NPAIHB

Member Tribes of the Northwest Portland Area Indian Health Board:

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

2121 SW Broadway
Suite 300
Portland, OR 97201
Phone: (503) 228-4185
npaihb.org

Transmitted via email:
Ransom.fox@mail.house.gov

April 18, 2023

Harriet M. Hageman, Chair
Subcommittee on Indian and Insular Affairs
House Natural Resources Committee
1324 Longworth House Office Building
Washington, D.C. 20515

Re: NPAIHB Follow-Up to Testimony on Challenges and Opportunities for Improving Healthcare Delivery in Tribal Communities

Dear Chair Hageman,

I thank you for the opportunity to testify before the House Natural Resources Subcommittee on Indian and Insular Affairs hearing on challenges and opportunities in improving healthcare delivery in tribal communities on March 29, 2023.

I provide the following supplemental information in response to written questions provided by Representative Westerman and Representative Leger Fernandez on April 4, 2023.

NPAIHB Responses to Questions

Questions from Rep. Westerman:

1. How has telehealth improved access to care? Do you have any information on how that has been different between tribally run healthcare facilities and IHS run facilities?

Many tribes in the Northwest were already providing some form of telehealth prior to the COVID-19 public health emergency (PHE). With the declaration of the PHE, tribal health programs were provided numerous flexibilities to expand telehealth, including audio only calls without compromising any Medicaid and Medicare reimbursement. Additionally, these flexibilities ensured they were not violating any federal privacy laws. Tribal health programs quickly rolled out telehealth services in their programs to reduce face to face encounters in the height of the pandemic.

Through the expansion of telehealth, tribal health programs found that expansion of telehealth reduced no-shows, maintained continuity of care, and expanded the breadth of services in an ambulatory care clinic. American Indian and Alaska Native (AI/AN) patients were more likely to show up for their telehealth visit than a face to face encounter which continued care for many patients that would have

otherwise gone unseen. Because many tribal health programs are in remote locations and cannot compete with larger healthcare systems, tribes face challenges recruiting and retaining specialty providers. For example, a number of Tribes have reported on successfully contracting with psychiatrists to provide services through telehealth. The upcoming end of the public health emergency and roll back of many flexibilities to provide telehealth, especially through audio-only threaten the ability of tribes to maintain telehealth services in their health programs.

Indian Health Service (IHS) and Tribal health programs are operated and managed very differently. Tribal health programs through their self-governance contracts and compacts are able to rapidly alter their services and operations to meet the needs of their communities compared to IHS-operated facilities. Some tribes noted that tribal health programs were more successful in implementing telehealth in their services and programs because of the limitations IHS-ran facilities have in making local decisions. One tribe explained that broadband is a significant limitation to one IHS operated facility to expand telehealth. Through the course of the public health emergency, this facility has not been able to procure and maintain a functioning and reliable Internet services throughout the facility. The direct service tribes often point to the inability for IHS-operated facilities to make decisions at their service units and having to seek permission through the Area office to make changes in their services, procure and purchase equipment, or even provide any specific staff training.

a. *What data you can share with the committee on how telehealth may have improved access to care?*

One tribe shared that with implementation of telehealth in their behavioral health program they were able to significantly reduce no-shows. The no show rate for this year was at 272 no-shows compared to 2,216 no shows in 2019 when telehealth was not offered.

2. *Could you further expand on the challenges the Portland area is facing regarding workforce shortages for both IHS and tribally operated facilities:*

The Portland Area face chronic workforce shortages that has been heightened by the COVID-19 pandemic. These shortages are due to programs not able to compete with salaries and benefits of working within larger health care systems and tribes being in rural areas in the Northwest. Now, tribal health programs are grappling with retention of their workforce.

a. What are the greatest challenges to maintain an effective workforce for tribal health programs?

Some of the greatest challenges is providers working for tribal health programs that are not from the tribal communities. This results in a revolving door of providers which makes it difficult to maintain steady workforce that the community grows to trust and build relationships. Additionally, housing and the remote locations of some tribal health programs make it difficult to recruit specialty providers.

b. Are there any tribally led efforts on recruitment and retention that IHS can

learn from or institute?

Through the course of the COVID-19 public health emergency, there were many flexibilities that made it easier for programs to implement telehealth. Many tribal health programs were quick to implement telehealth to expand services and minimize face to face exposure. As part of the expansion of telehealth across the U.S., tribal health programs used this as an opportunity to contract with providers to provide services through telehealth. For example, a number of tribes reported implementing telepsychiatry programs because psychiatrists are very difficult to recruit to tribal health programs. Requiring face to face visits to continue telepsychiatry services threaten tribal health programs from providing these critical services.

Another tribally-led effort to address recruitment and retention of providers in the Northwest is through the expansion of the Community Health Aide Program (CHAP). CHAP addresses chronic workforce shortages by training community members to become midlevel providers to return to and serve their communities. CHAP providers can be trained to provide dental services, behavioral health services, and medical services. The NPAIHB and the Northwest Tribes have developed education programs to train dental therapists and behavioral health aides, and are in the process of building out a community health aide education program. This Subcommittee should continue to support additional funding to further build out the CHAP workforce and education programs in the Northwest.

3. *Your statement mentioned the Community Health Aide Program and your work to develop a program for the Pacific Northwest.*
   a. Can you further expand on how you are working to establish that program?

NPAIHB, through the Tribal Community Health Provider Program (TCHPP) has been working on CHAP implementation since 2015. In order to expand CHAP in the Northwest, we have worked in three areas: regulatory, education programs, and tribal/clinical integration.

<u>Regulatory</u>
For our regulatory work, NPAIHB has been working on the development of the Portland Area CHAP Certification Board, national infrastructure, and state infrastructure. The TCHPP staff work closely with tribal partners and Portland Area IHS Staff on the design and implementation of the Portland Area CHAP Certification Board (federal certification board necessary for certification of providers and education programs), Academic Review Committees, Area specific standards and procedures, and other infrastructure necessary to provide regulatory oversight to CHAP providers and education programs. This work is similar to national accreditation agencies and state licensing boards. Last week, the IHS Director has formally recognized the Portland Area CHAP Certification Board which will allow our Portland Area CHAP providers to become certified.

TCHPP staff work closely with Portland Area IHS and IHS Headquarters through the national CHAP Tribal Advisory Group to support the design, creation, and implementation of federal infrastructure necessary for CHAP implementation. TCHPP also provides technical support to other Areas interested in CHAP implementation and provides regular learning opportunities

through a CHAP learning collaborative Echo, giving presentation at conferences and meetings, and 1:1 with other Area partners.

TCHPP staff work closely with the Tribes and state Medicaid agencies on state infrastructure including state plan amendments, state legislation (when necessary), administrative rules, and other state specific activities to ensure CHAP providers are integrated into IHS and tribal health systems and reimbursed by third party payors.

CHAP Education Programs

In Alaska, there are education programs for all CHAP provider types available. TCHPP staff for the Portland Area work closely with curriculum experts, tribal partners, and education institutions to design, implement, and support CHAP education programs for all disciplines of CHAP specifically to meet the needs of the 43 Tribes in Washington, Oregon, and Idaho. In the Portland Area, there are education programs for Dental Health Aide Therapists (DHAT) at Skagit Valley College in partnership with the Swinomish Indian Tribal Community and Behavioral Health Aides (BHA) at the Northwest Indian College in partnership with the Lummi Nation and Heritage College in partnership with the Yakama Nation. We are in the process of developing a Community Health Aide (CHA) education program to further expand primary and emergency care clinicians in tribal communities. These education programs have not received funding from the IHS for year to year operations. All of our education programs would benefit from federal funding to support their operations.

TCHPP staff are working closely with curriculum experts to design curricula for the remaining levels of Dental Health Aides (DHA) and BHAs and Practitioners and all levels of Community Health Aides. TCHPP staff are also working closely with tribal partners and education institutions to design and implement education programs around these curricula.

The TCHPP team and the Northwest tribes recruit students into the programs and support the students once they have entered the programs through funding (stipends and scholarships), mentorship programs such as with Elders, knowledge holders, and culture keepers ECHO, and other direct support of students.

Because of the limited financial resources available for CHAP, TCHPP staff are constantly fundraising to support implementation, tribal partners, education partners, and students. We encourage the Subcommittee to come to the Northwest to visit our CHAP education programs to learn more on CHAP implementation in the lower 48. This is an opportunity to expand access to care across IHS and Tribal health systems.

Tribal/Clinical Integration

Lastly, TCHPP staff work closely with tribal health programs to provide clinical supervision for CHAP providers, train supervising providers, and work with all levels of staff to integrate CHAP providers into existing processes and structures. We host the CHAP ECHO Learning Collaborative every month to bridge the gap between traditional practices and modern standards of care through bringing together DHATs, BHAs, and CHAs.

b. Would that program that works only with tribally run healthcare programs, or do you think it could work within IHS also? Would any structural changes need to happen at IHS to make the CHAP program work within IHS's system?

The CHAP program is designed to work both with tribally run health care programs and with IHS programs. IHS will need to do some work on their internal infrastructure in order to incorporate CHAP into their workforce, so IHS facility implementation might take a few years longer than implementation in tribally run health care programs. That infrastructure work has already begun at the IHS Headquarters level.

CHAP – done correctly CHAP is structural change – CHAP was designed to sit outside of state regulatory environments and provide tribes and tribal organizations the ability to regulate a health system where they could provide the necessary tools to break down current barriers to health provider education and care. Current implementation outside of Alaska is struggling to grasp the supportive (and not regulatory) role that the federal government is meant to take in successful CHAP implementation. The Alaska CHAP Program has been successful for over 60 years and has been tribally run and operated with support from the Alaska Area IHS office. This has allowed CHAP to develop organically in Alaska Native communities over that time and provides the backbone of primary care in Alaska Native communities.

In order for CHAP to be successful outside of Alaska to the same degree – tribes and tribal health organizations need the flexibility to build a CHAP that is responsive to their needs and does not necessarily look exactly like the existing IHS system which has been failing tribes for centuries. Tribes are in the best position to understand the unique structural barriers that affect their citizens' ability to enter health provider education programs and access primary care.

CHAP education programs are tailored to meet the unique needs of tribal communities and are also successful for non-tribal citizens interested in health provider careers. Doing things like embedding prerequisites into pre-sessions (prerequisites are often barriers to entry), providing extra academic support during the education program, "indigenizing" curriculum to make it more relevant to the communities served, and building competency-based education programs are some of the ways that CHAP education programs are tailored to meet the needs of tribal communities.

c. What other creative possibilities exist that tribal organizations and IHS could implement?

Structural change is slow and hard won because the existing structures have so much support to keep them in place – if we could focus on CHAP implementation with an eye toward structural change, this could open up so many possibilities for tribal health programs, IHS, and tribes to experiment with creative ways to meet the health care needs of their communities

4. *The Subcommittee has heard from many different tribes that the Purchased/Referred Care program has several challenges:*

a. Can you describe some of the issues you have heard about within the Portland Area, and what challenges are your tribal members facing when dealing with the P-R-C program?

The Purchased/Referred Care (PRC) program is a critical program for the Portland Area because there is no IHS or Tribal hospital. The PRC program makes up over one-third of the Portland Area budget. IHS and Tribal health programs have to purchase all inpatient and specialty care which results in very limited services available for these programs to cover. Tribally-operated PRC programs need additional funding to cover higher level of services. Without year-to-year increases to PRC to fund the access to care factor, inpatient care for Portland Area Tribes goes severely underfunded.

One tribe has reported challenges in demonstrating eligibility for and obtaining specialty care from their IHS-ran PRC program. Some of these challenges include onerous documentation requirements not required by the IHS handbook or any other IHS authority; length of time IHS takes to process authorizations for PRC referrals; private health providers considering refusing to accept PRC referrals because of the administrative barriers to receive timely payment. These challenges have resulted in AI/AN people not receiving the necessary care they need, being referred to collection agencies for unpaid bills, and even deaths. We are happy to provide your office with the name of the tribe for any additional follow-up on these PRC issues stemming from IHS-operated facilities.

b. And what suggestions or recommendations would you provide to the committee to make that process better?

We recommend that the Committee supports increased funding for PRC. PRC has not received a significant increase since 2014 which has resulted in less funding available to expand covered referred services. For any changes to IHS-ran PRC programs, the IHS facility and Area Office should consult with the tribes on the chronic challenges in obtaining eligibility for and accessing PRC services in an IHS-operated facility.

5. *In your testimony, you mentioned difficulties in accessing certain grants at IHS and SAMHSA. Could you further expand on those difficulties?*

The Northwest Tribes have been advocates for the expansion of Indian Self-Determination Education Assistance Act (ISDEAA) contracts and compacts across the Department of Health and Human Services (HHS). Tribal self-governance and self-determination compacts and contracts provide tribes the administrative flexibility to develop programs and services that meets the needs of the tribal communities. Over the past years, more and more funding has been made available in agencies such as SAMHSA and CDC, but they have required tribes to submit competitive grants. Many tribes do not have the administrative capacity to track open grant opportunities, apply for those grants, and maintain in compliance with exhaustive granting requirements.

COVID-19 showed how successful the self-governance and self-determination programs. Many tribes faced challenges maintaining their grants when they had to alter their programs and services to limit face to face exposure. Many tribes were unable to spend down their grants during COVID-19, such as Special Diabetes Program for Indians (SDPI) and behavioral health grants. With contracts and compacts, Tribes are able to easily move around funds to address the most pressing health-related issues. This resulted in quick response to address the public health emergency that ultimately resulted in American Indians and Alaska Natives being of the most vaccinated racial and ethnic groups in the U.S.

a. What are the specific challenges for tribes and tribal organizations?

The federal government has treaty and trust obligations to provide healthcare services to American Indian and Alaska Native people. Grants do not fulfill these treaty and trust obligations because they do not provide funding to all tribes and tribal organizations. Tribes do not always have the administrative staff or grants specialists to keep track of opened grant opportunities, apply for those grants, and maintain in compliance with specific reporting requirements.

One specific challenge with SAMHSA grants is the burdensome Government Performance and Results Act (GPRA) Data Reporting requirements. We have found that GPRA reporting requirements took more time to complete and submit than the actual delivery of services provided by the funds. These reporting requirements use more administrative resources than the SAMHSA funding provided to Tribes and tribal organizations. Currently, SAMHSA grants are set with a 20% administrative funding cap, but grantees frequently find additional resources must be expended to complete the reporting requirements. In other cases, many Tribes and Tribal organizations lack the time, staff, and resources necessary to meet the GPRA grant reporting and because of this, they are unable to apply for those grants or may decide not to reapply.

b. *What do you think should be changed about the grant process to make them more accessible to tribes and tribal organizations?*

First and foremost, we recommend that IHS and HHS moves away from grant funding and allow tribes the option to receive funds through their contracts and compacts. This Subcommittee must support legislation expanding ISDEAA contracting and compacting to HHS and its agencies. Until there is legislation in place, HHS agencies should allocate funds to IHS to distribute to Tribes through ISDEAA contracts and compacts using existing formulas. Moving forward, Tribes should be exempt from GPRA reporting requirements, so more resources can go directly to services instead of being redirected to data collection, data entry, and data reporting.

Questions from Rep. Leger Fernandez:

1. Could you share more on the anticipated impacts and loss of services that would occur if the FY24 enacted congressional budget reflects FY22 enacted levels for the Indian Health Service (IHS)?

In the Consolidated Appropriations Act of 2023, Congress appropriated $7 billion for IHS which includes a $327 million increase over FY 2022 enacted level.[1] Of this increase for the overall IHS budget, Hospitals and Health Clinics received $100 million increase, Tribal Epidemiology Centers received additional $10 million, dental services received $12 million increase, Purchased/Referred Care received $12 million increase, and Alcohol and Substance Abuse received $8 million increase. These are all crucial line items to Portland Area IHS and Tribal health programs which has allowed providers to keep pace with population growth and medical inflation. Medical costs are significantly increased in the Northwest and our tribal health programs cannot compete with large healthcare systems in the urban areas.

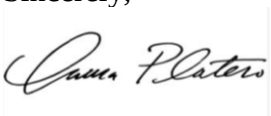
Additionally, Purchased/Referred Care (PRC) received only a 1% increase over FY 2022 enacted levels. This does not even cover medical inflation and population growth. PRC has not received a significant increase since 2014. When there are increases to the PRC budget, the Portland Area Tribes receive additional funding to account for the lack of an IHS/Tribal hospital in the Area, often referred to as the access to care factor. Cutting PRC back to FY 2022 levels would put us even further behind to even address population growth and medical inflation let alone to fund the access to care factor. We request this Subcommittee ensures that PRC is prioritized for increased funding and that it is not further cut.

Lastly, the Northwest Portland Area Indian Health Board operates the Northwest Tribal Epidemiology Center (NWTEC) that provides health-related research, surveillance, training and technical assistance to improve the quality of life of AI/AN people in the Northwest. With the increased funding for TECs, we have been able to expand the NWTEC and employ eight (8) epidemiologists and biostatisticians to increase services to the Northwest Tribes. The NWTEC conducts critical data linkage work to improve data validity and accuracy as AI/AN are chronically misclassified in state and federal data sets. Without accurate data, this impacts our Tribes from understanding healthcare needs and funding priorities. Any proposed cuts to TECs would require us to scale back our epi-related work including reducing the number of epidemiologists and biostatisticians we have on staff.

Conclusion

Thank you for this opportunity to submit follow-up responses to the Indian and Insular Affairs Subcommittee. I invite the Subcommittee to come visit the Northwest Portland Area Indian Health Board and our Northwest tribes to learn more about our challenges and programs and services. For more information, please contact Elizabeth J. Coronado, Senior Policy Advisor, NPAIHB at 559-289-9964 or ecoronado@npaihb.org.

Sincerely,



Laura Platero, JD
Executive Director
NPAIHB

[1] See Consolidated Approps Act 2023, Pub. L. No. 117-328.