Alaska

Community Health Aide Program

In Crisis

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for the

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INTRODUCTION

The purpose of this report is to acquaint Congressional members, their staff and other concerned individuals with the provision of health care services to rural Alaskan Natives, Alaska's Community Health Aide Program (CHAP) and the status of the Community Health Aide (CHA). The CHAP has been in existence for 30 years. Originating as a group of volunteers who distributed medication for a specific disease condition, the CHAs are now the foundation of health care in rural Alaska. Funding for the program has not kept pace with program change over time. As a result, dedicated, caring, underpaid CHAs are now providing health care to residents of rural Alaska in substandard clinic facilities.

We urge you to do the following:

1) acquaint yourself with the CHAP;
2) recognize the contributions the CHAs make in maintaining the health of the residents of 171 rural Alaskan communities;
3) commit to insuring that CHAP receives sufficient funding to provide a quality program inclusive of adequate training, support and supervision for the CHAs.

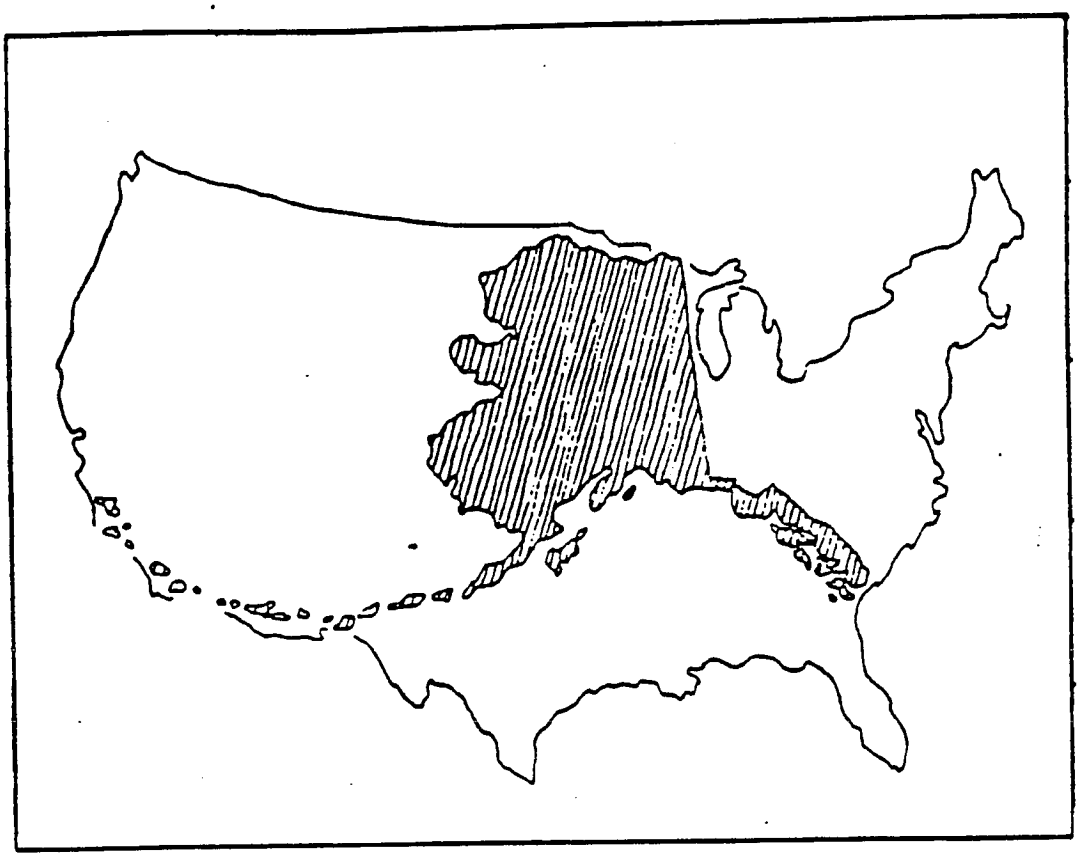
ALASKA - THE LAND AND THE PEOPLE

PHYSICAL CHARACTERISTICS

Alaska's extreme climate and geographic characteristics have a significant impact on the health of the population and the organization of the health care system. The harsh climate and terrain contribute heavily to the incidence of accidental injuries and death. The Arctic winter and darkness influence the behavioral health of the population. (State Health Plan for Alaska, 1984)

Alaska has a total land mass of 586,585 square miles and constitutes one-fifth the area of the United States. See Figure 1. There is a tremendous variation in climate and terrain, ranging from a mountainous maritime environment in Southeast Alaska to an arctic plain in the Arctic Slope area. There are four major climate zones: a temperate maritime climate in the southern coastal area; a continental climate in interior Alaska; a transitional climate in western Alaska and in the southcentral area north of the Pacific border mountain ranges; and, an arctic climate in the region north of the Brooks Range. (State Health Plan for Alaska, 1984)

FIGURE 1



Alaska - total land mass is one-fifth the United States

From: State Health Plan for Alaska, 1984.

TRANSPORTATION

The majority of villages in rural Alaska are isolated from each other, separated by tremendous distances, vast mountain ranges, stretches of tundra, glaciers, and impassable river systems. Most of the communities are not connected to a road system. Air transportation is the primary means of travel on a statewide basis. Provision of goods and services to this remote region is extremely difficult.

WEATHER BOUND WITH TWO CRITICAL PATIENTS

Weather conditions on the coast of northwest Alaska can be severe. High winds and blowing snow can close the airstrip for days. Such were the conditions when the CHA was called to see a patient who was having difficulty breathing. The patient had a collapsed lung. While caring for the patient, the CHA was called to the home of a woman who was six months pregnant and in labor. Both patients needed immediate medical treatment in a hospital setting. Severe cross winds prevented planes from landing. After four days of providing round-the-clock treatment, the CHA mobilized the village residents to create a snow-pack airstrip perpendicular to the existing runway. Unable to land in severe crosswinds, a plane was able to land with the wind. A plane arrived and transported the patients to the hospital 100 miles away. The patient with the collapsed lung eventually recovered and returned home. The young woman in premature labor was able to carry her child to term and delivered a healthy baby.

POPULATION CHARACTERISTICS

With a 1980 population of 480,481, the population density of Alaska was 0.68 persons per square mile as compared to a national population density of 64.0. Seventy-six percent of the population (365,000 people) live in three urban centers. Fifteen percent (72,000 people) live in sub-regional centers which are 400-700 miles from the urban centers and nine percent (42,722 people) live in 171 small villages located up to 1,300 miles from the nearest sub-regional center. Ninety percent of these villages are accessible only by aircraft.

The people living in the remote villages are primarily Alaskan Natives. Residents, by tradition and out of necessity, rely heavily on subsistence activities. Lacking an economic base, hunting, fishing, trapping and berry picking provide many of the basic necessities of life.

The population age distribution plays a large role in determining the health status and health service needs of a given population. National and State studies have correlated age to the prevalence of acute and chronic conditions as well as the utilization of health services. Children less than five years old and women in the child bearing years are high consumers of health care services. Older persons are likely to experience chronic conditions requiring contact with the health care system. This is true in the Alaskan Native population as shown in TABLE 1.

TABLE 1

Average Annual Alaskan Native Per Capita Visits for Health Services by Age Group and Gender*

Age Group	Male	Female
< 5 yrs	7.3	6.4
5-14 yrs	3.6	3.2
15-24 yrs	3.2	5.5
25-44 yrs	3.6	6.4
45-64 yrs	4.7	6.5
65 + yrs	6.4	6.8

* Source- U.S. Public Health Service, Health and Human Services, 1980.

In general the Native population has a relatively large percentage of youth (42.7% Native as opposed to 30.6% non-Native are 17 years of age or younger). In the age group 65 years or older Alaskan Natives account for 4.6% of the population as opposed to 2.6% non-Natives. (State Health Plan of Alaska, 1984) A high percentage of the population falls within the high user age groups. Eleven percent (7,054 people) are less than 5 years old and 22% (14,108 people) fall within the ages of 15-44 years old.

HEALTH STATUS - ALASKAN NATIVES

The health status of rural Alaskan Natives is related to poverty, rapid social change, the harsh climate and terrain, and the isolation of the communities in which they live. The accidental death rate among Alaskan Natives is 229 per 100,000 population compared to a national rate of 80 per 100,000 population. The suicide rate for Alaskan Native males 20-24 years old is 257 per 100,000, more than 20 times the national suicide rate. The incidence of tuberculosis among Alaskan Natives in 1985 was nearly 10 times the rate for the entire United States population.

The 1981 infant mortality rate for Alaskan Natives is 18.8 deaths per 1,000 live births compared with a non-native infant mortality rate of 8.24. (Alaska Department of Health and Social Services, 1987) Hepatitis B, otitis media, respiratory, and gastrointestinal disorders are a frequent cause of morbidity amongst Alaskan Natives.

THE COMMUNITY HEALTH AIDE PROGRAM (CHAP)

The CHAP is a unique system of health care designed to extend primary care services to the Alaskan Natives living in villages located great distances from the nearest traditional health care facility. In the United States this system of health care is found only in rural Alaska. Natives are hired by the Regional Health Corporations (PL-638 Contractors) from candidates chosen by the communities in which the CHA will serve. The CHAs begin their training in the delivery of health care services after they are hired.

Basic training consists of three training sessions, each lasting 3-4 weeks, and a two week preceptorship. For curriculum overview see Attachment 1. Training sessions are interspersed with several months of village clinical experience. Completion of training takes two to three years. Unlike other primary health care providers, CHAs carry the full responsibility for their position prior to completion of training.

Supervision is a very important component of any program. Supervisors ensure the quality of the product (in this case the quality of health care provided at the village level), monitor all aspects of job performance, and support and guide the worker.

Medical supervision is provided to CHAs through daily scheduled telephone or radio contact with hospital based physicians. The CHA presents pertinent information about the condition of the patients he or she has seen. The physician then advises the CHA on the appropriate treatment for each patient. An assigned physician visits the village clinic twice a year to provide direct services as well as observe the clinical skills of the CHA.

Overall job performance of the CHA is monitored by CHA Supervisors employed by the health corporations. The Supervisors ensure that corporation policies are implemented for these village based employees. Corporation Supervisors for CHAs provide supervision through field visits to village clinics and through daily to weekly telephone communications with the CHA. Supervisors monitor CHA job performance in all aspects and assist the CHA in achieving a high standard of performance. They support, teach and give guidance to CHAs, assist with problem resolution, provide moral support, and serve as a liaison for the medical system and the CHA, and the CHA and the village. The Supervisors work very closely with the local governing body in each village to ensure that CHAs receive support from within the village as well as from outside the village.

CHAs provide services in clinics leased by the village from the Indian Health Service (IHS). The Village Built Clinic Program was created to address the need for adequate health care facilities in Alaskan villages served by CHAs. The purpose of the program was to provide operational costs for clinics owned by villages or traditional councils.

HISTORY OF THE COMMUNITY HEALTH AIDE PROGRAM

The CHAP evolved in response to the need to extend medical care to Alaskan Natives living in rural Alaska. Before the end of World War II, there were few hospitals or health programs in Alaska. In 1955, the IHS assumed responsibility for the provision of health care to Alaskan Natives. Hospitals were established in nine population centers. These hospitals served those Natives living in the vicinity of the hospital but for the most part failed to reach those living in the many villages that the hospitals were intended to serve. Failure to reach the remote rural areas was most likely due to transportation limitations imposed by the geography of the region and vastness of the land. No road system connected the centers to the villages served. Therefore access to the service was limited.

The limitations of the hospital based system became very evident during the tuberculosis (TB) epidemic of the 1940's and 1950's. During the early years of the epidemic, large numbers of victims were sent out of the region for care in sanitariums. As medicines became available, an attempt was made to treat patients closer to home. Village volunteers monitored the administration of antitubercular medicine to patients in the village and served as intermediaries for the patient and physician. These volunteers were called "chemotherapy aides". (O'Hara - Devereaux, 1980)

The program successfully brought TB under control. The value of this village-based program was firmly established. These village-based volunteers were the predecessors of the CHAP. From 1955 to 1964 village health aides, most of them volunteers, began to take on more responsibility for a variety of health problems. In the past 20 years, the role of the CHA has evolved and expanded.

ROLES AND RESPONSIBILITIES OF THE CHA - 1988

The village clinic and the CHA are the focus of all health care in rural Alaskan villages. CHAs are the only health care providers residing in rural Alaskan villages. Currently, 171 villages with population ranges of 25-800 people are served by CHAs. The village CHA is the first level of contact with the health care delivery system for rural Alaskan Natives. CHAs maintain standard clinic hours five days per week and respond to medical emergencies 24 hours a day, 365 days per year.

The CHA examines and treats each patient according to protocols outlined in the Community Health Aide/Practitioner Manual* or as directed by the supervising physician via telephone or radio. Most patients are successfully treated by the CHA in the village. Serious or complicated cases are referred to the physician and transported to the nearest hospital if necessary. CHAs provide care to acutely ill patients, provide emergency care, perform prenatal care, well baby checks, immunizations, and other preventive activities. They work with numerous Federal, State, and local providers of services. They assist with the investigation and containment of infectious disease outbreaks. In addition, they manage the clinic pharmacy, supplies, equipment, and facility.

The CHAs have become an indispensable, important component of health care for rural Alaskan Natives. They ensure that basic primary care services are available, accessible, continuous, acceptable to the population, and cost effective. Although little known, the CHAP is one of the most successful models of integrated primary care in the world, particularly for regions or communities that are rural and remote. (O'Hara-Devereaux, 1980)

The importance of this program cannot be over-estimated. In FY '87 the CHAs had 208,501 patient visits. For rural Alaskan Natives the average cost of round trip transportation for a visit with the nearest physician is $175.00. Since the majority of patients exist below the federal poverty level, without the CHA, many Alaskan Natives would not have access to health care.

EMERGENCY

On a beautiful spring day, the CHA was taking care of family duties. Someone screamed and the CHA grabbed her medical bag and ran to a neighbor's house. A child had been bitten in the neck by a dog. The child was barely breathing due to a gash in her windpipe. Within a short time, the child's breathing was further impaired due to localized swelling. The CHA provided emergency treatment for 1 and 1/2 hours until an airplane arrived to transport the child to the closest hospital, 45 minutes air-time from the village. This experienced CHA was able to manage the localized swelling and keep the child alive until help arrived.

* Burgess, Robert, M.D. Community Health Aide/Practitioner Manual. U.S. Department of Health and Human Services, Alaska Area Native Health Service, U.S. Government Printing Office, Washington, 1987.

FUNDING FOR THE CHAP

Despite the extensive role in the rural health care delivery system, it wasn't until 1968 that the Federal government recognized the CHAP concept. In that year, Congress authorized funds to train and provide a salary for 185 CHAs working in 157 villages. In 1977, Congress authorized expansion of the CHAP to 205 positions in 171 villages. In 1988, Congress continues to recognize 205 positions as shown in TABLE 2.

TABLE 2

Community Health Aide to Village Ratio By Year

YEAR	RATIO CHA : VILLAGE
1968	1.2 : 1
1977	1.2 : 1
1988	1.2 : 1

Funding for the CHAP is based on Congressional recognition of positions; a set amount of dollars is granted per position. Since 1968 the responsibilities of CHAs have expanded greatly; training for CHAs has increased significantly (from 2 weeks to 12); the number of patient visits has risen sharply; and the Alaskan Native population has increased by 49%.* Officially the provider to village ratio has not changed at all in 20 years. Currently the Federal government funds the CHAP at $5,532,304. This level of funding is insufficient to sustain the CHAP.

In order to preserve the CHAP, the State of Alaska and the regional Native health corporations and local communities have implemented a crisis response strategy. The State contributes approximately $2,000,000 annually for the training and supervision of CHAs. Emergency funding provided by the corporations and local communities amounts to a 52% subsidy, based on the actual costs of operating the program in comparison to Congressional allocation. These emergency funds are obtained by re-programming dollars from other important health programs.

* This information is calculated from Rogers, 1971 and Alaska Department of Labor, 1987.

The impact of this subsidizing effort on health care services for Alaskan Natives is best understood in terms of the extreme underfunding for all Alaskan Natives and American Indian health care. Currently, the per capita personal health care expenditure for Alaskan Natives/American Indians is $575 compared to $1,150 for the U.S. general population. Therefore, subsidizing the CHAP seriously undermines the viability of other critical health programs which are already terribly underfunded. (U.S. Department of Health and Human Services, 1986)

COMMUNITY HEALTH AIDE PROGRAM IN CRISIS

PROGRAM UNDERFUNDED

The current status of the CHAP is a direct result of inadequate funding throughout the Program's 30 year history. As stated previously, the CHA to village ratio is 1.2:1. From the beginning of the Program, health corporations recognized that one person alone could not be responsible for the provision of health care 24 hours a day, 365 days per year. A back up system was needed so that the village would not be without health care in the absence of the CHA. The Alternate CHA system evolved to meet this need.

CHAs employed to provide health care services on a regularly scheduled basis are known as Primary CHAs (P-CHA) and represent the positions allocated by Congress. Currently there are 239 P-CHAs. (Attachment 2) Health corporations have split a number of FTE positions to half time positions to maximize CHA utilization.

Alternate CHAs (A-CHA) generally substitute when the P-CHA is sick, leaves the village for training, or takes annual leave. In some regions A-CHAs assist with emergency coverage during evenings, nights, weekends and holidays. There are 225 A-CHAs statewide (Attachment 2). The responsibilities of the A-CHAs are the same as P-CHAs. While on duty, they assess, treat and otherwise respond to all villagers in need of health care.

A-CHA positions are not officially funded by the Federal or State governments. In general, health corporations use Federal dollars to pay the A-CHA during the time the P-CHA is away from his/her duties. Thus funding intended to provide salaries and training for 205 positions actually supports 464 positions.

IHS uses a Resource Requirement Methodology (RRM) to estimate the amount of funding required to bring IHS services to parity with the general United States population. The Health Corporations have concerns about the CHAP component methodology. None the less, the IHS RRM derives a total budget need of $21,611,627 to support the CHAP. (Attachment 3) At the present time, the Federal Government funds the CHAP at $5,532,304 which is 26% of the total IHS projected need. With the State's contribution to the program, CHAP is operating at 37% of the total need.

The Program is in danger of total collapse as demonstrated by:

1. A statewide attrition rate of 33% (151 of 464 CHAs in Fiscal Year (FY) 1987. (Attachment 4 and 5)

2. The existing training system cannot meet current training needs. Thirty percent of the CHAs practicing today have less than the first four (of twelve) weeks of basic training. 57% have had less than 8 weeks of basic training. Inadequately trained, inexperienced CHAs are providing health care in the villages. (Attachment 6)

3. Rural clinics are physically inadequate and lack basic clinic supplies. Many clinics do not have running water and many lack hand washing facilities in each examining room. Heating systems break down frequently.

1. CHA ATTRITION RATE

As stated previously, the statewide attrition rate for CHAs is dangerously high at 33% (151 of 464 CHAs in FY '87). Unlike all other health care providers, trained and experienced CHAs are replaced by untrained, inexperienced lay people who have an 8th to 10th grade educational level. The quality of care plummets in a village when a CHA resigns. It takes years to restore the quality of care to a high level.

In 1987, the attrition rate for the P-CHAs statewide was 28% (66 of 239) with a range of 0%-37%. (Attachment 4)

Reasons given by the P-CHAs for attrition included:

a. burn out;
b. overwhelming job responsibilities;
c. low salary;
d. responsibility of providing emergency care 24 hours per day, 365 days per year;
e. not enough training;
f. family responsibilities;
g. stress of providing emergency care;
h. job too demanding;
i. too much on call; and
j. retirement.

The 1987 attrition rate for A-CHAs was 37% (84 of 225) with a range of 0% - 63%. (Attachment 5)

Reasons given by the A-CHAs for attrition included:

a. not enough pay;
b. lack of training;
c. lack of opportunities to utilize skills learned in training;
d. unpredictable work schedule;
e. lack of opportunities to work; and
f. promotion to primary position.

The attrition rate in both P-CHAs and A-CHAs is high. P-CHAs are overworked and stressed out from the responsibility they carry and their workload. A-CHAs provide a valuable service but are undertrained, underutilized, and stressed from attempting to provide quality care with little training and experience.

Stresses of the Job

The role of the CHA is not an easy one. The responsibilities and stresses of the position are extraordinary. A few of the most obvious stresses are as follows:

1. **CHA is the sole health care provider in an isolated community; has limited training and basic equipment only.**

   a. Attaining full certification as a CHA takes a minimum of 2 years; often longer. Learning the necessary skills and feeling competent in performing these skills takes years of practice.

   b. Back-up support for dealing with emergencies and difficult medical problems is not immediately available. Assistance may be hours away. Telephone communication with a professional is helpful but does not really substitute for "hands on" assistance from a competent professional.

      CHAs suffer tremendous pain and guilt if their best efforts cannot save a patient's life. Processing and resolving these feelings in the village is difficult because the CHAs, who often support others in need, find it difficult to reach out for comfort and support for themselves. Further, they must maintain patient confidentiality.

   c. Lack of peer support in the village.

d. Village clinic facilities are basic structures with limited medical equipment. Heating systems break down frequently. Many clinics do not have running water. Maintaining high standards of sanitation in the clinic is difficult when water must be hauled to the clinic.

2. **The work of the CHA is unpredictable.**

The work day of a CHA is as unpredictable as the day of an emergency room physician and is often as taxing. Because he or she lives in a small isolated community the CHA is never really "off" duty.

3. **Practicing in a small isolated community, the CHA must provide health care services to close family members.**

This type of situation is avoided by all practitioners who recognize the difficulties of remaining objective when caring for family members.

4. Lack of support from villagers.

a. Villagers don't seem to understand that a CHA, up for the entire night tending to victims of major trauma, may not be able to open the clinic on time in the morning.

b. Even with a well advertised "on call" schedule in place, villagers often disregard the schedule and demand services from the CHA of their choice, thereby ensuring that all CHAs in the village are on call 24 hours a day, 365 days of the year; in essence the CHA becomes a slave of the village.

5. **Demands for services are high.**

a. CHAs are called out in the middle of the night to tend to minor discomforts.

1. Saying no to such requests can produce heavy criticism from villagers who feel the CHA should respond immediately to their requests.

2. Saying no can result in a deep sense of guilt over not responding, and lost sleep wondering if the CHA should have responded to the request. Maybe the person is really in need of attention.

3. Saying yes results in lost sleep and more requests for home visits for minor problems.

b. As the sole village based health care provider, the CHA is called upon to provide a wide variety of services in addition to direct health care.

1. The CHA is often called upon to provide counseling to individuals experiencing psychosocial difficulties. The demand for such services is high due to social disruption secondary to a culture in transition and a high level of alcohol abuse in the villages.

2. The CHA is viewed by the community as a supportive person. He or she is requested to support the terminally ill patient and their families.

3. The CHA must assist itinerant health care providers during their trips to the villages. This entails long hours as itinerant providers work late in the evening and require the assistance of the CHA.

6. **The demands of the job make it difficult to participate in important subsistence activities.**

   a. Year round, full-time employment makes it difficult to participate in traditional subsistence activities which decrease the cost of living in the village and contribute to well being.

   b. Family and job related responsibilities often pull the CHA in opposite directions.

7. **The CHA is a high profile figure in the community. In a small community the CHA is subject to close scrutiny. Criticism, justified and unjustified, and small town politics often contribute to the stresses of the job.**

FATAL "HIGH"

A CHA was called to examine two teenagers who were complaining of vision problems. During her assessment of the patients, the CHA learned that these two teens and 9 friends had consumed an unknown substance in a effort to get "high". The CHA immediately telephoned the physician at the hospital 60 miles away. She successfully conveyed the seriousness and extent of the problem. Airplanes were sent to the village to transport the victims to the hospital. The hospital mobilized their disaster plan. By the time the planes had arrived in the village, the CHA had identified the substance (methanol - small amounts can be fatal), gathered the victims together, determined the amount each had ingested, and triaged the victims so that those who were sickest arrived first at the hospital. The outcome: one teen died and four were flown to the tertiary hospital in Anchorage, 400 miles away. Accurate assessment of the problem and quick response on the part of the CHA saved ten teenagers' lives.

In summary, the job of the CHA is difficult and stressful. In general, CHAs are dedicated to their jobs, conscientious, and take the responsibility of their positions very seriously. Balancing the job with family responsibilities, community activities, and important subsistence and cultural activities, is at times impossible.

Compensation

In January, 1988 a statewide survey of the twelve CHAPs found that annual salaries for Primary (P-CHAs) CHAs ranged from $7,380 to $34,788. The weighted average annual salary for P-CHAs statewide is $17,397. (Attachment 7) The salary for Alternate CHAs (A-CHAs) is considerably less because they work so infrequently. During FY 1987, A-CHAs of the Yukon Kuskokwim Health Corporation, representing 42% of the State's A-CHAs, earned an average of less than $4,000/year.

A comparison with the Alaska Area Native Health Service (AANHS) salary range for various positions found that 68% of the CHAs earned less annually than a nursing assistant. A custodial worker in the AANHS system earns $34,346 - $40,066. One hundred percent of CHAs make less than a custodial worker. Although each CHA is on-call 24 hours a day, they are compensated for 6-8 hours of clinic time only.

A typical CHA is a 38 year old woman with 3 children under 21 years of age. If all CHAs (P-CHAs and A-CHAs) in Alaska were earning the maximum salary currently provided, only 15% would be earning an annual income above the Alaska Public Assistance eligibility criteria for a family of five members ($21,300/year).

2. TRAINING

Training should be provided in a timely manner to assure a high quality health care system. It is dangerous and unethical to sustain a health care system which is funded at such a level that adequate training cannot be provided. IHS funds the Anchorage CHAP (A-CHAP) to provide Primary CHA training only. Three additional training centers have evolved because A-CHAP was unable to meet the training demands of the Corporations and because the Corporations recognized that Alternate CHAs must have basic training to provide quality care. The State and Corporations have had to fund these training programs. Still funding is not sufficient to meet the current needs for training. The high attrition rate makes it impossible to meet the training need. Primary CHAs are targeted for completion of basic training. Alternate CHAs receive an abbreviated 4 week course which does not sufficiently prepare them for their work.

Currently there are 464 CHA positions in the state: 239 Primary CHAs and 225 Alternate CHA positions. At the time of the statewide survey in January 1988, 49 positions were vacant. 30% of the CHAs currently employed have had less than the first four weeks of basic training while 57% have had less than eight weeks of basic training.

CHAs can function remarkably well with less than twelve weeks of basic training however the quality of care rises markedly with increased training and experience. Currently the statewide standard for CHA training is: Primary CHAs are to be certified within three years of date of hire and Alternate CHAs should have at least Session I training within 6 months. The current statewide training capacity is 29 sessions/year as shown in TABLE 3.

TABLE 3

Statewide CHA Training Capacity
Sessions Per Year

Training Center	Session I	Session II	Session III	TOTAL
IHS - Anchorage	4	4	3	11
Kuskokwim College	2	2	2	6
North Pacific Rim Health Corp.	4			4
Norton Sound Health Corp.	3	2	3	8
			TOTAL	29

The minimum number of sessions needed to attain the current standard of training for all 464 CHAs is 50.2 sessions (based on six students per session).. The current unmet need is for 22 additional training sessions. (Attachment 8) This will be an ongoing annual need if steps are not taken to reduce attrition.

3. VILLAGE BUILT CLINIC PROGRAM

The Village Built Clinic Program (VBCP) became operational in 1969-70. Participation was limited to a total of 141 clinics. By 1987, 141 clinics were participating with a total budget of $1,691,340.00, for an average annual lease per village of $11,995.32. From its outset, the VBCP has been subject to the ebb and flow of federal funds subsidizing participating clinics. Villages that were added to the program during "lean" budget years received a lower original lease amount than those added during "fat" budget years. The funding allocated to each clinic per year is determined by the year in which the clinic lease was granted. It is not based on size, expenses, or other considerations. Currently 30 village clinics are not covered by this program.

The impact of inadequate lease appropriations is that clinics are not properly maintained. Break down in heating, electricity, water systems where they exist, and telephones occurs frequently. Village clinics are often inadequately heated making it impossible for CHAs to provide services in the clinics. Clinics with marginal systems freeze up during cold weather destroying medication and disrupting existing water systems. Attachment 9 shows the problems with the Village Built Clinic Program allocation methodology.

An example of the problems with the methodology is the 2,400 square foot Mountain Village clinic. Staffed by 3 P-CHAs and serving 729 people with 4,813 patient encounters in 1987, Mountain Village has a monthly lease of $678.00. The Tununak clinic is 768 square feet. It serves a population of 330 and has 1 P-CHA. In FY '87 the CHA had 1,324 patient encounters. It has a monthly lease of $1,168.00. In the past, Mountain Village would supplement this grossly inadequate lease amount with village operating funds. Such supplements are no longer possible due to the growing economic crisis in the state.

SUMMARY OF PROGRAM PROBLEMS

The Community Health Aide Program is a vital component in the health care delivery system of rural Alaska. It is culturally acceptable and cost effective. Health care is delivered by Alaskan Natives for Alaskan Natives fostering independence and self-determination at a current cost of $37 per patient visit. There is an immediate and critical need to redress the problems of underfunding that have resulted in an unacceptably high attrition rate, unmet training needs and the problems associated with CHAs operating in substandard clinics. These problems adversely affect the quality of health care that CHAs provide. As quality of care diminishes, the risk of liability increases.

In December of 1987, revisions to the Federal Tort Claims Act made dramatic changes in the Federal government's responsibility for medical liability to all P.L. 93-638 contractors. As a result of these revisions, the Federal government has accepted responsibility for medical liability for Community Health Aides. In its current condition, the CHAP is extremely vulnerable to medical malpractice lawsuits.

HELP FOR A CRITICALLY ILL INFANT

A young health aide was caring for a three month old infant who had pyloric stenosis. This is a stricture that develops where the stomach enters the small intestine, preventing food from being digested. Every time the infant was fed, she vomited the entire feeding. This condition requires prompt medical treatment or it becomes life threatening. Because of severe weather conditions, there was no transportation out of the village. Telephone and radio communications were down. The baby could not be transported to a hospital and the CHA had no means of consulting with a physician. The infant required intravenous feeding, but her veins were too small to insert an intravenous feeding tube. Without nourishment, the infant would die. The CHA opened a bottle of intravenous fluid and spoon fed the infant one-half teaspoon every 15 minutes around-the-clock for three days. The small amounts of fluid given around-the-clock enabled the baby to absorb the fluids and provided sufficient nourishment to sustain life, until the baby could be transferred to a hospital for surgery.

RECOMMENDED INTERVENTIONS FOR THE COMMUNITY HEALTH AIDE PROGRAM

Concerned with the current status of the CHAP, a Subcommittee of five statewide CHAP Directors (Attachment 10) met in Anchorage March 7-11, 1988. The purpose of the meeting was to evaluate the CHAP and develop a plan to restructure the program to improve the quality of health care CHAs provide and to improve the working conditions of the CHA. This process is long overdue. Their work was supported by the Alaska Native Health Board and the Association of Regional Health Directors.

To ensure access to and provision of quality health care to rural Alaskan Natives the following changes are necessary:

1. Increase the number of officially funded FTE positions from 205 to 448 CHA positions; this replaces the A-CHA system (229 A-CHAs).

2. Institute a work schedule which recognizes that CHAs maintain regular clinic hours plus respond to emergency calls 24 hours a day, 365 days per year.

3. Increase the statewide CHA training capacity to ensure that all CHAs can complete basic training within three years of hire and that CHAs have at least the first four weeks of training completed prior to assuming patient care responsibilities.

4. Provide that CHAs are adequately compensated for the responsibilities of the position.

5. Provide adequate support and supervision to CHAs.

6. Extend the Village Built Clinic Program to include all village clinics. Currently 30 clinics are not covered by the program. Also upgrade basic clinic facilities and increase financial support for operation and maintenance of the clinics.

1. FORMULA FOR DETERMINING FTE POSITIONS NEEDED

A formula was developed by the CHAP Director Subcommittee to determine the number of FTEs needed to provide services in village clinics. This formula is based on population plus the minimum number of FTEs needed to maintain regular clinic hours plus provide care for emergencies 24 hours a day. The CHAP Directors created this formula based on experience with health care provider staffing patterns and village population. TABLE 4 outlines the formula.

TABLE 4

CHA Allocation Formula

Village Population	Positions Needed Based On 1 CHA Per 200 Population	Total # of CHAs Needed to Provide Regular Clinic Hours Plus Emergency Coverage 24 Hours
25-99	.5	1
100-199	1.0	2
200-299	1.5	3
300-399	2.0	3
400-499	2.5	5
500-599	3.0	5
600-699	3.5	6
700-799	4.0	6
> 800	4.0	7

This formula was applied to every village currently served by CHAs. It was then refined to reflect individual CHAP Directors' knowledge of specific village staffing needs. This resulted in a total need for 448 FTE CHA positions. (Attachment 11)

2. CHA WORK SCHEDULE

The recommended work schedule for CHAs to provide regular clinic hours plus 24 hour a day emergency care is two weeks on duty followed by one week off. The work schedule for all village population ranges is shown in Attachment 12. This schedule would enable CHAs to provide quality health care and will dramatically reduce attrition. No other health care providers are required to maintain a schedule currently demanded by the present system.

3. TRAINING RECOMMENDATIONS

Currently a large number of CHAs have not completed Basic Training. A major effort must be undertaken to upgrade the training level of all CHAs. This includes currently employed CHAs, the new hires needed to meet the recommended 448 FTE staffing level, and the ongoing need with a 10% attrition rate.

Due to concerns about quality of care provided and CHA liability issues, this upgrading of CHA training level should be accomplished in three years. Currently the training centers have the capacity to provide 29 sessions per year. (TABLE 3) The current need for sessions is 69 over the next three years followed by a maintenance level of 24 sessions per year. (TABLE 5) The CHAP Directors recommend that the current centers be expanded to meet the need rather than starting new training centers as the expanded need is a temporary one.

TABLE 5

Number of Total Training Sessions Needed Per Year Over Three Years to Upgrade the Program to 448 FTE

	Sessions per Year
Total Number of Sessions Needed Per year to Upgrade to 448 Positions	45
Total Sessions Needed per Year to Meet a 10% Attrition Rate*	24
TOTAL	69

*If working conditions for CHAs are improved the attrition rate should fall to 10% and training needs will reflect the target attrition rate.

4. COMPENSATION

Compensation for CHAs is variable across the state due to marked differences in the cost of living and availability of local resources to supplement salary. However all CHAs should be paid at a minimum level reflective of the responsibilities of the position. The CHAP Director Subcommittee recommends a starting salary rate of no lower than $28,047 and to increase this when the CHA is certified, to no lower than $33,385. The job of the CHA is similar in responsibility to that of mid-level practitioners providing primary health care. Therefore, their compensation must reflect this responsibility.

5. SUPERVISION

The Supervisor is the primary support mechanism for employees performing a very stressful job in an isolated setting. Supervision is provided through frequent telephone consultations and 3-5 day long visits twice a year. This is not sufficient.

In order to reinforce basic teaching, provide assistance with clinic management, and support the CHA, three village visits per year would be more appropriate. To accomplish this a reasonable Supervisor to village ratio is 1:5.

CHAs are frequently called to the scenes of suicide attempts and completions, homicides, and accidents resulting in major trauma. Every patient is a family member, relative, or close neighbor. Caring for these victims leaves lasting scars on the CHA. Nightmares, mental anguish, and flashbacks trouble the lives of the CHAs. On-site face to face Supervisor visits are vital in assisting the CHA to work through job related stress and trauma.

The Supervisors should not be providing basic training. Both the supervisor and instructor role are demanding and equally important. When these two functions are provided by the same staff the supervisory role gets compromised.

Supervisor Village Visit

The Supervisor stepped off the plane in the village and walked to the clinic. She was greeted by the CHA. Immediately the CHA referred to the death which had occurred in the village four months before. The CHA had been called to a home where a 16 year old had placed a gun under his chin and pulled the trigger. The boy was alive. The CHA assessed the patient and called the physician for help. A plane was dispatched. As the CHA worked on the boy, he clung to her hand and begged her to help him. Directed by the physician, the CHA did everything she could to help the patient. But the patient stopped breathing. She tried to resuscitate him but he died in the 3 hours it took for the plane to arrive. The patient was her young brother. The CHA felt guilty that she had not saved the boy and had been unable to talk to anyone about her feelings.

6. VILLAGE BUILT CLINIC PROGRAM - EVALUATION AND UPGRADING

The Village Built Clinic Program needs to be expanded to include all village clinics. The program also requires a thorough evaluation so that a funding methodology can be developed based on operating costs (including fuel, electricity, water, sewer, supplies, and equipment), number of patient visits annually, and population.

CONCLUSION

Implementation of this plan will result in the following:

1. Significant decrease in CHA attrition rate within two years of implementation.

2. Improve the working conditions for CHAs.

3. At the end of three years 70% of the State's CHAs will be certified. This will result in the provision of higher quality of care at the village level.

4. CHAs will be better supported by their Supervisor with more frequent village visits. This will contribute to a decrease in the attrition rate which has a direct relationship to quality of health care.

5. All CHAs will have an adequate clinic in which to work. Clinic facilities will be properly maintained and operational <u>if</u> the Village Built Clinic Program is evaluated and additional funds are allocated.

The CHAP Director Subcommittee strongly recommends that a Statewide evaluation of this plan be done in three years to avoid the program reaching such a crisis situation again. The type of in-depth evaluation just completed must occur every three years.

Funding for this program must be channeled directly to the CHAP and not through the IHS RMMNA formula. This program is unique and not well funded through current channels.

PROGRAM BUDGET NARRATIVE - STATEWIDE

PERSONNEL:

1. CHAs

   A. Number: Based on village population formula developed by CHAP Directors March 1988: 448 CHAs

   B. Salary: Average of the range $28,047 - $33,385: $30,716.

2. Supervisor

   A. Number: Based on a ratio of 1 Supervisor per 5 villages according to proposed state regulations: 36 Supervisors

   B. Salary: Average of the range $36,507 - $49,293 is $42,900. Salary-range from projections and figures submitted at the CHAP Director Subcommittee meeting, Anchorage, March 7-11, 1988.

3. Director

   A. Number: One Program Director per Health Corporation: 12

   B. Salary: Average of the range $39,998 - $55,974 is $47,981. Salary range from projections and figures submitted at CHAP Director Subcommittee meeting, Anchorage, March 7-11, 1988.

4. Support Staff: Process CHA paperwork submitted to central office. Secretarial support for Supervisors and Program Directors.

   A. Number: 1 position for each 25 CHA positions (448) is 18

   B. Salary: Average of the salary range $22,00 - $28,000: $25,000.

TRAINING

A. Cost of training: includes travel, perdiem, instructors, equipment, and supplies.

SESSION	LENGTH OF SESSION	COST PER STUDENT
Session I	4 weeks	$ 8,000
Session II	3 weeks	$ 6,000
Session III	3 weeks	$ 6,000
Preceptorship	2 weeks	$ 4,000

*Based on Anchorage-CHAP Training Center cost per student FY '88 - Robert Burgess.

B. Estimate of Current Need - Training

There are currently 415 CHAs employed (49 vacant positions). The CHAP Director Subcommittee recommends a total of 448 CHAs. Based on current training status of all employed CHAs and number of vacancies based on 448, CHA total training needs are:

1. 33 positions vacant. CHAs need: Session I, II, III, and Preceptorship.

2. 124 CHAs have had less than Session I training. CHAs need: Sessions I, II, III, and Preceptorship.

3. 64 CHAs have had Session I. CHAs need: Sessions II, III and Preceptorship.

4. 48 CHAs have had Session II. Need: Session III and Preceptorship.

5. 179 CHAs are certified and need ongoing training.

C. An attrition rate of 10% can be achieved because the population is not transient. To achieve a 10% attrition rate we must decrease stress by improving work schedule, increase incentive (salary), increase support through closer supervision, and increase confidence and self-esteem through provision of full training for all CHAs. Our current attrition rate is 33% statewide. 10% of 448 FTE is 45 FTE. This number is used in calculating the training budget: Ongoing Need.

D. A plan for meeting the ongoing educational needs for CHAs who are certified must be factored into future training budgets.

TRAVEL BUDGET

1. Supervisor travel budget is based on the following:

   A. Village travel

      1. Villages needing visits: 171
      2. Average round trip transportation costs: $175
      3. Perdiem: Village perdiem rate of $45 per night
      4. Number of trips per village per year: 3 trips
      5. Number of nights in village: 3

   B. Supervisor travel for Continuing Medical Education

      1. Total trips: One Anchorage trip for each supervisor: 36 trips
      2. Average round trip transportation cost: $350
      3. Perdiem rate (Federal standard): $125 per night
      4. Number of nights in Anchorage: 2

2. Program Director Travel

   A. Village Travel

      1. Village trips per year: 10
      2. Average round trip transportation costs: $175
      3. Perdiem rate for village travel: $45
      4. Average length of trip: 2 nights

   B. Anchorage travel

      1. Anchorage trips per year: 4
      2. Average round trip transportation costs: $350
      3. Perdiem rate for Anchorage travel: $125/night
      4. Average length of trip: 3 nights
      5. Number of Program Directors: 12

BUDGET BASED ON 100% OF NEED

PERSONNEL:

448 FTE CHAs @ average salary $30,716	$13,760,768
12 FTE Program Director @ average salary $47,981	575,772
36 FTE Supervisor @ average salary $42,900	1,544,400
18 FTE Support @ average salary $25,000	450,000
Total Salary	$16,330,940
Fringe @ 25%	4,082,735
Total	**$20,413,675**

TRAINING - Need if recommended FTE 448 is accepted:

157 need Session I, II, III, Prec. @ $24,000	$ 3,768,000
64 need Session II, III,-Prec. @ 16,000	1,024,000
48 need Session III, Prec. @ $10,000	480,000
To upgrade training need	$ 5,272,000
Ongoing Training Need (10% attrition @ 448)	
45 needing Session I, II, III, Prec. @ $24,000	$ 1,080,000
Total training need	**$ 6,352,000**

TRAVEL BUDGET:

Supervisor - village 513 trips @ $310 per trip	$ 159,030
Supervisor - Anchorage 36 trips @ $600 per trip	21,600
Program Director - village 120 trips @ $265 per trip	31,800
Program Director - Anchorage - 48 trips @ 725	34,800
Total travel	**$ 247,230**

The Total Annual Budget needed to maintain a program at a minimum level is:

1. All salary	$20,413,675
2. Training @ 10% attrition rate	1,080,000
3. Travel	247,230
Direct Cost	$21,740,905
Indirect Cost 22%	4,782,999
Total cost	$26,523,904

To upgrade the training level for all CHAs $5,272,000 are needed.

This needs to be phased in over a three year period a cost of $1,757,333 per year.

The total cost of the CHAP Program Training Upgrade years is:

Direct Cost	$23,498,238
Indirect Cost 22%	5,169,612
Total cost	**$28,667,850**

Budget for the CHAP FY '89 - FY '92 is:

Fiscal Year	Total Budget	
1989	$28,667,850	
1990	$28,667,850	
1991	$28,667,850	
1992	$26,523,904	(maintenance budget)

It is important to note that the FY '88 Statewide CHAP Funding is:

IHS	$ 4,984,398
Anchorage CHAP	546,906
State HB 215	2,047,316
State to Kuskokwim College	200,000
	$ 7,778,620

The Projected need as determined by the CHAP Directors for maintaining the program is: $26,523,904

Thus CHAP is operating at 26% of need. This contributes directly to the problems experienced by the CHAP and described in this document.

Realizing that budgetary constraints have necessitated cuts in Federal and State funded programs and that full funding of the CHAP at this time may not be possible, the CHAP Directors have prepared a budget with a 25% reduction in salaries. We strongly recommend these funds be made available immediately. These funds will begin to address the serious problems until full funding is possible.

REVISED BUDGET
25 % DECREASE IN SALARY
FOR ALL POSITIONS

PERSONNEL:

448 FTE CHAs @ average salary $23,037		$10,320,576
12 FTE Program Director @ average salary $35,986		431,832
36 FTE Supervisors @ average salary $32,175		1,158,300
18 FTE Support @ average salary $18,750		337,500
	Total Salary	$12,248,208
	Fringe @ 25%	3,062,052
	Total	**$15,310,260**

TRAINING - Present need if recommended FTE 448 is accepted:

157 need Session I, II, III, Prec. @ $24,000	$ 3,768,000
64 need Session II, III, Prec. @ 16,000	1,024,000
48 need Session III, Prec. @ $10,000	480,000
To upgrade training Need	$ 5,272,000

Ongoing Training Need (10% attrition @ 448)

45 CHAs need Session I, II, III, Prec. @ $24,000	$ 1,080,000
Total training need	**$ 6,352,000**

TRAVEL: Supervisor Travel Budget and
Program Director Travel Budget

Total	**$ 247,230**

The total annual budget needed to maintain the program following the modified budget is:

1.	**All salary**	$15,310,260
2.	**Training @ 10% attrition rate**	1,080,000
3.	**Travel**	247,230
	Direct Cost	$16,637,490
	Indirect Cost 22%	3,660,248
	Total cost	**$20,297,738**

To update the training level for all CHAs $5,272,000 are needed. This needs to be phased in over a three year period @ a cost of $1,757,333 per year over the next years.

The total costs of the CHAP during Program Training Update years is:

Direct Cost	$18,394,823
Indirect Cost 22%	4,046,861
Total cost	**$22,441,684**

Modified CHAP Budget for FY '89 - FY '92 is:

Fiscal Year	Total Budget	
1989	$22,441,684	
1990	$22,441,684	
1991	$22,441,684	
1992	$20,297,738	(maintenance budget)

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Rogers, G. "Alaska Native Population Trends and Vital Statistics, 1950-1985." Research Note. Institute of Economic and Govt. Research. University of Alaska, Fairbanks, Alaska 1971.

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ATTACHMENT 1

CHA Basic Training Curriculum Overview
(3 Sessions Totaling 10 weeks)*

Introduction to the Community Health Aide program
Concepts of Health and Disease
Anatomy and Function of the Body Systems
Patient Encounter Evaluation Skills
  Complete and Problem-Specific History Taking
  Physical Exam and Vital Sign Skills
  Assessment and Plan for the Problem
  Recording of Findings and Reporting to Physician
  Use of Reference Texts The Community Health Aide/Practitioner Manual and the Village Drug Reference (VDR)
Procedures and Laboratory Tests
Health Problems by Body Systems
  Head, Eyes, Ears, Nose, Mouth, Throat (HEENMT)
  Respiratory System
  Cardiovascular System, Blood and Lymphatics
  Gastrointestional System
  Urinary System
  Male and Female Reproductive Systems
  Breast
  Musculoskeletal System
  Nervous System
  Endocrine (Regulatory) System
  Skin
Medicines
  Basic Concepts
  Administration of Medicines
  Maintaining a Clinic Medicine Cabinet (Pharmacy)
Obstetrics
  Prenatal Care
  Labor and Delivery
  Emergency Childbirth
  Post-Partum Care
Pediatrics
  Fetal Alcohol Syndrome
  Newborn Exam and Complications
  Well Child Exam and Clinic
  Growth and Development Assessment
  Immunizations
  Health Surveillance - School Screening
  Pediatric History and Exam
  Serious Infections in Children
  Child Abuse and Neglect
Gynecology
  Family Planning
  Evaluation of The Rape Victim

Mental Health
  Mental Illness (depression, suicide, anxiety and others)
  Mental Health Promotion
  Alcohol and Drug Abuse
  Family Violence
  Grief and Loss, Death and Dying
  Stress Management for the CHAs
Preventive Health and Epidemiology
  Communicable, and Water and Food Borne Diseases in Alaska
  Water and Food Borne Disease in Alaska
  Tuberculosis
  Sexually Transmitted Diseases
  Accident Prevention and Home Safety
  Office of Environmental Health (water and sewage, rabies)
Health Surveillance and Promotion
Chronic Illness
Nutrition
Health Education Techniques
Clinic Management and Administration
Basic Education Skills and Independent Study
Emergency Trauma Training (State of Alaska Certified)
  1 week course in summary includes:
    Body Surveys - Airway and Breathing
    Cardiopulmonary Resuscitation
    Poisoning
    Assessment and Treatment of Trauma
    Bandaging, Splinting and Transport

* This overview does not indicate sequence.

The Certification Process for Community Health Aides

The requirements for statewide Certification are:

1. Successful completion of Sessions I, II, and III of Basic Training

2. Successful completion of a two week Preceptorship -supervised clinical experience.

3. Completion of the CHA "Skills List".

4. Passing grade (80%) on the written and practical statewide "Certification Examination".

5. Completion of documented field experience at the CHA's village clinic to satisfy 24 University of Alaska credit hours of Basic Training (approximately 600 hours of field work as a CHA).

6. Satisfactory evaluation of field performance following Basic Training by physician, public health nurse and CHA Supervisor.

HEALTH CORPORATIONS AND CURRENT CHA POSITION DISTRIBUTION MARCH, 1988

HEALTH CORPORATIONS	# OF VILLAGES	# OF CURRENT FTE POSITIONS	# OF CURRENT P-CHAs	# OF CURRENT A-CHAs	TOTAL # OF CHAs
Aleutian/Pribilof Islands Association, Inc.	7	6.5	7	6	13
Bristol Bay Health Corporation	29	33	39	26	65
EEDA Regional Consortium of Tribes	1	1	1	0	1
Copper River Health Department	6	3.5	6	5	11
Kodiak Area Native Association	6	6	6	6	12
Maniilaq Association	11	15	18	14	32
North Pacific Rim	4	3	5	2	7
North Slope Borough Health Corp.	6	7	16	0	16
Norton Sound Health Corporation	15	20	21	44	65
Southeast Alaska Regional Health Corporation	7	13	13	5	18
Tanana Chiefs Conference, Inc.	28	29	30	67	97
Yukon Kuskokwim Health Corporation	48	64	74	50	124
*Independent Village Contract Tyonek, Yakutat Metlakatla	3	4	3	0	3
TOTALS	171	205	239	225	464

*FTE=Full Time Equivalent

TABLE 1
SUMMARY OF RMMNA PROJECTED NEED FOR CHP PROGRAMS
ALL ALASKA SERVICE UNITS
March 8, 1988

	(1) Direct FTE's	(2) Admin FTE's	(3) Total FTE's	(4) Direct FTE Need ($)	(5) Admin FTE Need ($)	(6) Total FTE Need ($)	(7) Support Allocation	(8) Total Need
APIA	14.2	5.7	19.9	$ 397,998	$ 219,669	$ 617,667	$ 160,593	$ 778,260
CRNA	7.0	2.8	9.8	196,196	107,908	304,104	79,067	383,171
KANA	10.6	4.3	14.9	297,097	165,716	462,812	120,331	583,144
NINILCHIK	1.6	0.6	2.2	44,845	23,123	67,968	17,672	85,640
NPR	6.7	2.7	9.4	187,788	104,054	291,842	75,879	367,720
TYONEK	2.0	0.8	2.8	56,056	30,831	86,887	22,591	109,477
ANCHORAGE SERVICE UNIT (total)	42.1	16.9	59.0	$ 1,179,979	$ 651,301	$ 1,831,279	$ 476,133	$ 2,307,412
ANNETTE ISLAND SERVICE UNIT	0.0	0.0	0.0	0	0	0	0	0
BARROW SERVICE UNIT	18.8	7.5	26.3	526,926	289,039	815,965	212,151	1,028,116
BRISTOL BAY SERVICE UNIT	45.9	13.8	59.7	1,286,485	531,831	1,818,317	472,762	2,291,079
INTERIOR SERVICE UNIT	49.3	14.8	64.1	1,381,780	570,370	1,952,150	507,559	2,459,709
KOTZEBUE SERVICE UNIT	45.3	13.6	58.9	1,269,668	524,124	1,793,792	466,386	2,260,178
MT. EDGECUMBE SERVICE UNIT	32.7	9.8	42.5	916,516	377,677	1,294,193	336,490	1,630,683
KETCHIKAN SERVICE UNIT	0.0	0.0	0.0	0	0	0	0	0
NORTON SOUND SERVICE UNIT	46.4	13.9	60.3	1,300,499	535,685	1,836,184	477,408	2,313,592
Y-K SERVICE UNIT	146.8	44.0	190.8	4,114,510	1,695,694	5,810,204	1,510,653	7,320,858
TOTALS FOR ALASKA AREA	427.3	134.3	561.6	$11,976,364	$5,175,721	$17,152,085	$4,459,542	$21,611,627

Prepared by Charles Mobraten
Ernst and Whinney

ATTACHMENT 3

(1 of 3)

NOTES TO TABLE 1

(1) Direct FTE's were obtained from the CHPS RRM projection sheets dated February 1988 that will be used as a basis for the FY88 SURAM allocation. Full-time equivalents are based on a 2,080-hour work year. Direct FTE's represent a need for village-based providers which are providing ambulatory care services. According to the October 1986 version of the RRMNA Staffing and Resource Requirements Manual, the need for direct CHP FTE's is based on the following staffing formula:

- Each service unit is given a base staff of .3 FTE's
- One health aid is added for each additional 263 users, counted as user population
- One health aid is added for every 917 direct ambulatory encounters
- One health aid is added for every 4,509 preventive encounters

There have been changes to the RRMNA methodology that make the above formula no longer correct. For FY88 the total number of direct FTE's projected for the Alaska Area as a whole is 427.3.

(2) Support FTE's project the need for administrative support personnel. The total number of administrative support personnel that were projected is 134.3 FTE's. According to the October 1986 version of the Staffing and Resource Requirements Manual, CHP administrative staff are projected at a rate of one administrative staff per every 3 1/3 direct FTE's. Again, changes to the formulas in the model make this formula no longer valid.

(3) Summarizes the total FTE need for the Alaska area as a whole by adding columns (1) and (2). The overall total FTE requirements generated for RRM for the Alaska area for the CHP module is 561.6 FTE's.

(4) Projects the total direct FTE need requirement in dollars. Column (4) assumes that RRMNA uses an average salary cost of $35,035 which results in an average position cost for the CHP personnel category of 28,028 using a multiplier of .8.

(5) Expresses the FTE need for administrative staff personnel. It assumes that an area-wide average salary of $35,035 is used which would result in an average CHP support salary of $38,539 using the existing salary multiplier of 1.1.

(6) Summarizes the total FTE requirement in dollars by adding columns (4) and (5).

NOTES TO TABLE 1--Continued

(7) Contains an estimate of support costs associated with the ancillary general services and administrative need projections. Support allocation assumes a support cost allocation rate of 26% of direct administrative FTE need. This allocation was based on a step-down that was performed for the Alaska Native Health Board resource reallocation study and distribution model development project that was performed in January 1987. Table 2 and Table 3 contain additional information on how the 26% rate was obtained.

(8) Expresses an estimate of total RRMNA need for the CHP program including the step-down of certain support costs. For the Alaska area as whole, that need is $21,611,627. The total estimated RRMNA need for the Alaska area whole for FY88 is approximately $141 million. The need for the CHP program, therefore, is approximately 15% of the total RRMNA need for the Alaska area as a whole.

ATTACHMENT 4

COMMUNITY HEALTH AIDE PROGRAM STATEWIDE SALARY SURVEY PRIMARY COMMUNITY HEALTH AIDES

CORPORATION	# OF PRIMARY CHAs	ATTRITION RATE-PRIMARY	<> CT OT EARNED HOURLY RATE	WORK DAY	ANNUAL SALARIES HOURLY RATE x HRS./DAY	FUNDING SOURCE
Aleutian/Pribilof Islands Association, Inc.	7	14%	CT $8.21 - $11.10 hr.	15-30 hour week	$7,380-$17,316	IHS
Bristol Bay Area Health Corporation	39	37%	$11.69 - $13.79 hr.	3-6 hour week 15-30hr/week	$9,117-$21,505	IHS plus Hlt. Cor.
EEDA Regional Consortium of Tribes	1		$7.81 hr.	8 hrs/day 40 hrs/wk.	$15,000	
Copper River	6	33%	$7.00 - $9.48 hr.	20 hours/week	$7,280-$9,850	IHS
Kodiak Area Native Association	6	0	$8.20 - $12.70 hr.	6 hr/day 30 hr/week	$12,816-$19,800	IHS
Manilaq Association	* 18	22%	$10.03 - $12.18 hr.	8 hr/day 40 hr/week	$20,862-25,334	IHS + clinic $
North Pacific Rim	5	20%	$6.82- 12.34 hr. CT	30 hr/week	$13,304-$24,068	IHS
North Slope Borough Health and Social Services Agency	** 16	44%	CT/OT $15.72 - $22.30 hr.	30 hr/week	$24,523-$34,788	IHS 23% Boro. 77%
Norton Sound Health Corporation	21	38%	$11.19 - $16.13 hr.	8 hr/day No OT or CT	$22,818-$32,905	IHS + VHS
Southeast Alaska Regional Health Corporation	13	31%	OT;$1.50/hr on-call $6.93 - $10.45 hr.	2-5 hr/day	$8,132-$14,570	IHS
Tanana Chiefs Conference, Inc.	30	10%	CT $7.60 - 16.30 hr.	20-30 hr/week benefits - primary	$7,692-$24,480	PHS-CHA (IHS)
Yukon Kuskokwim Health Corporation	*** 74	30%	CT $7.84 - $10.51	30 hr/week	$12,230 - $16,396	IHS

Information on CHA salaries was obtained in a statewide survey of CHAP Directors.
* IHS allocation - 15 positions
** IHS allocation - 7 positions
***IHS allocation - 64 positions - 5 positions have been split.

<> CT=Comp time OT=Overtime

1/88 YKHC/CHAP

ATTACHMENT 5

COMMUNITY HEALTH AIDE PROGRAM STATEWIDE SALARY SURVEY ALTERNATE CHA INFORMATION

CORPORATION	# OF ALT. CHAs	ATTRITION RATE-ALT.	WORK DAY	HOURLY PAY RATE	PAID ONLY FOR HOURS WORKED	FUNDING SOURCE
Aleutian/Pribilof Islands Association, Inc.	6	60%	Covers for primary	$8.21	X	IHS
Bristol Bay Area Health Corporation	26	44%	Covers for primary	$11.69	X	CHR, Village Council
EEDA Regional Consortium of Tribes						
Copper River	5	16%	Covers for primary	$8.24	X	IHS
Kodiak Area Native Association	6	0	Covers for primary + 24 hrs. month	$7.50-$8.50	X	IHS
Manilaq Association	14	14%	Covers for primary + 64 hrs. month	$10.00	X	Revenue sharing vill.
North Pacific Rim	2	50%	Covers for primary + 80 hrs. month	$6.82-$8.31	X	IHS
North Slope Borough Health Corporation	0	0				
Norton Sound Health Corporation	44	25%	32 hrs. month	$8.75	Paid standard amt. to "be available"	
Southeast Alaska Regional Health Corporation	5	20%	Covers for primary	$6.93-$10.45	$1.50 hr. stand by fee + hrs. worked	IHS
Tanana Chiefs Conference, Inc.	70	32%	Covers for primary + 20 hrs. month	$8.50-$10.00	X	IHS
Yukon Kuskokwim Health Corporation	52	63%	Covers for primary + 18 hrs. month	$7.84-$10.51	X	IHS + Village Council

Information on CHA salaries was obtained in a statewide survey of CHAP Directors.

1/88 YKHC/CHAP

ATTACHMENT 6

COMMUNITY HEALTH AIDE CURRENT STATEWIDE TRAINING STATUS
MARCH 1988

CORPORATION	TRAINING COMPLETED				TOTAL # CHAs
	NEWLY HIRED	SESSION I	SESSION II	SESSION III/CHP	
Aleutian/Pribilof Islands Association, Inc.	2	4	1	7	14
Bristol Bay Area Health Corporation	26	14	4	19	63
EEDA Regional Consortium of Tribes	--	--	--	--	1
Copper River Health Department	2	1	--	6	9
Kodiak Area Native Association	1	5	--	6	12
Maniilaq Association	2	7	4	17	30
North Pacific Rim	1	1	1	4	7
North Slope Borough Health and Social Services	--	4	--	13	17
Norton Sound Health Corporation	1	10	12	24	47
Southeast Alaska Regional Health Corporation	1	--	2	13	16
Tanana Chiefs Conference, Inc.	40	--	3	26	69
Yukon Kuskokwim Health Corporation	48	18	20	44	130
TOTAL	124 (30%)	64 (15%	48 (12%)	179 (43%)	415*

* 49 Positions vacant

ATTACHMENT 7

* MEAN ANNUAL SALARY FOR CHAs BY CORPORATION JANUARY, 1988

HEALTH CORPORATION	MEAN ANNUAL SALARY
Aleutian/Pribilof Islands Association	$12,348.00
Bristol Bay Area Health Corporation	$15,311.00
EEDA Regional Consortium of Tribes	$15,000.00
Copper River	$ 8,565.00
Kodiak Area Native Association	$16,308.00
Maniilaq Association	$23,098.00
North Pacific Rim	$18,686.00
North Slope Borough Health and Social Services	$29,655.00
Norton Sound Health Corporation	$27,862.00
Southeast Alaska Regional Health Corporation	$11,351.00
Tanana Chiefs Conference, Inc.	$16,086.00
Yukon Kuskokwim Health Corporation	$14,313.00

Statewide weighted annual average salary for Primary CHAs is $17,397.00.

* $\frac{\text{Minimum Salary} + \text{Maximum Salary}}{2}$ = Mean Annual CHA Salary

ATTACHMENT 8

SUMMARY STATEWIDE TRAINING NEEDS TO UPGRADE TRAINING TO MINIMAL STANDARDS + MARCH 1988

	SESSION I	SESSION II	SESSION III	TOTAL
A. Current Capacity Students	78	48	48	174
B. Current Students Needing Sessions*	173	64	48	285
C. (B-A) Unmet Need Students	95	16	0	111
D. Unmet need-number of Sessions	16	3		19
E. Unmet Need This Year	16	3	3	22
		TOTAL SESSIONS NEEDED		22

+ Minimum standards: All Primary CHAs = Certified

All Alternate CHAs = Session I

* - Includes 49 Currently vacant positions

Column D represents number of students divided by 6 (Anchorage standard class size)

Column E represents need based on each student in need attending two sessions per calendar year.

This table represents current need based on current CHA training status statewide, March, 1988.

ATTACHMENT 9

Comparison of Average Monthly Lease Funds and Number of Leases by Corporation

Health Corporation	Avg. Monthly Lease	Total Number of Leases
Bristol Bay Area Health Corporation	$ 692.95	20
Southeast Alaska Regional Corporation	$ 895.00	4
Norton Sound Health Corporation	$ 1265.00	12
Maniliaq Association	$ 1094.88	9
Anchorage*	$ 796.42	26
Tanana Chiefs Conference, Inc.	$ 1109.04	22
Yukon-Kuskokwim Health Corporation	$ 1116.27	44
North Slope Borough Association	$ 1062.50	4

* Includes Aleutian/Pribilof Islands, Inc., EEDA Regional Consortium of Tribes, and Copper River Health Department.

ATTACHMENT 10

CHAP DIRECTOR SUBCOMMITTEE
MARCH 1988

CHAP DIRECTOR	HEALTH CORPORATION
Debra Caldera Chairman-Subcommittee	Yukon Kuksokwim Health Corporation
Rosemary Simone	Norton Sound Health Corporation
Barbara Knutsen	Bristol Bay Area Health Corporation
Grace Lincoln	Maniilaq Association
Marilyn Eaton	Copper River Health Department

ATTACHMENT 11

APPLICATION OF CHA ALLOCATION FORMULA
TO ALL VILLAGES CURRENTLY SERVED BY
COMMUNITY HEALTH AIDES

VILLAGE AND HEALTH CORPORATION	POPULATION*	NUMBER OF FTEs REQUIRED
Aleutian Pribiloff Island Association		
Akutan	80	1
Atka	93	1
False Pass	77	1
**King Cove	547	3
Nelson Lagoon	44	1
Nikolski	46	1
**Sand Point	671	3
**St. George	191	2
Bristol Bay Area Health Corporation		
Aleknagek	180	2
Chignik Bay	129	2
Chignik Lagoon	40	1
Chignik Lake	164	2
Clark's Point	79	1
Egegek	112	2
Ekwok	107	2
Goodnews Bay	241	3
Iguigig	38	1
Illiamna	126	2
Ivanof Bay	49	1
King Salmon	648	6
Kokhanok	68	1
Koliganek	161	2
Levelock	109	2
Manokotak	309	3
Naknek	382	2
Newhalen	165	2
New Stuyahok	339	3
Nondalton	234	3
Pedra Bay	70	1
Perryville	137	2
Pilot Point	79	1
Platinum	65	1
Port Heiden	108	2
Portage Creek	35	1
South Naknek	195	2
Togiak	556	5
Twin Hills	44	1

VILLAGE AND CORPORATION	POPULATION*	NUMBER OF FTEs REQUIRED
Copper River Native Association		
Chitina	40	1
Gulkana	98	1
Mentasta	66	1
Chistochina	64	1
Cantwell	91	1
**Copper Center	229	2
EEDA		
Ninilchik	451	5
Kodiak Area Native Association		
Akhiok	109	2
Karluk	114	2
Larsen Bay	217	3
Old Harbor	344	3
Port Lions	302	3
Ouzinkie	235	3
Maniilaq Association		
Ambler	255	3
Buckland	248	3
Deering	153	2
Kiana	392	3
Kivalina	285	3
Kobuk	65	1
Noatek	329	3
Noorvik	529	5
Point Hope	597	5
Selawik	589	5
Shungnak	226	3
North Slope Borough Health Department		
Anaktuvuk Pass	238	3
Atgasuk	190	2
Kaktovik	209	3
Nuiqsut	337	3
Point Lay	104	2
Wainwright	508	5

VILLAGE AND HEALTH CORPORATION	POPULATION*	NUMBER OF FTEs REQUIRED
Norton Sound Health Corporation		
Brevig Mission	164	2
Elim	237	3
Gambell	494	5
Golovin	131	2
Koyuk	202	2
Little Diomede	158	2
St. Michaels	287	3
Savoonga	487	5
Shaktoolik	163	2
Shishmaref	410	5
Stebbins	372	3
Teller	247	3
Unalakeet	759	6
Wales	143	2
White Mountain	164	2
North Pacific Rim		
Chenaga Bay	99	1
English Bay	192	2
Port Graham	188	2
Tatitilek	112	2
Southeast Alaska Regional Health Corporation		
Angoon	588	5
**Craig	924	2
**Hoonah	917	4
Hydaberg	463	5
Kake	634	6
Klawock	613	6
Tenakee Springs	142	2

VILLAGE AND HEALTH CORPORATION	POPULATION*	NUMBER OF FTEs REQUIRED
Tanana Chiefs Conference Inc.		
Allakaket	188	2
Artic Village	132	2
Beaver	80	1
Chalkyitsik	94	1
Circle	94	1
Eagle	79	1
Evansville	86	1
**Galena	947	1
Hughes	92	1
Huslia	272	3
Kaltag	278	3
Dot Lake	77	1
Koyukuk	143	2
Manley	88	1
**McGrath	509	1
Minto	209	3
Nenana	544	2
Nikolai	122	2
Northway	146	2
Nulato	368	3
Rampart	59	1
Ruby	241	3
Steven's Village	97	1
Tokotna	54	1
Tanacross	149	2
Telida	38	1
Tetlin	89	1
Venetie	237	3

VILLAGE AND HEALTH CORPORATION	POPULATION*	NUMBER OF FTEs REQUIRED
Yukon Kuskokwim Health Corporation		
Akiachak	459	5
Akiak	289	3
Alakanuk	556	5
Aniak	481	5
Anvik	83	1
Atmuautluak	234	3
Chefornak	277	3
Chevak	532	5
Crooked Creek	126	2
Chuathbaluk	124	2
Eek	257	3
Emmonak	613	6
Grayling	225	3
Holy Cross	238	3
Hooper Bay	686	6
Kalskag	154	2
**Kasigluk	405	4
Kipnuk	408	5
Kongiganek	291	3
Kotlik	409	5
Kwethluk	546	5
Kwigillingok	244	3
Lime Village	48	1
Lower Kalskag	281	3
Marshall	281	3
Mekoryuk	152	2
Mountain Village	682	6
Napakiak	299	3
Napaskiak	303	3
**Newtok	207	2
Nightmute	153	2
Nunapitchuk	356	3
Oscarville	63	1
Pilot Station	425	5
Pitka's Point	106	2
Quinhagak	453	5
Red Devil	42	1
Russian Mission	231	3
St. Mary's	458	5
Scammon Bay	304	3
Shageluk	144	2
Sleetmute	130	2
Sheldon's Point	124	2
Stony River	92	1
Toksook Bay	362	3
Tuluksak	321	3
Tuntutuliak	293	3
Tununak	318	3

VILLAGE AND HEALTH CORPORATION	POPULATION*	NUMBER OF FTEs REQUIRED
Independent Village Contracts		
Iyonek	269	3
Yakutat	456	5
Metlakatla	1544	1
Total Number of FTEs Needed		448

*Alaska Population Overview, 1985 Estimates, Alaska Department of Labor, April 1987.

**Formula application to this village modified by CHAP Director's knowledge of conditions in a specific village.