Letterhead

*Submitted via email to: consultation@ihs.gov*

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Indian Health Service

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

Dear Dr. Thundercloud:

TRIBE INTRODUCTION

Thank you for the opportunity to provide comments on the draft policy statement that proposes an expansion in the use of community health aides (CHAs) at Indian Health Service (IHS) facilities across the country. We also thank IHS for listening to tribes and coordinating the telephonic and in-person tribal consultations. The [TRIBE] 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 Therapists (DHATs) and Behavioral Health Aides (BHAs) as part of the expansion.

**Summary of Recommendations:**

1. Expansion of CHAP would benefit tribes in the Lower 48;
2. CHAP providers are currently utilized in a variety of clinical and village settings and the national policy should not limit where CHAP providers may deliver health services;
3. Nationalization of the CHAP program must be based in tribal community values and priorities, and should be reflective of the communities served;
4. Legislative fix is needed to expand DHATs in the lower 48;
5. Regional Federal CHAP Certification boards should be established with federal baseline standards;
6. Implement a full CHAP Pilot Project in the Portland Area;
7. National workgroup should be established for CHAP expansion; and
8. IHS must Foster an internal culture that supports mid-level providers to ensure the success of an expansion.
9. **Expansion of CHAP Would Benefit the Tribes in the Lower 48**

[TRIBE]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. 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:

* 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; and
* Results in cost savings to tribes and individuals that no longer have to travel long distances or receive care outside of the IHS system.

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 Alaska Native and American Indian 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.

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, and village based care in the community.

The health care system as it is today is not meeting the needs of many tribal communities in the lower 48. This is an opportunity to look critically at the healthcare delivery system in Indian Country and make meaningful changes through the CHAP program. Tribes must be given the opportunity to tailor their health care delivery system to meet the needs in their communities and of their tribal members.

This is a clear opportunity for tribes in the lower 48 to benefit from the years of thoughtful adaptation and evolution of the CHAP program to create a better health system for American Indian and Alaska Natives (AI/AN) nationwide.

Improving care and access is not just about bringing more providers to Indian Country but includes fixing the current system of training health professionals. We can and should “grow our own” providers. CHAP has created an education system that breaks down barriers to training health professionals from tribal communities. That should be replicated in the Portland Area.

1. DHATs 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 DHATs in this proposed CHAP expansion is a necessary element for [TRIBE] to support the policy.**

It is well documented that 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. [ADD LOCAL DATA OR DETAILS OF CURRENT ORAL HEALTH ACCESS OF YOUR TRIBE]

It doesn’t 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 tribally-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 require *state authorization* in order to 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 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.

1. BHAs Play a Key Role in Addressing Mental Health and Substance Abuse Issues

[TRIBE] also strongly supports the inclusion of BHAs 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. [ADD LOCAL DATA OR DETAILS OF CURRENT BEHAVIORAL HEALTH SERVICES ACCESS AT YOUR TRIBE]

AI/AN communities face behavioral health service delivery issues that are complicated by personnel shortages and limited resources. AI/AN often have to travel long distances to obtain behavioral health services not offered at their IHS or tribal clinic. In addition, AI/AN who have participated in inpatient substance abuse treatment programs often return to their communities without adequate services to maintain their behavior change. Tribal communities throughout Indian country are struggling under the weight of providing behavioral health care to their members and BHAs are part of the solution.

**We strongly support the expansion of BHAs as part of the CHAP expansion.**

[PROVIDE DETAILS HERE ABOUT HOW CHAP WITH CHA/P, DHA/T, AND BHA/P COULD ENRICH THE CURRENT HEALTH DELIVERY SYSTEM AT YOUR TRIBE. WHAT PROVIDERS ARE YOU INTERESTED IN INTEGRATING, HOW COULD THIS ALLOW YOU TO BREAK DOWN THE CURRENT BARRIERS TO CARE EXPERIENCED BY YOUR COMMUNITY. HOW WILL THIS EXPANSION ALLOW YOU TO TAILOR THE HEALTH DELIVERY SYSTEM TO MEET YOUR TRIBAL MEMBERS WHERE THEY ARE. HOW EXCITED ARE YOU FOR THE CAREER PATHWAYS FOR YOUR TRIBAL MEMBERS]

1. **CHAP providers are currently utilized in a variety of clinical and village settings and the national policy should not limit where CHAP providers may deliver health services.**

The Dear Tribal Leader Letter (DTLL) states, “Community health aides are proven partners, and utilizing them to the fullest extent permissible in hospitals and clinics operated by the IHS and Tribes....” [Emphasis added]. The statute and current practice is broader than described in the DTLL and allows CHA/P to provide services “...to Alaska Natives living in villages in rural Alaska”. The statute also allows for telehealth in health clinics located in or near those villages for use by CHA/P providers. At the core of the CHAP program is the provision of services at the village and community level and access to that type of primary care is missing currently in many communities.

1. **The nationalization of the CHAP program must be based in Tribal community values, priorities, and should be reflective of the communities served.**

The success of the CHAP program in Alaska has been to understand the role of the village-based communities and its recognition to build on these strengths to develop the program. There are aspects of the Alaska CHAP program that are likely to be universal and other aspects of the Alaska CHAP program that will need to be tailored by region and even by tribe. The role of the tribal community is critical to meeting the unique health needs and addressing health disparities for each of the Tribes involved. The nationalization of the CHAP program must be community driven to reflect the priorities, needs, and values of the communities served.

Any program developed by local areas should promote shared decision making among the program's governing body, staff, and CHAP practitioners. The local area programs should have established partnerships and referral protocols with Indian health programs and community-based social service agencies. The local area programs should also provide opportunities for career mobility and professional development.

1. **Legislative Fix needed to Expand DHATs in the 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.

IHCIA supports increasing the number of American Indians and Alaska Natives entering health professions and allows AI/AN communities to have MAXIMUM voice in shaping their health care delivery system. The preemptive language in the IHCIA that excludes DHAT services from a national CHAP violates the very foundation of tribal sovereignty. Tribes have the inherent right to address the health and well-being of its citizens. Moreover, it perpetuates paternalism and cements it into law. That paternalism has no place in our health programs.

The full expansion of the CHAP program including all levels of CHA/P, DHA/T and BHA/P allows tribes (tribal leaders) to choose from a full suite of paraprofessionals to intelligently tailor their healthcare delivery system to meet the needs of their tribe/area.

1. **Regional Federal CHAP Certification Boards Should Be Established with Federal Baseline Standards**

We support the establishment of regional federal CHAP certification boards (regional certification boards). Tribes in some areas may be better positioned to proceed with establishing a CHAP than others so allowing pilot regional certification boards for those ready to proceed early would provide guidance for regional certification boards in other areas. In addition, regional certification boards would be familiar with the tribes in their area and would have a more manageable certification caseload than establishing a national federal CHAP certification board.

However, there must be federal baseline standards for consistency of services provided by any CHAP program that the regional federal CHAP certification boards follow. IHS must ensure that regional certification boards and CHAP programs have a common baseline structure, curriculum, and standards to ensure consistency in the CHAP professions across all of IHS, tribal, and urban Indian programs. No single CHAP model is applicable to all tribal communities, however, individuals seeking care from providers within the CHAP program must be allowed to have some basic expectations for the care that they will receive. Without some federal baseline standards, we leave all CHAP providers (CHA/P, DHA/T, BHA/P) vulnerable to the whims of powerful non-native provider associations, and attacks on the quality and consistency of care provided at every level.

1. **Implement Full CHAP Pilot Project in the Portland Area**

Tribes in the Portland Area are already beginning to use DHATs in their dental programs. We have a close relationship with the Alaska Native Tribal Health Consortium due to the work related to expanding the use of DHATs in the Portland Area.

We urge the IHS to build a pilot program in the Portland Area to establish a FULL CHAP (including all levels of CHA/P, DHA/T, and BHA/P). The lessons learned from such a pilot program may translate to establishing a CHAP on a larger scale across the Indian health system.

The close proximity to Alaska and good working relationship with ANTHC will allow tribes in the Portland Area to begin exploring training sites in Washington, Oregon, and Idaho. DHATs are the most controversial provider in the CHAP program and there is general acceptance for that provider in the Portland Area. There is an existing excitement around CHAP due to the expansion of DHATs so the Portland Area is a natural fit as some of the groundwork has already been laid.

1. **National 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 continues the national dialogue with tribal leaders. 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.

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
* 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.
* Representatives from the Alaska CHAP board
* 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 American Indian Higher Education Consortium, the National Indian Education Association, or a similar body representing tribal colleges.

1. **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 ground work 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.

1. **Conclusion**

Please accept these comments with our sincere request to work together with the Indian Health Service to increase access to healthcare for our members through the successful implementation of this draft policy.

Please contact XXX if you have any questions or to discuss these comments.

Sincerely,