



# NON-PHYSICIAN PRACTITIONERS IN INDIAN HEALTH SERVICE



## INTRODUCTION

This paper discusses the role of non-physician practitioners (NPPs) in the Indian Health Service (IHS).<sup>1</sup> American Indian/Alaska Native (AI/AN) communities experience significant health disparities compared with other Americans. AI/ANs die at higher rates than other Americans from tuberculosis (750%), alcoholism (550% higher), diabetes (190% higher), unintentional injuries (150%), homicide (100%), and suicide (70%).<sup>2</sup> Addressing these health care disparities requires multiple strategies, including increased funding for Indian health services and other efforts aimed at increasing access to care.

Recent discussions on health care reform in the U.S. have included the needs for reducing health care costs and increasing access to health care, particularly in rural and underserved communities. One strategy for addressing both of these goals is increasing the utilization of NPPs, which include (but are not limited to) registered nurses, advanced practice nurses, physician assistants, and clinical pharmacists. While not physicians, these practitioners are able to provide many of the health care services sought by patients in primary care and in some specialty settings, and can refer appropriately to other health care professionals. They are trained in their professions for several years and must pass national boards exams for licensing and/or certification. In addition to NPPs, community health representatives (CHRs) also provide needed health care services in American Indian/Alaska Native (AI/AN) communities. CHRs are usually AI/AN community members and they serve as community health promoters/educators, health advocates, and health paraprofessionals who regularly visit the homes of clients, conduct health assessments, and provide transportation when needed.<sup>3</sup> In Alaska, they are known as Community Health Aides/Practitioners (CHA/Ps) and they provide limited dental care and behavioral health services.

Previous studies in some clinical settings have demonstrated that use of NPPs is cost-effective and clinically efficacious. A Robert Wood Johnson Foundation-funded study comparing medical residents with nurse practitioners and physician assistants in hospitals found that there were not significant differences in clinical outcomes that were measured, including: length of hospital stay, in-hospital mortality, incidence of transfusion reaction, incidence of drug reaction, complications from an invasive procedure, completeness of admission notes, and readmission rates.<sup>4</sup> Studies published in 2000 demonstrated that clinical outcomes were equivalent for care provided by nurse practitioners and physicians, and that patient satisfaction was the same or better when nurse practitioners

---

<sup>1</sup>This paper was authored by Puneet Sahota and Ahniwake Rose. For questions about this paper, please contact: [psahota@ncai.org](mailto:psahota@ncai.org).

<sup>2</sup>Indian Health Service. 2009. IHS Fact Sheets: Indian Health Disparities. <http://info.ihs.gov/Disparities.asp>

<sup>3</sup>Indian Health Service. General CHR Information: History & Background Development of the Program. <http://www.ihs.gov/NonMedicalPrograms/chr/index.cfm?module=history>

<sup>4</sup>Robert Wood Johnson Foundation. 2002. Nurse Practitioners and Physician Assistants Handle Same Acute Care Activities as Doctors. <http://www.rwjf.org/reports/grr/023213.htm>

provided care.<sup>5,6</sup> In addition, studies by the RAND Corporation have shown that physician assistants working in ambulatory care practices can save as much as 20% of the costs of medical care and provide at least 80% of medical services without compromising patient satisfaction.<sup>7</sup> Studies conducted through the American Colleges of Clinical Pharmacy across two decades also showed that provision of clinical services by pharmacists in multiple care settings resulted in significant economic savings.<sup>8,9,10</sup> A multi-site community pharmacy health management program for over 500 patients with diabetes also demonstrated positive clinical and economic outcomes.<sup>11</sup>

This paper first provides general background information on NPPs and how these health professionals' services, as well as those of CHA/Ps, are currently utilized in the IHS.<sup>12</sup> Next, prospects for increasing the use of NPPs in AI/AN communities are discussed. Finally, specific policy changes that could enhance the use of NPPs in both IHS and tribally-administered health programs are presented.

## NON-PHYSICIAN PROVIDERS

### Registered Nurses

Registered Nurses (RNs) are a diverse group, and include nurses with associate's degrees and bachelor's degrees. RNs may specialize in a variety of fields, including ambulatory care, critical care, trauma, emergency transport, holistic care (acupuncture, massage, aroma therapy, and biofeedback), home health, hospice and palliative care, infusion, long-term care, medical-surgical care, occupational health, perianesthesia, perioperative, pediatrics, obstetrics, intensive care (adult, pediatric, and neonatal), long term care, rehabilitation, coronary care, public health/community health nursing, forensic nursing, mental health, radiology, rehabilitation, and transplant. RNs can specialize in several ways, including choosing to work in a specific setting, working with individuals who have specific health conditions, working with a specific organ system, or working with a specific population (*e.g.*, elders). These specialist RNs are referred to as "Clinical Nurse Specialists" (as noted below under *Advanced Practice Nurses*). The median salary of RNs in 2006 was \$57,280, and

---

<sup>5</sup>Mundinger, M., et al. 2000. Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians. *Journal of the American Medical Association*, 283(1):59-68. <http://jama.ama-assn.org/cgi/content/full/283/1/59>

<sup>6</sup>Horrocks S, Anderson E., Salisbury C. 2002. Systematic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors. *British Medical Journal*, 324:819-823. <http://www.bmj.com/cgi/content/full/324/7341/819>.

<sup>7</sup>American Academy of Physician Assistants. 2008. PA Facts. <http://www.aapa.org/paf/images/stories/Diversity/PAFactsSheet.pdf>

<sup>8</sup>Schumock GT, Meek PD, Ploetz PA, Vermeulen LC. Economic evaluations of clinical pharmacy services--1988-1995. The Publications Committee of the American College of Clinical Pharmacy. *Pharmacotherapy*. Nov-Dec 1996;16(6):1188-1208.

<sup>9</sup>Schumock GB, M. Meek, P. Vermeulen, C. Arondekar, B. Bauman, J. Evidence of the Economic Benefit of Clinical Pharmacy Services: 1996-2000. *Pharmacotherapy*. 2003;23(1):113-132.

<sup>10</sup>Perez AD, Fred. Hoffman, James. Meek, Patrick. Touchette, Daniel. Vermeulen, Pete. Schumock, Glen. Economic Evaluations of Clinical Pharmacy Services: 2001-2005. *Pharmacotherapy*. 2009;29(1):128.

<sup>11</sup>Fera T, Bluml BM, Ellis WM. 2009. Diabetes Ten City Challenge: final economic and clinical results. *Journal of the American Pharmacists Association*, 49:e52-e60.

<http://www.diabetestencitychallenge.com/pdf/dtccfinalreport.pdf>

<sup>12</sup>This paper largely focuses on the IHS rather than contracting/compacting tribes' health care programs because national data are not available for the use of NPPs in tribally-administered facilities.

ranged from \$40,000 to over \$83,000. Salaries vary widely depending on specialty area and practice setting.<sup>13</sup>

### Advanced Practice Nurses

Advanced Practice Nurses (APN)s work in a variety of settings, including ambulatory and acute care. The four types of APNs are<sup>14</sup>:

- Clinical Nurse Specialists (CNS): Provide direct patient care and expert consultation in one of many nursing specialties. CNS areas of clinical specialty might include a population (*e.g.*, women's health or pediatrics), a setting (*e.g.*, critical care, emergency room), a disease or medical subspecialty (*e.g.*, diabetes, oncology), a type of care (*e.g.*, rehabilitation), or a type of health problem (*e.g.*, pain, wounds).<sup>15</sup>
- Certified Registered Nurse Anesthetists (CRNA): Administer anesthesia to patients undergoing surgery or women in labor requiring an epidural, monitors patients' vital signs during surgery, and provides post-anesthesia care.
- Certified Nurse Midwives (CNM): Provide prenatal care, deliver babies, and provide postpartum care.
- Nurse practitioners (NP): Provide basic preventive health care to patients and also serve as primary and specialty care providers. NPs' scope of practice depends on their specialty area of certification. Common specialty areas include family practice, pediatrics, adult practice, gerontology, neonatal care, acute care, women's health, and psychiatry.

NPs, CNMs, and CRNAs all have at least a Master's degree. Some NPs also have doctoral level training. Most NP, CNM, and CRNA educational programs include at least two years of full time study, and require at least Bachelor's of Science in Nursing (BSN) for admission. Many programs also require one to two years of clinical experience as an RN. CNMs are RNs who have graduated from a nurse-midwifery program and have passed a national certification exam.<sup>14</sup>

The degree to which different types of APNs are required to collaborate with or be supervised by physicians varies by state licensing laws. NPs can prescribe medication in most states. In 11 states, including Oregon, New Mexico, Alaska, and Montana, NPs may practice independently without physician collaboration or supervision. Only a minority of states require physician supervision of NPs, while in most states, NPs are required to work in collaboration with physicians. Regulations differ among states regarding the extent of such collaboration and in many cases, is loosely defined.<sup>16</sup>

Salaries for APNs range from \$50,000 to over \$110,000 per year, depending on the specialty and area of practice<sup>13, 17</sup>. When CRNAs and acute care NPs are included, salaries can be up to \$250,000 per year.<sup>17</sup>

---

<sup>13</sup>Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2008-09 Edition*, Registered Nurses, <http://www.bls.gov/oco/ocos083.htm>

<sup>14</sup>For more information on APNs, see: <http://www.allnursingschools.com/faqs/apn.php>

<sup>15</sup>National Association of Clinical Nurse Specialists. FAQs: What is a Clinical Nurse Specialist? <http://www.nacns.org/AboutNACNS/FAQs/tabid/109/Default.aspx>

<sup>16</sup>Gilchrist, Heather. The Advanced Practice Nurse's Struggle to Gain Prescription Authority. Missouri Nurses' Association. [http://www.missourinurses.org/pdf/ap\\_struggle.pdf](http://www.missourinurses.org/pdf/ap_struggle.pdf)

<sup>17</sup>Personal communication, Carolyn Aoyama, CNM, MPH, Senior Consultant for Women's Health and Advanced Practice Nursing, Indian Health Service.

### Physician Assistants

Physician assistant (PA) training programs last at least two years, and admission requirements vary by program. Most programs require at least two years of college and some health care experience.<sup>18</sup> All PAs must also complete a national board certification exam in order to receive state licensure for practice. PAs work in all medical and surgical specialties and settings as part of PA-physician teams. A majority of PAs work in general primary care settings, but many pursue other work experience in specialty areas such as surgery, emergency medicine, and internal medicine. PAs must be supervised by a physician, and the level of supervision varies by state law. In some states, and in the IHS, PAs can be supervised remotely through telephone or electronic communication with physicians.

Median income for PAs in 2006 was \$80,356. Income levels vary from \$40,000 to over \$100,000 depending on the specialty, practice setting, geographical location, and years of experience.<sup>18</sup>

### Clinical Pharmacists

Pharmacists training today earn a Pharm.D. degree, which has replaced the Bachelor of Pharmacy degree. This degree can be completed in a minimum of six years, but the average length of training is closer to eight years of total postsecondary and professional school education. Pharmacists can also pursue further training for a Master's of Science or Ph.D. to gain additional clinical, laboratory, and research experience. Some pharmacists pursue one or two year residency or fellowship programs. Pharmacists work in community settings, such as retail drugstores, and in health care facilities. Pharmacists distribute drugs to patients, counsel them about use of medications, and monitor patients' health while they are on medications. Finally, pharmacists advise patients and other health care practitioners about medication safety, including drug interactions, adverse events, and prevention of medication errors.

The median salary for pharmacists in 2006 was \$94,520, and ranged from \$67,000 to more than \$119,000.<sup>19</sup>

## **NON-PHYSICIAN PROVIDERS IN THE INDIAN HEALTH SERVICE**

### Roles of NPPs in IHS

The IHS has utilized the services of NPPs for several decades. NPPs enable the IHS to stretch limited resources as they can provide some of the same services as physicians at a lower cost. However, the extent to which NPPs are utilized varies across IHS Areas and facilities. Decisions about hiring and utilization of NPPs are made locally by each IHS health care facility. As a result, expansions in the role of NPPs would require changes at the local level. The innovative uses of NPPs in IHS facilities described below represent some of the best-case scenarios and are not universally representative of all facilities or Areas. The current innovative roles for NPPs in some IHS facilities might serve as a model for future roles these providers could have in AI/AN communities. Increased funding and authority for IHS are vital for facilitating future expansions of the NPP workforce in Indian country.

---

<sup>18</sup>Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2008-09 Edition*, Physician Assistants, <http://www.bls.gov/oco/ocos081.htm>.

<sup>19</sup>Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2008-09 Edition*, Pharmacists, on the Internet at <http://www.bls.gov/oco/ocos079.htm>

NPPs work in a variety of ambulatory care, hospital, and community health settings in the IHS. For example, RNs can work in a hospital-based nursing practice, ambulatory care settings, or in public health nursing. Public health nurses (PHNs) emphasize patient care (especially maternal and child care) and assessment of community needs.<sup>20</sup> They target health education, health promotion/disease prevention, administer immunizations, and make home visits to patients, among other public health services. Along with physicians, RNs, APNs, PAs, and pharmacists participate in primary care settings in some IHS facilities, where they see patients with routine concerns. Specialty APNs, such as certified nurse midwives, certified nurse anesthetists, and psychiatric nurse practitioners also work in IHS facilities. For example, in some facilities, nurse midwives might provide prenatal care while OB/GYNs attend deliveries and perform surgeries. In other settings, nurse midwives provide all pre- and post-natal care, including deliveries for uncomplicated pregnancies.

IHS utilizes NPPs in innovative ways that could be further expanded if increased funding and authority were made available. For example, in some IHS facilities, in addition to nurse practitioners, physician assistants, and physicians, pharmacists also see patients in primary care settings. Many pharmacists in the IHS provide broad primary care clinical services, including assuring appropriateness of therapy, providing patient counseling, and disease management for both stable and unstable chronic diseases. These IHS pharmacists perform patient assessment, have various levels of prescriptive authority (initiate, adjust, or discontinue treatment), formulate clinical assessments, develop therapeutic plans, manage chronic disease, and provide many other cognitive clinical services including health promotion, disease prevention, and appropriate coordination of care for follow-up. Pharmacists in IHS only take these collaborative clinical roles with the support and approval of the physician working in the clinic through a collaborative practice agreement where the physician serves as a “supervising” provider. Most state regulations (41 out of 50 states) allow pharmacists to expand their roles under some form of collaborative practice agreement. However, the Centers for Medicare and Medicaid Services (CMS) guidelines do not allow for Medicare Part B billing of collaborative care services provided by pharmacists during patients’ regular clinic visits.<sup>21</sup> Increased use of pharmacists and other NPPs in outpatient settings might free up physicians to care for patients with more complex medical problems while maintaining quality of care and containing costs.

Advanced Practice Nurses (APNs) provide primary and specialty care in IHS facilities. APNs practice under the IHS National Scope of Practice for Advanced Practice Nurses, which preempts state licensure guidelines.<sup>22</sup> However, state licensure laws do apply to IHS APNs related to the prescribing of controlled substances. In the IHS, APNs work as licensed, independent practitioners. They examine patients, establish medical diagnoses, order and interpret screening tests and diagnostic procedures, formulate treatment plans, and prescribe medications. Telemedicine is used in conjunction with the services of psychiatric nurse practitioners in some IHS facilities. Psychiatric nurse practitioners have special expertise in treating mental health concerns, and can provide clinical care to patients in remote settings that might not be able to support hiring a local psychiatrist or

---

<sup>20</sup>Indian Health Service. IHS Nursing Employment Opportunities.  
<http://www.ihs.gov/MedicalPrograms/Nursing/index.cfm?module=general>

<sup>21</sup>New Mexico Medicaid guidelines do allow billing for some of these services at levels more commensurate with those for other NPPs providing the same level of clinical service (personal communication, CAPT Scott Giberson, National HIV/AIDS Principal Consultant, Office of Clinical and Preventive Services, IHS).

<sup>22</sup>Indian Health Service. 2009. Indian Health Manual. Part 3, Chapter 4, Section 11 – Advanced Practice Nurses.  
<http://www.ihs.gov/PublicInfo/Publications/IHSMannual/Part3/pt3chapt4/pt3chpt4.htm#11>

psychiatric nurse practitioner. For example, the Phoenix Indian Medical Center provides mental health to Hopi and White River Apache patients via telemedicine. This program could be expanded to include other sites if there were adequate staffing.<sup>23</sup> However, there are still relatively few psychiatric nurse practitioners employed by IHS. Their services could be utilized more, particularly in combination with telemedicine. Specialty nurse practitioners in a variety of fields, such as in acute care and geriatrics, could have an expanded role in IHS.<sup>23</sup> These NPs have distinct expertise (and therefore, qualifications for credentialing) by specialty. Increased use of telemedicine could also expand access to specialty care for rural areas.

Physician assistants provide primary care in IHS, along with nurse practitioners, physicians, and pharmacists. Like nurse practitioners, some PAs also work in specialty care settings, including surgical care (at IHS facilities where surgery is performed), internal medicine, emergency medicine, dermatology, and pediatrics.<sup>24</sup> PAs require supervision of physicians, but can still practice with considerable autonomy. IHS guidelines allow PAs to be supervised by any means that allows person-to-person exchange of information, such as telephonic consultation, according to the IHS Manual.<sup>25</sup> PAs could be utilized more widely in IHS, and particularly could enhance access to primary care in remote areas, if the option of telephone supervision by physicians was exercised more.<sup>24</sup> PAs could also have an expanded role throughout IHS in primary and specialty care settings, as well as in telemedicine programs, if adequate funding were provided to increase staffing.<sup>24</sup>

Employment and Salary Information for NPPs in IHS

The U.S. as a whole is facing a shortage of health care providers, particularly nurses, physicians, and PAs, and the IHS is also affected by this problem. As health care reform increases the number of individuals covered by health insurance, the demand for health care providers will also increase. Competitive pay scales are important for IHS to be able to recruit highly qualified health care providers of all types; including NPPs. IHS currently has significant vacancy rates in all health care professions.

IHS employment data for 2009 are shown in the table below<sup>26</sup>:

Total IHS employees: 15,676 (71% are Indian)

	Physicians	Nurses	Dentists	Pharmacists	Physician Assistants*	Engineers	Sanitarians
Number of vacant positions	854	2,491	301	537	232	432	301
Vacancy rates	18%	23%	24%	11%	23%	5%	3%

\*Data as of 3<sup>rd</sup> quarter FY 2008.

<sup>23</sup>Personal communication, CDR Deborah Price, NP, MSN, MPH.

<sup>24</sup>Personal communication, CDR Frances P. Placide, PA-C, MMS, IHS National PA Chief Clinical Consultant.

<sup>25</sup>Indian Health Service. 2009. Indian Health Manual. Part 3, Chapter 28 – Physician Assistants.

<http://www.ihs.gov/PublicInfo/Publications/IHSMannual/Part3/pt3chpt28/part3Chapt28.htm>

<sup>26</sup>Year 2009 Profile. Indian Health Service. <http://info.ihs.gov/Profile09.asp>. For physician assistants, unpublished data provided by IHS.

Gross average annual salaries for selected NPPs in IHS are<sup>27</sup>:

Commissioned Corps = CC  
Civilian Service = CS

Pharmacist (CC)        \$102,142.00  
Pharmacist (CS)        \$ 80,352.00

Nurse Practitioner (CC) \$121,936.00  
Nurse Practitioner (CS) \$ 80,893.00

Physician Assistant (CC)    \$103,097.00  
Physician Assistant (CS)    \$ 76,509.00

The IHS workforce is complex and consists of multiple personnel systems, including the Commissioned Corps, Civilian Service, contractors, and tribal hires. Tribally-administered facilities vary in salaries offered and may in some cases be more competitive with the private sector than IHS salaries. Compiled national data for tribally-managed facilities are not collected by IHS. The salaries listed above are averages for all NPPs working in IHS, including those at different ranks in the Commissioned Corps. As a result, many NPPs have significantly less income than the average salaries above. For example, starting salaries for family practice PAs are significantly lower for IHS than in the private sector. In 2008, the starting salary in IHS was \$44,000, while it was \$53,000 in the Department of Veterans' Affairs (VA) and \$76,000 in the private sector.<sup>24</sup> Gross annual salaries for the VA are \$91,464 for physician assistants, \$78,983 for registered nurses (this category includes RNs and NPs), and \$107,244 for pharmacists.<sup>28</sup> It is important to note that the vacancy rates in the table above only reflect currently unfilled positions in the IHS, not the actual numbers of health care providers needed in AI/AN communities. The actual unmet need for health care in AI/AN communities is likely much greater than current IHS vacancy rates – an overall expansion of the IHS workforce would help to address the significant health disparities in AI/AN communities.

## COMMUNITY HEALTH REPRESENTATIVES

In addition to traditional NPPs, the IHS also utilizes community health representatives (CHRs) to provide basic health care services. The IHS CHR program began in 1968, when the IHS requested funds to train 250 Community Health Aides (CHAs) in Alaska. The CHR program was a result of AI/AN communities identifying the need for such a program, lobbying for it, and obtaining funding. The IHS CHR program was created to: increase the involvement of AI/ANs in addressing their own health concerns, improve the understanding and cross-cultural communication between AI/AN people and IHS staff, and to enhance access to basic health care and education in AI/AN communities. Today, there are over 1400 CHRs representing 250 tribes in the 12 IHS service areas. An education conference is held every three years by the National Association of Community Health Representatives (NACHR).<sup>3</sup> CHRs are community members, and so they serve as role

---

<sup>27</sup>Indian Health Service, unpublished data.

<sup>28</sup>Human Resources Information System; personal communication with VA Human Resources staff.

models for their communities and advocate for community members' health needs. As health educators and paraprofessionals, they perform a wide variety of duties, which include<sup>29</sup>:

- Visiting clients in their homes and referring those in need of care to the appropriate facility.
- Explaining health programs, policies, and procedures to community members.
- Organizing community health promotion and disease prevention events, which might cover topics such as immunizations, well baby clinics, safety in the home, medication/drug storage, and sanitation.
- Educate people about potential health consequences of behaviors such as alcohol use, cigarette smoking, poor eating habits, and poor hygiene.
- Provide transportation to health care facilities for those in need.
- Arrange for police/ambulance transport in emergency situations.
- Enter patient specific data into the patient medical record through using the CHR component of the Resource and Patient Management System (RPMS, the IHS medical record system).

The IHS CHR program began in Alaska, as noted above. The Alaska Community Health Aide (CHA) Program was established in the 1950s in response to many health concerns in rural Alaska, including tuberculosis, high infant mortality, and a high injury rate. The CHA Program now includes approximately 550 CHA/Ps in more than 170 rural Alaska villages. When necessary, they refer patients to NPPs, physicians, regional hospitals, and the Alaska Native Medical Center (ANMC). They also work in collaboration with public health nurses, physicians, and dentists to make visits to Alaska Native villages. CHAs receive four sessions of training, which each last three to four weeks. In between sessions, CHAs work in clinics completing a practicum and take an examination at the end, qualifying them as Community Health Practitioners (CHPs).<sup>30</sup>

The Alaska CHA program includes behavioral health aides and Dental Health Aide Therapists (DHATs). DHATs work under the general supervision of a dentist, meaning that the dentist has “authorized the procedures and they are being carried out with standing order issues to a specific dental health aide.” DHATs document all patient encounters and report daily to their supervising dentist. However, they provide dental services in remote villages not connected by roads to supervising dentists. Current ratios are three to five DHATs per supervising dentist. DHATs focus on patient and community education in prevention and healthy lifestyle choices, and provide referrals to dentists for services beyond the scope of DHAT practice.<sup>31</sup>

The first U.S. based DHAT training program, DENTEX, began in 2007. DENTEX is a collaboration between the Alaska Native Tribal Health Consortium and the University of Washington School of Medicine Physician Assistant Training Program (MEDEX Northwest) to train Alaska Native dental health professionals to provide dental therapy, under the supervision of dentists, in Alaska Native communities. Thus far, a cohort of three students graduated from the U.S.

---

<sup>29</sup>Indian Health Service. The Role of a CHR.

<http://www.ihs.gov/NonMedicalPrograms/chr/index.cfm?module=jobRole>

<sup>30</sup>Alaska Native Tribal Health Consortium. 2006. Alaska Community Health Aide Program, CHAP General Program Information and History. <http://www.akchap.org/GeneralInfo.cfm>

<sup>31</sup>National Congress of American Indians Policy Research Center. Oct. 3, 2008. The Potential for Expansion of the Dental Health Aide Therapist Model. Submitted to the W.K. Kellogg Foundation. For more information about this report, please contact Christina Daulton (Christina\_Daulton@ncai.org).

program in 2008. There are currently six other students in their second year of training and eight students in the first year of training.<sup>32</sup> Prior to DENTEX, DHATs received two years of training in New Zealand.

The National Congress of American Indians Policy Research Center studied the feasibility of expanding this program to American Indian communities outside of Alaska, and concluded that such an expansion would “be a major health breakthrough for Native populations across the country.”<sup>31</sup> There are significant barriers to such an expansion, however, which are discussed in more detail below.

## RECOMMENDED POLICY CHANGES

There are a number of policy and regulatory changes that should be made in order to increase the utilization of NPPs in the IHS and AI/AN communities. Although the recommendations below are for national and state policy changes, local decision makers also have influence on the utilization of NPPs in AI/AN communities. Even if the policy recommendations below are adopted, the level to which NPPs are utilized will depend on local facilities’ hiring policies and the scope of practice allowed for NPPs.

Recommended policy changes at the national and state level include:

1. **Increased salaries for NPPs.** Salaries for health care providers offered by the IHS often lag behind those in the private sector. Given national shortages in the health care provider workforce, it will be difficult for IHS to recruit highly qualified providers without increases in the salaries offered. Policy changes that could address this problem are:
  - a) **Updating OPM Pay Scales.** Pay scales and health professionals’ classification standards in the U.S. Office of Personnel Management (OPM) guidelines have not been updated for many years. The OPM oversees civilian employees of the federal government. Because pay scales are outdated, they are significantly less than those offered in the private sector, according to many IHS employees. OPM payscales should be updated so that they are more in line with private sector salaries.
  - b) **Title 38 Style Authorization for the IHS.** The IHS also could benefit from more broad authorization to negotiate salaries with all health care providers. Under U.S.C. Title 5, Sections 1104 and 5371, the OPM authorizes the employment of health care providers. OPM has delegated authority to the Department of Health and Human Services (DHHS) for the discretionary use of some provisions of Title 38, which were originally available to the Department of Veterans Affairs (VA). Title 38 allows the Veteran’s Administration to provide “competitive pay” to health care providers, including nurses.<sup>33</sup> It also provides “hybrid status” to certain health care providers, meaning that these positions are managed directly by the VA rather than by OPM. The professions included under “hybrid status” for

---

<sup>32</sup>Alaska Native Tribal Health Consortium. 2009. Alaska Dental Health Aide Therapist Initiative. <http://www.anthc.org/chs/chap/dhs>

<sup>33</sup>U.S. Code. Title 38, Part V, Chapter 74, Subchapter IV, § 7451. Nurses and Other Health-Care Personnel: Competitive Pay.

the VA are listed in P.L. 108-170, Title III, Section 301.<sup>34</sup> OPM has delegated certain Title 38 provisions to DHHS: special salary rate authority, Baylor Plan, premium pay, authority to establish qualifications, qualification based on grading system, head nurse pay and nurse executive special pay, hours of employment, pay for physicians and dentists, and nurse locality pay system. The authority delegated to DHHS for use of some Title 38 provisions will expire on June 30, 2012. OPM may extend that delegation if the evaluation of DHHS' use of it is satisfactory.

Providing IHS with full authority to negotiate health care provider salaries could be achieved by:

- Legislation creating separate authority for IHS under similar provisions as Title 38.
- Including all health care providers in such authorization, expanding it beyond the current “hybrid status” professions, physicians, dentists, and nurses.
- Legislation allowing IHS automatic authority to utilize VA pay systems as they are enacted.

Such terms could be included in the Indian Health Care Improvement Act or other legislation related to Indian health care.

Although increased salaries will require additional funding, IHS would also save money by requiring fewer contract providers. When Title 38 authority was first provided to the IHS for physicians, overall IHS saved money because of decreased use of contracting services.

2. **Expansion of the IHS Loan Repayment Program.** IHS staff report receiving many more applications for IHS loan repayment positions than are currently available. In particular, loan repayment funding should be increased for NPPs. Although loan repayment is helpful, in the long-term, more competitive salaries are necessary for retaining highly qualified professionals. Otherwise, some health care providers may spend a few years with IHS for their loan repayment period and then leave. Increased continuity of care would result from more competitive salaries overall.<sup>35</sup>
3. **Advocating for change in state licensure guidelines.** As noted above, state licensure laws vary widely in the level of physician supervision/collaboration required for NPPs. DHATs are not considered licensed health care providers in most states. State-by-state advocacy for liberalization in licensure guidelines for NPPs and the inclusion of DHATs as licensed providers may enhance their utilization across Indian country. In addition, provision of state Medicaid reimbursement to DHATs would also enhance utilization of their services.<sup>31</sup>
4. **Provide adequate Medicare and Medicaid compensation for services provided by NPPs.** IHS and tribal health programs are not able to bill Medicare and Medicaid for all services provided by NPPs and CHRs. In some cases, less compensation is provided (e.g., 85%) than if the same services were delivered by a physician. Advocacy for policy changes would need to occur both at the federal and state levels, since Medicaid reimbursement policies vary by state. Specific recommended policy changes related to reimbursement include:

---

<sup>34</sup><http://www1.va.gov/oro/docs/Pub.L.108-170.pdf>.

<sup>35</sup>Personal communication, CDR Frances P. Placide, PA-C, MMS, IHS Loan Repayment Program, PA Discipline Chief.

a) **Reimbursement should be based on clinical service.** Clinical services should be reimbursed at the same level regardless of the practitioner providing the service. NPPs should be able to bill for the same amount as physicians if the clinical services provided are equivalent. If NPPs were reimbursed at the same level as physicians, they could also be held to the same productivity expectations.<sup>17</sup> Parity in billing would increase revenue for the IHS and tribal health programs and would provide an incentive for increased use of NPPs' services.

b) **Medicare Part B compensation for pharmacists.** As noted above, pharmacists are increasingly providing direct clinical care in IHS primary care settings. The ability to bill for these services through Medicare Part B, commensurate with other NPPs providing similar services, would allow pharmacists to improve outcomes to beneficiaries in IHS and free up physicians to see patients with more complex medical issues. One mechanism for allowing pharmacists to be covered under Medicare Part B would be to amend the Social Security Act so that pharmacists are included in the definition of "health care providers." The Social Security Act already lists several types of health care professionals as "providers," including registered dietitians, NPs, PAs, and CNMs, but does not name pharmacists. CMS regulations would also need to be changed so that pharmacists are recognized as health care providers eligible for Medicare Part B reimbursement. A demonstration project that includes Medicare Part B compensation for pharmacists might be the first step in moving towards national legislation allowing for billing of pharmacists' clinical services. Advocacy in state legislatures for Medicaid reimbursement for these services might also be useful.

c) **Reimbursement for PHN services.** Some valuable services provided by PHNs are currently not reimbursed by third party payers. For example, home based assessments, hospital discharge follow up, maternal and child health, early detection of diseases, and health education services provided by PHNs are not reimbursed.<sup>36</sup> Third party payer reimbursement of these services would help to support the PHN program in the IHS.

d) **Reimbursement for CHR services.** Services provided by CHRs, including DHATs and behavioral health aides, are currently not reimbursed by third party payers. Reimbursement for these valuable services would be helpful to IHS and provide an incentive for expanding the use of CHRs, particularly DHATs, behavioral health aides, and CHRs who work as emergency first responders. Credentialing systems for DHATs and behavioral health aides, which might include state licensing (as noted above), may help to justify third party reimbursement for their services.

5. **Expanding the DHAT program outside of Alaska.** The proposed 2009 Indian Health Care Improvement Act Amendments (H.R. 2708, Section 121) contain a provision restricting the expansion of the DHAT program outside of Alaska. This provision would limit the ability of DHATs to provide dental care throughout Indian country, and should be removed. The American Dental Association has opposed expansions of the DHAT program. However, DHATs provide critical dental care in areas with very limited access to dentists and increased use of DHATs could improve dental health throughout Indian country. A demonstration project of the DHAT program outside Alaska might be an incremental step towards increased use of DHATs in AI/AN communities.

---

<sup>36</sup>Personal communication, Elmer Brewster, MPH, MSW, Indian Health Service.

6. **Develop demonstration programs for innovative use of NPPs.** Funding for new models of utilizing NPPs could be provided to tribal health programs and IHS. For example, health care facilities might try increasing the number of NPPs collaborating with a single physician, and shifting responsibility for basic primary care to NPPs and complex cases to physicians.<sup>17</sup> Some federally funded Community Health Centers (CHCs) already use a similar model where most primary care providers are APNs or PAs and only one or two physicians work in the clinic. Innovative use of NPs with specialty training and clinical nurse specialists could also be piloted. For example, acute care NPs might be utilized as hospitalists and emergency NPs could be employed in emergency departments.<sup>17, 23</sup> Innovative NPP demonstration programs might help to build the evidence base for increased utilization of NPPs in IHS and tribal health programs. Such evidence might also be useful in future legislative and appropriations discussions related to NPPs in Indian country.
7. **Develop a demonstration program for telemedicine access to specialty care.** Mental health in particular is an area that could be expanded to provide behavioral health services to remote areas. Other specialty care might also be provided remotely.<sup>23</sup> NPPs, such as psychiatric nurse practitioners, other specialty nurse practitioners, and PAs could be included in any such telemedicine demonstration projects. Existing telemedicine programs, such as the mental health program at the Phoenix Indian Medical Center, could be expanded if adequate funding were provided to hire more staff. Demonstration programs might be useful for sites that do not yet have telemedicine programs, while current sites could benefit from increased funding and staffing.
8. **Economic modeling study of the IHS workforce.** DHHS could conduct or support a study examining how the IHS workforce could be ideally comprised to maximize health care access and control health care costs. It is likely that increased utilization of NPPs would be cost-effective while maintaining quality of health care, but a detailed study of this issue is needed. Such a study could quantify the unmet health care needs for AI/AN communities and the health care workforce presently budgeted to address these needs. This proposed study could also model: (1) the optimal health care workforce and budget necessary to address AI/AN health care needs, (2) the gap between the present workforce and the optimal one, and (3) the relative cost-benefits of different workforce compositions (*i.e.*, comprised of different proportions of physicians, NPPs and CHRs). A study of this kind might help to inform future policy making and appropriations.

## CONCLUSION

In sum, NPPs have the potential to be utilized more in AI/AN communities. Increased use of NPPs could enhance access to both primary care and specialty services in Indian country, particularly for rural AI/AN communities. Teams of health care providers, including physicians, NPPs, and community health workers (such as CHRs, DHATs, and behavioral health aides) will be important in maximizing access to care that is culturally-competent while also controlling health care costs. NPPs and community health workers are especially important for providing access to health care in remote and underserved areas, and these providers' work can be facilitated through the use of communications technology for physician supervision/collaboration. Any new proposed legislation

or regulatory changes aimed at increasing use of NPPs should consider the needs of both the IHS and tribally-administered health care facilities.

*This paper was published by NCAI on August 13, 2009.*