



Creation of a National Indian Health Service Community Health Aide Program

IHS's Request for Comments: Due July 29th

On June 1, 2016, the Indian Health Service (IHS) released a [Dear Tribal Leader Letter](#) and a [policy statement](#) titled, "Creating a National Indian Health Service Community Health Aide Program." IHS is "exploring necessary steps to create a national Community Health Aide Program, including the creation of a national certification board." IHS's goal is to "see community health aides utilized to the fullest extent permissible in IHS and tribally run hospitals and clinics. "

Community health aide programs (CHAP) are not new to the Indian health system. Within the Indian health system, CHAP programs include the Alaska CHAP program and the IHS community health representative program (CHRP). CHAP services have proven to be a sustainable, effective, and culturally acceptable method for delivering health care. Poor recruitment and retention of providers at IHS facilities support national expansion of CHAP. Community health aides include workers in health education, communicable disease control, maternal and child health, dental health, behavioral health, family planning, environmental health, and other areas.

The purpose of this briefing paper is to provide Tribal leaders with background information on these programs, including the historical barriers to mid-level providers, for the comment making process. We strongly encourage Tribes and Tribal organizations to submit comments, as this is an excellent opportunity to work with the Indian Health Service to shape the proposed expansion in such a way that is truly beneficial to American Indians and Alaska Natives.

The National Indian Health Board and Northwest Portland Area Indian Health Board will work collaboratively to develop a template comment letter to assist Tribes in making their own comments. **Please join us on a Tribal Only Call on July 7, 2016 to discuss the proposed comments and to provide input on the CHAP program expansion.** Email Devin Delrow, National Indian Health Board, ddelrow@nihb.org to receive conference line information.

As Tribes and Tribal organizations work on developing their comments to this proposed expansion, it is important to consider how a national program would affect those programs already in effect in Alaska and Washington. Careful consideration must be given to what a national program would look like, what kind of oversight would such a program have over the different Areas? Would it be appropriate to have a national certification board or are Area specific certification boards more appropriate? In addition, what certification levels do we want for the CHA/Ps? Is there legislative language that we want to add or be changed to support the new program? Ideas around funding and implementation are extremely important to include in your comments.

Background

ALASKA COMMUNITY HEALTH AIDE PROGRAM

What is the Alaska Community Health Aide Program?

The Community Health Aide Program (CHAP) emerged from a 1960s program of the Indian Health Service (IHS) that successfully employed local, Alaska Native village workers to distribute medicines in response to a number of health concerns, including: the tuberculosis epidemic, high infant mortality and high rates of injury in rural Alaska. For the past 50 years, CHAP has proved an effective method for diminishing the health disparities of Alaska Natives by promoting access to health services for Alaska natives residing in rural and remote communities. These communities are generally too sparsely populated to sustain a physician, dentist or mid-level provider. CHAP trains local residents to provide basic health care, assuring that health services are available in the local community from culturally competent providers who speak the native language.

Formalized curriculum and training were developed in the 70s to assure Community Health Aides/Practitioners (CHA/Ps) could receive training with minimal time away from the communities and families. There is a CHAP Certification Board in Alaska that sets standards for all providers in the CHAP program and provides oversight of the program.

CHAP has evolved over time to accommodate advances in medicine and the health needs of the population, and doing so at a comparatively low cost. CHAP provides patient-centered primary care, as opposed to specialty care, and delivers more care in the community rather than in the acute care setting. CHAP now consists of a network of approximately 550 (CHA/Ps) in more than 170 rural Alaska villages. CHA/Ps work within the guidelines of the 2006 Alaska Community Health Aide/Practitioner Manual, which outlines assessment and treatment protocols. There is an established referral relationship which includes midlevel providers, physicians, regional hospitals and the Alaska Native Medical Center. In addition, providers such as public health nurses, physicians and dentists make visits to villages to see clients in collaboration with the CHA/Ps

Benefits of a CHAP program

The current healthcare delivery system is failing tribal communities in many ways. Not only is access often a challenge due to expense and location, but there is a significant lack of AI/AN providers. The Alaska CHAP program:

- Provides routine, preventative, and emergent care;
- Respects the knowledge and resources in the tribal community and grows providers from that source. Community Health Aids are selected by their communities to receive training;
- Trains AI/AN community members who speak the native languages and can provide culturally appropriate care;
- Breaks down barriers to care and barriers to training;
- Creates an accessible entry point for AI/AN people wishing to become health care providers;
- Utilizes a training program that emphasizes not just skill and proficiency but also ensure Aides could receive training with a minimal time away from communities and families.

- Brings care to communities;
- Fosters a team approach to delivering health care services.

Community Health Aide Program Certification Board

The Community Health Aide Program Certification Board sets standards for the Alaska CHAP and certifies individuals as community health aides and practitioners, dental health aides (including primary dental health aides, dental health aide hygienists, expanded function dental health aides, and dental health aide therapists), and behavioral health aides and practitioners. These individuals are subject to specific requirements and engage in specific scope of practices.

Providers in the Alaska CHAP program

The Alaska CHAP program includes Community Health Aides (CHA/Ps), Behavioral Health Aides (BHA/Ps) and Dental Health Aides (DHA/Ts). The CHAP program provides needed health, oral health, and behavioral health services while also emphasizing wellness and healthy choices.

There is an established referral relationship which includes midlevel providers, physicians, regional hospitals and the Alaska Native Medical Center. In addition, providers such as public health nurses, physicians and dentists make visits to villages to see clients in collaboration with the CHA/Ps, DHA/Ts, and BHA/Ps.

Community Health Aide

Alaska has 5 levels of Community Health Aides that build upon each other.

Community Health Aid level 1-4 (CHA I, CHA II, CHA III, CHA IV) and the top level, Community Health Practitioner (CHP). The scope of practice for each provider is different and encompasses all of the scope of practice for the levels below the highest level of training reached by the individual. Depending on their level of certification, CHAs can provide services such as:

- Emergency first aid
- Patient examinations
- Follow up (in collaboration with treating physician or mid-level provider)
- Carrying out treatment recommendations
- Patient and family focused education and instruction
- Preventive health programs
- Infection and disease control
- Immunizations
- Store and dispense prescription drugs (with physician instructions)

Dental Health Aide

Dental Health Aides are primary oral health care professionals. They provide basic clinical dental treatment and preventive services. They are multidisciplinary team members and advocate for the needs of patients.

There are 3 levels of Dental Health Aides that build upon each other.

Dental Health Aide level 1-2 (DHA I, DHA II) and the top level, Dental Health Aide Therapist (DHAT). The scope of practice for each provider is different and encompasses all of the scope of practice for the levels below the highest level of training reached by the provider. Depending on their level of certification, DHAs can provide services such as:

- Diagnosis and Treatment
- Planning, Prevention
- Basic Hygiene
- Radiographs
- Infection Control
- Restorative
- Pediatric
- Urgent Care
- Extractions
- Community Projects
- Clinic Management
- Equipment Repair and Maintenance

Behavioral Health Aide

The Alaska Behavioral Health Aide (BHA) Program is designed to promote behavioral health and wellness in Alaska Native individuals, families and communities through culturally relevant training and education for village-based counselors.

There are 4 levels of Behavioral Health Aides that build upon each other.

Behavioral Health Aide level 1-3 (BHA I, BHA II, BHA III) and the top level, Behavioral Health Practitioner (BHP).

Depending on their level of certification, a BHA:

- Is a counselor, health educator, and advocate.
- Helps address individual and community-based behavioral health needs, including:
 - those related to alcohol, drug and tobacco abuse
 - mental health problems
 - grief
 - depression
 - suicide
- BHAs seek to achieve balance in the community by integrating their sensitivity to cultural needs with specialized training in behavioral health concerns and approaches to treatment.

IHS COMMUNITY HEALTH REPRESENTATIVE PROGRAM

What is the IHS Community Health Representative Program?

The IHS Community Health Representative Program (CHRP) aims to create a workforce that improves health across the communities they serve. CHRP is a unique community-based outreach program, staffed by a cadre of well-trained, medically-guided, tribal and Native community people who provide a variety of health services within AI/AN communities.

Benefits of CHRP

CHRs are important because they are experts in the dialects and the unique cultural aspects of their patients' lives. CHRs are a role model for the communities they serve; they are the ones people can go to when they need guidance, an advocate their needs, and help. The daily roles of CHRs vary as do the clients they serve. The following are examples of typical duties a CHR might perform.

- Visiting clients at home and referring those in need of care to the proper facility.
- Explaining available health programs, the health policies and procedures that the community members must follow when seeking health care
- Organizing community health promotion and disease prevention events and facilitate learning.
- Offering transportation to health promotion facilities for those in need
- Entering diagnostic patient-specific data into official patient medical records through the use of the CHR component of the RPMS (Resource and Patient Management System)
- Arranging for police/ambulance transport during accidents or emergency situations

HISTORICAL BARRIERS TO COMMUNITY-BASED AND MID-LEVEL HEALTH CARE PROVIDERS

Transforming the health care system to meet the demand for safe, quality, and affordable care may require a fundamental rethinking of the roles of many health care professionals. A variety of historical, cultural, regulatory, and policy barriers often limit the ability of allied professionals to contribute to widespread and meaningful change. Organized medicine and dentistry have often challenged expanding the scope of practice for other allied and mid-level providers. Much of this work has invited genuine debate and has aided in the definition of strong practices for other health professions. As Nurse Practitioners, Nurses, Dental Therapists and Physicians Assistants have proven over the last 60 years, mid-level and allied health professionals can provide safe, affordable, high quality, patient-centered care.

There were early struggles to define the role of the Nurse Practitioner in medicine. Some physicians, especially those practicing in rural areas of the country, welcomed the Nurse Practitioner's help, while organized medicine guarded their profession's traditional roles. Legal challenges to the Nurse Practitioner's role followed, as they began to practice at the full extent of

their certification and licensure. In a 1980 landmark case, *Sermchief v. Gonzales* (1983), the Missouri medical board charged two women's healthcare Nurse Practitioners with practicing medicine without a license (Doyle & Meurer, 1983). The Missouri Supreme Court ruled that the scope of practice of advanced practice nurses (APNs) could evolve without statutory constraints (Wolff, 1984). Similar struggles are anticipated as the role of other health professionals is expanded and created.

The expansion of duties for Dental Health Aide Therapists has been as intensely fought as the expansion of Nurse Practitioners and Physicians Assistants. The American Dental Association and state dental associations have taken a strong position against dental therapy under the pretext of patient safety and quality. The ADA believes it is in the best interests of the public that only dentists diagnose dental disease and perform surgical and irreversible procedures. This position, however, is not evidence based, and has no peer reviewed literature to validate the position.

Similar to the legal challenges to the Nurse Practitioner's role, in 2006, the American Dental Association and Alaska Dental Society filed a suit against the Alaska Native Tribal Health Consortium (ANTHC), the State of Alaska, and eight Dental Health Aide Therapists (DHAT), claiming that DHATs were practicing dentistry without a license (*The Alaska Dental Society, et al v. SOA, et al.* (2006)). Ultimately, the ADA lost the court battle and were ordered to pay a settlement. DHATs, ANTHC, and the Corporations continued to grow the DHAT portion of the CHAP program. That has not stopped the ADA from continuing to oppose the DHAT program. The ADA lobbied successfully to include 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.

IHS's request for comments on expansion of CHAP provides an opportunity for Tribes to express the need within their communities for every type of mid-level provider and propose how such providers could be incorporated into the Indian health system nationally.

For more information, please contact:

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Online Resources:

Alaska CHAP Program: <http://www.akchap.org/html/home-page.html>

IHS Community Health Representative Program (CHRP): <https://www.ihs.gov/chr/>

IHS Dear Tribal Leader Letter on CHAP: <http://www.npaihb.org/download/policy/fedpolicy/Dear-Tribal-Leader-Letter-CHAP-Expansion.pdf>

IHS Policy Statement on the Expansion of CHAP: <http://www.npaihb.org/download/policy/fedpolicy/IHS-Draft-Policy-Statement-on-the-Expansion-of-CHAP.pdf>