Members,

My name is Hoskie Benally, Jr. and I am a member of the Navajo Nation of Shiprock, New Mexico. For the past 14 years, I have been the Chief Executive Officer of a private non-profit American Indian owned organization, Our Youth, Our Future, Inc. (OYOF). OYOF has operated a residential treatment center on the Navajo reservation and a community health center in Farmington, N.M. A majority of our funding came from the Indian Health Services (IHS) and the collection of Medicaid dollars.

Currently we serve as advocates for American Indian adolescents and families in the area of alcohol and other drug treatment along with mental health disorders. We conduct outcome base research on our programs and disseminate information in order to improve the lives of our adolescents in need of treatment. Through these endeavors, OYOF has developed the Multisystemic Cultural Treatment Model for American Indian adolescents and their families. This treatment model uses a multi-modal assessment strategy to measure symptom changes and pro-social functioning at intake, termination, 6, and 12 months following termination. This is one of the few if not the only manualized treatment model for American Indian adolescents that includes a treatment outcome design. In addition, it has a quality assurance system developed for American Indian programs. OYOF has responded to the call of future substance abuse treatment to be guided by a blend of best practice clinical treatment and innovative high-tech computer technologies. This approach is to facilitate alcohol and other drug and mental health treatment that is high-quality, timesaving, consistent, evidence-based and cost-effective. OYOF secured a Center for Substance Abuse Treatment (CSAT) three-year grant to conduct a program evaluation and a cost analysis of the residential treatment program. Critical information was gleaned from the data that provided pertinent information to improve treatment of our adolescents. Without this vital information our program may not have achieved the success we have experienced.

It is important to realize that a majority of our success was due to the implementation of a user friendly management information system (MIS). The following are some of the tasks that the MIS completed:

Manages clinical service hours (prescribed vs. actual received services)
Tracks clinician's billable hours for Medicaid and Managed-Care services
Tracks client's response to treatment and the need of additional services
All clinical documentation is automated allowing for close supervision of treatment

This system generates reporting requirements and supports outcome base treatment. The above tasks improve the overall quality assurance of the program and allows for a structured and consistent treatment to be implemented.

This system allowed us to meet all of our JCAHO accreditations, Children, Youth, & Families Dept., State of New Mexico and Medicaid regulations. In addition, we had Government Performance Regulation Act (GPRA) indicators and also the monthly, quarterly, and annual tribal government reports. Many of these reports overlapped and when we were collecting this data on a manual basis was almost impossible to accomplish. Upon implementing a MIS clinical documentation system, our ability to collect and collate the data was improved substantially. However, it is important to note that the overlap continued and we spent many hours disseminating this information for the different governing entities. We created innovative ways to meet these standards by developing a computerized report that met majority of the data reporting requirements. It is important to realize that majority of American Indian treatment programs do not have this capability or the skilled staff to meet this level of reporting. The initial step of implementing a MIS can be costly if an analysis is not conducted to determine the actual need in hardware, software, and staffing. There are many for-profit organizations that have developed such MIS and are being used in Indian country. Accurate Assessments has worked with IHS since 1998 customizing software to meet the specialized needs of the treatment programs. They are currently serving over 130 American Indian treatment programs. This is the MIS that OYOF has used since 1998 and was instrumental in collecting data that secured our CSAT grant.

Recently, IHS has made the decision to write and develop their own MIS for substance abuse. Even though there are excellent programs that exist in the field for possibly half the cost. Therefore, it may not be the most cost effective approach for IHS. We have been waiting for more than three years for IHS to respond to the need of treatment programs to have "real time" data that they can access simply by sitting at their computer. In addition, many treatment programs do not collect their GPRA data and the area offices have difficulty meeting their data requirements. This lack of quality data collection is a result of the lack of communication with the field and IHS. The following are some of the reasons why agencies do not receive quality data:

1. Lacks of compliance due to no initial buy in from the field in what to collect and the importance of such data;
2. Trusting IHS to analyze and interpret the data in a culturally appropriate manner;

3. Providing “real time” data reports and/or feedback;
4. Lacks of a user friendly system that can accommodate the many challenges of rural programs;
5. Lacks of ongoing support and training to make the data have practical application to the field;
6. Finally, many of the programs do not have properly trained staff to complete the tasks.

Finally, how do we decrease the”red tape” of securing the funding from the government to the tribes and/or treatment programs? This is not an easy question to answer. It is very complex and has much to do with the lack of standards that are required for tribal treatment programs to meet. Many of the programs do not have evidence-based treatment that requires a data collection component let alone the expertise to collect such data that would be require to write a grant. It will be vital that this committee look at the whole system and take this opportunity to develop a system that not only wants to fund programs, but will demand accountability from any program that secures such funding. However, the most important issue is that my people receive the best treatment possible and that we begin to make gains in keeping our young people from a life of alcohol and drugs, trauma, poverty, and the loss of hope.

I thank you for the valuable opportunity to submit written testimony and to provide oral testimony to this committee. If you have future questions, you can contact me at 505–327-7379 and/or 505-368-4873.

Cordially,

Hoskie Benally, Jr.