National Indian Health Board

Submitted via email to: consultation@ihs.gov

October 27, 2016

Alec Thundercloud, M.D.
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Indian Health Service
5600 Fishers Lane, Mail Stop: 08N34-A
Rockville, MD 20857

Re: IHS Expansion of Community Health Aide Program Draft Policy Statement Consultation

Dear Dr. Thundercloud:

On behalf of the National Indian Health Board (NIHB), I write to submit comments in response to the Indian Health Service's draft policy statement that proposes an expansion in the use of community health aides at Indian Health Service (IHS) facilities across the country. We appreciate that IHS acknowledges the need for expanding this program as well as the potential dramatic significant impact this will have on Indian Country. We support expanding the program as long as careful consideration is made with full Tribal and Urban input during program creation and implementation. We submit these initial comments along with a request for further extensive Tribal consultation to implement the program.

Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

As the national organization, representing all 567 federally recognized Tribes, we appreciate the potential significant impact that nationalization of the CHAP will have for the Indian health care system. While we support IHS' efforts to address its recruitment and retention challenges through the nationalization of the CHAP, ultimately **Tribes know which care models work best in their communities and we support flexibility**

for Tribes to choose how to adopt and implement CHAP, should IHS move forward with a national policy.

I. Background

The Indian health care delivery system is drastically underfunded, at 54% of need.[1] For example, in 2015, IHS spending for medical care per user was only $3,136, while the national average spending per user was $8,517. This correlates directly with unacceptable higher rates of premature deaths and chronic illnesses suffered throughout Indian communities. Funding is not the only resource that the Indian health care delivery system is in need of. Recruitment and retention has always been a challenge for IHS and Tribes, particularly for those hospitals and clinics located in rural areas. There are unique challenges to delivering health care in any rural area, including provider shortages, isolation, long travel distances, scarcity of specialty care, and under-resourced infrastructure. A pressing need and opportunity exists with the Indian Health Service, and its many rural, geographically isolated hospitals and clinics, to reform the way it recruits and provides medical professionals to underserved areas.

The Community Health Aide Program (CHAP) is an excellent example of reform that was developed in response to a need for providers in Alaska. In the 1960s, Alaska Natives were experiencing a tuberculosis epidemic, high infant mortality and high rates of injury in rural Alaska. Limited access to health care providers, compounded by challenges posed by remoteness of the villages, transportation, and weather concerns made it very difficult for Alaska Natives to get the quality health care they needed. The CHAP model, a Tribally created and driven system, was developed in response. CHAP trains local residents to provide basic health care, assuring that health services are available in the local community from culturally competent providers who speak the Native language. For more than 50 years, CHAP has proven as an effective method for diminishing the health disparities of Alaska Natives.

CHAP has an enormous amount of potential for Tribes and AI/ANs outside of Alaska. This potential was recognized during the reauthorization of the Indian Health Care and Improvement Act (IHCIA). Tribal advocates supported the ability of IHS to expand CHAP to Tribes outside of Alaska and the support, coupled with the successful history of the program, had widespread lawmaker support along with language included in IHCIA ensuring that IHS had the authority to expand the CHAP outside of Alaska.[2]

As IHS moves forward with pursuing a national CHAP, careful consideration and Tribal consultation must take place on the parameters and scope of the program, the amount of flexibility that I/T/Us will have in growing the program, and where the funding comes from. Because there is much undetermined about what the program will be, NIHB strongly recommends that IHS work closely with Tribes, Tribal organizations, Urban

[1] NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP'S RECOMMENDATIONS ON THE INDIAN HEALTH SERVICE FISCAL YEAR 2018 BUDGET, 10 (2016)
[2] 25 U.S. § 1616 I (d)(1)

Indian programs to ensure that the CHAP is implemented in a thoughtful and considerate manner that respects Tribal sovereignty and authority as well as delivers quality, culturally-competent care for AI/ANs.

II. IHS Must Foster an Internal Culture that Supports Mid-Level Providers to Ensure the Success of an Expansion

Indian Country is not alone in facing access issues. Many rural communities have problems with provider shortages. As a result, a number of national and State Medicaid reform proposals include the development of health para-professionals similar to community health aide practitioners with a focus on developing a workforce model armed with the knowledge, skills, and drive to implement change in the health care system. Community health aide practitioners have and can increase access to care and are sustainable. In addition, they provide high-educational opportunities for community members, and have expanded the local economy through job creation, cost of care savings, and improved health.

As with any significant change to the health care delivery system, there are professions with a vested interest in maintaining the status quo. The expansion of the CHAP program to the lower 48 will upset that status quo. As IHS continues to work with Tribes in developing this program, we strongly request that the rulemaking process be delayed for as long as possible in order to prevent undue influence by outside entities that may not understand the full scope or intent behind expanding the CHAP to the lower 48. Once Tribes have engaged with IHS on the scope and parameters of the program, the rulemaking process can begin.

In addition, it is important that the culture of professionals within IHS and serving Tribal communities throughout the country be one of acceptance. Without the support and advocacy of providers within the IHS, any expansion will be vulnerable to failure, obstructed, and potentially unsuccessful. The IHS leadership must begin to lay the groundwork now to change the culture of providers within the agency and foster a culture of acceptance and embrace new ideas to improve the delivery of quality health care to AI/ANs.

III. Concerns Surrounding IHS' Draft Policy Statement

NIHB applauds the agency's support and recognition of the CHAP program in Alaska. As a first step in expanding the program nationally, IHS released a draft policy statement as an enclosure in its June 1st *Dear Tribal Leader Letter* (DTLL) that provides some initial administrative and programmatic requirements. Before IHS moves forward on expanding CHAP, we share and support the concerns of our Tribal partners and constituents on the draft policy statement below:

Clarify that Community Health Aide Practitioners are Not Limited to Hospitals and Clinics

The DTLL states that "Community health aides are proven partners, and utilizing them to the fullest extent permissible in hospitals and clinics operated by the IHS and Tribes…" This statement is limiting because IHCIA provides broader authority for CHAP to provide services to "Alaska Natives living in villages in rural Alaska…" and is not bound by operating in hospitals and clinics.[3] This is indeed the current practice in effect in Alaska. We recommend that the scope of practice not be limited to hospitals and clinics operated by IHS and Tribes as long as quality standards are maintained.

Clarify Distinction between Community Health Aide Practitioners and CHRs

The DTLL provides examples of community health aides that are working within the Indian health system and other federal agencies. Community Health Representatives (CHRs) are listed and provides the impression that CHRs are the same as community health aides. This is not the case and NIHB requests that IHS clarify that CHRs are not the same type of provider as community health aide practitioners and are authorized and operated under a different IHCIA authority.[4] The training and scope of practice for CHRs and community health aide practitioners are significantly different.

Clarify that Community Health Aide Practitioner Oversight is by a Medical Provider

The DTLL states that, "The principal provider of health services at the village level in Alaska is the community health aide (CHA). Overseen by the village council…" This is misleading as village councils may hire and determine working hours, however the oversight and direct supervision of a community health aide practitioner is by medical providers that work for Tribal Health Organizations.

Clarify the Types of Community Health Aide Practitioners

The draft policy statement says that "CHAPs have included paraprofessionals such as nursing aides, behavioral health aides, community health workers, psychiatric aides, and others." Please note that community health aide practitioners are not nursing aides or psychiatric aides. These provider types require very specialized training that is beyond the CHAP curriculum as it has been implemented in Alaska.

The draft policy statement includes a footnote on page 1 that states, "the term community health aide includes behavioral health aide, nursing aide, and dental health aide." Please note that the term "nursing aide" is not used in the Federal Community Health Aide

[3] 25 U.S. § 1616 I (a)(2)
[4] *Id.* at (a)

Program Certification Board (CHAPCB) standards and procedures. Nursing aide training is separate from the community health aide practitioner training and scope.

Utilize the Alaska Model

The Indian Health System is already severely underfunded and under-resourced; as IHS moves forward with expanding the program nationally, we recommend that IHS utilize the CHAP in Alaska as a model. This way, IHS will not have to spend the enormous resources and investments that it takes to create a brand new system from whole cloth. The Alaska model can be adapted nationally but only after thorough Tribal consultation has taken place and is done in a manner that is respectful to each Area and concerns and assurances are made that quality care is maintained. In addition, as IHS develops a national program, it is important that there are no adverse or unintended consequences on the Alaska CHAP.

Alaska community health aide practitioners are the frontline of health care in their communities-- nearly 550 providers in 170 Alaska villages are responsible for over 300,000 encounters per year. The Alaska CHAP is community driven and noted for its role in both providing care in remote villages and increasing access to care at their Tribally managed hospitals and clinics. They are part of a team of care providers and work under field supervisory staff and referral physicians at regional hospitals and clinics. This ensures access to the entire range of care that may be needed by patients. Some services are provided directly by community health aide practitioners, other services include providing technical expertise, and supporting patients as they navigate the health care system.

Community health aide practitioners in Alaska are trained for two years, receiving about four months of formal didactic and clinical training, with supervised clinical practice taking place between sessions. The training sessions include instruction to provide competency in understanding all body systems, provisions of emergency care. They receive training on common chronic conditions, maternal and child health, behavioral health, and certain procedures like suturing and lab testing. Community health aide practitioners must maintain emergency medical skills like basic life support, trauma stabilization and treatment. After initial training, community health aide practitioners are required to take continuing education every two years.

The community members receiving care from community health aide practitioners speak positively about the community insider status and general cultural competence of the program. Health information is more readily understood and integrated when it is coupled with social supports, including comfort, empathy, and fostering a safe setting in which the community health aide can give instructions and provide services. Community health aide workers are also more likely to identify and understand influences in the community that are impacting health and health care. This understanding can improve the chances of diagnosis and identification of other support systems to assist the patient with improving their overall health. As shown in Alaska, community health aide

practitioners offer high quality, culturally competent care and a deep understanding of the community, its traditions and cultures, as well as its health needs.

The DHAT Program and Need for Expansion

One of the greatest areas of need in Tribal communities is access to reliable, high quality, affordable dental care. As a result, the inclusion of the Dental Health Aide Therapist (DHAT) in this proposed CHAP expansion is a necessary element for NIHB to support this policy.

It is well documented that American Indians and Alaska Natives (AI/ANs) carry a disproportionate burden of oral disease. Over 80% of AI/AN children suffer from dental cavities by the age of eight, compared with 50% for the same age for the rest of the population. AI/AN children ages two to five have an average of six decayed teeth, when other children in the U.S. have only one decayed tooth. For example, in one New Mexico Pueblo, 70% of adults and 58% of children suffer from untreated dental decay.

It does not have to be this way. More than 40,000 Alaska Natives across 81 communities have gained access to dental care through the DHAT model in Alaska, and Alaska Native children are now being seen with no cavities. The DHAT model also builds community health care delivery capacity and creates jobs by training community members to become DHATs. DHATs are a Tribal-led solution that adopts an evidence-based, culturally – competent care model with over a decade of demonstrated oral health quality outcomes in Tribal communities. The DHAT program is also economically efficient for Indian health programs because it increases access and lowers costs, while maintaining the same quality of care as that provided by a dentist.

In order to make the full expansion of the CHAP program most effective for Tribal communities, we request that the Indian Health Service propose legislation that would repeal statutory language restricting the use of Dental Therapists through the CHAP program. Language was added to the Indian Healthcare Improvement Act (IHCIA), without the consent of Tribes that would require a state legislature's approval for IHS to employ Dental Therapists at Tribes in the lower 48 within the CHAP program.[5] NIHB believes that this is a direct violation of the principle of Tribal sovereignty, and that Tribal governments, not state legislatures, should dictate who is able to deliver care in their community. We ask for the Agency's partnership as we work to have this provision repealed, so that DHATs can be an integral part of any CHAP nationalization program.

Need for Behavioral Health Aides

The inclusion of Behavioral Health Aides in the expansion of the CHAP program has the potential to address a serious need in Indian Country. The high rates of alcohol and substance abuse, mental health disorders, suicide, violence, and behavior-related chronic

[5] 25 USC § 1616 1616 I (d)(2)(B)

diseases in AI/AN communities is well documented. Each of these serious behavioral health issues has a profound impact on the health of individuals, families, and communities. AI/ANs are significantly more likely to report past-year alcohol and substance use disorders than any other race, and suicide rates for AI/AN people are 1.7 times higher than the U.S. all-races rate. Domestic violence rates are also alarming, with 39 percent of AI/AN women experiencing intimate partner violence-the highest rate in the U.S.

Native communities face service delivery issues that are complicated by personnel shortages, limited health care resources, and distances to obtain services. There also are other issues that inhibit access to appropriate behavioral health services. These include referrals from school, detention, court, housing, primary care, child welfare, and other systems. In addition, research has demonstrated that AI/ANs do not prefer to seek mental health services through Western models of care due to the lack of cultural sensitivity; furthermore suggesting that AI/ANs are not receiving the services they need to help reduce these alarming statistics.[6]

Community based, culturally-informed providers are desperately needed in the I/T/U system. Behavioral Health aides are a potential solution to fill this need in Indian Country. However, in order for them to be effective and provide quality care, they must be trained, not just on treatment, but also prevention, aftercare, and postvention. The training and certification requirements for these aides to practice in Indian Country must be vetted and approved by the Tribal communities in which they will be working in to ensure that quality care is given in a manner that is also culturally sensitive and appropriate.

Regional Federal CHAP Certification Boards Should Be Established

In its *Dear Tribal Leader Letter*, IHS poses the possibility of creating a national certification board to provide oversight of the community health aide program within IHS. While we appreciate that IHS is proposing to create a national program to provide oversight and support for the CHAP program, as it is implemented around the country, we do have concerns around how a national certification board would interact with the Federal Community Health Aide Program Certification Board (CHAPCB) in Alaska. In order to prevent adverse or unintended consequences, we recommend that Alaska's CHAPCB continue to be autonomous and exempt from any of the requirements that IHS might establish through the creation of a national CHAP or any other regional Area certification boards.

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[6] Beals, J., Novins, D.K., Whitesell, N.R., Spicer, P., & Mitchell, C.M., & Manson, S.M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental Health disparities in a national context. *American Journal of Psychiatry, 162*, 1723-1732.
Heilbron, C.L., & Guttman, M.A.J. (2000). Traditional healing methods with first nations women in group counseling. *Canadian Journal of Counseling, 34*, 3-13.

We also recommend that instead of having a national certification board, each IHS Area Office should establish their own CHAP certification board. Tribes in the Area should then have the option to participate in CHAP or not. Any nationalization of the CHAP program should respect the sovereignty of Tribes currently using one or all of the providers in the CHAP program. NIHB recommends that Area Certification Boards would be more appropriate as it would allow Areas to tailor their CHAP programs to best meet their current community needs. It would also ensure that successful programs like Alaska would not be adversely affected by changes made at the federal level in the program, and that funding amounts for the Alaska CHAP program are not reduced when establishing a national CHAP program; as mandated by statute.[7]

However, in nationalizing the program, IHS should ensure that the Area Certification Boards have a common structure, curriculum, and standards to ensure consistency in the CHAP professions across the I/T/U system and that quality care is delivered. In determining these national standards, there must be extensive Tribal consultation from every Area and subject matter experts from Alaska could be used to assist in the development or in the distribution of information around what has been successful in Alaska. It is suggested that IHS look closely at the CHAPCB and licensing board at Swinomish when considering strategies and options for the nationalization of the CHAP program. It would be counterproductive to create national licensing processes, rules, regulations, and/or laws that would hinder, prohibit or make irrelevant the existing Tribal infrastructure and successful licensing and certification entities in Alaska and Washington.

Funding for Implementation

As IHS moves forward with expanding CHAP nationally, we request that IHS seek additional funding for implementation of CHAP and that the Administration work closely with Congress to provide the necessary resources. As discussed, the Indian Health Service is already severely underfunded and any reallocation of current resources to meet the needs for CHAP would have adverse impacts on other programs. We would like assurances that IHS will not reallocate funding from other programs to implement CHAP. Tribes, IHS, and Congress need to work together to ensure that adequate funding is made available for CHAP as it has the potential to address the gaps in the delivery of quality care to remote communities.

Develop an I/T/U Workgroup for CHAP Expansion

Due to the magnitude of the proposed transformation of the health care delivery system in Indian Country in the lower 48. We suggest that IHS hold **a 2-3 day national conference** to discuss with Tribes in person this program expansion. The CHAP program is well known in Alaska, but less understood in the rest of Indian Country. Tribal leaders

[7] 25 USC § 1616 1616 I (d)(2)

and providers all over Indian Country need adequate time to become educated in order to foster meaningful participation.

Finally, we believe that having the right expertise in the room through the CHAP nationalization development process is of paramount importance. We suggest a CHAP nationalization workgroup be immediately formed that includes at a minimum, but not limited to the following individuals and/or expertise:

- Indian Health Law experts familiar with the CHAP program
- National Indian Health Policy experts familiar with the CHAP program
- Indian Health Policy experts from each of the IHS Areas
- Providers or individuals representing different provider disciplines, including a Community Health Practitioner, a Dental Health Aide Therapist, and a Behavioral Health Practitioner, alongside a doctor, dentist, and behavioral health provider.
- A representative from the Alaska CHAP board
- A representative from the Alaska Native Tribal Health Consortium
- A representative from the Swinomish licensing board
- A representative from the National Congress of American Indians
- A representative from the National Indian Health Board
- A representative from the National Council of Urban Indian Health

We reiterate our strong support for the national expansion of the CHAP program. The CHAP program is a model that is:

- Created by Tribes;
- Tribally driven;
- Being improved and refined in Tribal settings;
- Educating and building Native providers from within Tribal communities;
- Providing consistent results in Tribal communities;
- Increasing the availability of Native providers and culturally competent care;
- Ensuring continuity of care for Tribal/community members.

This model respects that Tribes are sovereign and have the authority and the responsibility to determine how to answer issues of access for their people.

Conclusion

Thank you for this opportunity to provide Tribal comments and recommendations on the IHS's draft policy statement proposing to expand the community health aide program nationally. NIHB hopes that IHS, in the spirit of its partnership and shared interest in improving American Indian and Alaska Native (AI/AN) access to quality health care, will work with Tribes to innovate and advance access to quality health care. Please contact NIHB's Director of Federal Relations at ddelrow@nihb.org or (202) 507-4072 if there are any additional questions or comments on the issues addressed in these comments.

Sincerely,

Lester Secatero
Chairman, National Indian Health Board