

COMMUNITY HEALTH AIDE PROGRAM: The Crisis Remains

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for the Alaska Native Health Board

March 3, 1989

The Community Health Aide Program is the backbone of the entire Native health care system in Alaska. It is the sole means for 42,772 rural Alaska Natives to receive primary care and to access secondary and tertiary health care. Found only in Alaska, the system evolved over the past thirty years when the traditional Public Health Service health care model of regional hospitals failed to provide health care to natives living in remote rural areas.

Community Health Aides (CHAs) serve in isolated villages with populations of 50 - 800 people. They are village based paraprofessional health care providers selected from and by the communities in which they serve. They perform a wide variety of health services ranging from emergency care to diagnosing and treating a wide variety of illnesses and providing preventive care. CHAs are the only health care providers living in the village. They consult daily with physicians by telephone or radio.

The Community Health Aide Program (CHAP) is widely recognized as a cost effective, acceptable and indispensable component of Native health care in Alaska. Last year CHAs provided care in 228,185 patient encounters. However, there is great concern statewide that the program is faltering.

In 1988, the Alaska Native Health Board supported a project aimed at identifying program problems. The report and briefing paper "Alaska Community Health Aide Program in Crisis" documents that the program is in crisis and is in imminent danger of collapse due to severe underfunding. The document outlines a need to fund a "no frills" program at \$28.7 million per year. In 1988 the program was funded with both federal and state dollars at \$7.7 million which is 27% of the need. The result, an annual statewide attrition rate of thirty-three percent (151 of 464 CHAs); eighty-five percent (85%) of CHAs are eligible for public assistance and most alarming, thirty (30%) of the practicing CHAs had less than the first four (of twelve weeks) of basic training. Finally, CHAs were not receiving adequate support and supervision in their difficult and demanding jobs.

This information was presented to Congress in March of 1988. Congress recognized the seriousness of the problems and granted a \$5 million increase for FY89. This brings the program funding level to forty-four percent (44%) of the need. We are nearly half way through FY89 and have not yet received any of the new program dollars. Therefore, we cannot show any changes in the program as a result of increased funding.

Over the past six months the Alaska Native Health Board, the Association of Regional Health Directors, the Community Health Aide Program Directors, and the Alaska Area Native Health Service have worked closely to determine how to distribute the new funds.

A more difficult decision was to determine how to utilize the funds.

The CHA salary, work schedule, training and support needs are great; each cause has its own merits in laying claim to the entire amount. However the CHA salary and working conditions were the most compelling problems and had to be faced first. Under the current system, primary CHAs are "on call" 24 hours a day, 365 days per year. Alternate CHAs are expected to provide back up for the primary CHA. They too must be available 8,760 hours per year. The CHAs are thus compensated at the following rates:

CHA-Hour Salary based on an 8,760 hour work year: March 1988

<u>CHA Mean Annual Salary</u>	<u>Hourly Rate</u>
Primary - \$17,397	\$1.99 per hour
Alternate - 4,000	.45 per hour

When the funds are available, most of the \$5 million in new dollars will be directed to CHA salaries and additional positions. Most if not all corporations will promote alternate CHAs to primary status and implement a more reasonable work schedule for all CHAs. This will greatly reduce CHA stress which is the primary reason CHAs leave their jobs. CHAs' salaries will be raised but most will still be eligible for public assistance until additional appropriations are obtained.

The second most compelling need is training for CHAs. The roles and responsibilities of a CHA are most similar to that of a midlevel practitioner with three to six years of training. Unlike midlevel practitioners, CHAs are given some or all responsibility of their positions at the time of hire PRIOR to beginning any formal training for the position.

The average amount of time that a CHA must wait to take the first four weeks of a ten week training course is six months. One third of CHAs practicing have not yet completed Session I. The list for CHAs waiting to take Session II and Session III is long. A CHA may need to wait several years to take these sessions. Meanwhile, they have the lives of men, women, and children literally in their hands. It is no longer tolerable for a CHA to wait six months or more for the first exposure to formal training.

Four CHA training centers are in existence today. Two receive some funding for their programs but the funding does not permit adequate numbers of training staff. The remaining programs are not formally funded and must pull funds from CHA support and from supervision funds to conduct needed basic training. This places a significant strain on all staff, and reduces resources targeted for direct care.

The current capacity, statewide, for CHA training is 29 sessions per year. The current need is for 69 sessions. Major expansion of the training program must occur. This in itself poses another major problem--lack of manpower to provide the training. It is extremely difficult to recruit and retain midlevel practitioners for training and for supervisory positions. In order to conduct 69 sessions per year twenty two (22) additional instructors will be needed. The short term solution to this problem is to continue to hire midlevel practitioners from outside the state. The long term solution is to encourage CHAs to pursue careers at higher levels in the health field and prepare and support them in their endeavor. Since 1981, 17 former CHAs have completed physician's assistant training. 14 have returned to and are working in the state. Efforts must continue and intensify to meet this health care manpower shortage.

The Community Health Aide Program is a cost effective means of providing health care to residents of isolated communities in Alaska. Appropriate technology is used to deal with health problems at the local level. A well developed referral system is in place to deal with health problems requiring a higher level of technology. Alternative methods to delivering primary health care to this population are impractical and cost prohibitive. Two alternatives come to mind:

#### ALTERNATIVE 1

Place midlevel practitioners in each village.

#### Problems:

- a. Currently, there are not enough midlevel practitioners in Alaska to fill this need. Positions would need to be filled from outside the state by people who would need to learn to work within the cultural setting in a Native Village.
- b. Seventy-eight percent (78%) of the villages have a population of less than 400 people. It would be extremely difficult to find practitioners to work in such small village settings. Most would be under utilized.
- c. The recruiting, relocating, salary and benefits cost per midlevel practitioner position would exceed \$65,000 per year.
- d. A high attrition rate would have to be anticipated due to isolation of the practitioner from colleagues and his/her own family.
- e. The practitioner would not necessarily be accepted by the community.

ALTERNATIVE 2

Transport all patients needing health care to a regional health care center.

Problems:

a. Last year CHAs provided care in 228,185 patient encounters. Round trip transportation costs could be estimated to be \$150 each. The cost of transportation only for providing access to care would exceed \$34 million per year. The cost of the actual patient encounter would have to be factored into the cost formula as well as the cost of expanding staff and physical plants to accommodate the increased patient load.

b. Weather conditions are severe and extremely variable in Alaska. Transportation disruptions due to weather are a frequent occurrence. Villages could be cut off from all services for more than a week at a time.

c. There would be no one in the village to take care of the day to day problems. Children with bacterial infections, fevers, and minor injuries and women needing prenatal exams would not be served. People simply cannot "save up" their illnesses for times that the weather permits air travel.

The Community Health Aide Program must be funded at \$28.7 million, as outlined in "Alaska Community Health Aide Program In Crisis." The total federal and state budget for FY89 for CHAs is approximately:

IHS (Anchorage - CHAP plus tribal component)	\$10,034,765
State House Bill 215	1,700,000
State to Kuskokwim College	<u>200,000</u>
TOTAL	\$11,934,765

Funding Shortfall:

Budget Need Per Year	\$28,700,000
Current Annual Budget	<u>11,934,765</u>
TOTAL amount needed annually to correct program deficits	\$16,765,235

It is critical that funding for the CHAP not be lost in the IHS distribution system. The CHAP program is such a unique feature of IHS activities that this appropriation needs to be delineated as a separate line item within the overall IHS budget.