

ALASKA NATIVE HEALTH BOARD
ASSOCIATION OF REGIONAL HEALTH DIRECTORS

COMMUNITY HEALTH AIDE PROGRAM
IN CRISIS

A Briefing Paper

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"Fostering Native Self-Determination in Primary Care, Prevention and Health Promotion"

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BRIEFING PAPER

The purpose of this paper is to alert Congressional members, their staff and other concerned individuals to the current status of Alaska's Community Health Aide Program (CHAP). The CHAP Program is the foundation of all health care for 42,722 rural Alaskan Natives. The program is in imminent danger of collapse due to severe underfunding. There is an immediate and critical need to redress the problem of underfunding which has resulted in an unacceptably high attrition rate and unmet Community Health Aide (CHA) training needs. This has compromised the quality of care CHAs are able to provide.

OVERVIEW OF THE COMMUNITY HEALTH AIDE PROGRAM

Alaska has a total land mass of 586,585 square miles and constitutes one-fifth the area of the United States. Within this vast area, 42,722 Alaskan Natives live in 171 villages located up to 1,300 miles from the nearest sub-regional center. Ninety percent of the villages are almost entirely inaccessible. Access is gained only through small single engine aircraft. Provision of goods and services and the delivery of health care to these remote sites is a challenge of unparalleled dimensions anywhere else in the Nation.

The CHAP Program is a unique system of health care. It is designed to extend primary health care services to underserved Alaskan Natives living great distances from the nearest traditional health care facility. This system of health care is found only in Alaska.

Community Health Aides (CHAs) are village based Alaskan Native paraprofessional health care providers. They are hired by

Regional Health Corporations (P.L.93-638 Contractors) from candidates selected by the communities in which they will serve. The CHAs begin their training only after they are hired. Basic training consists of three training sessions each lasting 3-4 weeks, followed by a two week preceptorship. Training sessions are interspersed with months of village based clinical experience. Certification is gained after successful completion of a statewide certification examination. Medical supervision is provided by hospital based physicians who consult with CHAs during daily telephone or radio contact.

Unlike other primary health care providers, CHAs carry the full responsibility for their positions prior to completion of training. The responsibilities of a CHA with four weeks of training are very similar to those of a fully trained and experienced CHA.

CHAs are the sole health care providers residing in rural Alaskan villages. They assess and treat patients according to standard protocols and as directed by supervising physicians. They provide care to acutely ill patients, emergency care, well baby checks, immunizations, and other preventive activities. In addition they manage the clinic facility. CHAs maintain standard clinic hours and provide 24 hour emergency care. The job stress associated with providing health care in an isolated remote location is severe and the turnover under present conditions is considerable.

The CHAP Program became firmly established during the tuberculosis (TB) epidemic of the 1950s. Village volunteers known as "Chemotherapy Aides" monitored the administration of TB medicines in a village based treatment program. The volunteers, predecessors of the CHAs, successfully brought TB under control in rural Alaska.

In the ensuing years the role of the CHA evolved and expanded. Despite their essential role in the Alaskan Native health care system it was not until 1968 that the Federal Government recognized the CHAP Program concept.

In 1968 Congress authorized funds to train and provide a salary for 185 CHAs working in 157 villages. In 1978 the program expanded to 205 positions in 171 villages and remains at that level today. Throughout the history of the Program the CHA to village ratio has been 1.2 CHAs per village. The ratio has remained the same despite greatly expanded responsibilities, increased training requirements, a 49 percent increase in the native population and an explosion in the demand for services. In FY 1987 CHAs provided care in 208,501 patient visits.

From the outset it was recognized that one person alone could not

carry the responsibility of health care in a village 24 hours per day. An alternate (substitute) CHA system evolved. Alternate CHAs (A-CHAs) substitute when the primary CHA (P-CHA) is sick, leaves the village for training or takes annual leave. They assist with emergency care as well. A-CHAs are an integral and important component of the CHAP Program.

Funding for the CHAP Program is based on Congressional recognition of positions. Today's funding provides for training and salary for 205 Primary CHAs. In actuality these funds are stretched to support 464 positions. Funds are insufficient to provide training, supervision, and salary.

By the Indian Health Service Resource Requirements Methodology (RRM) the CHAP Program is grossly underfunded. According to RRM calculations for the CHAP, a fully funded program would cost \$21,611,627. By contrast the Federal Government funds the Program at \$5,532,304.

During the last five years, the State of Alaska has provided funds to the CHAP Program in an effort to rescue this grossly underfunded program. The state contributes \$2.2 million per year for supervision and training of CHAs. They do not provide funds for CHA salaries. These additional funds do not begin to cover the actual level of need. Further it is possible that these funds could be reduced in response to the current severe state financial crisis.

THE COMMUNITY HEALTH AIDE PROGRAM: IN CRISIS

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

1. A statewide attrition rate of 33% (151 of 464 CHAs in FY 1987).
2. The training system cannot meet CHA training needs. Thirty percent of CHAs practicing have less than the first four weeks of basic training. Fifty-seven percent have less than 8 weeks of basic training. Less than half are certified.
3. CHA salaries are inconsistent with the responsibilities of the position. Less than 15% of the CHAs are earning an income level above the Alaska Public Assistance eligibility criteria.
4. CHAs are inadequately supervised and supported in a very difficult and stressful job.
5. 28-30 villages do not have clinics leased by IHS. Many villages with clinic leases receive insufficient funds to maintain and operate the clinic facility.

The fragility of this system has serious consequences. The quality of care provided by an inadequately trained, inexperienced CHA is significantly less than that of a fully trained, experienced CHA. The quality of care for an entire village plummets with the resignation of one experienced CHA.

Coverage under the Federal Tort Claims Act was recently extended to P.L.93-638 contract employees, including CHAs, who perform medical functions. If the current funding problems continue CHAP will become more vulnerable to malpractice claims. The program needs an infusion of funds to avoid this result.

ADDRESSING THE CHAP CRISIS: A PROPOSED SOLUTION

It is clear that the Program is in crisis and demands immediate attention. To be effective, any proposed solution must address the current problems and guarantee basic medical care for rural Alaskan Natives.

During the last five months, work has been underway to define the problems and craft solutions to prevent the collapse of this program. This work culminated in a meeting of a subcommittee of statewide CHAP Program Directors, March 7-11, 1988. They developed a plan to restructure the program to improve the quality of care CHAs provide and to improve the working conditions of the CHAs to decrease the attrition rate.

The plan includes the following:

1. Increase the number of funded positions to 448.
2. Institute a work schedule which would reduce CHA burn out.
3. Increase the CHA training capacity to meet need.
4. Provide CHAs with salaries that compensate them fairly for the responsibilities of their positions.
5. Improve support and supervision to CHAs.
6. Extend the Village Built Clinic Program to all clinics served by CHAs. Ensure that clinic leases provide sufficient funds to operate the clinics.

The cost of restructuring the system would be \$28.7 million annually over the next three years to meet the training requirements of 448 full time equivalents (FTE) after which \$26.5 million per year would be required. The genesis of the \$28.7 million is set forth in "Alaska Community Health Aide Program In

Crisis". The cost does not include improving clinic facilities and operation and maintenance costs.

Realizing that budgetary constraints have necessitated cuts in Federal and State funded programs and that full funding of the CHAP Program at this time may not be possible, the CHAP Directors have prepared an alternative budget with a reduction of all CHAP personnel salaries by 25%. This less preferred alternative would require an initial budget of \$22.5 million over each of the next three years followed by a maintenance budget of \$20.3 million per year. The CHAP Directors caution that this less preferred alternative fails to fully correct the inadequate CHAP Program salary structure.

CONCLUSION

The Community Health Aide Program is a vital component in the health care delivery system for rural Alaskan Natives. CHAs provide health care services to 42,722 Alaskan Natives living in remote, isolated villages of 50-900 people who would not otherwise have access to health care. 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 of this program.

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.