

COMMUNITY HEALTH AIDES

ALASKA'S UNIQUE HEALTH CARE PROVIDERS

"Community Health Aides and Practitioners are key to improving health status in Alaska."

-Karen E. Pearson, April 30, 2001

Community Health Aides (CHAs) and Community Health Practitioners (CHPs) are the primary source of health care for over 50,000 Alaska Natives in 178 communities. CHAs and CHPs (CHA/Ps) are not doctors, nurses, or paramedics, but health care providers trained and supported in a program that is unique to Alaska.

When antibiotic treatment for tuberculosis (TB) began in the 1950s, public health service physicians and nurses trained volunteers in villages to give the medications and to supervise the care of the large numbers of rural TB patients. Tuberculosis rates in the villages began to decrease. Some of the trained assistants began to spend part of their time on prevention of other major problems such as infant mortality, childhood diseases, and injuries.

The Community Health Aide Program was federally funded, with formal training standards established, in 1968. Today, CHA/Ps are frontline workers, the first and most crucial link in a network of care that includes field supervisory staff (experienced CHA/Ps or mid-level providers such as nurse practitioners or physician assistants), emergency medical air services, public health nurses, physicians in hub communities, small rural hospitals, and the Alaska Native Medical Center in Anchorage. (The Alaska Native Medical Center serves as the main referral hospital and provides consultation and back-up for other providers for the Alaska Native health care system in the state.)

Most CHA/Ps are Alaska Natives working in their own villages. They provide culturally appropriate care in a community they know and understand. Health aides often develop close relationships with their supervisors and referring physicians that enable them to mediate between cultures for the benefit of their patients.

It is a tough job. CHA/Ps must work closely with the village leadership to get support for the clinic. Tragedies such as suicides, homicides, and the deaths of children contribute to the stress of long hours, long stretches of on-call time, and managing emergencies hundreds of miles from the nearest doctor. Providing care to friends and family can also be stressful.

Health aides participate in all the challenges of modern health care. The number of elders with chronic diseases is increasing. The reduction in infectious diseases depends on a complex schedule of immunizations that changes every year. New drugs, new procedures, and new equipment arrive daily in remote clinics. The health aide model is now being used to train behavioral health aides and oral health aides to meet other crucial needs in Native villages.

AFHCAN

The Alaska Federal Health Care Access Network (AFHCAN) completed its overall mission for the 1999-2002 project period, linking 235 federal and state sites in Alaska in a telehealth network.

AFHCAN estimates approximately 3000 "store-and-forward" telemedicine cases completed in the prior year.

Common applications include:

- * video otoscope*
- * digital camera*
- * digital ECG*

Telepsychiatry is used regularly by the Alaska Department of Corrections—Anchorage-based psychiatrists and a psychiatric nurse practitioner have video and voice visits weekly with 25 to 30 patients a week. The patients are located in correctional facilities in Seward, Fairbanks, Ketchikan, Juneau, Kenai, Bethel and Nome. Kotzebue was to be added to the list starting in September 2002.

Gateway Mental Health Center in Ketchikan, Bartlett Memorial Hospital, and Alaska Psychiatric Institute and Maniilaq Medical Center also have telepsychiatry programs.

-Alaska Telehealth Advisory Council 2002 Annual Report

CAREER REFLECTIONS

Edna Charley described her career as a Community Health Aide Practitioner shortly before her retirement in May 2002:

“It was 1976 and the health aide program was just getting started in Glennallen. They needed somebody and they knew I had been a nurse. My kids wanted to move up there. They grew up in Anchorage, but they liked village life. So I agreed to do it.

“There was no clinic. I worked out of my house and out of my car. All we had was a little cabin. I just moved into that little cabin and all my medicines were in that little black bag. I kept it in my trunk. That was the only safe place to lock it up.

“Chistochina is a tiny village—33 people. I’d call the kids in for fluoride treatment, do home visits and take blood pressures. I was on the village council, too, so I kind of pushed for a clinic. We took one of the older houses there and got some money to fix the inside. There was no running water and no sewer. The heat was propane. No refrigerator, but it was cool enough in there we didn’t need one. I liked it, but because it was on the highway system, a lot of people went to the doctor. It wasn’t that much of a challenge. But I got promoted and became a health aide supervisor.

“I moved back here to Kake, my hometown, October 6, 1987. It was a major change. Having 700-800 people here, more in the summer. When I first came I was the only health aide. But we had real good docs. They were supportive of the health aides. I appreciated that because I’ve worked where they weren’t supportive, where they question your abilities and your knowledge. It means a lot to me that I’ve had that support.

“Moving to the village to be a health aide, I had to learn the political part just to get a clinic. I was involved in the village council. I was on the health board, service unit board, and Native health board. And then, AFN (Alaska Federation of Natives), too. I learned all about communication. I enjoyed that. I was on the city council for a while, too. Always with the same direction: health and safety.

“I like the direct patient care. I resisted stuff like the computer. I didn’t like the idea of patient information being on there. But it really helped.

“The equipment—the digital camera and video otoscope—helps a lot. Being able to get directions right away from the doctors. They get it and call us right back. Helps a lot and saves traveling money. And the polycam. It’s like a TV where you can have a meeting and camera and everyone can talk. It’s not delayed and it’s not jerky. It’s live; it’s really nice. We use that for getting directions on patient care.

“The major changes are the technology. I was thinking about that little black bag, the old-fashioned doctor’s bag. We have a lot more drugs. You could never carry them in the old black bag! We have a lot more vaccines, and the schedule is always changing. We have x-ray. There’s a lot to learn. Our manual used to be a little yellow book. Now it’s three books. Another difference is getting more dental care here. That’s what we do, too—we point out what we think we need, like the increase in dental care.

“I think what really helped me was having the doctors being supportive and having confidence in my ability. Makes a big difference. And then the staff here, we get along and we’re supportive of each other. And we laugh a lot. Many things to laugh about! I think my own personal faith is what kept me going. And, it just happens that the staff here, too, has strong faith and we draw on each other a whole lot. My grandchildren help a lot, too. They help you realize life goes on.

“The part I like, besides the direct patient care, is the education and prevention. The ‘Kids Don’t Float Program,’ the ‘Peacemaking Circle.’ We used to go to the school to give health education, sex education, that kind of thing. I think it is a major part of our job.

We try to influence the health, the well-being of the community. We started community clean up. It still goes on. We did a diabetes screening—went door to door. They wouldn’t come to the clinic. When I came we had three diabetics. Now there are 28. That’s a shift, too. But I think we are making people become more aware of those kinds of things. That’s our responsibility, not just taking care of the cold or the laceration.

We pushed for the swim program, too. That’s going on this summer. It only makes sense. We live right here, by the water. If people are fishing for salmon, they are on the water. We’re lucky that nothing’s happened, but we don’t want to wait for something to happen.

“We have to be role models, too, as well as teachers. It doesn’t make your work very strong if you aren’t living it yourself. You can’t just preach about things, especially in small communities. You can’t teach about alcohol abuse if you’re abusing it yourself. We are involved with the Healing Heart Circle, something positive in town.

“I think the health aides, the ones who hang in there, are the same kind of people who are involved in the community. You have to know all that, what’s going on in the community. We have to know our community pretty well.

“Having the self-determination for the tribe, and being responsible for our own healthcare, have made a big difference. When I grew up here, there was nothing. I remember suffering with ear infections, toothaches. Most of the babies were born here. Big difference. Not that long a time, really. One lifetime.”

Kids Don’t Float (KDF)

Between 1990 & 1998, the drowning rate in Alaska was two and a half times the national average. The Kids Don’t Float program began in the Katchemak Bay area in 1996 in response to the high drowning rate among children there. The pilot project focused on water safety education and supplied 15 life jacket loaner boards around the bay.

In 1997, the Coast Guard and ISAPP collaborated to extend this life saving courtesy throughout Alaska. Today there are over 300 sites by rivers, lakes, and bays. There are six documented cases in which children were likely prevented from drowning because of a KDF loaner vest.



PFD Otter says, “Kids Otter wear a life jacket while playing in or near the water!!”

www.chems.alaska.gov/kids_don't_float.htm

WHAT NUMBERS CAN TELL US

Approximately 500 Community Health Aides (CHAs) and Community Health Practitioners (CHPs) work in rural Alaska (300 and 219 respectively). 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 per day, seven days per week, 365 days per year.

Primary and emergency care for approximately 50,000 Alaska Natives is delivered at a cost of \$900 annually per patient or \$150 per patient visit.

Attrition rates for CHA/P have ranged from 12 percent to 33 percent a year since 1987. Attrition rates increased 8 percent from 1993 to 1999. Stress and burnout account for a significant part of the loss of this health care workforce.

The number of village-based clinics increased from 140 in 1970 to 178 in 2001. The Denali Commission is targeting rural communities in an intensive clinic building and renovation program.

Most villages served by CHA/Ps have between 101 and 500 residents.

Distribution of CHA/P Clinics by Size of Village

Population	Number of Clinics	Percent of 178
<100	37	21
101-500	102	57
501-1,000	36	20
>1000	3	2

Source: Community Health Aide Program Update 2001, Alaska Board Tribal Health Directors, February 19, 2001.

THINGS TO CONSIDER

“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.” (*Community Health Aide Program Update 2001*, Alaska Native Health Board, Association of Tribal Health Directors, February 19, 2001. p.19.)

Several communities with mixed Alaska Native and non-Native residents have community health aide clinics. Those clinics using Denali Commission or federal Community Health Center funding will serve patients regardless of status as Indian Health Service beneficiaries. Communities without a CHA clinic that have an interest in developing a similar service can inquire of the Alaska Division of Public Health Primary Care and Rural Health Office about progress in developing arrangements for similar services.

TO FIND OUT MORE

Alaska Community Health Aide Program
www.akchap.org

Primary Care and Rural Health Office
Alaska Division of Public Health
(907) 465-3091
www.chems.alaska.gov/

REFERENCE CHAPTERS IN HEALTHY ALASKANS 2010, VOLUME 1

Chapter 6. Educational and Community-Based Programs
Chapter 8. Injury Prevention
Chapter 7. Health Communication
Chapter 13. Oral Health
Chapter 15. Access to Quality Health Care
Chapter 18. Immunizations and Infectious Diseases
Chapter 23. Diabetes
Chapter 26. Public Health Infrastructure