

Community Health Aide Program

Overview 2007



Alaska Association of Community Health Aide Program Directors

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March 7, 2007

Community Health Aide Program 2007 Overview Executive Summary

Community Health Aide Program (CHAP) 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 combined program expenses of \$55M provide 270,000 emergency and primary health visits annually to approximately 50,000 Alaska Natives at a cost of approximately \$1,100 annually per patient (\$55M/50,000).

Today over 550 Community Health Aides/Community Health Practitioners (CHA/Ps) are employed by 27 tribal health organizations in 178 rural communities. CHA/Ps are the patients' first contact within the network of health professionals in the Alaska Tribal Health System.

The Community Health Aide Program was 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. The program emerged, in part, as a result of the tuberculosis epidemic and the use of village workers to distribute antibiotics in the 1950s. It became a formal, federally funded program in 1968 under the authority of the Act of November 2, 1921 (25 U.S.C. § 13, popularly known as the Snyder Act) pursuant to 25 U.S.C. § 1616l (Section 121 of Public law 94-437, the Indian Health Care Improvement Act, as amended) and directives and circulars of the United States Department of Health and Human Services, Public Health Service, Indian Health Service, and the Alaska Area Native Health Service (1).

CHA/Ps complete training and education requirements as outlined in the *Community Health Aide Program Certification Board Standards and Procedures*. They work within the guidelines of the *Alaska Community Health Aide/Practitioner Manual, 2006 Revised Edition*, which outlines assessment and treatment protocols. There is an established four tiered referral relationship, which includes mid-level providers, physicians, regional hospitals, and the Alaska Native Medical Center. In addition, providers such as public health nurses, physicians, and dentists make visits to villages to see clients in collaboration with the CHA/Ps.

The success of the Community Health Aide Program model has been used as a template to develop a dental care component; which now has 33 certified providers addressing dental needs specifically. A behavioral health component is in progress to address unmet needs in mental health and substance abuse.

CHAP 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. Improvement in infant mortality and immunization rates are a direct result of the work of the Community Health Aides and their long term relationships with their communities. The Community Health Aide Program is a model for the delivery of primary health care services which could be used throughout the rural United States.

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Introduction

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 addresses these needs and builds on the CHA Program as the foundation of village health care. The dental component of this process is well established with dental health aide training, education, and competencies incorporated into the *Community Health Aide Program Certification Board Standards and Procedures*. Efforts are underway to include behavioral health services (mental health and substance abuse) which focus on prevention, early intervention, and case management to help reduce outpatient, emergency, and inpatient medical workload and cost. This process facilitates an integrated approach to health care services in Alaska villages.

Alaska

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 (2). 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.



**Village of Stebbins in Norton Sound
6 CHA/Ps Serve a Population of 547**

Same Scale Comparison - Alaska Area to Lower 48 States

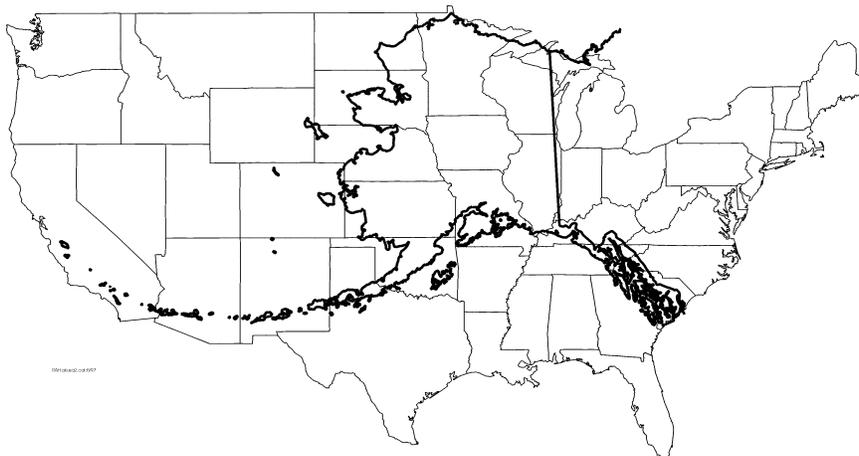


Figure 1

Population and Health Status – Alaska Natives

The Alaska Native population has increased by 20% since 1990. Alaska Natives now represent 19% 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 34% 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. Fifty one percent are less than 25 years old. While only 5% are older than 65 years (U.S. All Races is 13% 65 or older), this group is growing rapidly. The median age for Alaska Natives is 23.6 years compared to 35.3 years for the U.S. All Races (3).

The Alaska Native age-adjusted unintentional injury mortality rates are 3.3 times the rate for U.S. All Races. Cancer is now the leading cause of death in Alaska Natives followed by heart disease, unintentional injuries, stroke, and suicide (3).

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 (24.3%) of Alaska Natives live below the poverty level compared to 12.4% for U.S. All Races (4). Until recently, emphasis of care was on infectious disease and accidents.



Prenatal, Newborn, and Well-Child Care

Community Health Aide Program History

In the 1940s and 1950s, 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).

“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.”

A Community Health Practitioner

Community Health Aide Program Today

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 1950s but are common today. Behavioral health diagnoses are common. AIDS is also a concern for both patients and health care providers.

Today there are approximately 550 CHA/Ps employed by 27 tribal health organizations working in 178 clinics. These providers have approximately 270,000 patient encounters per year (6). 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.

Training Center Capacity

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.

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.

There are currently four Community Health Aide Training Centers. Each is managed by a tribal health organization with a combined operating budget of \$ 4.5 million per year (7). Faculty attrition and hiring cycles create a backlog for training. There is a total system capacity of approximately 240 training slots per year which does not include training related to dental and behavioral health initiatives. Training for a new-hire Community Health Aide through to Community Health Practitioner takes approximately 2 years. After successful completion of a training session, the individual may work and be certified at that level.

Since we know that CHA/Ps are typically the first responders in a village emergency, they are required to pass an Emergency Trauma Technician or Emergency Medical Technician course. Emergency care skills are reviewed and additional skills are taught in each of the four training sessions.

Great strides in technology and connectivity over the past few years have made it possible to offer a Session I training presented by Distance Delivery which began in February 2007 for eight students in remote villages.

CHA Assessing Patient with a CHP Mentor



CHA/P Workload

Many of Alaska's rural villages are small, employing only two or three CHA/Ps. A multiuse concept is logical with respect to utilization of resources. The typical village clinic performs multiple functions such as:

- primary care health clinic
- public health clinic
- dental office
- pharmacy
- laboratory
- counseling center
- patient travel center

CHA/Ps must be supported by their village tribal councils, community and family members 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 may contribute to stress, burnout, and resignation.

Field Supervision

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. Frequent contact and face to face visits are strong factors in the success of a Community Health Aide.

“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...”

A Community Health Practitioner

Quality Assurance

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 instructors, supervisors, and clinical medical staff and who work directly with the CHA/Ps, appropriately do this work.

The Community Health Aide Program Certification Board Standards and Procedures and the Alaska Community Health Aide/Practitioner Manual provide training and standard of care

guidelines. The CHAM 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 and develop a treatment plan.

Attrition and Burnout

As it happens with other medical and nursing disciplines, Alaska is losing some of its most experienced CHA/Ps from the "graying" of the profession. At times the losses are coming from younger and less experienced CHA/Ps who become frustrated by the immense responsibility and the lack of sufficient clinic staff and supervisory and technical support.

CHA/P attrition rates have been documented at several points since 1987 with a range between 33% in 1987 to 12% in 1993. An August 2006 Attrition Survey of CHAP Directors indicates the current attrition rate of 20.2 % (8).

Village Built Clinic Lease Program



**Sand Point, Alaska
Integrated Health Service Facility**

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 of the facility such as janitorial, electricity, water, sewage disposal, fuel, loan amortization, insurance and repairs (9).



Figure 2

Funding Issues

The CHA Program has achieved success despite the lack of sufficient dedicated funding streams. The annual estimated funding of \$55 million is pieced together from a variety of tribal, federal, private and state funding sources and is not sufficient to meet program needs over time.

The CHA Program has been historically funded through Indian Health Service funds. The IHS annual funding level of \$33.3 million is not keeping up with basic medical inflation, nor with the high cost of providing care in rural and remote locations.

Modest enhancements have been made possible through Medicaid reimbursements that total approximately \$2.7 million annually (10). Various state grants contribute another \$ 2 million to the program.

Thus, the Alaska Tribal Health Programs have been forced to supplement the CHA Program with approximately \$17 million annually. These funds typically come from reprogrammed health resources, effectively taking other dedicated health resources to ensure basic coverage for patients in rural Alaska.

Unfortunately, as these health care resources get more limited, it is unclear how much more the Alaska Tribal Health System can continue to absorb, while maintaining our commitment to provide quality, safe care for our patients. Additional resources are necessary to address inflation, pay cost increases and provide for increased patient needs.

Conclusion

For almost forty 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. 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 approximately \$55M and provides emergency and primary health care to approximately 50,000 Alaska Natives at a cost of approximately \$1,100 annually per patient (\$55M/50,000). Stated another way, the cost is approximately \$200 per visit (\$55M/270,000 patient visits).

A more detailed description of the Community Health Aide Program funding need can be found in the document, "Community Health Aide Program Update 2001: Alaska's Rural Health Care at Risk" (11).

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