Community Health Aide Program

Update 2001

Alaska's Rural Health Care at Risk

CHAP Directors' Association

for the

Alaska Native Health Board

Association of Tribal Health Directors

Final Report

May 8, 2001

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Alaska Association of CHAP Directors 1999-2001

Definition of Terms

- **Community Health Aides (CHAs)** and **Community Health Practitioners (CHPs**) are referred to collectively as CHA/Ps. Individually a person is a CHA or CHP depending upon the level of their education and experience.
- **CHAP** means Community Health Aide Program.
- **CHAP Directors' Association** is the organization of individuals who supervise and lead the tribal Community Health Aide Programs.

The following is a report by the CHAP Directors to the Alaska Native Health Board and the Association of Tribal Health Directors outlining the status of the CHAP program at this time. This report was presented to the combined groups on November 29, 2000 and February 19, 2001.

CHAP 2001 Update - Executive Summary

The Community Health Aide Program developed to meet the health care needs of Alaska Natives in remote villages. It is the only health care delivery system of its kind in the United States. This program emerged, in part, as a result of the tuberculosis epidemic and the use of village workers to distribute antibiotics in the 1950's. It became a formal, federally funded program in 1968. Today 500 Community Health Aides/Community Health Practitioners (CHA/Ps) in 178 rural communities provide emergency and primary health care services in their villages.

CHA/Ps are the patients' first contact within the network of health professionals in the Alaska Native Health Care System. This network also includes field supervisory staff, referral physicians at regional hospitals and a tertiary care facility.

The CHAP Directors meet regularly and share the problems and advances of their programs. Over the last few years there have been growing concerns related to the obligation to provide increasing health care services, limited resources and increasing turnover of all program personnel. This awareness, coupled with funding that has not kept pace with programmatic needs, motivated the CHAP Directors' Association to complete a needs assessment of the statewide program. In June 1999 a survey was sent to the CHAP Directors requesting information on financial and programmatic shortfalls. This report summarizes the data, concerns and recommendations.

An increase in the number of CHA/P positions is thought to be the best way to address many identified concerns: more patient encounters, greater complexity of care, increased requirements for training and certification, rapid advances in technology, and factors related to attrition.

Supervision is an essential component of this program and has been identified as an area of critical need. Supervisors help assure the quality of health care provided at the village level, monitor job performance, and support and guide the worker.

Educators and supervisors must create or modify all of the essential documents used to guide the practice of the CHA/Ps. In addition to assuring medical accuracy, the manuals must take into account the CHA/P role, level of basic education, level of CHA/P training and supervision, types of patients seen, the referral system, and the realities of clinical practice in remote locations. Frequent updates are critical to maintain the current standard of medical care.

Based on a current review of Community Health Aide Program needs, the CHAP Directors' Association makes the following recommendations to increase annual funding.

- Increase CHA/P positions by 25% (125 positions) Cost: $ 6.1 M
- Increase supervisory positions by 45% (23 positions) Cost: 2.3 M
- Increase Training Center capacity Cost: 1.2 M
- Assure Program Standards Cost: .3 M

In addition, the need for increased funding for the Village Built Clinic (VBC) Program has been identified as a key factor in the delivery of quality health care. In order to meet identified VBC needs, $2.2 M is required now for operation and maintenance of the 170 clinics currently leased. As new and larger clinics are built it is anticipated that an additional $ 2.9 M will be required for these leases.

- Fund current VBC needs Cost: $ 2.2 M
- Fund projected VBC needs (2003-2005) Cost: 2.9 M

The total cost to implement CHAP program and VBC recommendations is an additional $12.1 M per year now, increasing to $ 15 million annually in 2003.

CHA/P services are a sustainable, effective, and culturally acceptable method for delivering health care. This unique program has demonstrated adaptability to advances in medicine and the evolving health needs of the population, and it does so at comparatively low cost. The total program operating budget is $45 M and provides emergency and primary health care to 50,000 Alaska Natives at a cost of $900 annually per patient ($45M/50,000). Adequate funding is needed to assure that the Community Health Aide Program continues as the foundation of health care delivery to rural Alaska Natives.

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B. AANHS – CHAP Resource List – April 17, 2001

Introduction

The Community Health Aide concept began in the 1950's in response to a number of health concerns including the tuberculosis epidemic, high infant mortality, and the high rate of injuries in rural Alaska. In 1968, the Community Health Aide Program (CHAP) received formal congressional recognition and federal funding. It has proven to be a cost effective, efficient and essential component in improving the health of the Alaska Native people by decreasing morbidity and mortality. This program is unique in the United States and has become a model for the delivery of primary health care services.

The CHAP Directors meet regularly and share the problems and advances of their programs. Over the last few years there have been growing concerns related to the obligation to provide increasing health care services, limited resources and increasing turnover of all program personnel. This awareness, coupled with funding that has not kept pace with programmatic needs, motivated the CHAP Directors' Association to complete a needs assessment of the statewide program. In June 1999 a survey was sent to the CHAP Directors requesting information on financial and programmatic shortfalls. All 26 programs responded to the survey. This report summarizes the data, concerns and recommendations.

To assure and improve the quality of village health care, it is recommended that additional funds be provided to support the following actions:

- Increase the number of CHA/P positions
- Increase the number of Field Supervisors
- Increase statewide training capacity
- Facilitate on-going updates of materials unique to CHAP (medical and medication manuals, curriculum and standards)

In addition, the need for increased funding for the Village Built Clinic (VBC) Program has been identified as a key factor in the delivery of quality health care. The following actions are recommended:

- Increase funding for current Village Built Clinic leases
- Increase number of leases and funding for new and larger clinics

Disparities in dental and behavioral health have been identified as top priorities in village health care. Aspects of dental and behavioral health services are already part of the primary care role of CHA/Ps (see Appendix A, CHA Curriculum 1997). By necessity emergency and acute care services must take precedence over dental and behavioral health services. There is a tremendous need for an increase in these services in Alaska communities.

The concept of "Village Health Services" with parallel programs for both dental and behavioral health workers using the model and infrastructure of the CHA Program would address these needs and build on the program as the foundation of village health care. This would assure an integrated approach to health care services in Alaska villages.

Alaska

Geography

Alaska has a total landmass of 586,585 square miles and constitutes one-fifth of the area of the United States (see Figure 1). Within this vast area, approximately 50,000 Alaska Natives live in over 178 villages located as far as 1300 miles from the nearest regional center (1). Ninety percent of the 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 and the delivery of health care to these remote sites is always a challenge.

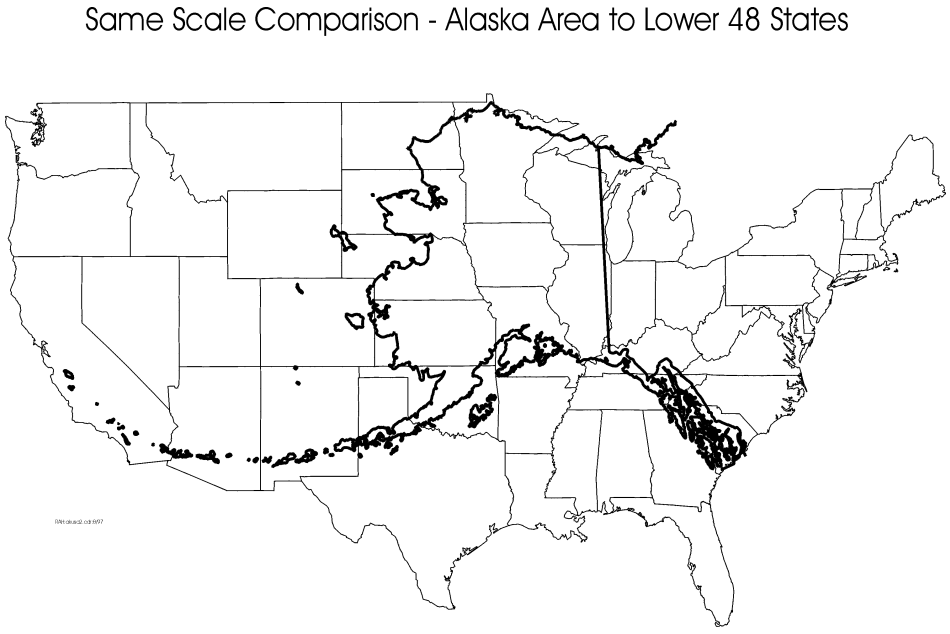

Figure 1

Weather

There is tremendous variation in climate and terrain, ranging from a mountainous maritime environment in Southeast Alaska to an arctic plain in the Arctic Slope area. 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. The villages are frequently isolated by weather so that travel to regional hospitals for medical care may be impossible for several days at a time.

Population and Health Status – Alaska Natives

The Alaska Native population has increased by 20% since 1990 (1). Alaska Natives now represent 16% of the state's population. The Alaska Native population is youthful compared to the U.S. All Races population. The youth (age birth to 14 years) comprise 33% of the Native population compared to 21% for the entire U.S. population. The percentage of infants (birth to 1 year) is twice that of the general population. The birthrate is 19.7 compared to 15.2 for the general population. Fifty two percent are less than 25 years old, while only 5% are older than 65 years (U.S. All Races is 13% 65 or older).

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 their childbearing years, are frequent consumers of health care services. Older persons are likely to experience chronic conditions requiring regularly scheduled contact with the health care system. In addition there is a trend for terminally ill patients to return home requiring intensive end-of-life care.

The accidental death rate among Alaska Natives is 4.5 times the rate for U.S. All Races and the suicide rate is 4.6 times that of U.S. All Races. In both cases the male rates are extreme.

The health status of rural Alaska Natives is also related to low socio-economic status, subsistence lifestyle, rapid social change, the harsh climate and terrain, and the isolation of the communities in which they live. Twenty-four percent of Alaska Natives live below the poverty level compared to 13.1% for U.S. All Races.

The following table illustrates the population distribution and health disparity between the Alaska Natives to the United States All Races (2):

	Alaska Native	All U.S.
% Youth (birth-14 ys)	33	21
% Infants	3.1	1.5
% <25 years old	52	----
% >65 years old	5	13
Birthrate (1,000 pop)	19.7	15.2
Accidental death rate	154.1	32.2
Suicide rate	58.8	14.8
Life expectancy in years	68.9	75.8
% Below poverty level	24	13.1

Until recently, emphasis of care was on infectious disease and accidents. Although accidents still contribute greatly to morbidity and mortality, lifestyle diseases have supplanted infectious disease in frequency. From 1985 to 1998, the Eskimo population had a 110% increase in diabetes mellitus, compared to the 23% increase seen for the entire United States. This represents a 4.5 fold increase, over the national rate, in the occurrence of this one lifestyle disease in the Eskimo population (3).

Although there is disparity in the morbidity and mortality data, there is improvement in the Alaska Native infant death rate. Infant mortality has decreased steadily over the past twenty years and is approaching the U.S. All Races Rate. Credit for this improvement goes to CHA/Ps and the network of Maternal Child Health programs in rural Alaska in association with improved housing and sanitation.

Infant Death Rates per 1,000 Live Births (4)

Year	Alaska Native	All U.S.
1980	17.6	12.6
1988	12.7	10.0
1996	8.1	7.2

CHA/P Program History

In the 1940's and 1950's, the tuberculosis epidemic necessitated sending many people away from their homes and communities for care in sanitariums. With the advent of effective antibiotic therapy, the possibility of home treatment was realized. In coordination with the Territorial Department of Health (now State of Alaska, Department of Health and Social Services) and later the United States Public Health Service, local villagers volunteered to assist in medical management of patients by administering medication and observing its consumption. As these volunteers (known then as "chemotherapy aides") worked alongside the doctors and nurses they learned additional skills. Health care workers and volunteers both realized the benefits of providing direct services in the village. A natural progression of training and supervision developed and the Community Health Aide Program evolved. With congressional funding in 1968, CHAs were paid a salary and formal training programs were established (5).

In 1988, members of the CHAP Directors' Association compiled a report called "CHAP in Crisis" (6). This document took a succinct look at the current state of CHAP affairs. As a result of that report there was a significant increase in federal funding for the program. Funding in 1988 was $5.5 million. In FY 1989 it increased to $10.5 million and in FY 1990 to $17.5 million. In FY 1997, $23.1 M was available to the program statewide. After that time funding for CHAP was not a distinct subset within the "Hospitals and Clinics" budget made available to tribal organizations through their Annual Funding Agreements in accordance with self-determination legislation. In 1999, concerns of increasing service obligations and limited resources prompted the CHAP Directors to re-examine the issues of "CHAP in Crisis".

Outcomes of "CHAP In Crisis" Increase in Funding

The additional funding from the "CHAP in Crisis" report provided for many positive changes in the statewide program. The total number of Community Health Aide funded positions increased, there was increased equity in salaries, benefits and training throughout the state and the number of faculty positions and student slots at training centers increased.

The increase in funded CHA/P positions did not result in "new" CHA/Ps. Prior to 1988-89 many villages had only one funded CHA/P position. There was a need for some relief coverage to allow for the absences of the CHA/P related to training, sick leave, vacation and emergency patient escort. Individuals volunteered or were reimbursed by local village councils. They were called "Alternates". When the "new" positions were funded, the already-working Alternates stepped into them. The new monies converted the Alternates to regular employees of the tribal organizations, with the same training, salaries and benefits as the "regular" CHA/Ps. Although the number of CHA/Ps per tribal organization increased, the actual number of workers per village essentially remained the same.

In addition to salaries and benefits extending to all CHA/Ps, the Training Centers received a large portion of the increased funds. This allowed training centers to address the backlog of students waiting to progress through training by adding additional faculty. Training Centers made a concerted effort to standardize the curriculum and assure quality throughout the program. That effort was first realized in 1993 and continues today through the work of the Academic Review Committee. In 1990, 40% of the CHA/Ps were CHPs. Today over 60% are CHPs.

One area, which was not adequately addressed by the increase in program funding, was Field Supervision. This remains one of the greatest concerns for both CHA/Ps and CHAP Directors.

CHAP Today

Overview

As the CHA program developed, the move for implementation of tribal self-determination also grew. In 1975, Public Law 93-638, the Indian Self-Determination and Education Assistance Act was passed allowing tribes to manage and direct health care programs. The law allows tribes to reprogram their federal funding in a manner which addresses their priorities and goals.

Disease patterns, and concurrently CHA/P duties, have changed over the last 50 years. When the program began, infectious diseases were the major emphasis with tuberculosis and meningitis causing great morbidity and mortality in the villages. Since then, infectious diseases are not as prominent but lifestyle diseases have become a dominant concern. Diabetes, heart disease and cancer were nearly unknown in the population during the 1950's but are common today. Cancer is now the leading cause of death in Alaska Natives. Behavioral health diagnoses are common. AIDS is also a concern for both patients and health care providers.

Today there are approximately 500 CHA/Ps working in 178 clinics (7). These providers have approximately 300,000 patient encounters per year. In addition to staffing and managing their individual clinics during regular office hours 5 days a week, CHA/Ps respond to medical emergencies 24 hours a day, seven days a week, 365 days a year.

CHAs are hired by tribal organizations from candidates selected by the communities in which they will serve. They start working in the clinic as soon as they are hired, learning the CHA/P role. Formal training occurs as soon as possible allowing them to provide patient care as they progress through training and required field work. Unlike other primary health care providers, CHAs carry the full responsibility for their position prior to completion of their education.

The CHA/Ps provide acute care evaluation and treatment for common medical problems; emergency care; preventive care: prenatal, well child monitoring and immunization, and health surveillance; and, chronic disease monitoring, evaluation and referral, while maintaining a village clinic. CHA/Ps work within the guidelines of the Community Health Aide Program Certification Board Standards and Procedures, as amended February 26, 1999 (8). The Alaska Community Health Aide/Practitioner Manual, 1998 Revised Edition, outlines assessment and treatment protocols and is an integral reference for each patient encounter. There is an established referral relationship which includes midlevel providers, physicians, tribally managed regional hospitals, and the Alaska Native Medical Center, a tertiary care facility. In addition, a variety of health care professionals make visits to the villages to see clients in collaboration with the CHA/Ps.

CHAP has expanded its curriculum and training over the last 32 years in partnership with the University of Alaska (since 1975). The curriculum provides breadth, depth, sequencing of content, synthesis of learning and rigorous assessment of learning outcomes (see Appendix A, CHA Curriculum 1997). The training for this large volume of medical knowledge and clinical skills is divided into four intensive basic sessions (6-8 students per class); each is four weeks long (8-10 hours/day) with approximately 50% classroom and 50% "hands-on" clinical practice, including direct patient evaluation and care. The training is competency based: to pass a session a student must receive 80% scores on all written (theory) and clinical skills examinations.

The CHA must pass an Emergency Trauma Training or Emergency Medical Technician course before the first session; emergency care skills are reviewed and additional skills are taught in each of the four training sessions.

The sessions of CHA training each last four weeks. After each session a post-session evaluation is completed by the employing tribal organization supervisor who visits the CHA in her/his village clinic for reinforcement of patient care theory and skills. The CHA must work a minimum of 200 hours (60 patient encounters) before the next session. The interval between sessions is often long (six to twelve months) due to the limited openings at the training centers. In addition to the four sessions, the CHA/P credentialing process includes: a field clinical skills checklist; an individualized 1-2 week clinical preceptorship; evaluations by the itinerant physician and public health nurse; and a statewide standardized written and medication skills exam. Upon successful completion of all requirements, a CHA becomes a Community Health Practitioner (CHP) and is credentialed by a training center. Training for a new hire, from Community Health Aide through to Community Health Practitioner takes approximately 2 years. Minimum standards for each level of CHA or CHP are defined by the CHAP Certification Board (8). A standardized training curriculum and regular on-site review of training centers help assure quality.

The University of Alaska Fairbanks (UAF) recognizes the academic rigor of the CHA/P education. Upon completion of the four sessions with post-session training components and clinical preceptorship the student receives 34 credits and is awarded a UAF Certificate in Community Health. The credits also meet the major specialty requirements for the Associate of Applied Science degree for CHPs who pursue additional education. More than 50 CHA/Ps have earned their AAS degrees, many have gained entrance to Physician Assistant and nursing programs and others have gone on for advanced degrees in other health related fields.

CHA/P Workload

From the early days of distributing tuberculosis medications, to the modern era, the workload of the CHA/P has changed dramatically, both in scope of practice and in sheer volume of work. Multiple factors converge, creating an increasingly complex CHA/P role. At the same time that Alaska Natives experience a birthrate 30% higher than the U.S. rate, the life expectancy of Alaska Natives has extended, increasing the number of frail elders in rural villages. Villagers at both ends of the age spectrum are frequent users of clinic services. The younger ages, requiring frequent visits for well child care and immunizations, are also prone to high rates of infectious diseases: ear infections, sore throats, respiratory illnesses and distress, often resulting in late night clinic visits. For the village elders, the added years of longevity bring high rates of chronic illness, including diabetes, hypertension, heart disease, and cancer, as well as an increased need for home care during the final years of life.

While the CHA/P is coping with an increased and more complex patient load, the demands associated with advancing technology and the requirements of accrediting agencies also impact their workload. New equipment, including programmable fax machines, computers, Automated External Defibrillators, and telemedicine equipment demand extensive training, made difficult by the distance between clinics and supporting resources. Without the training, the equipment is useless. Yet resources, both in personnel and in village travel budgets, are inadequate to meet the demand.

"I'm never off." the CHA/P says. The responsibility of being on call for emergencies 24 hours a day, 7 days a week, 365 days a year is a huge burden. Never knowing when one will be called to a serious accident, or having to respond to a major medical emergency, adds to the job stress. This stress is accentuated by the close relationships in the village, and the need to care for family and close friends, a practice that is normally discouraged in cities and towns with expanded health care options. In the village, the CHA/P has little or no choice. CHA/Ps have considerable difficulty when complying with State reporting laws, mandating that they report in situations involving violence and child abuse/neglect especially when family members are involved.

High rates of alcoholism, suicide, and risk taking behavior make traumatic events a common village occurrence. A recurring complaint of CHA/Ps is the immense burden of being the sole provider in an emergency. The importance of maintaining confidentiality, especially in a small village, makes discussing traumatic events with friends and family impossible.

> *"Since I started working, which is 9/17/90, we have had these emergencies: fatal knife stab to the heart, several heart failures, strokes, deliveries, broken bones, drownings, accidents: snowmachine, all terrain vehicle, boating, sports, and work related; infants choking, chronic patient emergencies, sudden infant death syndrome, allergic reactions: to bugs, food, home products; child abuse, domestic violence, alcohol related accidents, severe frostbite, gunshot wounds, suicides and least of all dealing with a sniper shooting at anybody just recently. Our closest hospital is 95 air miles away……"*

The challenges of living and working in a harsh environment are particularly felt during emergencies when transportation may be impossible due to weather or equipment (no runway lights, inability to clear runway, lack of plane or helicopter) for medivac. The CHA/P has no choice but to manage as best she/he can, feeling the weight of life and death in her hands.

Many of Alaska's rural villages are small, employing only two or three CHA/Ps. Some villages have only one. While hospitals and larger medical practices have a range of support personnel and services, the village clinic performs multiple functions: primary care health clinic, public health clinic, dental office, pharmacy, laboratory, home care resource, counseling center, patient travel center, and others including occasional veterinary services. This multi-use concept is logical with respect to utilization of resources, but as the clinic manager, the CHA/P must often assume responsibility for coordinating many activities and providers in addition to her own multi-task workload (provider, receptionist, lab technician, pharmacist, patient educator, travel clerk).

CHA/Ps must feel supported by their councils and community in order to be an effective health care provider. Frustration due to lack of support, unreasonable demands such as non-urgent after-hours call-outs and criticism all contribute to stress, burnout, and resignation. For example, the absence of a Village Public Safety Officer (VPSO) leaves CHA/Ps in danger when alcohol and physical violence are involved and forces the CHA/P to make reports and referrals that normally would be the job of the VPSO. Some villages have limited or non-existent First Responder groups which places a greater responsibility on the CHA/P. CHA/Ps frequently state that they never feel really off duty. The village council and community can influence the working conditions for the CHA/P, which can positively impact the health of the community while retaining trained health care providers in the village.

Attrition and Burnout

While Alaska is losing some of its most experienced CHA/Ps from the "graying" of the profession, more often the losses are coming from younger CHA/Ps who are frustrated by the immense responsibility that rests on their shoulders, and the lack of sufficient clinic staff and supervisory and technical support. Discussions of "burnout" have become common. Anger flares at unmet requests for an itinerant CHA/P when a co-worker is sick or away for training or when a CHA/P has a sudden need for personal time off and is unable to take it because they must staff the clinic. As village grants secure funding for other well-paying employment, the CHA/P sometimes leaves to take on less taxing work. Some leave because their spouses are now working, and they feel more liberty to respond to their family demands. Sometimes the departure of one of the village CHA/Ps prompts the departure of another. Already stretched thin by a demanding job, the remaining CHA/Ps express anxiety related to the additional burden of a new hire CHA, and the inherent years of study and experience needed for the new CHA to reach a level of competency lost by their co-worker's departure.

CHA/P attrition rates have been documented at several points since 1987. Significant increases in funding led to program changes recommended by "CHAP In Crisis"(6) with impressive results. However, those strategies are no longer effective for the current program. The concern now is the increasing attrition rate and the multiplicity of causal factors.

CHA/P Attrition Rates & Percent Change Over Time (9)

- FY 87 33% -
- FY 89 24% 9% ↓
- FY 92 18% 6% ↓
- FY 93 12% 6% ↓
- FY 99 20% 8% ↑

Since 1993 the attrition rate of CHA/Ps has climbed to 20%. The loss of every single CHA/P translates into a significant loss to the village and the service delivery network. The rising attrition rate is seen as a "red flag" indicator of a potential trend to lose even more CHA/Ps from the system.

Need for an Increase in Community Health Aide/Practitioner Positions

An increase in the number of CHA/P positions is thought to be the best way to address many concerns already identified: more patient encounters, greater complexity of care, increased requirements for training and certification, rapid advances in technology, and factors related to attrition. Currently, there are approximately 500 CHA/P positions. A 25% increase would provide 125 additional positions for a total of 625. The estimated cost is $ 6.1 million.
(See Budget Summary, page 18).

- Current unmet need = 25%
- Average salary (@ $18/hour) $ 37,440
- Fringe @ 30% 11,232
- Total per position 48,672
- Total cost (125 x $48,672) 6,100,000

Field Supervision

Overview

Supervision is an essential component of this program. Supervisors help assure the quality of health care provided at the village level, monitor job performance, and support and guide the worker. This is critical due to the nature of the CHA Program - a corps of indigenous health care providers specifically trained to meet the needs of a population with significant health status disparities living in some of the most remote locations in the world.

Overall job performance of CHA/Ps is monitored by the Field Supervisors employed by the tribal organizations. The supervisors ensure that the policies of the organization are implemented for these village based employees. Supervisors for CHA/Ps provide oversight via field visits to village clinics and through daily to weekly telephone communications with the CHA/P. Supervisors monitor CHA/P job performance in all aspects and assist the CHA/P in achieving a high standard of performance. They support, teach and give guidance to CHA/Ps, assist with problem resolution, provide moral support, and serve as a liaison between the medical system and the CHA/P, and the CHA/P and the village. The Supervisors work very closely with the local governing body in each village to ensure that CHA/Ps receive the necessary support from the community.

There are three critical components to field supervision:

- Administrative (recruit CHA/Ps, evaluations, schedules, policies, regulatory compliance with CLIA, OSHA, JCAHO)
- Clinical (post session learning needs, evaluations, quality assurance, medico-legal issues)
- Psychosocial support (critical incidence stress debriefing)

According to the CHAP Directors' 1999 Survey, 39% of Field Supervisors are CHPs, 7% are RNs and 54% are midlevel practitioners. All supervisory personnel can provide administrative and psychosocial support but clinical competency assessment requires a midlevel practitioner. In fact, the CHP may be the best to provide the psychosocial support. The CHP who was born and raised in a village can usually pinpoint the psychosocial concerns of Native communities much faster and with greater accuracy than an outside medical professional. Clinical practice competence issues, however, must be managed by midlevel practitioners. If supervisors do not have this level of training, the employer must hire additional staff or contract with midlevel practitioners to provide this aspect of supervision.

Since 1991, the need for field supervision has increased. There has been an increase in the number of people to supervise while the number of supervisors has remained essentially the same. There are currently more clinical quality assurance issues and requirements, increased post session training follow up needs, increased complexity of workload and interventions, and an ongoing refinement and expansion of the CHA/Ps' role in improving the health status of rural Alaska Natives.

Presently, the ratio of villages and CHA/Ps to Field Supervisors is so high that none of the essential components of supervision are being well attended. Field Supervisors report that they are doing too many things, causing the quality of each to suffer. It is difficult to prioritize the choice between meeting mandatory federal regulatory standards, keeping up with the CHA/Ps' medical training and providing emotional support to a CHA/P who has just responded to an

emergency. If there are not enough CHA/Ps to staff the clinic, some supervisors must go to work in the clinic, or the clinic is forced to close leaving the village with only emergency response medical care. This is occurring more frequently in more regions of the state.

Field Supervisors are increasingly responsible to staff statewide program activities. As part of self-determination, tribal organizations now have the role of setting program goals and priorities. Field Supervisors have replaced Indian Health Service personnel on many committees which determine program priorities and needs. As front-line workers, Field Supervisors are the appropriate people to do this work. It does, however, create another demand for their time, which is typically allocated for the direct supervision of CHA/Ps in the village.

An optimal number of Field Supervisor visits to each clinic would be four per year. If a Field Supervisor had four villages, this schedule would require a minimum of 16 weeks of travel per year. Field Supervisors who are members of one of the committees mentioned above should have time allotted for this in their scope of responsibilities. Additionally, no Field Supervisor should supervise more than 12 CHA/Ps and there should be at least one midlevel provider in each region. In order for CHA/Ps to receive adequate training, the Field Supervisors' workload must be proportional to the need.

According to the 1999 CHAP Directors' Survey, the attrition rate for Field Supervisors was 20%, the same as for CHA/Ps. The loss of one field supervisor impacts the entire region and can have a significant effect on the progression of a CHA/P through basic training sessions since "on the job" skill evaluation is an essential part of training.

Field Supervision Needs

The current unmet need of Field Supervisors is 20%, based on the number of CHA/Ps currently in the program. Our plan calls for a 25% increase of CHA/Ps, so future needs would dictate an increase of Field Supervisors to match. This amounts to a need for a 45% expansion in Field Supervisors, or 23 positions.

- Current unmet need = 20%
- Projected expansion = 25%
- Total need for increase in Field Supervisors (20% + 25%) = 45%
- Present positions 52
- Needed positions 23 (52 positions x .45=23.4)

The new positions would be CHPs, RNs or midlevel practitioners at the discretion of individual programs. An estimated annual salary is $75,000, and may vary depending on the qualifications and experience of the applicants. Using a $75,000/year salary, 30% fringe benefit and $2,500 for required credentialing and continuing education, each position would cost $100,000. Twenty-three positions would cost $2.3 million dollars. This will meet both the immediate and future needs for field supervision. (See Budget Summary, page 18).

Average salary	$ 75,000
Fringe @ 30%	22,500
Credentialing, CME	2,500
Total per position	100,000
Total cost	2,300,000

Training Center Capacity

Overview

In the past 50 years, the role of the CHA/P has evolved and expanded, as has the training of these health care workers. The curriculum is standardized and is always in a dynamic state of change to accommodate advances in medical practice, medication regimes, and technology.

All training is centered on a curriculum developed specifically for this program. In addition, the Alaska Community Health Aide/Practitioner Manual, 1998 Revised Edition, (CHAM) and the Village Medicine Reference, 1997 (VMR) are reference texts used during each patient encounter. Students are taught a comprehensive approach to each patient including how to obtain a history, how to perform a physical examination, how to make an assessment and how to develop a treatment plan. The short intensive nature of CHA medical training requires a faculty to student ratio of 1 to 1 or 1 to 2 depending on the competency of the students' clinical skills (8). The development of the 1993 curriculum (Revised 1997) and Review and Approval Committee brought tight standardization to training so that students can attend sessions from center to center. This has assisted students to progress through all four sessions of training in the most timely manner.

There are currently four Community Health Aide Training Centers. Each is managed by a tribal health organization and can accommodate from 42-64 students per year. The total system capacity is 208 students per year.

▪ Alaska Native Tribal Health Consortium (Anchorage)		Capacity: 54
▪ Norton Sound Health Corporation (Nome)		Capacity: 48
▪ Southeast Alaska Regional Health Consortium (Sitka)		Capacity: 42
▪ Yukon Kuskokwim Health Corporation (Bethel)		Capacity: 64
	Total	208

Based on the 1999 CHAP Directors Survey, there is a projected need for 285 slots in the training program (an unmet need of 27%). This accounts for attrition, new positions and 2/3 of the number of previous sessions' students working through the four-session curriculum. It does not include the potential impact on the training centers related to dental and behavioral health initiatives.

Expansion of the current training facilities is limited most often by clinical opportunities essential to training. In addition to four Basic Training sessions, some Training Centers offer Pre-Session I, preceptorships, recredentialing, advanced skill training and continuing medical education which are also critical program elements. However, this further increases the demand on faculty and financial resources.

In FY 2000, a Training Center closed due to lack of funds. In order to operate, Training Centers require supplementary funds from their tribal organizations in excess of the historic Indian Health Service funding. Closure of this Training Center cost the statewide program 36 training slots, a significant contribution to the 27% unmet need for training slots.

Increase Training Capacity

The recommendations for increasing the capacity of the Training Centers are twofold. First, there is need for an additional Training Center. This means 6 full time faculty, administrative support, equipment and supplies which will yield 48 additional training slots. Faculty must be midlevel providers in accordance with program standards (8). Salary and benefits are the same as Field Supervisors. The estimated cost of an additional Training Center is $800,000. (See Budget Summary, page 18).

- 6 Full-time faculty @ $100,000 $ 600,000
- Admin. support, supplies, equip. 200,000
- Total cost 800,000

Second, we recommend that an additional faculty member be hired for each Training Center to increase the Centers' ability to do recredentialing and continuing medical education. Four faculty would cost $400,000. (See Budget Summary, page 18).

- 4 faculty @ $100,000 each $ 400,000

CHA Program Medical Manuals, Curriculum and Standards

Overview

Since this program is unique in the United States, educators and supervisors must create or modify all of the essential documents used to guide the health care practice of the CHA/Ps. The instructor and supervisory staff, who work directly with the CHA/Ps, appropriately do this time consuming work. In addition to assuring medical accuracy, the manuals must take into account the CHA/P role, level of basic education, level of CHA/P training and supervision, types of patients seen, the referral system, and the realities of clinical practice in remote locations. Frequent updates are critical to maintain the current medical standard of care. At this time, there is no set budget to insure that this occurs nor are these additional activities factored into the workload of the program administrators, faculty, or supervisors.

Two texts support the daily practice of the CHA/Ps. The Alaska Community Health Aide/ Practitioner Manual, 1998 Revised Edition, (CHAM - previous editions in 1976 & 1987) and the Village Medicine Reference, 1997 (VMR - previous editions in 1979 & 1988). The CHAM provides standard of care guidelines and Medical Standing Orders. It is indexed by symptoms and provides the CHA/P with a "how to" guide to collect a patient's history, perform appropriate examination and lab tests, formulate an assessment (diagnosis) and develop a treatment plan. The VMR provides information on over 270 medicines, which includes: uses, dosage, warnings, side effects, storage and dispensing directions with special instructions for patient education.

The CHAP Directors have three permanent working committees that provide essential feedback to the CHAP Directors and the CHAP Certification Board on the critical elements of maintaining program standards. All committees have broad regional and professional representation. CHA/Ps themselves have become key consultants in all aspects of program management.

- Academic Review Committee (ARC) ensures that the curriculum and credentialing process are uniform throughout the state. This committee meets quarterly and has representation from the four training centers, tribal organizations and the University of Alaska Fairbanks CHAP Liaison.

- Review and Approval Committee (RAC) assures that the training centers comply with program standards related to course content, clinical skill competency, student evaluation, and faculty standards. This group also meets quarterly and provides on-site review to each of the training centers.

- CHAM/VMR Committee oversees the content of these texts and assures that the content accurately reflects the standard of care. This groups meets as needed. In an effort to revise the current CHAM and VMR, the group has had extensive teleconference meetings and some face-to-face work sessions.

Funding Needs to Keep Current CHA/P Medical Manual and Curriculum

It is estimated that a budget of $300,000 a year will assure the currency of statewide program standards. (See Budget Summary, page 18).

▪ Program Standards	$ 300,000
▪ Curriculum	65,000
▪ Training Center Reviews	35,000
▪ CHAM/VMR	200,000

Village Built Clinic Lease Program

Overview

In 1969 the Indian Health Service (IHS) obtained authorization and funding to initiate a Village Built Clinic (VBC) leasing program to meet the need for health facilities in isolated Alaska villages. The VBC leasing program is available only to village clinics in which a Community Health Aide is responsible for providing primary health care. Lease monies support operation and maintenance expenses (janitorial, electricity, water, sewage disposal, fuel, loan amortization, insurance and repairs) of the facility. The formula for determining the lease amount uses community population, size of clinic building and other data to directly calculate the annual lease payment(10). For the past decade clinic managers have indicated that the lease amounts do not cover the services to sustain the facility. The lease formula is resource driven and does not meet needs but divides a fixed, inadequate sum of money among clinics. This results in sub-optimal maintenance of critical facilities. This is becoming an increasing problem as villages actively plan for new and larger clinics to support their primary care services.

Small villages may share clinic facilities with neighboring villages to maximize resource utilization or enhance service delivery (sub-regional clinics). Most villages have between 101 and 500 residents. The following table shows the size of the population groups served by the CHA/Ps.

Population	# Clinics	% of 178
< 100	37	21
101-500	102	57
501-1,000	36	20
> 1,000	3	2

In 1970 there were 140 village clinics, in 1989 there were 170 and today there are 178 clinics (but only 170 lease slots available). In general, village clinic facilities are old and too small to meet the demands of the population they serve and the scope of services which they provide.

Figure 2

There is no counterpart to the VBC program in other IHS regions. In Alaska, the lease cost is based on appropriation, which is approximately $7.00/square foot for actual clinic space compared to $17-$20/square foot for negotiated full-service leases in the continental United States. The current VBC program is unable to meet its intended purpose of providing full service leases to village clinics. The FY 2001 IHS budget for the VBC program is $3.7 million. Adequate funding for the VBC lease program is critical to the sustainability of the clinic facilities in rural Alaska. Based on available budget verses operational cost it is estimated that the VBC program is funded at 63% of need. Although the VBC lease program is managed by the IHS, tribal organizations have been in consultation with the Alaska Area Realty Officer in an effort to advocate for an equitable lease program (10).

Current Funding Needs

In order to address the inadequacy of the current VBC lease program, funding must take into account the actual operational costs of clinic facilities and an inflation rate of 30% over the last 12 years (based on Consumer Price Index). (See Budget Summary, page 18).

- Increase funding to meet current lease/operational costs $ 2,230,000 per year

Projected Funding Needs

At this time many communities are eligible for funding through the new Denali Commission Rural Primary Care Facilities program to repair, renovate and construct health clinics or multi-use facilities. Based on the Alaska Rural Primary Care Facility Needs Assessment (ARPCFNA) Final Report prioritization summary (11), 48 of 53 communities with the greatest need for clinic renovation, repair or new construction are currently served by a Community Health Aide clinic.

Several factors influence the need to project additional funding for the VBC program 3-5 years into the future. These factors include: the limited number of leases available, documented need for repair, renovation and new construction (11) and, the need for villages to demonstrate sustainability. Tribal organizations also compete successfully for capital building projects through other state and federal agencies. In all cases there is a requirement to demonstrate facility sustainability which makes additional VBC funding essential for all clinics. (See Budget Summary, page 18).

Therefore it is recommended to:

- Increase the number of leases by 30 to a total of 200 leases
- Provide funding for larger clinics and “new lease” facilities.
- Project additional VBC funding beginning FY 2003 $ 2,850,000 per year

Additional Funding Issues

Current Tribal Supplement

Historic documents such as Resource Deficiency Reports cite the Indian Health Service budget as providing 40-60 % of the level of needed funding (LNF) for health programs. The Indian Self-Determination and Education Assistance Act (Public Law 93-638) has allowed tribes to reprogram their federal funding in a manner which best addresses their program goals. Federal dollars for the CHA program are distributed to tribal organizations as part of a larger budget known as "Hospitals and Clinics" through an Annual Funding Agreement with the Indian Health Service. The CHAP dollar amount is undetermined. However, the Alaska Area Native Health Service and Alaska Native Tribal Health Consortium recently estimated the federal dollar amount for the Community Health Aide Program statewide to be $ 31.3 million/year. Funding from various state grants contributes another $ 2 million to the program. Tribal programs must provide the balance of funding required to maintain services in their member villages.

All tribal organizations employing CHA/Ps were asked to report their total program operating budget for 2001. Training center budgets and clinic operation budgets were not included. Twenty-three organizations responded and reported a total of $43.4 million in actual operating budgets. Based on these reports, CHAP Directors estimate that the total operational cost for all programs statewide to be $45 million. After accounting for the $31.3 million in federal program funds and $2 million in state funds ($33.3 million), tribal organizations provide an additional $11.7 million (or 26% of the total budget) in funding to provide these essential primary health care services in the villages.

Future Revenue

With the formalization of the Community Health Aide Program Certification Board in 1998, CHAs at level III, IV, and CHPs who are certified by the board, are eligible for reimbursement for their services to Medicaid enrolled patients. As of March 2001, 264 CHA/Ps meet these criteria. The State of Alaska made a Medicaid State Plan amendment which allows reimbursement for CHA/P services from Medicaid using a specified modifier on the referral physician's Medicaid Identification Number. Many of the 300,000 annual patient encounters are reimbursable at a rate of 85% of that allowed to a physician for the same primary care visit.

Potential revenue for the statewide program has not yet been determined. However, the tribal organizations who have submitted claims have been reimbursed almost $500,000 in 19 months of Medicaid billing activity for CHA/P services (12).

Recommendations and Summary of Need

Based on a current review of Community Health Aide Program and Village Built Clinic needs, the CHAP Directors' Association makes the following recommendations. The total cost to implement these recommendations is an additional $ 15 million annually.

1. Increase CHA/P Positions by 25% (125 positions)	Cost:	$ 6.1 M
2. Increase Supervisory Positions by 45% (23 positions)	Cost:	2.3 M
3. Increase Training Center Capacity	Cost:	1.2 M
4. Assure Program Standards	Cost:	.3 M
5. Increase Current VBC Leases	Cost:	2.2 M
6. Fund Projected VBC Leases	Cost:	2.9 M
	Total Annual Increase:	$ 15 M

Conclusion

For over thirty years, local Native CHA/Ps have been delivering primary health care to the people in their remote villages. CHA/P services are a sustainable, effective, and culturally acceptable method for delivering health care. CHA/Ps provide health care with a continuity that could not be matched by any other providers who would move in and out of the villages. This unique program has demonstrated adaptability to advances in medicine and the evolving health needs of the population, and it does so at comparatively low cost. The total program operating budget is $45 M and provides emergency and primary health care to 50,000 Alaska Natives at a cost of $900 annually per patient ($45M/50,000). Stated another way, the cost is $150 per visit ($45M/300,00 patient visits). Adequate funding is needed to assure that the Community Health Aide Program continues as the foundation of health care delivery to rural Alaska Natives.

Village clinic facilities have been identified as a key factor in the delivery of quality health care. The current Village Built Clinic lease program is resource driven and is unable to meet its intended purpose of providing full service leases to village clinics. Additional monies are needed immediately to account for inflation and actual operational costs of existing clinic facilities. In the future (FY 2003-2005) it is recommended that 30 more lease slots be available to support additional, newer and larger facilities as they are built.

For further information please contact the CHAP Directors' Association (refer to Appendix B).

"When I first started I told my husband, 'This is only temporary until you get a job.' But I got used to it and I learned a lot. I liked the thought of being there for the people, helping them. After I went to training I didn't want to quit. I learned so much and wanted to use it to help out."

BUDGET SUMMARY

CHAP UPDATE 2001

May 8, 2001

RECOMMENDATIONS:		**ESTIMATED COST:**
1. Increase CHA/P Positions by 25%		**$ 6.1 Million**
(500 x .25 = 125)		
Average salary ($18/hr. x 2080 hr/yr)	$ 37,440	
Fringe @30% ($37,440 x .30)	11,232	
Total per position	48,672	
Total cost (125 x $48,672)	6,084,000	
2. Increase Field Supervision by 45%		**$ 2.3 Million**
(52 x .45 = 23)		
Average salary	$ 75,000	
Fringe @ 30% ($75,000 x .30)	22,500	
Credentialing and CME	2,500	
Total per position (75,000 + 22,500 + 2,500)	100,000	
Total cost (23 x $100,000)	2,300,000	
3. Increase Training Capacity		**$ 1.2 Million**
Additional Training Center		
Faculty (6 x $100,000 ea)	$ 600,000	
Admin., supplies, equip.	200,000	
Increase Capacity at 4 Existing Centers		
Faculty (4 x $100,000 ea)	$ 400,000	
4. Maintain Program Standards		**$ .3 Million**
Curriculum/ ARC Support	$ 65,000	
Review and Approval Committee	35,000	
CHAM/VMR	200,000	
5. Increase current VBC leases		**$ 2.2 Million**
Based on actual lease/operation cost vs. resource methodology		
6. Fund projected VBC leases		**$ 2.9 Million**
Add 30 new leases to total program		
Provide funds for sustainability of new and larger clinics		

Total Annual Increase: $ 15 Million

List of References

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9) Spore, Kelly. Community Health Aide Program Review of Statistical and Qualitative Data, August 1993.

10) Alaska Area Native Health Service. Indian Health Service Village Built Clinic Lease Program. Report from Paula M. Poncho, Area Realty Officer, May 4, 2001.

11) Denali Commission. Alaska Rural Primary Care Facility Needs Assessment Final Report, October 2000.

12) State of Alaska, Division of Medical Assistance. Medicaid Reimbursement for CHA/P Services July 1999-January 2001, personal correspondence with Kelly Hause, Medical Assistance Administrator, February 8, 2001.

COMMUNITY HEALTH AIDE BASIC TRAINING CURRICULUM

COMMUNITY HELATH AIDE PROGRAM
RESOURCE LIST Updated August 6, 2003

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COMMUNITY HELATH AIDE PROGRAM
RESOURCE LIST Updated August 6, 2003

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See 2003 Calendar for listing of meetings and events

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