Research Report

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Tribal Community Health Representatives (CHR): Home care workforce insights, experiences, and recommendations for elder care.

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Executive Summary

Background

The Community Health Representative (CHR) Program was established by Congress in 1968 to provide an outreach component meeting the specific healthcare needs of tribes and tribal communities. This program predates the official recognition of non-tribal Community Health Workers (CHWs) by the American Public Health Association. The CHR workforce goal is to reflect the IHS's mandate to provide health services to American Indian and Alaska Native (AIAN) populations. An assessment of the CHR role in elder care must include consideration of the role of AIAN culture in elder care practices. The recent COVID-19 pandemic exacerbated health service delivery challenges for tribal nations already facing an underdeveloped and underfunded healthcare and public health infrastructure. Tribal elders living in their homes or in multigeneration housing often suffered from reduced services, isolation, and a lack of resources during the pandemic.

The purpose of this project was to assess whether the workforce in Tribal and urban clinic settings has a sufficient supply of workers with access to training and resources, and to identify the barriers and facilitators to meeting the health care needs of elders.

This project aimed to address three research questions:

- What is the role of the home care workforce for Tribal elders and how do they vary across tribal urban and rural areas?
- Is home care training available to Tribal workers and is it culturally reflective of unique Tribal community needs?
- What are barriers and facilitators in providing the needed home care in Tribal communities?

Methods

For this project a qualitative approach was used to assess the experiences of CHRs and their managers in providing or overseeing CHR services to tribal elders in rural, urban, clinic and home settings. Twenty (20) individuals were recruited from 10 sites in California using snowball sampling. Email based invitations and a project description were sent to identified and known contacts. Fourteen (14) agreed to participate in the study via an interview. Interviews consisted of semi-structured recorded sessions of 45-60 minutes conducted via zoom or telephone by AIAN professionals trained and experienced in qualitative methods. Interviewees provided verbal consent and were given a copy of the consent form prior to the interview. The study was approved by the UCSF IRB and the California Rural Health Indian Board IRB. Thematic analysis was conducted using Dedoose™ qualitative software. Two project investigators coded the interviews and discussed key themes until they reached consensus.

Results

Nine key themes illustrate the study results including strengths and challenges in the tribal CHR work environment. Those themes included:

1) Community Health Representative (CHR) Role & Services
2) Tribal Home Care Settings

3) Social Determinants of Health (SDOH) Impacting AIAN Elders
4) American Indian/Alaska Native (AIAN) Culture in Elder Care Practices
5) Drivers of Optimal CHR Elder Care
6) Barriers to Optimal CHR Elder Care
7) Organization Support for the CHR Workforce
8) The Tribal CHR Workforce Characteristics
9) COVID-19 Impact on CHR Services

Interviewees stressed the importance of the CHR role in addressing health disparities. However, they also noted the vulnerability of the role to budget cuts. This issue stems from constraints with funding sources for CHR services which are often grant based and lack sustainability. Elder care services in the CHR scope were often described as focused on home visits, assuring that basic needs are met, with a particular need for transportation for clinical appointments and health related resources. Sometimes the CHR was the primary provider of health and social care for tribal elders.

Many of the CHR interviewees described how their role is impacted by the rural environments in which many tribal elders live. These challenges include driving long distances to reach clients, often along mountainous roads to access and provide needed elder resources. They also described the impacts of limited internet and telephone and other communication connectivity.

Other key findings relate to the need for culturally appropriate training for the CHR role, as well as organization staff and leadership, and the importance of awareness of the historical trauma experienced by the AIAN receiving health services. Tribal CHR training challenges emerged from the individual level data revealing specific barriers. Most of the interviewees mentioned training barriers related to lacking guidance on a well-informed training plan including tribal CHR training options, training gaps, availability, or fit/relevance of training.

Discussion

CHRs should be members of the community they serve so that they are well positioned to reflect the AIAN culture, norms, and standards of their patients. There are ongoing barriers to the CHR role at both the structural and individual level. An example is the lack of access to and competency with communication technology among clients. Structural barriers include a chronic lack of funding for CHR services leading to insufficient staffing of CHRs, and low pay. We present ten (10) recommendations to support, enhance, and sustain the CHR role so that they are enabled to provide optimal care and services to tribal elders.

Introduction

According to the Indian Health Service (IHS) – "The Community Health Representative (CHR) Program is an IHS-funded, tribally contracted program of well-trained and medically-guided community-based health workers." The CHR program was established by Congress in 1968 – "in response to the expressed needs of American Indian and Alaska Native (AIAN) governments, organizations to provide an outreach component meeting the specific healthcare needs of tribes and tribal communities" (**1**). The IHS CHR Program has a lengthy history that predates the largely analogous and non-tribal frontline workforce group, Community Health Workers (CHW) who were officially recognized by the American Public Health Association as a New Professionals Special Primary Interest Group in 1970 and became a Section in 2007 (**2**). The IHS indicates that the CHR program has continued to expand and is currently the largest tribally contracted and compacted program with more than 95% of CHR programs being directly operated by Tribes under P.L. 93-638 of the Indian Self-Determination and Education Assistance Act, as amended and authorized by the Indian Health Care Improvement Act (1).

The origins of the CHR workforce are rooted in and reflect the IHS's mandate to provide health services to AIAN populations and the agency's vision**:** *Healthy communities and quality health care systems through strong partnerships and culturally responsive practices* (1). However, the "culturally responsive practices" stated in the HIS vision is undefined on the agency's website. A 2020 Arizona Community Health Representative Coalition report articulates AIAN culture in CHR services as: "*the liaison/advocate motivates and assists the agencies by clarifying the role of Native traditions, value systems, and cultural beliefs, to meet the health care needs of the communities, thereby reducing the potential for conflict and misunderstanding regarding the health conditions of AIAN people*" (3). The report goes on to say that the "*CHR assist[s] IHS and non-IHS health agencies to design and/or redesign services to ensure greater responsiveness to the needs of AIAN communities*". Consequently, an examination of the CHR role in elder care must also include consideration of the role AIAN culture in elder care practices.

The recent advent of the COVID-19 pandemic revealed significant problems in occupational and consumer safety in systems that provide home care support and services. Tribal nations across the United States faced similar challenges when responding to COVID-19 including ramping up protections for elders who depend on home care supports and services. However, tribes facing these challenges did so in the context of underdeveloped public health infrastructure, one of the most underfunded healthcare delivery systems in the nation, and chronic healthcare workforce shortages (4, 5). Consequently, long-standing problems in tribal systems that provide home care support and services were exacerbated during the pandemic. These problems also persist during non-emergency periods. In other words, tribes continue to face elder vulnerability when health services and long-term home care capacity remain static and under resourced. Notably, American Indian/Alaska Native (AIAN) populations, and elders in particular, are highly impacted by the social determinants of health and health disparities including a myriad of chronic conditions while frequently residing in medically underserved areas (6, 7). AIAN cultural tenets often require that Tribal elders are supported in-home or in multi-generational housing, as opposed to skilled nursing or other long term care facilities. As a result, the Tribal healthcare workforce and CHR in particular is the primary group tasked with providing health services to elders. In the current setting with the pandemic waning, there is an opportunity to examine the conditions of the Tribal CHR workforce and identify ways to support their efforts and improve their capacity to provide equitable, culturally informed elder care and preventive services.

Purpose

The purpose of this project was to assess whether the workforce in Tribal and urban clinic settings has a sufficient supply of workers with access to training and resources and identify the barriers and facilitators to meeting the health care needs of elders. The study sought to empower and center CHR voices to describe the impact of organizational support, structural and community level social determinants, and American Indian culture(s) on the CHR role. Findings from this project will be used by tribal communities to assess and disseminate best practices and recommendations for workforce recruitment and retention.

Methodology

This study used a qualitative approach to describe the experiences of CHR and their managers in providing/overseeing CHR health services to elders in tribal rural, urban, and suburban clinic and home settings. A qualitative approach creates a mechanism to communicate experiences directly from the CHR workforce to employers, external health system partners, and tribal stakeholders regarding resource needs, drivers and barriers to delivering elder care, needs for CHR training and competencies, and facilitators for professional growth. CHR and manager insights have the potential to guide strategies and approaches for optimizing elder care thereby adding value to the care team in a post pandemic environment. Lessons learned are also important for preparing the CHR workforce to face emerging public health challenges that will likely affect clinical and home care services in the future. The study questions include the following:

1) What is the role of the home care workforce for tribal elders and how does it vary across Tribal rural and urban areas?
2) Are home care training and resources available to tribal workers and do they reflect the unique cultural needs of a given tribal community?
3) What are barriers and facilitators to providing optimal home care in tribal communities?

This study was approved jointly by the Institutional Review Boards (IRB) at University of California San Francisco and the California Rural Indian Health Board (CRIHB).

Efforts were made to recruit participants in four geographic regions across the United States: California, Oregon, South Dakota, and Wyoming. However, participant recruitment was achieved only in California. A total of 20 participants were eligible to participate. Each of the 20 were contacted and provided with a study email introduction, consent form, and brief introduction of the UCSF Health Workforce Research Center on Long-Term Care. A total of fourteen of the 20 eligible participants were interviewed. The research team attempted to contact the remaining six eligible participants up to three times; however, they ultimately did not respond to the invitation to participate in the study.

Sample, data collection and analysis

A convenience sample was drawn from the California Area Indian Health Service (IHS) clinic system statewide utilizing existing contacts known to the project's co-principal investigators and team members. Participants were recruited using snowball sampling methods, between July 2023 through February 2024. Snowball sampling was the most successful recruiting method since participants were referred via trusted contacts and team members meeting the inclusion criteria. Inclusion criteria were that participants: worked as a Community Health Representative (CHR), or Nursing Supervisor of home care, or Manager or Director overseeing elder

care services in a tribally operated or urban American Indian clinic. Data were collected through semi-structured recorded interviews of 45-60 minutes conducted via zoom or telephone, with the consent of the participants, by AIAN professionals trained and experienced in qualitative methods. A qualitative interview guide was created with open-ended questions and additional prompts to encourage participants to speak freely but also ensuring capture of in-depth insights on the topics of interest (8). The qualitative approach is appropriate for the AIAN community members given the cultural norms and preferences of AIAN and enables indigenous ways of knowing that according to the SAMHSA Native American Center for Excellence, "includes individual and oral histories and interviews with program participants and key informants … as a means to engage reflective dialogue" (9). Interview questions focused on seven different domains:

1) Organization profile, personal/professional background, reasons for choosing CHR career
2) The scope of CHR services provided to tribal elders
3) Experiences in CHR service delivery during the COVID-19 pandemic
4) AIAN culture and its influence on elder care
5) Perceived drivers and barriers to providing optimal elder care
6) Organizational support for the CHR role
7) CHR workforce characteristics

ZOOM™ software was used to record the interviews, and REV Transcription Services were used to produce transcriptions of the interviews. Given the cultural and linguistic context of the interviews a list of Tribal names and places were provided to REV. The interviews were arranged at times best accommodating participants' work schedules and to ensure comfort with taking part in the interview. An email introduction including a brief study description, key contact information, and the verbal consent form was sent to participants 5-10 days before the scheduled interview. This lead time was provided to enable review of materials and to ask questions prior to the interview date, if desired. The verbal consent form approved by the IRB was reviewed again at the beginning of the interview and each participant was provided another opportunity to clarify study information and ask questions. After completing the interview, a $50 gift card was emailed to the participants to compensate them for their time.

Analysis

Once the interviews were complete, the two Co-Is reviewed and initiated coding the transcripts. Both research team members then coded the transcripts in Dedoose™ qualitative analysis software to ensure the rigor in the coding. Each Co-PI made multiple passes through the transcripts. The independent coding of each Co-PI was compared and resulted in alignment. After the independent coding, the Co-PIs assessed the codes for emerging themes through thematic analysis and formed the final themes that best reflected participants' experiences and perspectives (10). Thematic analysis is considered a method for identifying, analyzing and reporting patterns to a research process in which qualitative data are first read and re-read. From there, initial codes are generated, themes identified and reviewed, and final themes are defined and named (8,10). Key themes were identified and related to CHR service delivery and CHR managers' strategies for meeting tribal elder basic needs, optimizing care, and reducing service gaps.

Results

Fourteen participants were interviewed. Participant characteristics include: 1) Gender, 2) Community type (rural, urban, suburban), 3) California Region (North, North Central or South Central), 4) Role (CHR, Manager/Director, Executive Director), and 5) Years of experience (Table 1).

Table 1. Study Participants

KII (N=14)	GENDER: MALE (M), FEMALE (F)	COMMUNITY TYPE: RURAL (R), URBAN (U), SUBURBAN (SU)	CA REGION: NORTH (N), NORTH CENTRAL (NC), SOUTH CENTRAL (SC)	ROLE: CHR (C), NURSE (N), MANAGER/ DIRECTOR (M/D), EXECUTIVE (E)	EXPERIENCE: (YEARS)
1	M	R/U	NC	D (NURSE)	10
2	M	U	SC	M (HR)	5
3	F	R	N	C	8
4	F	R/U	NC	C	15
5	M	U	S	E	8
6	M	SU	NC	C	1
7	M	R/U	NC	M (MPH)	15
8	F	R	N	C	15
9	F	R	N	M (NURSE)	20
10	F	U	SC	C	16
11	F	SU	NC	C	10
12	F	R	N	C	1
13	F	R	N	C	2
14	F	R/U	STATEWIDE	C	24

Five of the 14 participants were male and nine were female. An equal number of participants (n=5) each were from the Northern most and North Central regions of California, followed by Southern Central California (n=3), the final participant worked statewide (n=1). A majority of the participants worked as CHR (n=9) and a smaller proportion of the participants worked as managers or directors overseeing CHR staff (n=4). The remaining participant is a tribal clinic Executive Director (n=1). Work experience varied between one year and 24 years, where half of the 14 participants had 8-24 years of experience comprising two managers and five CHRs. A total of four managers/directors were interviewed. Two of the four CHR managers/directors were credentialed in nursing, one had a master's degree in public health, and one had a human resources background.

Key Themes

Nine overarching themes were identified as impacting this group of tribal CHR's beliefs about optimizing elder care in light of the lessons learned during the COVID-19 pandemic:

1) Community Health Representative (CHR) Role & Services
2) Tribal Home Care Settings

3) Social Determinants of Health (SDOH) Impacting AIAN Elders
4) AIAN Culture in Elder Care Practices
5) Drivers of Optimal CHR Elder Care
6) Barriers to Optimal CHR Elder Care
7) Organization Support for the CHR Workforce
8) The Tribal CHR Workforce Characteristics
9) COVID-19 Impact on CHR Services

The themes shed light on strengths and challenges in the tribal CHR work environment. Themes related to the role of AIAN culture in elder care, SDOH experienced by tribal elders, the structural determinants and physical settings of tribal clinics providing elder services, scope of services, and organizational supports are described in terms of their impact on the efforts of the tribal CHR workforce.

1. Community Health Representatives: Role and Services

Historical Origins in Tribal Communities and Role

"*We used to have CHRs back in '86 and '87, nineties, where they went out to the homes. They were nurses, MAs going to the home because it's so rural… And so back then, we had the CHRs going to the homes, checking the blood sugars, checking the blood pressures, checking to see if their medications, how they're doing…They were realizing that our native people, we first want to address the whole person. Mental, physical, but that also includes home. [Our clinic] realized that our whole life affects us, not just medical, not just optometry, not just dental. The stressors at home, the difficulties, social determinants of health, and the historical trauma [of] our Native people*" (KII 4)

The CHR program origins as described by the IHS website (1) were reflected in the stories and memories of participants interviewed for this study. Of the 14 participants, six mentioned the history of the CHR program and ruminated on its importance to tribal communities for addressing health disparities as well as legitimizing the CHR role as a profession - "*Some of the longest-standing programs for this concept of work and community health representatives, in particular, are through Indian Health Service and through Tribal Health. So, I think that, as far as I know, IHS helped build the foundation that we're all working with right now, which is great. And so, I think they did a lot of work to show the benefit and to build the stature of the position and the profession*" (KII 1). Notably, participants also mentioned the vulnerability of the CHR program to budgetary cuts - "*They did have transporters. And once upon a time, they used to be joined together in one department. And I think because of budget cuts, things happened where the CHRs were cut out. And four years later, they opened up the CHR department and brought it back. And so of course, I was one of the first hires to come back"* (KII 11). One participant expressed a lack of understanding of the basis for closing the CHR programs - "*before me, I believe there was a CHR program at [clinic] that ran for many years. And I don't know anything about it. And it just went away"* (KII 1). Multiple participants mention newly created, reestablished, or reorganized CHR programs into new departments reflecting shifting aspects within the tribal clinic systems but also hints at the need for the CHR role: "*Care coordination is a relatively new department, and this is work that we haven't really ever necessarily done before. Our program really is designed around social determinants of health and figuring out what barriers are to getting our population in for treatment, whether that's medical,*

dental, whatever it is they need, but what are those barriers? And some of those barriers could be that they're confined to their home, maybe they're distrustful of the healthcare system, maybe transportation is an issue" (KII 7). Another participant shared the multi-dimensional role and expected health supports required of CHRs, "*They're going to have a dual role. For one, it's to promote wellness through either lived experience or peer support process, but also, too, as a community healthcare worker, it's identifying and connecting them to services; it may seem pretty broad and to some people who don't work in healthcare, work-integrated healthcare model, it's maybe difficult for them to comprehend - we're looking to address mental health and medical health"* (KII 2). Most notable among the perspectives shared about the CHR is a deep appreciation for this workforce group and its integration into the cultural fabric of tribal healthcare delivery. Participant 14 cogently shared this appreciation, "*I absolutely have nothing but love for CHRs, our community health reps, because their relationships that they have with our elders is a bond that's so strong and a trusting bond that our community members have with them. Not only do they transport them to appointments if needed, but they come into their homes and many of them help around. They provide them with the direct contact or education in their homes, and not only just to their elders, but the folks that actually take care of them, aunties, uncles, cousins, grandkids*".

Multi-Dimensional CHR Role

The IHS website states that CHR may access extensive training in topics spanning health care provision, disease control, and prevention, and are the frontline workforce for addressing disparities and improving the SDOH using a community-based approach. As such the CHR role was conceptualized to be multi-dimensional and is expected to provide a wide a range of supports and services including: "access to care and coverage, social/cultural cohesion, transportation, food access, environmental quality, social justice, housing, and educational training opportunities" (1). The CHR role as described by IHS reflected in the study participant responses. However, a majority of the participants (n=8) also emphasized certain aspects of the CHR role not fully captured by the IHS website. These additional aspects center on patient dynamics and interactions characterized by exceptional levels of engagement and commitment. Four distinct additional aspects emerged to evidence the CHR role as multi-dimensional.

The first aspect of the multi-dimensional CHR role is being an intuitive and empathetic caregiver outside of the clinic – "*CHWs are looked at as more of [doing] a medical assessment where they're looking for needs in the home, […] to refer to medical services and even to some supporters connecting them with possibly food services, signing up for insurance and other types of resources, though. To me, it's more of motivating them [elders] to be better and connecting with them on that emotional type of level, though, to meet them where they're at mentally*" (KII 2), and "*Some people may not want to tell everybody what they need, but if you see it visually, okay, you see that, you make that assessment. But you need to be there with the person…They may not say it because [of] culture, or the pride, or they just don't like asking for help* (KII 10). Another participant shares that they use seemingly casual interactions and observations to assess elders - "*You get in the car, and they [elders] tell you everything. So, I see where they're at physically every day and they really do need some help"* (KII 11). This participant perspective establishes that each encounter is an opportunity to better know and respond to the needs of elders in their care. The sensitivity and vigilance with elder's health status and needs can translate to an exceptionally committed level of support - "*I would say I am their comfort person. I'm their middleman between the doctor and the patient or the elder. I am their support. I mean, that's what I feel. I'm*

their go-to if they need me in any way night or day. If I can't help that night, I definitely will that next morning, first thing that morning. But if emergency, I'm definitely there" (KII 13).

The second aspect of the multi-dimensional CHR role is being a communication bridge to clinical providers, "*CHRs and workers are vital, I believe, because they bridge that gap between the provider who only has so much time with them*" (KII 3). Participant 3 goes on to say - "*I'm able to have the blessing of going into a person's home. And really having that time to be able to sit with them for an hour, or two hours, and just listen. And really hear what the needs are". And be able to communicate that back to the provider. And that's where we can establish referrals, or the needs assessment, whatever it is that I can provide, or what the doctor wants"*.

The third aspect of the multi-dimensional CHR role is navigating clinical care informed by lived experiences, as shared by a participant in a leadership role, about CHRs: "*They understand the healthcare system from both the patient point of view and the professional point of view, and they know the system in and out. …there is that many of these CHRs have basically, you could say, lived through a healthcare system that either met their needs or didn't meet their needs*" (KII 5). Another perspective on approaching the role through lived experience was shared by a CHR participant – "*I guess just having that kind of family and also realizing there's so many people with needs in my family, in my community that don't even know what's out there"* (KII 6). The importance of the navigation aspect is shared by multiple participants - "*We're helping them navigate their healthcare system here at the clinic as well as outside of our clinic. And we're helping them access the referrals and schedule those appointments. Sometimes it's setting up the transportation to those appointments, any X-rays, those type of things. We have helped in our department with medication management; We've helped them with Medicare and Medi-Cal services. We've helped with food resources. Sometimes it's just a wellness check or a check in over the phone just to see how they are"* (KII 11). The navigation function can include CHRs taking a deeper dive into the patient's medical record - *"We were the ones to go into EHR, "Okay, let's see what they all need. Let's write a letter of this and this and this and this is what you need"* (KII 12).

The fourth aspect of the multi-dimensional CHR role is being a community champion and trusted partner**: "***I've done that, [provided] many evidence-based programs like the Timed Up & Go, and just different types of programs that I feel that are really beneficial to our elders, especially when you're living in a rural area because we all know that the response time can be anywhere from 30 minutes, 45 minutes to if they come if they're not busy somewhere else. So CHRs are the closest community champions that we have to get services to our elders… our CHRs know where everybody lives, they know how to get to places, they have established relationships"* (KII 14).

Scope of Services - General

Study participant's descriptions of their scopes of work align closely with the IHS. Most of the participants (n=8) identified technical assistance as the most utilized and provided service for an array of patient needs, including helping educate patients with "*digital technologies, internet technologies, using devices and tools and things that the elder community just didn't have a chance to learn because they didn't grow up with it like younger generations have*" (KII 1), and health education, "*That's what every one of my home visits are about." I educate on something, diabetes, heart disease. I'm always educating about anything, or [what] I see going on in the home"* (KII 8). The technical assistance may also include instruction on properly using medical devices

and accessing benefits and resources - "*We show them how to use their wheelchair, how to use their walkers, how to walk proper[ly]. We help them to get their house repaired through the FIT program through the tribe… I mean we, basically, do everything in our car to go*". A core number of participants (n=4) mention aiding with accessing programs that alleviate challenging social determinants, "*I may not be able to answer the legal stuff, but I can find them the legal people that can answer it for them. And then the resources, like money… some families that aren't able to have school shoes. Helping get PG&E [utilities] paid for, helping get some rent paid for, helping with HEAP [home energy assistance program] ... It's all wraparound care of the person of the family and stressors that we know now what it does to our health, the stress on our health"* (KII 4). The technical assistance may include aid to access an array of safety net programs, "*if [they] need help with signing up for Medi-Cal disability benefits, social security, housing, whatever that might be"* but, also mentions having a partner network to connect patients to a variety of resources, *"You're also working with the other community specialists such as myself that they might have a resource that I need that we don't have or vice versa, and they can refer them out here*" (KII 10).

The second most used CHR service provided as mentioned by participants is connecting patients to essential resources – "Access of housing and food. I mean, those are always our top. If our patients aren't having those two things, nothing else matters" (KII 11).

The third most used service is case management – "We do vitals, then we do case management with the patient. We do a lot of scheduling. We pick up the elder. A lot of times we'll transport them out to town, which is about an hour away, to their specialists. And lots of pain management, not narcotics, but we do lots of diabetes meds and show them what they look like and they do all their own pill boxes and stuff" (KII 8), and "We do fall risk prevention, just a lot of medication management, chronic disease management, flu vaccines, home visits, do a lot of diabetes education" (KII 3).

While not widely mentioned by the participants, needs assessments were identified as a core service, "*It's mostly needs assessments*" (KII 2). Finally, facilitating medication support was also mentioned by a CHR in an urban setting as an important service, "*if they're going to let's say that they need a medication or something in that regard to where they're going through financial hardship, they're not able to, we're also assisting with that as well*" (KII 10).

Scope of Service - Elder Care

A major subtheme, "elder services" emerged as a distinct category within the CHR general scope. Only "elder services" as a subset of CHR services will be described here since elders also receive those detailed in the CHR general scope. A majority of participants shared views on this theme, starting with a subgroup highlighting elder social activities, gatherings, and/or group classes as important health promoting activities - "*We have groups here to develop our Elders. When I say develop, we have Tai Chi and we have Bingocize. Bingocize is an evidence-based practice. Tai Chi, people look at it as more of a martial arts curriculum, but it's been proven to reduce Elder falls*" (KII 2). Participants providing their views on this theme share an understanding that elder gatherings, groups, and sessions support elder wellness on multiple dimensions – social, mental, physical and spiritual – as the connection between Tai Chi and fall prevention illustrates. Another example of an elder activity shared combines a social event with wellness training, in this instance the topic is historical trauma (11, 12) at a holiday luncheon – "*Annual elders Christmas luncheon.... A couple of*

years ago, we did a healing from boarding school gathering for our elders. We got to have the Native Wellness Institute come out and talk with them. My light went off. And so always keeping in mind our elders and what they're needing" (KII 4). Another participant highlighted elder activities with a socio-cultural approach to Native American traditions – "*we have women's talking circle, we have bingosize, we have drumming as well, beading regalia groups*" (KII 10). Participant six summed up the benefits of these types of elder activities to the CHRs, professionally and personally, "*We build a lot of relationships with the community, with our elders within our groups. One of my favorites I'd like to share is… that we have a bingosize; You build relationships, you're sitting next to them, you're playing bingo, but you're also talking about whatever they would like to talk about and see how they're doing, interact with them".*

In addition to social and wellness activities, resources and supports to specifically meet elder needs was mentioned - "Supplies for patients who need everything, from just their basic needs from Depends, or having a wheelchair or a cane, a walker, getting these things for a bath, toilet, those kinds of things that help them in the house" (KII 6) and "*We have portable AC units that we assess for. "Hey, they don't have an AC unit near them." We have these little portable; But also, too, within their living around the house though, are they being taken care of? Are they okay? Is there any type of elder abuse going on with them? Do they have appointments that they're not making it to, though, because they don't have transportation services* (KII 2). Most of the participants who mentioned resources mentioned obtaining resources specific to elder needs.

Most Valuable Service - Home Visiting

The IHS website lacks a clear description of elder home visits. However, IHS offers an online course on the topic of CHRs Conducting Home Visits (https://ihs.talance.com/browse.php) for tribal applicants meeting eligibility requirements. Home-based elder care delivered to AIAN elders emerged as an overarching subtheme in this study. Participants shared a variety of perspectives on home visits, as a standalone service – **"***We have a program that's to reduce Elder falls…So part of it would [be] being a home assessment and getting a contractor to go out to their home, install maybe guardrails for them to walk down, let's say, a flight of stairs"* (KII 2). And as one service within a comprehensive plan to improve elder quality of life – "*Being able to go into a home and do a home safety assessment. And then being able to provide medical equipment that can prevent falls, because that's their biggest fear, is not having their independence and also being able to live in their own home. They don't want to be in a nursing home, which I don't blame them whatsoever"* (KII 3). One participant shared their view on the value of home visiting in light of their organization not yet providing this service - "*Going out to their homes in between their appointments. Checking that medication, checking that blood pressure, checking to see them at home when they're not able to come in. That's a huge one. I've talked with our leadership here. It's opening the door for it here… checking on them in their environment, in their home where they're comfortable, where they're safe I think is a huge one that's really important"* (KII 4). Another participant shared their view of CHR home visits as a component of optimizing clinical staffing resources – "*go[ing] to their home and see what they can and can't do to get them what they need, I think, is a huge benefit of CHRs. I can't send a doctor to everyone's house. There's just not the workforce to do it. But we could send the CHRs to lots of people's houses, to lots of different facilities, to lots of different places in the community. And they can help get people what they need and be a voice for them"* (KII 1). Home visits stood out as the service that enables CHRs to provide a patient centered approach reflecting AIAN health equity and cultural standards. This sentiment is summed up by participant 12 - "*Things that we do for our elders. Home*

visits, we have our few that we go out and check on and just make sure that they're doing okay and how they're feeling and if they need their blood sugar checked or their blood pressure, if they need wood in the house. Heavy lifting, we try to help them with that because it's kind of hard. Being able to make sure that they're getting the resources, and their needs met. It's not easy for them to come out and get medication or get transportation to get to the clinic, get their equipment. So, we were able to go out and set it up for them, help them make sure that it's comfortable. If they have any concerns, we're able to come back and communicate the concerns that they have". A total of 8 of the 14 respondents ranked home visiting as the most valued CHR elder care service they provide.

Most Utilized Service - Transportation

Transportation services emerged as a major subtheme of CHR services standing out as a critical factor influencing the capabilities of the CHR workforce. Transportation was identified as both a driver and barrier of CHR services with total of 13 of the 14 participants mentioning either the significance of transportation barriers, "*We're talking about if, say [...] was one of my clients and she had some sort of injury or chronic disease that couldn't be handled in the rural area so [they] would have to be referred out to, could be Medford in the Oregon area, could be Coos Bay, could be down here to UC Davis or San Francisco. And we're talking about travel that could be up to six, seven, eight hours*" (KII 14), or the high patient utilization of transportation services, "*Transportation seems to be one of the biggest issues and is probably utilized the most"* (KII 7). Notably, 7 of the 14 participants selected transportation as the most used and/or valued of the CHR services - "*They're able to respond and engage and transport and meet them where they're at during crisis or non-crisis type of needs. And so I think that's a huge contribution when we think of immediate service, on-the-spot service, coordination and care for crisis intervention"* (KII 5). Five of the 14 participants indicated the lack of transportation as a service gap.

2. Tribal Home Care Settings

All participants (n=14) described the geography, facility(ies), and demographic attributes characterizing their organization location and service environments. Notably, participants employed by tribal health clinics located

in highly rural locations (n=5) described expansive service coverage areas with critical transportation barriers– "*Our service area, our command medical center IHS service area is very large just… we're the only clinic that is like a hundred miles within the windshield of any other clinic. And […] the next medical health clinic, which is an hour away*" (KII 8). These rural environments as described by the participants emerge as a context for built-in structural determinants including but not limited to a lack of transportation, a lack of medical services - specialty care in particular, inpatient, and hospice, as well as communication technology and connectivity barriers, "*We're an hour drive from the closest hospital. The road is a windy mountainous road; we're the only healthcare provider for the entire region, both native and non-native. All of our healthcare providers live out of the area and commute in and the clinic provides housing for them including me. Internet service is tricky. We say that if the phone, the power, and the internet are all working on the same day, it's a good day"* (KII 9).

While these highly rural environments often lend themselves to challenges in accessing health services, the participants also convey a sense of pride of place, community, and affinity for the environment, "*there's a lot of forest, a lot of greenery, a lot of rivers, a lot of hills. We have a lot of different Native Americans within our areas. And it's so beautiful that it is very rural for a lot of people…we get that come to visit, they're like, "Wow, this is very rural". So, our service area is really big and so there's a lot of services and a lot of hats that we wear as being a*

CHR and a lot of responsibilities that we really take on because we're all they have within this little rural area" (KII 4). Another participant provides a sobering glimpse into the strengths and challenges found in highly rural locations - "*We're very rural, very country… just our own little nook of California, more northern California, mountains, rivers. The closest big stores like Walmart and Costco [are] an hour and a half away from us"* (KII 12).

Surprisingly, participants from urban environments describe similar challenges with expansive service coverage areas including greater transportation needs and the potential to exacerbate health service inequities without close attention to the local or zone level access barriers within a large service area – "*This region is very vast; we're the only healthcare program in the county that serves Native Americans so it would create a health disparity if we were just choosing to serve [only] the biggest, largest city in our service area"* (KII 2). A similar issue of being categorized as an urban organization while also having responsibility for providing services to rural, hard to reach places was raised by another participant – "*Geographically, we have mountains, we have valleys, we have very hard-to-reach dirt roads kind of places where transportation is essential… that's where our population lives*" (KII 5). A subgroup of participants (n=3) representing two tribal sites serve patients in both rural and urban settings. These participants mention low socio-economic status, type of insurance coverage, and a lack of specialty care as limiting factors to accessing health services. As described, these factors generally create organizational challenges to providing care in rural areas, however they are not necessarily alleviated in urban areas – "*We've got people that don't have electricity, and then we have people that live in [a large urban center]. So, I mean, it's a wide breadth. [The other] County [we serve is] generally more rural - both areas, we have trouble finding specialists, lots of just lack of services, and especially lack of services for folks that take Medi-Cal"* (KII 1). *"Being in rural settings, it can be hard to find, especially, doctors, nurse practitioners, folks like some of our higher licensure staff. But then, also just filling positions at the front desk or call center can be challenging, too* (KII 1)." The implications of the lack of services and providers is illustrated by another participant in this subgroup – *"We have American Indians come from far, faraway places. We're not really county-specific; there are programs within [our organization] that are county specific, but as far as our medical and dental, all that, it's not confined by county lines"* (KII 3).

All 14 participants were asked about whether their organization served only AIAN patients or whether other populations could access their services. Of the 14 participants, 6 indicated that their organization served only eligible AIAN (in addition to non-Indian eligible family members, employees, etc.), and 8 indicated that their organization served both AIAN and other populations. Each participant provided an estimate of the total number of elders served within their patient populations.

3. Social Determinants of Health Impacting AIAN Elders

The SDOH emerged as a primary theme in this study with 12 of the 14 participants describing factors related to low socio-economic status, barriers to accessing health services, socio-cultural issues, and the political and built environments. Each of these factors, according to the Healthy People 2030, affect a wide range of health, functioning, and quality-of-life outcomes and risks (13). A total of 8 SDOH factors emerged comprising the theme with four of these identified by participants as needing attention due to their impact on AIAN elders:

Table 2. 8 SDOH Factors Affecting AIAN Elders

8 SDOH FACTORS		4 FOCUS AREAS	
1.	AIAN eligibility for "purchased referred care" (PRC)	X	(n=3)

2.	Elders as caregivers		
3.	Health disparities		
4.	Historical trauma and loss of culture	X	(n=4)
5.	Low health literacy		
6.	Low socio-economic status (SES)	X	(n=10)
7.	Stigma		
8.	Structural Discrimination/Racism	X	(n=3)

Four SDOH Focus Areas

AIAN Eligibility for Purchased Referred Care (PRC)

The first SDOH factor identified by study participants as impacting AIAN elders is "purchased referred care" given its critical role in facilitating access to specialty health services. For an AIAN elder to receive this benefit their AIAN identity must be verified (often a CHR function), and they must meet eligibility requirements established by the federally recognized tribe that they are enrolled in as well as the Indian Health Service (IHS) - "*It opens up the door to care, essentially. Because we're a tribal facility, we offer free comprehensive services for verified Indian folks. And so, getting that verification just literally opens the door for services through us that are paid for by the Indian Health Service….So, if someone needs to see a specialist and they are qualified and they meet the requirements for a purchased referred care program, we can actually use dollars that are given to us from the Indian Health Service to cover those services*" (KII 1). One participant mentions the connection between PRC and access to other resources for AIAN elders making AIAN verification a significant driver for accessing health services and mitigating adverse social determinants, "*We have purchased and referred care. We do have that, and again, we do have our CHR who is specific to our American Indian population stemming from verification services to getting benefits, travel to and from appointments. We also have our […] TANF folks that come once a month. Just about anything that our elders need, we provide it to them, all the way from there's a rental assistance program. You name it, we provide it to the best of our abilities"* (KII 7).

Historical Trauma and Loss of Culture

Several study participants shared their perspective on the impact of historical trauma (11, 12) to the AIAN community and its effect on health service delivery with the elders in their care – "*From my understanding of the history, the wars that were so terrible at least to a lot of people here, I think a lot of them, they're very disconnected; They're very much disenfranchised from what's going on all around them, and I think that leads to a lot of problems, mental health, physical health*" (KII 6). Participants also shared the opinion that it is important to acknowledge the historical trauma that elders have experienced, and that the CHR as a community member will empathize and understand the magnitude of this factor since they are likely to share

these experiences - "*It is a stressful situation to even just come in, and so CHR is able to connect with them, understand having the empathy, having the knowledge, knowing that I've got history of a boarding school survivor is my mom. And knowing what we went through, what our ancestors went through, and being able to have somebody that looks like us that sometimes talks like us but understands and knows to connect between that doctor and that patient, to connect with the dentist or that patient, connect to other resources out there and be the buffer, maybe, the buffer for them* (KII 4). The AIAN elder sensitivities mentioned are foreseeable given that racial inequities can occur in current contexts, cultural erasure for example continues to permeate social and health delivery environments – "*We are all trying to first of all solidify our identity as Natives, but also having it be represented here in the community as we still exist. Many people think that we're extinct and we no longer are here*" (KII 6). Ultimately, the historical trauma discussion while challenging, is recognized by the participants as an opportunity for personal and professional growth - *"So having that teaching of the trauma, but knowing that there's hope, that there's healing, getting the aspect of healing and learning how we heal, what it takes and for this community to heal and reading somebody. Knowing when you cross the line, knowing when you've said something that, oh, they don't agree with or upset them, learning to take a step back. Looking at yourself and taking that step back, taking that breath and connecting as a person to person*" (KII 4).

Low Socio-Economic Status (SES) - AIAN Elders

Low SES, and specifically unhoused and financially vulnerable elders emerged as the topic mentioned by a majority of the participants – "*Usually their housing situation, and that's a big one that we don't have a lot of help for. There's a need to have someplace for them safe to live; They don't have a secure living environment, so what I mean is sometimes I could speak to that there are some that are living in shelters, in their car. There's some, they're staying with relatives; here's a program that approached us that we're trying to send people to for food… those two major things I think I hear a lot of that we're just not able to really close the gap on"* (KII 6). Another participant repeats a similar experience – "*I've had several in the past that were on the street, and they'll wear layers of jackets that have pockets on the inside, and they'll put their cell phone and their medication and whatnot, and as they fall asleep, somebody steals it from them. And I mean, how many times is pharmacy going to release the same medication?"* (KII 11). The multi-factor vulnerabilities of unhoused elders are of great concern to CHRs as they recognize that unhoused elder's circumstances are often complex, extend to other family members, and stem from other health and SES disparities, "*Housing is a big one. I'm seeing a lot of people become homeless, and it's heartbreaking. And then their basic needs become more crucial than taking care of their health management and making appointments. And when they start losing family members to whatever's out there, drugs, alcohol, and then they become very occupied with trying to save their children and their family, and then they lose that support. So housing is huge"* (KII 3). Even when AIAN elders are housed, the participants mention other vulnerabilities such as financial hardship, "*I've gotten a lot of requests to assist with financial assistance. Financial because they're going through a financial hardship, which we see in the numbers going up a little higher than since I started*" (KII 10). An additional concern expressed is elders' ability to care for themselves if they lack a social support system, "*In terms of basic needs like showering, eating properly, cooking, not eating, but cooking. There's a lot of risk to that. We have served elders that have burned themselves just by trying to cook a simple meal. We have had elders that say*, "Hey, I can't shower properly. I'm not showering."… [risk of] *slips and falls. Those things are caused just by fragile elders"* (KII 5). Of the participants sharing insights on this low-SES subtheme, four mentioned the problem as place-based and due to rural versus urban resource availability (3 rural, 1 urban based participant) with one

participant mentioning urban environments as having more services – "*There's more resources like if they have a drug habit, if there are mental health issues, things of that sort, there are so many resources. Partly because it's a bigger city, more resources, more monies, more whatever that might be. But here, I do see the difference, I do. Coming from a bigger place to a smaller community* (KII 10). Notably, all of the participants who mentioned the problem with unhoused elders were from urban and suburban settings.

Structural Discrimination and Racism

"*There are long standing and persistent health and health care disparities among American Indians and Alaska Natives (AIANs), which are a result of centuries of structural discrimination, forced relocation, reduced economic opportunities, and chronic underfunding of health care for this population*." (14)

Three study participants mentioned structural discrimination and racism as a barrier to providing optimal AIAN elder care. The problem according to the participants was amplified during the COVID-19 pandemic and continues in the post COVID-19 context. Most notable is the perceived lack of equitable treatment and service provision by county jurisdictions and healthcare agencies – "*There was a point in time where [tribal individuals] comprise, two or 3% of the entire county's population, but 15% of those hospitalized were from AIAN and they were our elders. We did track folks in and out of the hospital; And the hospital was sending people home too early. We had elders that got sent home and ended back in the hospital because they were...sending them home too early. They weren't stable enough, and the public health officer knew it - we are so far away and there wasn't support, all of that kind of stuff*" (KII 9). Moreover, the CHRs describe a sense of non-responsiveness to AIAN elder needs- "*We felt like the hospitals maybe didn't completely understand the disease burden that our native elders often are carrying. And then the whole distance and that kind of stuff. That was something that every day I was like, "Oh my God.*" (KII 9). The lack of attention from county public health and health care agencies to AIAN resident needs extended to acute COVID-19 care, long-term public health and social services, and ultimately tribal systems- "*Then whenever the beginning of the monoclonal antibodies were available and they were only available through the hospital, and I was advocating that our folks get it, it was like, "You guys can't have it all," and, "Don't you get it from IHS?" And they couldn't make it work and... So long story short, we actually ended up standing up the only monoclonal antibody treatment clinic in Northern California actually on the reservation and we ended up doing 50 treatments; We couldn't even get them. They wouldn't even consider it"* (KII 9). This lack of support by county agencies for both AIAN residents and tribal clinic system partners continues in the post-COVID-19 environment - "*So all that funding and all that help within [our] County doesn't qualify for our elders within the Reservation because we get our own funding for those people; [if we call and] say, "Hey, we have a patient that really needs the resources here and they're… "Well there's a waiting list," or "You guys get your own funding, you guys got your own funding for the reservation, so you guys should already have that resource*" (KII 8). These interactions with county agencies as described demonstrate a lack of consideration of the potential eligibility of AIAN elders to receive services as county residents and begs the question of whether residing on a reservation is an actual legal barrier to services or a misrepresentation on behalf of County personnel. The interactions also reveal assumptions by county agency personnel about the adequacy of funding of tribal health delivery systems which according to the DHHS Assistant Secretary Planning & Evaluation, Office of Policy 2022 Report are the lowest of all publicly funded health systems at approximately 48% of the level of health care needs of AIAN (15). In addition to refusing to help alleviate health inequities experienced by AIAN elders, this treatment leads the tribal clinic and CHR workforce to conclude that there is a racial bias, a reiteration and reoccurrence of

harms that result in and reflect historical trauma given the fact that lives, in particular elder lives, were at stake – "*there was some sense that there was racism going on as well too. I know our public health officer felt that that's what was happening*" (KII 9).

4. AIAN Culture in Elder Care Practices

To meet the intent of the IHS mission, the CHR should be members of the community they serve so that they are well positioned to reflect the AIAN culture, norms, and standards of their patients. This criterion is conceptualized to create a knowledge bridge between AIAN patients and the non-AIAN providers and clinic systems. This criterion was largely but not always met by the participants in the study. Despite this gap, the role of AIAN culture in elder care practices emerged as a theme for CHR services provided to elders. Two subthemes also emerged: 1) The cultural role of CHRs in AIAN elder care, and 2) The importance of cultural competency of the health care team providing AIAN elder care.

Among the 14 participants, 10 shared insights into the AIAN value and culture of caring for elders. For example, - "*For me, it's just growing up and learning and knowing the resources and the importance of our elders, our story keepers, our traditions, what we learn from our elders. Mom and dad is usually working, and so we're with our grandparents, we're with our elders, whether it's the auntie or somebody who's looking after us…So it's just I think because of the way I was brought up, to honor, love, and respect and be blessed that we have our elders. Whoever it is, whether it's a relative or not, those people lived life and that we can learn from, and healing and the songs or the traditions or the stories*" (KII 4). A subtext that stood out in this participant's statement and echoed with other participants is the value of being responsible for elders regardless of or lack of kinship ties, "*It's somebody's grandmother, it's somebody's auntie. And I know that my mom is in Montana and she's an elder on our reservation, and I know that she gets picked up for transportation. She has relationships with CHRs. They remind her of all of her upcoming screenings that are due, and they stay with her the whole time and bring her home. And I appreciate that somebody's taking care of my mom. So that's my driving factor*" (KII 3). The AIAN cultural value of caring for elders is recast among many of the participants as benefiting the CHR as much if not more than the elders in their care, "*I was really raised to respect our elders, hold the door for the elders, care for your elders. And so, I've just always had a compassion of wanting to care for the elder; the rewards I receive at the end of the day of helping our elders, our people, tribal elders as much as I can*" (KII 8). Another participant mentions the unique benefits received in working with and being proximal to elders, including learning about culture, and obtaining wisdom - *"[elders say] Ask these questions now because you're not going to know when we're gone." I know that's the toughest part. I think everyone needs to see an elder daily. And if you can't daily, at least twice a week to stay sane and to stay positive and for the future of our world we're living in"* (KII 13).

Cultural Role of CHR in AIAN Elder Care

A subtheme of the AIAN culture on elder care that emerged is the cultural role of CHR in AIAN elder care - "*It was about coming to a place where I belonged and that I would be able to use myself in the way I saw that I was most useful… Allowing us to take care of our own elders or taking care of my own grandmother allowed me to see that their comfort level wasn't there, that there wasn't that concern about are they going to be made fun of? It's not even just an ego thing, it's just a feeling overall that you don't matter…I have aunties too […] they go to different clinics, but I talk to them a lot and I think that what you get from them too is a sense of pride. They were proud of me to come here and to do this, to help other elders and other people in our*

community" (KII 6). This perspective aligns with findings in the Arizona Community Health Representative Coalition 2020 report, mentioning the importance of employing CHRs from the AIAN community and shared by two study participants - "*CHRs working in Indian country generally like to be served by their own, someone who can relate, someone who can relate to their traditions and culture, someone who they can identify to, someone that looks like them, looks like the population that's being served....and they have a general sense for culture as it relates to elder population, and sensitivity training around how to properly engage and communicate and serve"* (KII 5), and, "*I could explain it the best, I think that in our community that if they know you or know of your people, that they're going to feel more comfortable in talking to you about what they're going through or their needs. And so it's like a connection. Even if they don't know your face, but they know your family or they know... They're obviously like, "Oh, so you're so-and-so, so I know your people." I feel like it does help being in this role because it's a familiar face that they know or a familiar family that they* know and that they're willing to and wanting to be around and communicate and get their needs met (KII 12).

Cultural Competency of the Healthcare Team

The second subtheme, the cultural competency of the healthcare team was identified as a critical factor by the participants for providing services to AIAN elders. Eight of the 14 participants shared their insights on this topic - "*I think that's really important to meet the cultural needs of lots of different groups…But for American Indian, Alaska Natives, I guess, in particular, because of just the long history of distrust that, unfortunately, the medical system has earned because of mistreatment over the years... so, I think CHR can play a big part in repairing some of that damage, building trust, and then being a voice coming from someone that has a similar background that looks like the people that they're working with"* (KII 1). In addition to the importance of cultural competency, one participant shared their perspective on how the lack of this skillset can negatively impact elder care, "*And then, the last one… cultural competency - Part of the training providers receive is don't work harder than the client. And if they feel that the client is really not working hard, they sometimes treat them differently, "Well, you don't care. So, I don't care," which to me is a bad attitude to have though*" (KII 2). As described, there may be a compelling argument for AIAN cultural competency provider training combined with elevating the CHR voice to neutralize potential insensitive proclivities or a lack of cultural knowledge a clinical provider or staff person may bring to an AIAN clinical setting. Two study participants touch on employing non-AIAN CHR and the importance of cultural competency with all employees - "*I get new employees, I'm always having to sit them down and just explain to them just as respect like when you go into somebody's house, you make sure that if an elder gives you something, you take it and you just respect them in their home. You don't go through their cupboard. I just really want people to know people's beliefs and respects before they start the job anywhere in [our clinic] or wherever it may be. But I just really think people need to be educated on the culture of people"* (KII 8). While challenges can occur with employees who lack cultural competency it is possible to gain needed competencies as shared by a non-AIAN participant, "*I'm not Native American, but I'm here and I respect the Native American, or any race for that matter, but here in particular Native American. Not everyone thinks the same way. There's different tribes and there's different ways of thinking. There's different ways of talking to them, different ways you may talk to one individual that's an elder as well that might be a little bit more serious or prideful. They may not say it, but just their body language to where, "Okay, I got this. I can do this myself." Maybe it's a matter of respect"* (KII 10).

5. Drivers of Optimal CHR AIAN Elder Care

In this study we aimed to better understand the conditions that support or detract from the CHR workforce delivering optimal care to AIAN elders. After exploring the CHR role, scope of work, setting, and the influence of AIAN culture on elder care practices, the focus turned to the perceived drivers and barriers to the CHR providing optimal care to AIAN elders. Two related themes emerged from the data. The first is individual level drivers of optimal CHR elder care and the second is external or structural level drivers of optimal CHR elder care.

Individual Level Drivers

Nine of the 14 study participants provided input on the individual level drivers of optimal elder care which centered on two types: 1) Hard skills (credentials, education, skills and training), and 2) Soft skills (dedication, engagement, being a "community" and "people" person). One participant, a CHR Manager/Supervisor mentioned the difficulty in striking a balance with CHR hard-skill development and over professionalizing the role - "*There's a difficult balance between requiring too much of certification and training and things like that because the people, at least the people that I think you want in those roles are people that can really relate to our patients; sometimes requiring too much certification or education or putting barriers to who can do the job, can get in the way of getting the best people in there. So, I don't want it to be overly professionalized"* (KII 1). While a supervisor might aim to strike a balance in CHR development, another participant, a CHR in a rural/suburban setting mentioned the value of having opportunities to pursue more education and training to advance their skills - "*What I like about here is they really do stress about education. So, since I've been here, I'm in an MA program through CRIHB at night; I'm also getting schooling here that's also supported through CRIHB, and [my tribal clinic] has its own training*" (KII 6). Another CHR, from a rural setting expressed the value of training as translating to improving their capabilities - "*They have this mental health first aid training that we've received, and that was really helpful. Maybe just kind of training on case management, what does that look like? And documentation, how do you document appointments… But training wise, I mean, anything. I'm open to all of it. Anything that can make me a better CHR, and I know my co-workers feel the same way"* (KII 3).

The other type of individual level drivers of optimal CHR care that was identified is soft skills or people skills. The US Department of Labor lists these as including but not limited to interpersonal communication, teamwork, enthusiasm, empathy, and collaboration (16). For the study participants dedication, engagement, love of elders and community, and being a "people person", were viewed as part of this skillset - "*This just comes to mind, the group of CHRs that we have are incredibly passionate about what they do, and they're very dedicated to our elders and to our population in general"* (KII 7); and *"Being engaged and be a good listener because they're going to... If you don't listen, you don't know what the needs are… I can do more. I want to do more, be able to do more." … So, then I started to research community healthcare worker… Community is what grabbed my attention… what else can I do to improve myself not only as a person, as a professional, and within the community; I'm still learning. I'm still learning, so I'm excited [for] what's in front of me"* (KII 10).

External Level Drivers

The other subtheme identified as driving optimal CHR elder care centers on external drivers. Three study participants shared insights on these which include having access to a wide range of resources, technology

and tools, and technical assistance. Having access to resources was mentioned most often - "*Just knowing what agencies are out there, like [partners or] whatever resources are out there to help families. And then being able to access those resources and help the families actually go through the paperwork and gather the information that they need to give*" (KII 3). As shared by one participant, accessing resources is dependent upon having established, robust partnerships - "*And we talk to the other CHWs and the community to figure out or try to get the resource, the phone number information. Or go visit that particular place to be able to give that information to the client, to our elder, to our patient*" (KII 10). Resource access overlapped with technology and tools as external factors facilitating optimal CHR care, a specific example provided was a technology called a unified resource platform - *"For referral[s] that's called Unite Us. I love it. I mean it's such a really good platform… I mean there's so many resources on that platform from long-term care to financial system as well, utilities, food banks, housing, transportation"* (KII 10). Tools that create efficiencies in CHR tasks were also mentioned - "*I have a schedule now… which is very helpful because you're able to plug everyone in electronically. It's in the system versus having just a to-do list or a calendar, things of that sort. You have a schedule, and you plug them in as needed for whether it's a call, in person, or they walk in all the time; Step by step*" (KII 10). Finally, technical assistance and topic area experts that CHRs can access for support was also identified as an important external factor - "*We here at the clinic find it to be very useful, especially when there's subject matter experts who have invested in research, invested in training, vetted training, training aspects of how to better engage. That technical assistance, I think, is very useful for us*" (KII 5).

6. Barriers to Optimal CHR AIAN Elder Care

Barriers to optimal CHR AIAN elder care were identified by study participants lending a sobering portrayal of workplace challenges that CHRs face. As with the drivers, two types of barriers were described – those at individual and structural levels. Additionally, one subtheme emerged from the individual level data characterized as: *Tribal CHR Training Challenges.*

Individual Level Barriers

The individual level barriers identified by study participants are ascribed to CHR as well as elders in their care. For elders, an example is low technology literacy. Specifically, elders struggle with new communication technology and devices such as smart phones, virtual meeting spaces, and email, each of which are significant for accessing or delivering health services and resources - "*Let's say that we help them apply, an example, apply for Medi-Cal. And now the workers are reaching out to the elder client and they may not know how to... Okay, I know how to work an iPhone. You can email, you can do this, you can do that. There's so many things you can do. They may not know"* (KII 10). Examples of this barrier were shared by multiple participants - "*They get these phones and it's wonderful, but they don't know how to use them. And so I have several that say, yeah, "I had my phone on and nobody called me." And I said, "Well, I've been calling, I've been leaving messages, or your voicemail's not set up"* (KII 11). This type of barrier among elders can lack a good solution, as one participant stated - "*You can't say just Google it*" (KII 13)

For individual level barriers ascribed to CHR, a spectrum was identified from a lack of clarity of what resources are actually available - "*I'm finding that the more we dig into it, the more I realize more time is needed because not a lot of time has been put into some of these resources; but we haven't really used them to know what we can get out of it."* (KII 6), to length of time to obtain resources, "*we'll put something in for somebody and sometimes that person won't get that for two to three months*" (KII 8), to the potential

bureaucracies encountered, "*I don't know if red tape is the right term for this, but just to get some of those resources for our patients could be frustrating*" (KII 7). A group of participants echoed the need for a one stop-shop for resources, such as the Unite Us platform mentioned previously - "*going out into the community and finding resources for our patients, I would absolutely say it can be challenging given that there's not a one hub that you go to and all these resources are in there. You've got to kind of dig around a little bit and make those connections at different community partners"* (KII 7), and - *"we learned little resources here and there that help with one item, but what about the wraparound? What about the whole person?"* (KII 11). A related but variation on this issue was mentioned by another participant - "*it seems to be the same route that the individual would go on themselves. And I want to know, is there a back door? Like, how can we do a provider referral?"* (KII 11).

In other sections of this study, certain participants mentioned an abundance of patient resources they are able to access. Here, other participants present starkly different circumstances characterized by resource scarcity and more closely reflecting data on the SES status of AIAN elders (17, 18, 19, 20) – "*And the housing thing, I just keep going back to that because we have so many that call and say, "I'm native and I'm a patient. Are you able to help me with housing? I have nowhere else to go*" (KII 11), and food insecurity - "*Finding the new resources has been challenging. Not all tribes help their elders in the sense if they're out of area or maybe they just don't have the funding. So, getting them in a place that's safe and warm to maintain their health has been a struggle for us. So, it's been that, and the food has been really huge. Sometimes they qualify for $23 a month of food stamps, which as we all know, that's a meal"* (KII 11). Finally, one individual level barrier mentioned was described as an acute or baseline need for the CHR team - *"Okay, let's do an action plan. What are the top priorities for our elders". I think that that's actually a big piece that's missing is somebody that can really do that community-based action planning and really make sure the voice of the elders is being incorporated in whatever's getting developed. "This is an acuity need.*" (KII 9).

Individual Level Barriers – Tribal CHR Training Challenges

One subtheme, Tribal CHR training challenges, emerged from the individual level barrier data. Twelve of the 14 participants mentioned training barriers in terms of lacking guidance on appropriate tribal CHR training options, training gaps, or fit/relevance of training (e.g. rural setting, tribal specific, etc.) - "*if you want to train a nurse, there's a real specific way that you get it done. And I think sometimes that can be limiting. But with CHW/CHR Promotora right now, there's stuff all over the place. And it's really hard to figure out what's the best one, what's the best training for someone that works in my setting, that works in the way that we're going to be able to? And then, if we want to expand* on things, *where do we go to teach them that and then to get them more what they need?"* (KII 1). In one case, the participant described this issue as creating new CHR hire administrative and onboarding burdens - "*We have to then analyze each staff member that we hire into that position and find out what they don't know, and then develop them more in the area. So it's, in a sense, tailor-train per the individual in there to really offer what we offer*" (KII 2). The potential for Tribal CHR training misalignment is illustrated by a CHR from a rural setting - "*I actually went and did the CHR training through the GRID program. And to be honest, it was really, really hard for me because the questions and the scenarios were really about more of city life. "If you want to run down to Rite-Aid to get someone's medication,"… I almost didn't pass because it was really hard for me to put my mind out to try to figure out the scenarios*" (KII 8).

In addition to describing training challenges, study participants suggested training options they viewed as essential to CHR work, leading to a sizable list of topics, including AIAN culture and cultural healing practices,

assessments, cultural competency, documenting in EHR systems, elder care, HIPAA and confidentiality, historical trauma, home visiting, injury prevention, medical assisting, organizational and time management skill building, and trauma informed care. Of these, two topics - elder care and AIAN culture and health were mentioned most frequently. For elder care, several options were recommended - "*Tai Chi, so basic slow moves; working on the evidence-based programs like I talked about, the Timed Up & Go; medication, how to store medication, those kind of things; Injury Prevention, Levels 1, 2, 3… to integrating basic injury evidence-based programs into elder care… how to set up a room for an elder for falls, making sure that rugs are moved and cords are out of the way"* (KII 14). Regarding AIAN cultural training recommendations, again a range was offered - *"training from the historical traumas, but also how we approach our learning, how we approach our health, how we approach storytelling, music, our ceremonies"* (KII 4). Finally, on the job training was also mentioned as a learning approach - "*We just had to kind of learn while we went. No elder care. And I had all my public health nurses over the years that were my bosses or my supervisors. I just kind of went with them and learned as I went*" (KII 8).

Structural Level Barriers

Eleven of the 14 participants provided feedback on the theme of structural level barriers CHR encounter in providing optimal elder care. The first of these centers on workload, time demands, and perceptions of insufficient CHR staffing to meet the patient population's needs. The workload demands, whether expressed as stemming from staffing insufficiencies, too many cases, or time constraints, were experienced across the whole participant group. Participants shared a sense of being overwhelmed, discouraged, or disheartened resulting from these types of barriers - "*if you saw this clinic, you would see it filled to the brim with people here… there's really only three reps and our nurse and what we're doing every day is prioritizing, but we need more people… Well, first of all, it's time. I don't have the time necessarily in one day to do as much, so sometimes I'm not able to do it or find another way that I won't be able to go out there and help them"* (KII 6). Participant six lamented over the impact of CHR workload demands on patient care, and carried the burden of not being able to mitigate the effects - "*What's going to hurt is that sometimes not be able to spend enough time with somebody and feeling like you're going to be just jumping from one to the next, and if you do that for too often, for too long, you're not putting in good work no more. To them, it's just surface level attention, and then it doesn't really mean you're really doing anything of quality; And that's actually being able to provide that, if we don't do that, it's just going to seem like we're just paying lip service to people and not really having any effect. I think that's probably the pressure that we feel most than anything, and then trying to do that as quick as possible and move on to the next one because you want to try to help as many as possible"* (KII 6). This perspective was shared among participants - "*I think the sheer volume that CHRs see a day would definitely be one of the biggest barriers, just because some of our patients require some additional case management"* (KII 7), and "*I feel like there's never enough hours in the day. There's never a day that we're sitting here, like, "What are we going to do today?" I mean, I get here at 7:00 and I hit the floor running…I would say lack of staff always comes into... I feel like there's always more need than what we're able to provide"* (KII 11). Finally, concerns for losing team members due to workload pressures was also shared - "*I would definitely say more workers, more employees, and definitely more incentives; we need to have more people hired to help with a lot of these services so our elders can get a hundred percent care what they need; we have a lot of turnover*". (KII 8). Staffing shortages, excessive workload, and time demands characterized study participant experiences whether they were located in a rural, suburban, or urban tribal setting.

A second structural level barrier identified by study participants is pay inequities and low pay. This barrier was viewed as contributing to difficulties in retaining CHR staff - "*I don't think [CHRs] and workers get paid a ton. I know I don't. And so we don't get to hang on to people that long, because it's kind of a stepping stone for something different, or just temporary so that they can go to school, or whatever it is that they're doing. So, I think if the pay were a little bit better, we might have more sustainability* (KII 3). Low pay is further described as an accepted albeit untenable workplace norm - "*I've become content with less, is that there's a lot of needs here where people have to work two jobs to make it. So, they have this and then they go to another part-time job or something to make ends meet; I hear that over and over again, but after a while you get burnt out because you're just working so hard to do the good work* (KII 6). Perceptions of pay inequity was also shared – rooted in timing of hire, lack of consideration of seniority, or fairness - "*Everybody who's getting hired is coming in and making what I've been trying to make, I've made, for the last... It's taken me, however, many years to get where I'm at. It's like, "Oh, gosh. Oh, you make that much. Okay" But that's just how life goes* (KII 3).

Managers/directors shared a different perspective on the CHR pay problems, instead pointing to structural contributors - "*Right now, what we're finding is that if you look at the pay grade for a community CHR funding is always very limited…They're definitely working. I feel like they're over leveraged because they do so much awesome work, but the pay is just not enough"* (KII 5). The low pay issue combined with high work demands was identified as frustrating CHR recruitment - "*I have a hard time getting people hired because of the wages are the lowest and how much we do for our people and also our resources is really hard to get the help and the funding"* (KII 8).

A third structural barrier was identified and described as challenges with funding for CHR services. The first two barriers, low pay and pay inequities were seen as rooted in this funding barrier. Nine participants describe a lack of funding, funding constraints, unwieldy billing and compliance requirements, and unsustainably low reimbursement levels for CHR services. Observations shared include funding inequities starting at the federal government level - "*There's limited resources. And it's unfortunate, of course, California is disproportionately... Natives in California don't receive the same amount of funding that natives from other states receive, and nor the natives under the program such as [urban organization] and other Indian organizations don't receive the same amount of funding allocation as those who receive like Medi-Cal and Medicare receive; you're automatically don't have enough to give them what they need, and you're forced to try to find other means to deliver the services that they need, which is a barrier*" (KII 2). One participant provided insights on grant funding constraints that limit CHR services to specific. predefined and approved services instead of identified needs - "*regarding the deliverables of their funding definitely impacts because you can't operate a staff outside of their funding. If they're only funded for certain things, and I can't leverage them to work outside of that because that's not what I'm getting the funding from my funder for though… There's lots of opportunities for them to do a lot more than what they're doing, but they can't because of the funding limitations*" (KII 2). Finally, billing requirements and low the CHR service reimbursement level were described as a facet of this barrier - "*Just some of the rules around them and what can be billed for and what can't. I don't think it recognizes the full breadth of what CHRs can contribute. So, I think actually getting sort full compensation for the services they're providing is going to be difficult*" (KII 1), and furthermore, "*I think the biggest gap that we're measuring right now is the reimbursement of the services that they provide… When we think of expansion and capacity building and workforce support, we cannot be sustainable without that reimbursement*" (KII 5).

Ultimately, sustaining CHR positions was viewed as tenuous when the funding is variable, too constricted, or too complicated to navigate, making it more difficult to ease structural barriers mentioned by the participants (understaffing, workload, low pay), "*There comes a limit where if I can't sustain a position, there's not a real clear path of how I'm going to sustain a position, I can't hire another CHR until I know that we get this billing thing figured out so that I know that we can afford them long-term… we're not currently billing and we're not currently getting the funding for the services in the way that we hope to in the future. "how much we can dedicate to that program is dependent on how much we're getting reimbursed for it, how much we can allocate for it. So, I feel like we take pride in giving our staff what they need to do to do their jobs, but that's always limited by funding*" (KII 1).

7. Organizational Support for CHR Role

A topic explored in this study is how Tribal CHRs view the support they receive from their organizations. Data for this theme was derived from a question about support received, by who, and what factors impact (worsen/ improve) the CHR role. Eleven of the 14 participants provided feedback on this topic.

CHR support was described by study participants in multiple ways, one example centered on the evolution of the CHR role within the health professions - "*I'm very excited that they're getting more recognition as a specific discipline and a profession that can do really important meaningful work, because I think that the skill set, the focus, their ability to work out in the community, to build trust with patients in ways that are different than anyone else can, I just think that they can offer services to patients that really fit that focus of keeping people healthy, also helping them heal when they're sick, also helping them manage chronic diseases, but can really get in into a community and help raise awareness for preventative care, connect them to our clinics early, help identify the barriers and things that are getting in their way of them meeting their own health goals; I just think it's a huge opportunity, and I'm very happy that it's being more recognized professionally*" (KII 1). This sense of being recognized and acknowledged for their contributions to the healthcare team was generally echoed among the participants, for example a CHR supervisor/manager from an urban setting stated, *"The community healthcare worker role is something that all organizations have a unique need for what they need. And [are] still figuring out the best way to leverage its community healthcare workers. For QI, QA purposes obviously as well though, is to better improve our referral process and follow up process, and the care that we give our clients. And if we're getting... And it's good feedback for us too, especially referring to an organization, what's your experience with that organization?"* (KII 2).

Organizational leadership was identified as a critical factor in setting the standards and norms for supporting the CHR role - "*We have the support of the people upstairs. When I say the people upstairs, it's the administration, the officers, that they really see this as an important part…That's one thing I like about community health, is that they ask us for our opinion and our input. They want the Native face to be here and they want us to have that connection too with our elders and talking with everybody in our community and seeing how we can bring our resources together, but also to express our needs*" (KII 6). Tribal leadership was also highlighted as critical since tribal clinic leadership is often composed of elected tribal officials and community leaders.

However, a participant also shared the potential tension that can occur when leadership is non-AIAN and/or lacks knowledge of culture and history, including the value of the CHR role, "*The executive director is tribal, the previous executive director's tribal in a tribal organization where the executive directors and all of management*

were not tribal. And the first thing they... Like, "Why do we have outreach departments? Why do we have CHRs?" …Completely understand even 20 years in only that I absolutely see it and that it's the board and leadership and the tribal community who say, "These departments in these positions are very important and we want them to grow" (KII 9).

Support from managers/directors was also described as critical, particularly for professional growth, "*My boss was throwing me out there to the meetings and getting involved with the community… And that's how I learned… and then going to these meetings networking with other people*", as well as managers being accessible and responsive to CHR needs - *"Anything that I may have a question on, or I may not think I don't have the resource or whatever that may be, my superiors, my manager, our CEO, everyone is like an open-door, open-door policy. Whatever you need, sure, let's figure out"* (KII 10).

Having the support of providers was also mentioned - *"I feel like we're supported as a team. The doctors communicate what they need from us, the nurses too, or whoever needs more support. We're able to all go together and say, "Hey, this is our objective. How can we all help each other to get it done or to support whatever we need to support?" (KII 12), and "Sometimes there's questions, but she has no problem answering and explaining… I think we all work together and they back us up and they agree with a lot of things and it's a lot of help. I know that what we do for the nurses and the doctors cause we're like that middleman to bring in"* (KII 13).

Examples were also provided on how CHR work is supported via teaming with managers, "*So I can do a list of all of our elders that we actively see in the organization. And I run and update that list twice a year. And I sit with our CHRs…. Using Case Management to Provide Elder Care. At least twice a year do an acuity scale of who are the ones that really when we can do it, we get out there to see them"* (KII 9) and tracking productivity in a formal manner - "*We use their program here. And so those codes as a CHR when you write a note completely tells you 10 different things that we've dealt with. Diabetes, hypertension, out in the community, educating about diabetes. It gives you a whole big template of what we've done that week. And so I would really be... It'd be nice if we would be able to get that back into our clinic where it can completely show what we do on a daily basis with those CHR* (KII 8).

In addition to the organizational supports insights on gaps in support were also identified by the study participants. Five of the 14 participants provided examples of gaps beginning with a lack of respect and inclusion as part of the healthcare team - "*Just not having other departments work with you… I've seen it where it was like we didn't have any support from anybody*" (KII 3). The lack of respect was also described, in terms of disrupting CHR workflows with unexpected asks - *"There's a last-minute training that's, okay, we needed to have a mandatory training or something. It's like well, I already set up a time. I have to call this individual to maybe set it up a little... Not that I can't do it, but a little later. Sometimes that happens because things have changed"* (KII 10). Not being valued or respected was reflected in how the CHR perceives their role within and to the organization - "*CHRs are so important," and that was the only person that ever said that to me. We are treated really low around... We just don't get no respect here. It's very hard. I'm sorry, I got to be honest as CHRs… I think we're just kind of on the back burner and we don't get as much respect as somebody that does have a certificate because I'm always hearing like, "Oh, CHRs don't really have certificates, they don't really have this, they don't really have that"* (KII 8). Being minimized by providers was mentioned as another facet of being devalued or demeaned - *"Our providers are supportive to the point that they can see that it helps them and sometimes, they don't see it all*" (KII 9). The description of the support

gaps was followed by recommendations for managers/directors and non-AIAN staff training - "*I think also good training for a PHN supervisor like how you work with tribal staff. Most PHNs, most nursing folk aren't from the community"* (KII 9). The same suggestion was made for tribal clinic executive leadership - "*CEOs and the CFOs, they go through all these conferences within Indian country and to know how to run the clinic… they need to be really educated on CHRs because that is definitely something that gets missed on within everywhere that we go*" (KII 8).

One final insight detailed the reasons for elevating and supporting tribal CHRs - "*Our CHRs need to be part of that team care and team approach because they have direct access to the knowledge, they know what's going on in the community, and they're that second set of ears for our elders, and our community, period. … [they] should be valued as much as the doctor, the cardiologist, the nurse because they have direct knowledge and experience*" (KII 14).

8. CHR Workforce Characteristics

Background and Motivation for Choosing a CHR Role

To better understand why a person chooses employment as a CHR and the characteristics comprising the CHR profile, study participants were asked to expand on their work and personal backgrounds. Two distinct pathways and motivating factors to employment emerged between participants who are CHRs versus managers/directors. This distinction occurs with the study participants as either motivation rooted in family and community versus assessing professional aims and then identifying the best employment fit for those aims. While distinctly different both pathways demonstrate personal factors grounded in helping people. For example, a CHR expresses their reasons as - "*I wanted to try to adapt what I had learned from my previous work and use it to the benefit of my family and friends and my community"* (KII 6), compared to a manager/director - *"My career as a nurse has been focused on trying to keep people out of the hospital. I mean, really, that's something that I learned really early on, is I didn't want to work in a hospital. I wanted to do work that kept people from getting sick; public health has always been really interesting to me"* (KII 1).

Community and cultural motivating factors shared were nearly uniform across the entire study participants - "*it's an organization and a field that I think you can make a direct impact on your own community; just knowing the fact that I really am making a difference in people that would otherwise not get medical care, that's something that's very, very important to me*" (KII 7). In addition, CHR shared being attracted to the field specifically to support elders - "*And I love it, because it's so rewarding and it's such a blessing to know that I respect them and they respect me and I'm here for them. It doesn't even feel like a job. It just feels like I'm just here to care for the elders and I just really, really, really am blessed to have this job and to do what I do; I like going into the homes, I like being out on the field. I'm just not a clinical person"* (KII 8).

Among CHR participants from both rural and urban areas, the characteristic that stood out most was having a personal background rooted in the AIAN cultural context of taking care of elders - "*I got into this because of what my experiences that I've been through, which I think that I'm very passionate about. Just have a very good understanding of what they go through because my parents are elders. And so, with all that, you connect it all together, and I think that's what grounds our community healthcare workers because of their experiences. Are you able to assist and want to help and whatever they might need?... you're able to do that and much more"* (KII 10).

Being exposed to the health professions while growing up in a tribal community e.g. seeing AIAN health professionals and having a connection to the clinic as a community asset was mentioned as an important factor in choosing CHR work - "*I love working with this community. This is where I grew up. My grandma was a nurse here, one of the first nurses when the clinic opened here; I've actually even had my... My first shot as an infant and were here at [this clinic]. I wanted to do more outside and kind of help the patients or the Native community with things in their everyday life. These things made it hard for you to get to the doctor. And when I realized that was actually a job that I could do, I just fell for it"* (KII 11), and - "*My grandmother and my aunt, they were doctors and my grandma went to nursing school, so I kind of learned different things growing up and stuff"* (KII 13).

Tribal CHR Job Preparation

Ten of the 14 participants discussed the education, preparation and work experience they had completed prior to pursuing their current role - with high variability across the group. Five participants representing four tribal clinics mentioned valuing certification or credentialing with two specifying the training completed - "*GRID program"* (KII 8) and the "*IHS Fellowship"* (KII 14). One participant characterized the CHR status in their organization as - "*they are certified community healthcare workers now"* and indicated that one *"will be an LVN"* (KII 2). The labeling of CHR and CHW implies that the CHR affiliated with KII 2 have completed CHW training and certification. Others mentioned entering the position through internal promotions or lateral opportunities - "*at the time I was working as a medical receptionist just to get my foot in the door because there weren't any medical assistant positions open. And I was approached by the site manager and the lead doctor, asking if I could kind of grow a department community health and outreach. And it just kind of took off from there. And then my title changed many times, and finally they landed on community health and outreach representative… I've been offered many different positions and interviews and places to go, but myself, I'm Native American, and it's just my passion to work with my people. And the integrity, and the gratitude that I receive at the end of each day, I know that I've touched lives. And so, I don't really have a huge desire to go anywhere else. I just love it"* (KII 3). Another participant mentions having worked their way up in healthcare settings to obtain a CHR role - "*first started working in the medical field… as a receptionist… [and then] went to an Promotora. I wanted to get more involved in the community*".

Overall, in response to the background questions the participants focused more on the training and preparation available to CHRs once in the position or in terms of future aspirations - *"[It] incorporates a lot of different aspects of culturally sensitive care. And I think it gets into basic patient education, advocacy, motivational interviewing, goal setting, some of those things…I talked a little bit about some of the additional training that we added on top of that. that's actually an area where I feel like we... and something that we're working on... It's just been an unstructured program for a long time. And like I said, I don't want to make it too structured, but I do want to give people the tools and the training that they need to do the work*" (KII 1).

Professional Growth and Development

In exploring the career paths of the participants in this study, professional growth and development concerns were raised by 8 of the 14 study participants, unsolicited. This topic was not part of the background questions posed to the participants; however, its importance emerges via the spectrum of insights communicated. The first of these is a perceived lack of CHR opportunity for advancement expressed by a manager/director - *"What I think we'll have to work on over time is, when you're a CHR, there's not a whole lot of places to grow and to*

go from there" (KII 1). The second concern mentioned by another manager/director centers on the limits of the CHR scope of services - "*it's not necessarily just their education because there are some issues. You can train people in a lot of different things, but what they're able to do, like our medical departments are not providers; So, they don't have that ability, that credential to be able to deliver some types of services that if they had that knowledge and they had that education would streamline a lot of things though, although it's not the function of their job"* (KII 2). A third manager/director provided additional insights on their perceived limits of CHR functions - "*They're really the peer-to-peer services and so they're limited in terms of how they can engage. Like a CHR could not provide a flu shot… [they] can provide entry levels of care, basic levels of care…more can be delivered if the CHRs didn't have limited capacity in terms of what they can do… So, the non-licensed care is something that they have to tread very carefully*" (KII 5).

The CHR scope limitations whether perceived or actual appear to impact morale and job-related wellness, posing an unstated threat to their job security - "*we definitely need to have more trainings and more education out there and more of somebody that's our [manager] or somebody that's our main person to keep us all moving along. Because, to be honest, I think we all just get burnout. I feel like we're always having to fight for our position*" (KII 8). Other CHR in the study offered suggestions for energizing the CHR role while complying with scope of work parameters - "*any sort of data collection that you can train our CHRs on is important because you all know that in Indian Country that we do not have the data… misclassification is always happening, but our CHRs, they know how to do this. And getting those things back into their scope of work, compensating them for that, and training them on that, building their capacity"* (KII 14) and, "*sometimes there's this thought that CHRs are going to be doing what nurses do without necessarily the training on how to do it [but] now moving into that community advocacy and health navigation and health education and community development kinds of work, which is what's in my heart. I see that for some of our folks in the CHR role, it's also like them stepping into this natural leadership position that many of them have without knowing it*" (KII 9).

9. COVID-19 Impact on CHR Services

The final topic explored in this study and the theme that emerged is the impact of COVID-19 on CHR services to AIAN elders. Contained in this theme are lessons learned and changes to the CHR role resulting from the pandemic. Of the 14 participants, four shared that the pandemic substantively affected elder services, primarily due to staffing shortages and difficulties in hiring - "*We had one CHR during the peak of COVID, but when they got the CHR [certification], they weren't here very much longer, they left"* (KII 2). Additional challenges identified include alterations in services delivered to protect staff and patients - *"[We] still provided transportation services. But even then we put up shields in our vehicles to protect our staff and our clients to create that barrier… [but] you had clients that didn't want people in their home. They didn't want COVID. They were afraid… and we had to protect our employees as well*" (KII 2). The scale and magnitude of the pandemic led to closures and a need to reprioritize services - "*It changed a lot during COVID and honestly, we were pretty new in our department, so immediately everything we were working on kind of halted and we became the frontline. Everything just went outside… Almost half of our clinic was sent home. And so really it was the frontline staff, which was like the medical"* (KII 11). The effect of COVID-19 related service alterations on elders is described in terms of the isolation they experience but also their fear of exposure - "*But I just feel like it was a lot of isolation for them and a lot of struggles getting the everyday products, the needs, the food, the medications… all those things became very hard for them to get. And some were very scared to come out of their homes as well* (KII 11). The challenge of trying to switch elders to virtual support as a way to provide

services while reducing exposure was identified - **"***It was really hard to get our elders involved with the different classes that we totally went virtual. And then just trying to help them get on board with Zoom meetings, and just technical equipment in general… So then it was kind of like me trying to learn so that I could teach them. And then how can I do that over the phone if I just do a drop-off of an iPad?"* (KII 3).

Six of the 14 participants shared COVID-19 experiences that did not entail full clinic closures but required rethinking ways to reach elders - "*We had to completely adjust the way that we cared for people. And we used our [CHRs], to try to reach the people that weren't necessarily trying to reach us",* and - *"So, we were getting phone calls and we were getting people that needed things, and we were doing telehealth visits and seeing people over the phone, but we knew we had a lot of folks out there that just maybe needed something and just didn't know how to ask for it"* (KII 1). Participant 1 goes on to describe the clinic's plan specifically to track and support elders - *"actually, we did, specifically, an elder outreach program where we basically made a list of all of our elder patients. And [a CHR] called them just to check in on them, just to see how they were doing and to see if there's anything that we could get them, and to help them be seen in ways that were safe for the time, but that also could meet their needs to the best of their ability* (KII 1). A second participant describes ramping up elder services - "*Our services never stopped. We were testing our elders out in the homes. We gowned up and wore masks and protected. We were a hundred percent protected, but our services never stopped. We still [were] able to go there and test them, take them their food, make sure that wood in a fireplace* (KII 8). And a third participant describes ramping up services for home bound patients - "*I just had the one CHR then and we [...] took over all of the case... We helped to support people stay on isolation and quarantine by delivering food and medications… phone calls by this time of the day," and then would go do the shopping and then deliver to households that needed stuff and was very integral, integral and all of that, helping people stay home and knowing where people were* (KII 9). Finally, a participant from a rural setting describes their organization's service delivery plan - *"still provid[ing] service, regardless of whatever it was. They were not set aside or neglected or anything. We did everything we still could, but for them to come, people just didn't go anywhere* (KII 13).

Discussion

This study resulted in a total of 9 themes emerging from participant interviews that shed light on perceived strengths and challenges characterizing this group of tribal CHR employment experiences:

1) Community Health Representative (CHR) Role & Services
2) Tribal Home Care Settings
3) Social Determinants of Health (SDOH) Impacting AIAN Elders
4) AIAN Culture in Elder Care Practices
5) Drivers of Optimal CHR Elder Care
6) Barriers to Optimal CHR Elder Care
7) Organization Support for the CHR Workforce
8) The Tribal CHR Workforce Characteristics
9) COVID-19 Impact on CHR Services

The themes, as a group convey insightful, thoughtful and important concepts for the context of providing care for AIAN elders in tribal settings. Some of these concepts warrant consideration and strategic planning for addressing much needed structural changes to improve CHR work conditions. Certain concepts can inform near term action and feasible alterations to the CHR work environment to appropriately support, sustain and develop this vital part of the health care team.

Of the 9 themes, a group of four, together (1, 2, 4, 5), stand out as demonstrating the anchoring of the CHR role to AIAN culture, history, and social political structures. As published on the IHS website the advent, integration, and continued growth of the CHR role within Tribal healthcare systems reflect the federal government's fiduciary responsibility to provide health services to tribes via treaties, congressional acts, and judicial action (1, 9, 21). The CHR program responds to the identified need for a community derived role that bridges geographical, provider, and cultural gaps that all too frequently characterize tribal settings (22).

Critically, this group of themes also reflects the importance of AIAN culture in elder care delivery. Historically, implementation of the CHR role meant that elder services were delivered by CHR from the Tribal community. By definition CHR services were imbued with and informed by cultural values and tenets. The importance of culture and having a CHR workforce that are community and culturally grounded is evidenced in the Community Health Representative Workforce Assessment (Phase II): A Report to the Arizona Advisory Council on Indian Health Care in Collaboration with the Arizona Community Health Representative Coalition who states that – "CHRs provide a vital link between the health care system and the community, promoting social and cultural cohesion through their role as linguistic and cultural liaisons. The CHR SOW includes language services, which encompasses interpretation during medical appointments, translation of medical documents (applications, discharge orders, etc.), and generally facilitating patient understanding of the health system" (4).

IHS reports similar foundational language regarding the CHR functions and has a Tribal CHR training program to support the role. Despite the IHS emphasis on providing culturally based training, questions remain, as captured in this study about whether the IHS training programs are:

1) Comprehensiveness and equivalent in quality to CHW training programs,
2) Keeping pace with tribal community patient needs,
3) Packaged to align with funder billing/reimbursement requirements,
4) Sufficiently standardized but also tailorable to various AIAN regions and include modules for managers/directors,
5) Sufficiently preparing CHR for delivering optimal elder care in settings where profound SDOH that have multi-detrimental impacts and exacerbate health elder care needs.

Many aspects of CHR work as conveyed in this study and derived from Themes 2 and 3 - reflect entrenched health service delivery inequities, and structural and political determinants that result in or exacerbate AIAN health disparities. Most of the examples shared are driven in large part by inadequate health care funding levels resulting in limits to care, workforce shortages, and underdeveloped tribal public health infrastructure as documented, for example, by DHHS Assistant Secretary Planning & Evaluation (ASPE), Office of Policy 2022

report and others (14, 15, 17, 18, 20, 21, 22). Health care funding inequities create significant structural barriers for addressing service gaps related to:

1) Transportation
2) Specialty care
3) Home based elder care
4) SDOH (housing and food insecurity, poverty reduction, health technology connectivity and literacy)
5) CHR pay inequities and low pay

In addition to structural health care inequities driven by funding limitations, a majority of participants also shared examples in Theme 2, of the ongoing structural problem with racism, discrimination, and myths held by county health systems and jurisdictions about the funding that tribes and tribal health systems enjoy. The key takeaway from Theme 2, is that more cross-jurisdictional work needs to be done to address the harms and residual problems related to historical trauma but permeating current contexts.

One other key takeaway, noted here was also derived from Theme 7, which demonstrated the impact of various forms of support or lack of support for the CHR role. These include treating the CHR as a valued and respected member of the health team, acknowledgement and visibility with executive leadership, support and collaboration with managers, and managers having perspective on the CHR work demands. Each of these forms of support have a high-level impact on CHR morale.

Recommendations

A total of 10 recommendations were identified to support the Tribal CHR workforce in two dimensions, one is internal to tribal systems and the other is external or outside of Tribal systems.

Recommendations: Internal to Tribal Systems:

1) Incorporate Indian preference in CHR hiring and/or ensure completion of appropriate cultural training with onboarding; all staff receive cultural training
2) Incorporate staff/leadership training to raise awareness of the value of CHR role
3) Require inclusion of the CHR team members in healthcare teaming, planning and decision making, and integrate with whole person care models
4) Assess elder care population needs including analysis of SDOH, development elder care, management plan, and identify CHR training aligned with assessment/plan to bridge skills gaps
5) Identify ways to optimize efficiencies in CHR tasks and workloads via technology, tools, and policies such as a unified resource tool “Unite Us” platform (23) described in this study, scheduling tools, assessment of CHR workflow to streamline and policies minimizing workflow disruptions
6) Advocate for CHR parity in pay with CHW scales with funder/funding sources

Recommendations: External to Tribal Systems:

7) Identify approaches for local health agency(ies) and systems, including cross-jurisdictional and tribal cultural competency training to ensure government staff is knowledgeable of myths versus facts regarding tribes in their jurisdictions
8) Educate local health agency(ies) and system(s) staff of legal obligations to AIAN county residents
9) Improve linkages with Tribal partners to resources that support AIAN community health and wellbeing (housing, food, basic needs)
10) Explore potential advocacy approaches with CHR services funders such as grants agencies, Medi-Cal Managed Care plans, and CAL-AIM to increase reimbursement for CHR services

Limitations

The limitations of this study include the lack of representation from tribal participants nationally, e.g. from other regions, the sample being restricted to California tribes, small sample size, and reliance on the snowball sampling method given the relational basis in Indian Country for accessing and recruiting tribal contacts. However, accessing even a limited number of Tribal CHR workforce can be considered appropriate for a qualitative study where the goal was centering and elevating the Tribal CHR voice as distinguished from analogous workforce positions such as CHW. Moreover, as mentioned previously, the qualitative approach is appropriate for the AIAN CHR given the cultural norms and preferences that enable indigenous ways of knowing, “include[ing] individual and oral histories and interviews with program participants and key informants … as a means to engage reflective dialogue” (9).

The data provided by the participants represents large regions of California. Notably, according to the 2020 US Census, California is home to the largest population of AIAN who identify as AIAN alone or in combination among all the states in the nation - 10.4% of the total AIAN population in the United States (22). California is also second only to Alaska with having the most federally recognized tribes located within the state (N=109) (22). Participants provided rich and expansive descriptions; we reached thematic saturation despite having only 14 participants. While each participant shared their excitement about participating in the study, as front-line staff they may have had hesitancy in discussing certain experiences deemed challenging, problematic, or complex as cultural tenets often require restraint when sharing information that may be characterized as criticism or complaints. That said, none of the participants expressed any concerns and many indicated an appreciation for a study focusing on the Tribal CHR workforce.

Conclusion

This research is relevant given the concerns with health equity among historically marginalized population groups such as AIAN elders and extends to those who provide culturally based home care – the Tribal CHR workforce. The pandemic produced many lessons including the need to take stock of the conditions of Tribal frontline workers as their importance increased by orders of magnitude during the pandemic as did the risk of burnout and losing this core part of the health care team (3, 22). Identifying systems level changes as well as local and internal adjustments that can improve and optimize the CHR work conditions and acknowledge their contributions, is of paramount importance as they are tasked, no less, than caring for our elders and future ancestors, the keepers of our cultural knowledge and memory.

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