



**NORTHWEST
PORTLAND
AREA
INDIAN
HEALTH
BOARD**

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Confederated Tribes of Colville
Confederated Tribes of Coos, Lower
Umpqua, and Siuslaw Indians
Confederated Tribes of Grand Ronde
Confederated Tribes of Siletz Indians
Confederated Tribes of Umatilla
Confederated Tribes of Warm Springs
Coquille Tribe
Cow Creek Band of Umpqua
Cowlitz Indian Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Klallam Tribe
Lummi Nation
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Nation
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinalt Indian Nation
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribes
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Indian Nation

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July 21, 2016

Submitted via email to: consultation@ihs.gov

Alec Thundercloud, M.D.
Director, Office of Clinical and Preventative Services
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:

The Northwest Portland Area Indian Health Board (NPAIHB) is a Public Law 93-638 Tribal organization that advocates on health care issues for the forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington¹. Our mission is to eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest Tribes in their delivery of culturally appropriate, high quality healthcare.

Thank you for the opportunity to consult on the draft policy statement that proposes an expansion in the use of community health aides at Indian Health Service (IHS) facilities across the country. The Northwest Portland Area Indian Health Board is in full support of expanding health care opportunities under the new draft policy for these aides, and strongly supports the inclusion of the Dental Health Aide Therapist and Behavioral Health Aides as part of the expansion. We submit these comments along with a request for an in-person consultation to further discuss strategic pathways for moving forward with this draft policy statement.

1. Expansion of the Community Health Aide Programs Would Benefit the Tribes in the Lower 48

NPAIHB welcomes the IHS draft policy as a recognition of the value of community-recruited paraprofessionals and mid-level providers in all aspects of healthcare in the Indian Health System. The Community Health Aide Program (CHAP) is a model that was Tribally created, Tribally driven and for those reasons has unique features that resonates with Tribes. Creating a workforce that comes from our communities and respects that we are sovereign and have authority to determine how to answer issues of access has proven benefits:

¹ A "Tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian Tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

- Provides routine, preventive, and emergent care within the community;
- Respects the knowledge and resources in the Tribal community and grows providers from that source through accessible and achievable training programs;
- Involves community participation in the selection of the individual who will become a CHA provider;
- Delivers patient-centered quality care that comes from providers that understand the history, culture, and language of their patients;
- Fosters a team approach to delivering health care services;
- Increases the efficiency of the entire healthcare team, allowing each member to practice at the top of their scope;
- Provides continuity of care in communities that face recruitment and retention challenges;
- Results in cost savings to Tribes and individuals that no longer have to travel long distances or receive care outside of the IHS system.

Alaska CHA/Ps are the frontline of healthcare in their communities-- nearly 500 providers 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.

a. Dental Health Aide Therapists Are Critical to CHAP Expansion

One of the greatest areas of need in our Tribal communities is access to reliable, high quality, affordable dental care. That is why inclusion of the Dental Health Aide Therapist in this proposed CHAP expansion is a necessary element for NPAIHB to support the policy.

It is well documented that American Indians and Alaska Natives (AI/AN) carry a disproportionate burden of oral disease. According to the IHS 2014 Oral Health Survey, the majority of AI/AN children have tooth decay. Most adults have lost teeth because of dental disease, periodontal disease is a significant problem for adults, and there is limited access to both preventive and restorative dental care. Profound health disparities exist between the oral health status of AI/ANs compared to non-AI/ANs across the country.

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.

Even though Tribes do not need the expansion of CHAP in order to move forward with integrating DHATs into their dental programs, they currently need *state authorization* in order to

Alec Thundercloud, M.D.

July 12, 2016

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

Page 3 of 5

use their Indian Health Service funding once DHATs are practicing. This funding is particularly important for Tribes with fewer resources and the least access to care. The state authorization pathway has been blocked in most states by the American Dental Association (ADA) at tremendous costs to Tribes. The longer we are faced with this route as the only option, the longer our members will endure lack of access to care. This new draft policy and any required change of federal legislation or administrative rules could offer a more reliable and expedited pathway to proven oral health care solutions.

b. Behavioral Health Aides Could Play a Key Role in Addressing Mental Health and Substance Abuse Issues

NPAlHB also strongly supports the inclusion of Behavioral Health Aides in the expansion of the CHAP program. The high rates of alcohol and substance abuse, mental health disorders, suicide, violence, and behavior-related chronic diseases in our communities are 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. Tribal communities throughout Indian country are struggling under the weight of providing behavioral health care to their members.

We strongly support the expansion of Behavioral Health Aides as part of the CHAP expansion.

2. Legislative Fix Needed to Expand DHATs in Lower 48

We strongly urge the IHS to address legislative barriers to carrying out a full expansion of the CHAP program, particularly in regards to the expansion of mid-level providers and to eliminate those barriers. For example, there is language in the Indian Health Care Improvement Act (IHCIA) that limits the ability of Tribes outside of Alaska to use DHAT services unless such services are authorized under state law.

3. Regional Federal CHAP Certification Boards Should Be Established

IHS should not adopt a national certification board. Instead, IHS must consult and work with each Area to establish regional Federal CHAP Certification Boards. Tribes in the Area should then have the option to participate in CHAP or not. It is suggested that IHS look closely at the existing certification board in Alaska and licensing board at Swinomish when considering strategies and options for the nationalization of the CHAP program. It would be

Alec Thundercloud, M.D.

July 12, 2016

Re: IHS Expansion of Community Health Aide Program Draft Policy Statement Consultation
Page 4 of 5

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. Any nationalization of the CHAP program should respect the sovereignty of Tribes currently using one or all of the providers in the CHAP program. The IHS should also consider whether Area specific certification boards would be more appropriate as it would allow Areas to tailor their CHAP programs to best meet their current 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.

4. National Convening and Workgroup Should Be Established 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 kicks off the national dialogue with a **2-3 day national conference** to discuss with Tribes this program expansion. The CHAP program is well known in Alaska but less understood in the rest of Indian country. Tribal leaders 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 nationalization process is of paramount importance. We suggest a nationalization workgroup be immediately formed that includes at a minimum 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 individual 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

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 honed 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.

Alec Thundercloud, M.D.

July 12, 2016

Re: IHS Expansion of Community Health Aide Program Draft Policy Statement Consultation
Page 5 of 5

And therefore, has unique features that may resonate with Tribes. 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.

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

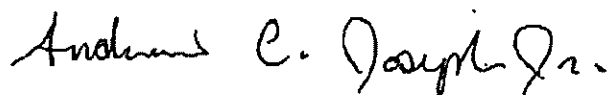
As with any significant change to the health care delivery system, there are professions with a vested interest in maintaining the status quo. The expansion of the CHAP program to the lower 48 will upset that status quo. It will be of paramount importance that the culture of professionals within the agency 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 insist that they accept and embrace new ideas to foster reformation of the health care delivery system in Indian country.

6. Conclusion

We submit these comments with the anticipation that we will work in partnership with the Indian Health Service to increase access to healthcare for our members through the successful implementation of this draft policy.

Please contact Laura Platero, Policy Analyst, Northwest Portland Area Indian Health Board at (503) 416-3276 or lplatero@npaih.org if you have any questions or to discuss these comments.

Sincerely,



Andy Joseph, Jr., Chairperson
NW Portland Area Indian Health Board

Colville Tribal Council Member