National Indian Health Board

Submitted via e-mail to: consultation@ihs.gov

June 7, 2019

RADM Michael D. Weahkee
Principal Deputy Director
Indian Health Service
5600 Fishers Lane, Mail Stop: 08E86
Rockville, MD 20857
ATTENTION: IHS National CHAP Consultation

Re: IHS National CHAP Interim Policy Consultation

Dear RADM Weahkee:

On behalf of the National Indian Health Board (NIHB), I submit the following comments on the Indian Health Service (IHS) draft National Community Health Aide Program Policy (CHAP Policy), in response to the IHS Dear Tribal Leader Letter (DTLL), dated May 8, 2019.

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. We appreciate the opportunity to provide comments on the draft CHAP Interim Policy.

For more than 50 years, the Community Health Aide Program (CHAP) in Alaska has provided critical access to medical, dental, and behavioral health services in rural and remote areas with little or no access to other health care services. CHAP nationalization holds great promise for the future health care delivery system for Tribes nationally and we applaud the Secretary for developing the infrastructure to enable Tribes outside of Alaska to benefit from CHAP. However, as described below, it is critical to be clear and distinguish CHAP nationalization from the very successful and vital Community Health Representative (CHR) program.

I. CHAP EXPANSION MUST NOT AFFECT THE CHR PROGRAM

NIHB and Tribes are extremely concerned with the President's proposed budget for FY 2020 that cut the CHR program by $39 million while at the same time proposed an investment of $20 million for the CHAP. While we welcome the Administration's support for the CHAP, the CHR program is critically important to our communities and funding and support for the CHR program must not be reduced in order to expand the CHAP. The CHR program bridges the gap between AI/ANs and health care resources by providing outreach and education from specially trained members of the community. CHRs are a liaison between the health and social services of the community and help coordinate access to health services, including: in-home patient assessment of medical conditions, glucose testing, blood pressure testing, prescription interpretation, and transportation. As IHS continues to work with Tribes to expand the CHAP, we request continued support and funding for the CHR program. Additionally, substantial changes to the CHR program should, at a minimum, come only after a rigorous consultation process between the federal government and Tribes.

II. BACKGROUND OF CHAP

In 2010, with the amendments to the Indian Health Care Improvement Act (IHCIA), Congress charged the Secretary with expanding the CHAP for Tribes outside of Alaska ("nationalization"). While we understand that the nationalization of the CHAP will build on the strengths of the Alaska program, it is essential that the national program be independent. This will allow the new program enough flexibility to respond to local conditions without undoing the Alaska-specific program adaptation that provides the basis for its continuing success.

Community Health Aides (CHAs) provide critical health care access as part of a team with physicians, dentists, and behavioral health professionals. This team-based model is an effective mechanism to improve access in a system with persistent recruiting challenges and vacancies. Community Health Aides are health care providers and extenders and have been invaluable in addressing some of the chronic health disparities experienced by American Indians and Alaska Natives.

In every category of health, American Indian/Alaska Native (AI/AN) people are lagging behind other groups in good health outcomes. AI/AN people experience a disproportionately high and uncommon burden of disease and mortality compared to their white counterparts. In recent decades, AI/AN have experienced a disproportionate increase in several preventable diseases, including diabetes, cardiovascular disease, and mortality compared to all other groups.[1] Prevalence of tooth decay in AI/AN children ages 2-5 is nearly three times the U.S. average. More than 70% of AI/AN children ages 2-5 years have a history of tooth decay experience

[1] Northwest Portland Area Indian Health Board. American Indian & Alaska Native Community Health Profile - Oregon, Washington, Idaho. Portland, Oregon: Northwest Tribal Epidemiology Center; 2014.

compared to 23% of white children.[2] Unfortunately, systemic inadequacies exist within the current health care system infrastructure and workforce, including a severe and chronic shortage of AI/AN health care professionals, which undermine the Tribes' ability to positively impact the health of AI/AN communities and future generations.

IHS data indicate that a 25% physician vacancy rate currently exists at Tribal health clinics nationally, and exceeds 45% in two Areas, Billings and Bemidji.[3] Nationally, the physician vacancy rate at community health centers is lower than this, at 21%, and at hospitals it is 17.6%.[4] With the leading causes of mortality being largely preventable diseases, and persistent physician vacancies at Tribal clinics directly linked to decreased access to health care and ongoing health disparities, nationalization of CHAP is timely.

Following the Tribal Consultation in late 2016, IHS formed a CHAP Technical Advisory Group (TAG). In February 2018, IHS and CHAP TAG began meeting to develop this draft CHAP Policy that will address expansion of CHAP to Tribes in the lower 48 states.

III. DRAFT CHAP POLICY COMMENTS AND RECOMMENDATIONS

NIHB makes the following comments and recommendations on the CHAP Policy:

1. Amend the CHAP Policy's scope (Section 1.B) to make clear that the Policy only applies to the CHAP described in 25 U.S.C. § 1616l(d) and that it does not apply to the Alaska CHAP organized under 25 U.S.C. § 1616(a) and (b).

We note that the IHS's Dear Tribal Leader Letters that initiated Tribal Consultation began the process of developing a formal CHAP policy and implementation plan to create a national CHAP under the provisions in the Indian Health Care Improvement Act (IHCIA) as amended at 25 U.S.C. § 1616l(d).[5] The consultation process that is underway regarding the CHAP policy sent out for consultation on May 8, 2019 only applies to a CHAP that is organized under 25 U.S.C. § 1616l(d). This is very important because the success of the CHAP in Alaska depends on its responsiveness to conditions in Alaska. Those conditions are often very different than the ones confronting communities outside of Alaska and it would be deeply problematic to dismantle the very successful Alaska program to ensure the success of a program created for conditions outside

[2] Phipps, Kathy and Ricks, Timothy. The Oral Health of American Indian and Alaska Native Children Aged 1-5 Years: Results of the 2014 IHS Oral Health Survey. Indian Health Service Data Brief. Rockville, MD: Indian Health Service. 2015: https://www.ihs.gov/doh/documents/IHS_Data_Brief_1-5_Year-Old.pdf.

[3] Indian Health Service. Agency Faces Ongoing Challenges Filling Provider Vacancies, 2018: https://www.gao.gov/products/GAO-18-580.

[4] AMN Healthcare. Clinical Workforce Survey: A National Survey of Hospital Executives Examining Clinical Workforce Issues in the Era of Health Reform. San Diego, CA, 2013: https://www.amnhealthcare.com/uploadedFiles/MainSite/Content/Healthcare_Industry_Insights/Industry_Research/executivesurvey13.pdf; National Association of Community Health Centers. Staffing the Safety Net: Building the Primary Care Workforce at America's Health Centers. Bethesda, MD, 2016: http://nachc.org/wp-content/uploads/2015/10/NACHC_Workforce_Report_2016.pdf.

[5] See IHS Dear Tribal Leader Letters dated June 1, 2016; January 4, 2017; and February 27, 2018.

of Alaska. Instead, the programs should be coordinated, but kept separate to allow the success of the Alaska program to continue, while allowing the national CHAP the latitude to develop a program that is equally responsive to very different conditions and challenges confronting IHS and Tribal programs outside of Alaska.

Accordingly, we urge the IHS to maintain and strengthen the provisions of the current CHAP policy to make it perfectly clear that it does not apply to the CHAP in Alaska established under 25 U.S.C. § 1616l(a) and (b). To accomplish this, we recommend that IHS revise the scope (Section 1.B) of the policy to include the appropriate citations from the IHCIA as follows:

> B. Scope. This policy applies to the National CHAP and covers those programs operating outside of Alaska pursuant to 25 U.S.C § 1616l(d). It is not applicable to the Alaska CHAP or its standards and procedures established pursuant to 25 U.S.C. § 13 and maintained under 25 U.S.C. § 1616l(a) & (b).

Including the recommended citations will clarify that the circular only applies to those programs established under the authority to nationalize the CHAP described in subsection (d). Our recommended change is also intended to ensure that the CHAP policy will not consolidate the national certification board with the Alaska CHAP Certification Board or merge the programs and certainly not without further Tribal consultation. To achieve the same success as the Alaska CHAP, the national CHAP must be able to develop standards and processes that are similarly responsive to each Tribe's local conditions.

2. Expedite work with Office of Personnel Management (OPM) to create series and classification of position descriptions for DHA/Ts and CHA/Ps. under Section 1(E)(7) and allow inclusion of federally operated facilities.

Section 1(E)(7) states that, "DHAT and Community Health Aides (CHAs) will be authorized to provide services in IHS operated programs once the Office of Personnel Management series and classification of position descriptions are approved. This requirement does not apply to Title I and Title V Tribes."

We recommend that IHS and OPM make this a priority because it is key to implementing this policy at the earliest opportunity and will facilitate immediate access to these culturally competent, high quality, primary health and oral health health care providers from their communities.

3. Strengthen language in Sections 3(A), 3(E)(9), and 3(F)(3) barring members of the National Certification Board (NCB), Area Certification Boards (ACB), and Academic Review Committees (ARC) from representing the interest of professional organizations.

NIHB fully supports the language prohibiting professionals on the NCB/ACB/ARCs from representing the interests of any professional association or organization in Sections 3(A), 3(E)(9) and 3(F)(3) in the CHAP Policy. Professional associations are charged with protecting their professions, and sometimes conflate what is best for them for what is in the interest of patient care. The lawsuit filed by the American Dental Association (ADA) and the Alaska Dental

Society to block DHATs from practicing in Alaska is a key example. They also pressured universities and health professionals who had partnered with ANTHC to develop the DHAT program to withdraw their support. They even lobbied to keep DHATs out of the national CHAP expansion, and they continue to actively block or restrict Tribes from accessing DHATs through state legislative activity. While there has been modest improvement in gaining support of professional associations in some locations over the years, it is essential to preserving the integrity of the CHAP and the certification standards and processes to ensure that participants are carrying out the mission of IHS and Tribal programs. This will ensure that the needs of patients are first and foremost rather than the perceived needs of the professions, which too often results in patients going without services altogether.

NIHB requests that the following language be added to sections 3(A), 3(E)(9), and 3(F)(3):

> NCB/ACB/ARC members shall not represent the interest of any professional association or organization. They shall carry out the mission of the IHS to raise the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest level and the missions of the Tribes served.

4. Maintain language in the CHAP Policy that supports portability of providers at Section 7.

NIHB supports the language that ensures the portability of providers across Areas in Section 7 and throughout the CHAP Policy. The CHAP program is not just a system of health care, it is also an education system that has the potential to create educational pathways and professional wage jobs in Tribal communities. It is important that individuals and Tribes that invest in these professions be able to practice wherever life takes them and for individuals to be able to continue their educational journey, wherever they are. Additionally, it is important for there to be a baseline to protect the integrity of the CHAP and the providers so that, while regional specialization is necessary, there is some baseline training for Areas to build upon. The nationalization of CHAP should ensure that, similar to other health professions, health aides have minimum scopes of practice and education.

6. Add additional authorities to Section 1(D).

NIHB agrees with the CHAP TAG recommendations and supports broadening the authorities section to include additional statutory authorities so that the national CHAP benefits from a more complete legal framework.

NIHB also requests inclusion of a citation to IHCIA in its entirety, or at least the provisions that address federal health goals and objectives and the role of training and supporting health professionals, as well as the inclusion of the "Public Health Service Act, 42 U.S.C § 254a." The Public Health Service (PHS) Act provides general authority for PHS agencies, including the IHS, to engage in a variety of health education, coordination, and innovative health delivery activities. Section 254(a) permits "sharing specialized health care resources," including personnel, space

and equipment, which can be extremely helpful in rural areas where that level of coordination is essential to successful delivery of health care services.

7. Add language in Section 1(E)(1) to recognize Tribally licensed CHAP providers in that they pre-date the CHAP Policy.

NIHB requests the inclusion of Tribally licensed CHAP providers in the CHAP Policy, aligning with the request made by the CHAP TAG. The CHAP Policy, as written, does not provide any recognition of those Tribal programs, Tribal sovereignty, or any guidance for how they can be incorporated into a CHAP once the federal infrastructure is in place.

Federal Indian law recognizes the legitimacy of Tribal programs and this recognition should be reflected in this CHAP Policy. NIHB understands that IHS initially disagreed based on its interpretation of what is authorized by the IHCIA. However, the Alaska program was developed under the authority of the Snyder Act, which applies equally to all services for AI/ANs. While the IHCIA requires the IHS to maintain the Alaska CHAP, it does not preclude the IHS or a Tribe from developing CHAP under preexisting authorities. There should be language recognizing existing Area infrastructure that was built prior to the development of this CHAP Policy, in addition to language recognizing Tribal sovereignty.

NIHB requests the revision of CHAP policy Section 1(E)(1) to incorporate the underlined language below:

> All CHAP providers certified by the Alaska Community Health Aide Program Certification Board (Alaska CHAPCB) who wish to provide services in a program outside of Alaska and any CHAP provider certified by a federal CHAP Area Certification Board (ACB) <u>or by a federally recognized Tribe or Tribal Organization's governing body, a Tribal board, that has adopted certification standards,</u> but wants to provide services in another area, must submit a copy of their certification to the receiving ACB for review and approval prior to being certified in that Area.

NIHB also requests that this language be included in Section 1(E)(3):

> If Tribes or Tribal Organizations outside of Alaska include a CHAP as a program, service, function, or activity (PSFA) in their ISDEAA contract or compact, the individuals working under their CHAP must be certified by the Alaska CHAPCB or other federal ACB <u>or, with the approval of the Tribe or Tribal Organization's governing body, a Tribal board</u>.

These requested revisions resolve the IHS's concern that federal certification standards be respected in CHAP expansion, because in this revision those federal standards serve as a minimum floor, addressing potential concerns about quality, yet Tribes are provided with an opportunity to adopt additional criteria that are consistent with cultural values or local needs and conditions. The requested revision is also consistent with the promotion of Tribal self-determination in the Indian Self Determination and Education Assistance Act, 25 U.S.C. §§ 5301

et seq. (ISDEAA), since the Tribal licensing authorities could choose to implement, as a minimum standard, federal program requirements, but adapt them as appropriate for the particular Tribal setting.

Failure to adopt the requested revision will undermine the successful expansion of a CHAP that facilitates coordination between IHS and Tribal programs, and could create needless confusion. Without the requested revision to the policy, Tribes may find themselves forced to choose between maintaining their own certification policies and standards on the one hand, and participation in the IHS CHAP program on the other. Needlessly creating such a dilemma for Tribes would be inconsistent with both the self-determination policy and the trust responsibility, and would do nothing to further the ultimate goal of expanding CHAP.

8. Remove language from Section 1(E)(6) highlighting the need for state authorization for the use of DHATs in CHAP programs.

Section 1(E)(6) states that, "DHATs shall practice only in states that authorize the use of DHAT services if a Tribe or Tribal Organization seeks to include a CHAP as a PSFA in Title I and Title V ISDEAA contract or compact. DHATs must meet the federal training requirements for certification." It is unnecessary to call out this portion of the IHCIA §1616l (d)(3)(A) as the relevant section is included in Section 1(D). Additionally, absent federal authorization, such as Public Law 280, Tribes and Tribal health programs are not generally subject to state law and without further explanation, this language will cause confusion and create significant challenges for Areas that cross state lines. NIHB requests removal of language from Section 1(E)(6) highlighting the need for state authorization for the use of DHATs in CHAP Programs.

9. Maintain language in section 1(E)(13) that requires consensus of a majority of Area Tribes to enter into relationships with another IHS Area for the purposes of certification of providers.

Section 1(E)(13) states that, "In the absence of an ACB, an IHS Area Director must consult with Area Tribes and will seek consensus of a majority of Area Tribes or Tribal organizations to enter into a relationship with another IHS Area that has an ACB or with the Alaska CHAP Certification Board (CHAPCB) for the purposes of certifying its CHAP providers." NIHB requests that Tribes be treated as participants in the expansion of the CHAP program, in addition to consultation, in their respective Areas. Requiring a consensus is an imperfect but good way to ensure that IHS Area Directors have sufficient buy-in and partnership with the Area Tribes in expanding CHAP.

10. Remove language in section 1(E)(13) that allows IHS Area Director to make final decision without a consensus from Tribes.

Section 1(E)(13) further states that, "In the absence of consensus, IHS Area Directors will reserve the right to make the final decision." NIHB is concerned that the assertion that the Area Director reserves the right to make the decision on how to best meet the needs of the Area when consensus is not met could mean that CHAP in some Areas is implemented without necessary input from the Area Tribes. This is not in keeping with the spirit of CHAP which is necessarily

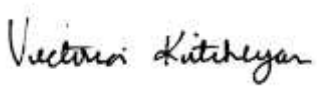
an organic, Tribally based, community program. Tribes are in the best position to understand the health, oral health, and mental health needs of their communities. The CHAP program was developed in Alaska to meet the specific needs of the AN communities because the system in place was failing their population. CHAP nationalization provides an opportunity to break down barriers to accessing critical health care services. A close partnership with the affected Tribes is essential to success. NIHB therefore recommends that the language in Section 1(E)(13) allowing IHS Area Directors to make a final decision be deleted.

IV. CONCLUSION

We appreciate the opportunity to comment on the proposed policy and explain the importance of expanding CHAP but we reiterate our request that the CHR program must be held harmless in efforts to expand and nationalize CHAP. We thank you for this opportunity to provide our comments and recommendations and look forward to IHS responses to our requests.

Should you have any questions regarding NIHB's comments, or for more information, please contact NIHB's Director of Policy, Devin Delrow, at ddelrow@nihb.org.

Sincerely,



Victoria Kitcheyan, Chair
National Indian Health Board