NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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Yakama Nation

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SUBMITTED VIA *HRSAcomments@hrsa.gov*

October 9, 2019

Thomas J. Engels
Acting Administrator
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857
ATTN: Rural Access to Health Care Services Request for Information

RE: Rural Access to Health Care Services Request for Information (RFI)

Dear Acting Administrator Engels:

On behalf of the Northwest Portland Area Indian Health Board (NPAIHB), I submit the following comments on the Health Resources and Service Administration (HRSA) Rural Access to Health Care Services Request for Information (RFI), issued September 5, 2019.

Established in 1972, the NPAIHB is a 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 specific health care issues. NPAIHB works closely with the IHS Portland Area Office, operating a variety of important health programs on behalf of our member tribes, including the Northwest Tribal Epidemiology Center.[1] 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. In addition, many of our tribal facilities are also accredited by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and/or Public Health Accreditation Board (PHAB).

NPAIHB appreciates the opportunity to provide comments to HRSA on how HRSA can conceptualize and measure access to health care in rural tribal communities in Idaho, Oregon, and Washington.

I. BACKGROUND

HRSA is seeking information about measuring access to health care in rural communities. Last year, HHS Secretary Alex Azar pulled formed a rural health task force with key leaders and stakeholders from across the department. The goal

[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."

of the taskforce is to bring together disparate efforts across HHS and develop the best understanding of where policy changes can help bring about the needed transformation. The rural health task force is examining all aspects of rural health policies, including how payments are affecting rural hospitals, and considering the most sustainable models for health care delivery.

Many Portland Area (Northwest) Tribes are located in rural areas so tribal members rely entirely on IHS and tribal facilities for their health care. With no IHS or tribal hospitals in the Portland Area, Portland Area Tribes rely on the Purchased and Referred Care (PRC) program to provide American Indians/Alaska Natives (AI/AN) with access to inpatient, outpatient and specialty care outside of an IHS or tribal facility. PRC is significantly underfunded and it cannot meet the health care need of all AI/ANs in Portland Area.

In every category of health, 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 system infrastructure and workforce, including a severe and chronic shortage of AI/AN health care professionals, that undermines 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] 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 the Community Health Aide Program (CHAP) is crucial.

II. SPECIFIC COMMENTS

A. What are the core health care services needed in rural communities and how can those services be delivered?

NPAIHB concurs with the list of core health care services identified by national organizations including: inpatient, outpatient, emergency care, primary care, mental health/substance use disorder, home care, long term care, oral health, public health and transportation. These core health services are also needed in tribal communities.

Delivery of these core health care services requires providing tribes with access to alternative, primary, and community-based providers that want to live in rural communities, and want to serve Medicaid, tribal, and other underserved populations. Housing must also be a consideration in increasing providers in tribal/rural communities. NPAIHB requests that tribes and I/T be included

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.

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

as a priority for HRSA rural health initiatives to improve access to core health care services. AI/ANs deserve immediate access to culturally competent, high quality, primary health and oral health care providers.

Importantly, many core health care services could be delivered by the use of paraprofessionals and mid-level practitioners. The Alaska Community Health Aide Program (CHAP), in existence for over 50 years, provides a model for a successful rural health care delivery system. CHAP consists of a network of approximately 550 Community Health Aides/Practitioners (CHA/Ps) in over 170 rural Alaska villages.[5] CHA/Ps work within the guidelines of the "Alaska Community Health Aide/Practitioner Manual" in assessing and referring members of their communities who seek medical care and consultation. Alaska CHA/Ps are the frontline of healthcare in their communities. Alaska CHA/Ps have improved access to behavioral health, oral health and health care services in underserved and rural tribal communities by supporting the training, recruitment, placement, and retention of behavioral health, dental health, and primary care mid-level and paraprofessional providers to address workforce shortages, reduce disparities, and ensure an equitable workforce distribution. The Alaska CHAP Certification Board sets standards for Community Health Aides/Practitioners (CHA/Ps), Dental Health Aides (DHAs), Behavioral Health Aides/Practitioners (BHA/Ps) and CHAP Training Centers.

The Alaska CHAP model is expanding and Northwest Tribes have taken the lead to establish the first CHAP program in the lower 48. The area-based CHAP model will be a critical part to addressing workforce shortages in the Northwest and across Indian country. NPAIHB has established a CHAP Board Advisory Workgroup, DHAT Advisory Workgroup and BHA Advisory Workgroup. Currently, 14 Dental Health Aide Therapists from Northwest Tribes have graduated from the Alaska DHAT program are now working at Portland Area I/Ts; and two Washington tribes have tribal members attending the Alaska BHA Training program. CHAP nationalization holds great promise for the future health care delivery system for tribes in the Northwest. NPAIHB requests that HRSA include CHA/Ps as providers who can address the health care provider shortage in rural tribal communities. HRSA must create funding opportunities and provide infrastructure support for CHAP expansion.

B. ***What are the appropriate types, numbers, and/or ratios of health care professionals needed to provide core health care services locally for rural populations of different compositions and sizes?***

Portland Area Tribes vary in the number of patients that they serve through their tribal clinic or health center. Portland Area Tribes serve a user population of less than 500 to a user population exceeding 5,000 patients. The majority of tribes in the Portland Area (66%) have reported between one and five health care staff vacancies. In most demand are doctors, dentists, pharmacists, and mental health counselors. Portland Area tribes also spend a significant amount of money on contract or temporary health care providers for 24-hour coverage in a tribal community which is must more costly than paying a salary.

As mentioned above, NPAIHB believes that the CHAP expansion in the Portland Area will increase access and should be supported by HRSA nationally. For example, in NPAIHB's BHA

5 Alaska Community Health Aide Program webpage: http://www.akchap.org/html/home-page.html

feasibility study, we determined that 49 BHAs could be utilized by tribes in our area. Currently, two Washington tribal members are in the Alaska BHA training program and six more potential students have been identified. The full potential of CHAP expansion has not been explored so HRSA's support is requested.

C. What other factors are important to consider when identifying core health services in different rural communities, such as current and projected population size, distance to the nearest source of care, availability of telehealth, and sustainability of services?

Other factors that are important to consider when identifying core health services in rural tribal communities include: access to an IHS or tribal hospital, level of PRC services available for AI/AN (i.e., some I/T are only able to provide "life or limb" services), access to specialty care providers, access to alternative/holistic care providers, access to Medicare or Medicaid providers, and broadband infrastructure in tribal communities and access to telehealth services.

D. How should we measure access to health care services in rural communities? What are the best ways of measuring quality of care in rural communities?

There are several factors that could be used to measure AI/AN access to health care services in rural tribal communities. Since there are no IHS or tribal hospitals in the Northwest, AI/AN access to an IHS or tribal hospital is an important factor. It would also be important to count the provider shortages within IHS and tribal facilities by looking at vacancies, as well as count the number of specialty providers that AI/AN have access to through PRC or Medicaid/Medicare, including distance to such providers.

As to measuring quality of care in rural tribal communities, NPAIHB believes that quality of care measures should focus on patients receiving culturally-competent, effective, safe, efficient, patient-centered, comprehensive, equitable and timely care. Tribal consultation should be conducted so that tribes can provide specific measures for AI/AN access to care and quality of care.

III. TRIBAL CONSULTATION

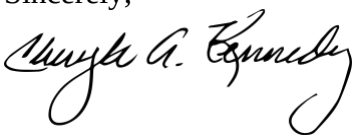
NPAIHB requests that HRSA issue a Dear Tribal Leader Letter (DTLL) to initiate meaningful tribal consultation on access for AI/AN rural access to health care services. Unique healthcare issues exist within each tribal community, and the agency has an obligation to seek and implement guidance from tribal nations. HRSA must uphold federal trust and treaty obligations to tribes and AI/ANs. These obligations are the result of millions of acres of land and resources ceded to the United States, and result in a legal and moral responsibility on behalf of the federal government to provide benefits and services in perpetuity to AI/ANs. The federal-tribal relationship has a long and complex history based on the United States Constitution, Treaties, Statutes, Executive Orders, and Court Decisions. The importance of consultation with Indian tribes was affirmed through Presidential memoranda in 1994, 2004, and 2009, as well as the release of Executive Order 13175[6] in 2000.

[6] Executive Order 13175 Consultation and Coordination with Tribal Governments, November 6, 2000.

IV. CONCLUSION

We thank you for this opportunity to provide comments and recommendations to HRSA on the request for information to increase access to rural health care services, and we look forward to further engagement with HRSA to meet critical health care access challenges in Northwest Tribal communities. If you have questions or would like more information about our recommendations discussed above, please contact Sarah Sullivan, Health Policy Analyst at (703) 203-6460 or by email to ssullivan@npaihb.org.

Sincerely,



Cheryle A Kennedy
Vice Chair, Northwest Portland Area Indian Health Board
Chair, Confederated Tribes of Grande Ronde