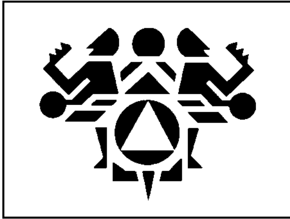

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Siuslaw, & Lower Umpqua Tribe
Coquille Tribe
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Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
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Shoalwater Bay Tribe
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Spokane Tribe
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Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
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Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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Submitted via email 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
ATTN: IHS National CHAP Consultation

***Re:* IHS National CHAP Interim Policy Consultation**

Dear Principal Deputy Director Weahkee:

On behalf of the Northwest Portland Area Indian Health Board (NPAIHB), I submit the following comments on the IHS National CHAP Interim Policy Consultation, in response to the IHS Dear Tribal Leader Letter (DTLL) dated May 8, 2019.

Established in 1972, the NPAIHB is a non-profit, Tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638, representing the 43 federally-recognized Indian Tribes in Idaho, Oregon, and Washington on health care issues. In the Portland Area, 75% of the total IHS funding is compacted or contracted and includes 6 federally operated service units, 16 Title I Tribes, 26 Title V Tribes, 3 urban facilities, and 3 treatment centers. NPAIHB operates a variety of important health programs on behalf of our member tribes, including the Northwest Tribal Epidemiology Center,[1] and works closely with the IHS Portland Area Office. 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 health care. Thank you for the opportunity to provide comments on the draft CHAP Policy.

The CHAP is pivotal to improving the health care for our people. The CHAP recognizes tribal sovereignty, provides for cultural community-based care, and assists to overcome provider recruitment and retention barriers. CHAP nationalization holds great promise for the future health care delivery system for

[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."

tribes in the Northwest and NPAIHB applauds the IHS for developing the infrastructure to enable Tribes outside Alaska to benefit from CHAP. The NPAIHB is in full support of expanding health care opportunities under the CHAP Policy – but that expansion must be done appropriately and must respect the sovereignty, cultural values and institutional capacity of the participating tribal communities.

I. BACKGROUND

In 2010, with the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA), Congress charged the Secretary with the nationalization of the successful CHAP to tribes outside of Alaska. Alaska has operated a CHAP for over 50 years. CHAP services have proven to be a sustainable, effective, and culturally appropriate method for delivering health care. The success of the CHAP in Alaska has been to understand the role of the communities and its recognition to build on their strengths to develop the program.

Health Aides 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. Health Aides are health care providers and extenders. Their scope of services is much different from Community Health Representatives (CHRs). CHRs also provide critical services to many people and communities and any discussion on the nationalization of CHAP should not include the elimination of another critical service provider or the elimination of their funding.

The nationalization of the CHAP must be based in tribal community values, priorities, and be reflective of the communities served. States all across the country have been passing legislation that will allow for the utilization of Dental Health Aide and Dental Health Aide Therapists (DHA/Ts) as part of the CHAP. While state legislation is not necessary to utilize Community Health Aides and Practitioners (CHA/Ps) or Behavioral Health Aides and Practitioners (BHA/Ps), due to language in the IHCIA, IHS believes that state legislation is necessary if tribes wish these oral health providers to be eligible for reimbursement and to be included in their annual funding agreements.

In every category of health, American Indian/Alaska Native (AI/AN) people are lagging behind other groups in positive health outcomes. AI/AN people experience a disproportionately high and uncommon burden of disease and mortality compared to their non-Native counterparts. In recent decades, AI/ANs have experienced a disproportionate increase in several preventable diseases, including diabetes, cardiovascular disease, and mortality compared to all other groups.[2] 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 compared to 23% of white children.[3] Unfortunately, systemic inadequacies exist within the current health care

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

[3] 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.

system infrastructure and workforce, including a severe and chronic shortage of AI/AN health care professionals, that undermines 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 a 23% vacancy rate exits in the Portland Service Area.[4] Nationally, the physician vacancy rate at community health centers is lower than this, at 21%, and at hospitals, it is 17.6%.[5] 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) and 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.

II. PORTLAND AREA TRIBES' PROGRESS IN DEVELOPING A CHAP

NPAIHB and Portland Area Tribes have seen first-hand the benefit of training tribal members to be DHATs and having DHATs in tribal communities, and have already begun laying the groundwork for a robust and community based CHAP, as follows:

- Tribes in Oregon, Washington, and Idaho have welcomed DHATs after their graduation from the Alaska Dental Therapy Education Program;
- There are currently 11 DHATs in the Portland Area.
- The Swinomish Indian Tribal Community has created a licensing board that other tribes in the state have used to license DHATs in an exercise of tribal sovereignty that is consistent with Washington State law for the practice of DHATs in Washington.
- Tribes in Washington and Idaho worked with state legislators to help pass state DHAT legislation to allow for the inclusion of DHATs in their CHAPs, and the Oregon tribes are using DHATs as part of a pilot project with the State;
- Washington tribes have prioritized significant funding and resources through the NPAIHB to build the infrastructure necessary to design and implement an Area CHAP Certification Board (ACB);
- NPAIHB, in partnership with Northwest Indian College (NWIC) and Area tribes, has begun the process of creating and implementing an education program for Behavioral Health Aides (BHAs) in the Portland Area; and
- In partnership with a local community college, NPAIHB, the Swinomish Indian Tribal Community, and Seattle Indian Health Board are implementing a Dental Therapy Education Program with support from the other Area tribes.

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

[5] 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.

As these points make very clear, tribes in the Portland Area are ready and eagerly anticipating this CHAP Policy to help facilitate the next phase of implementation in our Area. The policy as proposed allows for flexibility and Area specific modifications while protecting the integrity of the providers and program though baseline standards.

III. DRAFT CHAP POLICY COMMENTS AND RECOMMENDATIONS

NPAIHB makes the following comments and recommendations on the draft CHAP Policy:

1. 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."

NPAIHB is pleased that the IHS has identified the necessary work in order to allow federally operated facilities to benefit from the CHAP. We recommend that IHS and OPM make this a priority because it is key to implementing this policy.

There are six federally operated facilities in our area, and they all deserve immediate access to these culturally competent, high quality, primary health and oral health care providers from their communities. In the Portland Area, the Confederated Tribes of the Colville Reservation have invested in a tribal citizen to receive the education necessary to become a DHAT, but the DHAT is currently unable to work in their IHS facility where the need is greatest. This is unacceptable and constitutes an unnecessary barrier to care for these communities.

NPAIHB requests that IHS prioritize working with the OPM to create a series and classification for positions for DHA/Ts and CHA/Ps. Continued delay in this area is not acceptable and only blocks access to culturally competent, high quality, primary care for tribal citizens receiving their care from IHS facilities.

2. 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.

NPAIHB fully supports the inclusion of language that NCB/ACB/ARCs shall not represent 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 their members, and they do not always act in the best interests of patient care. This has been demonstrated numerous times by the American Dental Association and the State Dental Associations, most notably when they sued the Alaska tribes to try to block DHATs from practicing in Alaska, and pressured universities and health professionals who had partnered with ANTHC to develop the DHAT program to withdraw their support, when they lobbied to keep DHATs out of the national CHAP expansion, and as they continue to actively block or restrict tribes from accessing DHATs through state legislative activity. The proposed language is critical

to preserving the integrity of the CHAP providers, especially DHATs, to provide recourse for the NCB, ACBs, and ARCs that find themselves with members that are not upholding their charge of representing the interest of tribal health programs, and to ensure that the needs of tribes and tribal health programs are central to the decisions of these certification and academic review bodies.

NPAIHB 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 "above the interest of the tribes or tribal health programs they serve."

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

NPAIHB supports the language ensuring the portability of providers across Areas in Section 7 and throughout the CHAP Policy. The CHAP 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 similar minimum scopes of practice and education.

4. Remove language related to Urban Indian Organizations from Section 1(B).

NPAIHB disagrees with language excluding applicability of the CHAP Policy to Urban Indian Organizations (UIO) in Section 1(B). DHATs are required to be authorized by states in order for this provider type to be utilized as part of the CHAP. Some states have included UIOs in their state DHAT legislation. UIOs are an important part of the Indian health system of care. Relocation policies, economic depression in rural areas, and other factors have led to large and robust AI/AN populations in urban centers. Even in urban areas, AI/AN individuals struggle with lack of access to care and report a preference to receive care at UIOs. Furthermore, there is no specific language in Section 119(d) of the IHCIA that excludes UIOs from hiring and using CHAP providers as part of the national program. Additionally, there could be opportunities through partnerships with tribes for UIOs to utilize these providers and expand access to care to the urban communities they serve.

For these reasons, NPAIHB recommends that "Urban Indian Organizations" be deleted from Section 1(B).

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

NPAIHB agrees with the CHAP TAG recommendations and supports broadening the authorities section to include additional statutory authorities so that the CHAP, as implemented outside of Alaska, would benefit from a more complete legal framework. This will support the tribal health programs that employ CHAP providers and that currently provide the legal foundation for CHAP in Alaska. IHS did incorporate most of the suggestions by the CHAP Tribal Advisory

Group (TAG), which NPAIHB endorses, and this is positive, as it supports the big picture regarding authority and potential flexibility for CHAP.

However, NPAIHB also requests inclusion of a citation to IHCIA in its entirety, not just 25 U.S.C. Section 1616l(d), or at a minimum, the provisions that address federal health goals and objectives and the role of training and supporting health professionals. NPAIHB also supports 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 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.

6. Add language in Section 1(E)(1) to recognize tribally licensed CHAP providers in the CHAP Policy.

NPAIHB requests that the policy clarify how tribally licensed CHAP providers in the CHAP Policy will be treated, aligning with the request made by the CHAP TAG. In the absence of a federal infrastructure, some tribes in the Portland Area have already created and implemented licensure of one provider type (DHATs) under CHAP over the past few years in an exercise of their own sovereign authority. These tribal standards equal or exceed the IHS's own Community Health Aide Program Certification Board ("CHAPCB") *Standards and Procedures* for Dental Health Aides, including DHATs. *See, for example*, Swinomish Tribal Code Title 15, Chapter 11[6].

Inexplicably, the CHAP Policy, as written, does not provide any recognition of those tribal programs, tribal sovereignty, or any guidance for how those tribal programs can be incorporated into a CHAP once the federal infrastructure is in place. It is incomprehensible that the work of our tribes, which have led the way with establishment of our own programs and standards for DHATs, would not be respected by IHS through recognition of tribal licensure in the draft CHAP Policy. NPAIHB strongly recommends that tribal licensure standards and programs be honored by IHS.

This recommendation is based on fundamental principles of federal law. It is well recognized that the inherent sovereign powers of Indian tribes include the "power to make their own substantive law in internal matters, and to enforce that law in their own forums[.]" *Santa Clara Pueblo v. Martinez*, 436 U.S. 49, 55-56 (1978). The U.S. Supreme Court has determined that "Congress has plenary authority to limit, modify or eliminate the powers of local self-government which the tribes otherwise possess." *Id.* at 56. Therefore, "'unless and until Congress acts, the tribes retain' their historic sovereign authority." *Michigan v. Bay Mills Indian Cmty.*, 572 U.S. 782, 788 (2014) (quoting *United States v. Wheeler*, 435 U.S. 313, 323 (1978)). In the absence of action by Congress limiting the authority of Indian tribes to exercise their inherent sovereign powers, tribes continue to retain "all inherent attributes of sovereignty that have not been divested by the Federal Government, [since] the proper inference from silence . . . is that the sovereign power . . . remains intact." *Iowa Mut. Ins. Co. v. LaPlante*, 480 U.S. 9, 18 (1987) (quoting *Merrion v. Jicarilla Apache Tribe*, 455 U.S. 130, 149 n.14 (1982).

[6]Swinomish Tribal Code, Title 15 – Business Regulations, Chapter 11 – Dental Health Provider Licensing. http://www.swinomish-nsn.gov/media/48067/1511dental.pdf accessed June 3, 2019

In this case, Congress has not enacted a law that limits the right of tribes to exercise their inherent sovereign authority to develop and implement a DHAT program as a matter of tribal law. NPAIHB understands that IHS disagrees with this conclusion, apparently based on an interpretation of what is authorized by the IHCIA. However, with regard to inherent tribal sovereignty, the touchstone of the inquiry is not what Congress has authorized but whether Congress has explicitly limited the exercise of their inherent tribal authority. The CHAP authorization in the IHCIA does nothing to limit inherent tribal sovereignty. As a result, the CHAP Policy must recognize that tribes retain their fundamental and inherent sovereign right to implement CHAP provider types on their own authority outside the IHS system.

The State of Washington has recognized and legislatively endorsed the exercise of tribal licensing authority by Washington tribes:

> (1) Dental health aide therapist services are authorized by this chapter under the following conditions:
>   (a) The person providing services is certified as a dental health aide therapist by:
>   (i) A federal community health aide program certification board; or
>   (ii) A federally recognized Indian tribe that has adopted certification standards that meet or exceed the requirements of a federal community health aide program certification board;…

RCW 70.350.20; *see also* RCW 70.350.10, Notes, Finding # 3 ("The legislature finds further that sovereign tribal governments are in the best position to determine which strategies can effectively extend the ability of dental health professionals to provide care for children and others at risk of oral disease and increase access to oral health care for tribal members. The legislature does not intend to prescribe the general practice of dental health aide therapists in the state."). The State's recognition of and respect for the exercise of tribal licensing authority points the way to a path by which IHS, as a trustee, may do the same.

NPAIHB 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 Indian tribe that has adopted certification standards that meet or exceed the requirements of either the Alaska CHAPCB or a federal CHAP Certification Board,</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.

This requested revision is fully consistent with IHS' concern that federal certification standards be respected in CHAP expansion, because in this revision those federal standards serve as a minimum floor, protecting federal interests, but tribes are provided with an opportunity to adopt more stringent 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 ISDEAA, 25 U.S.C. §§ 5301 *et seq.*, since the licensing tribes satisfying this revised CHAP Policy

would be implementing, as a minimum standard, federal program requirements, but adapting that federal minimum as appropriate for the particular tribal setting.

Failure to adopt the requested revision is likely to create needless conflict and confusion between IHS and tribes who have already adopted certification standards that meet or exceed CHAPCB standards. 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 federal minimum standards adopted by the CHAPCB.

Finally, the language of the requested revision is drawn directly from the language of the Washington Legislature in RCW 70.350.20(1)(a)(ii). In the years since enactment, there have been no reports of adverse consequences resulting from the Legislature's adoption of this language or the Legislature's recognition of tribal licensing sovereignty. IHS, as trustee and as an agency carrying out the IHCIA and ISDEAA, should similarly recognize and endorse tribal sovereignty and licensure of CHAP providers by adopting the requested revision to the CHAP Policy.

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

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, §1616*l* (d)(3)(A), as the relevant section is included in Section 1(D). Additionally, tribes and tribal health programs are not generally subject to state law and without further explanation, this language could cause confusion, especially in Areas that cross state lines. The Policy's recitation of language supporting state authority, while at the same time refusing to recognize tribal licensing authority, is fundamentally inconsistent with the government-to-government relationship between the United States and tribes, and with the trust responsibility to tribes. NPAIHB requests removal of language from Section 1(E)(6) highlighting the need for state authorization for the use of DHATs in CHAP.

8. 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." NPAIHB requests that tribes be treated as participants in the expansion of the CHAP, in addition to consultation, in their respective Areas. In the Portland Area, the IHS Portland Area Office has worked closely in the past four years with tribes in preparation for implementing the CHAP. Portland Area tribes expect this to continue; however, other Areas may not benefit from the level of support Portland Area Tribes have received from their Area Office and believe that it is important to require consensus from tribes in the Area. Requiring a consensus is an imperfect but

good way to ensure that IHS Area Directors will be compelled to seek buy-in and partnership with the Area tribes in expanding CHAP. We agree with the language in Section 1(E)(13) that requires a consensus of a "majority of Area tribes or Tribal organizations."

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

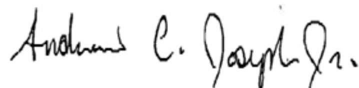
Section 1(E)(13) further states that "In the absence of consensus, IHS Area Directors will reserve the right to make the final decision." NPAIHB is concerned that the assertion that the Area Director reserves the right to make the decision on how to best meet the needs of the Area when consensus is not met could mean that CHAP in some Areas is implemented without necessary input from the Area s. 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 behavioral health needs of their communities. The CHAP was developed in Alaska to meet the specific needs of the AI/AN communities because the current system was failing their population. We must use the opportunity of expanding CHAP nationally to break down the various barriers perpetuated by the current system. A close partnership with the affected tribes is essential to success. NPAIHB recommends that the language in Section 1(E)(13) allowing IHS Area Directors to make a final decision be deleted.

IV. CONCLUSION

Please accept these comments on behalf of NPAIHB with our sincere request to work together with IHS, in the spirit of its partnership and shared interest to increase access to health care for our members through the successful implementation of the draft CHAP Policy. We believe it is essential that this native solution to native health disparities be made available as fully and as promptly as possible throughout Indian Country to those tribes that seek to participate. We thank you for this opportunity to provide our comments and recommendations and look forward to IHS responses to our requests.

Please contact Christina Peters, Tribal Community Health Provider Project Director, cpeters@npaihb.org, or Laura Platero, Policy and Government Relations Director, lplatero@npaihb.org if you have any questions or to discuss these comments.

Sincerely,



Andy C. Joseph Jr.
Northwest Portland Area Indian Health Board Chairperson
Colville Tribal Council Member