Factors Influencing Retention and Attrition of Alaska Community Health Aides/Practitioners:

A Qualitative Study

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EXECUTIVE SUMMARY

The Alaska Community Health Aide Program (CHAP) Directors' Association served as the Advisory Committee for the project. In this capacity, they advised and oversaw methodology development and data collection. Later, they reviewed findings and approved the final document for dissemination. Finally, researchers from Texas A&M University's Southwest Rural Health Research Center conducted an Alaska site visit during the project's planning phase and participated in methodology development. This project would not have been successful without the participation of CHA/Ps, community members, and tribal health organization employees Statewide across Alaska.

The purpose of this study was to identify the factors that contribute to Community Health Aide/Practitioner (CHA/P) retention and attrition, with an emphasis on the influence of CHA/P support structures within the community and from family, colleagues and employers.

The study relied on qualitative methods of analysis, specifically on key informant interviews. The Alaska Center for Rural Health (ACRH) adopted a rigorous methodology to select a sample of CHA/P villages to interview. With substantial input from the CHAP Directors' Association, and sensitivity to geographic and ethnic representation, the research team selected ten communities with low CHA/P attrition and five communities with high CHA/P attrition. Researchers visited the 15 remote Alaskan villages to interview CHA/Ps, community members, and CHA/P employers. Full transcripts of the 146 interviews were recorded and analyzed using NUD*IST software. Analysis included the coding of interviewee comments into 482 categories, or nodes.

The data were initially organized and sorted by a number of factors to identify those most pertinent to CHA/P retention and attrition. Two particular analyses were found to reveal clear distinctions and are presented in this report. They are: comparing CHA/Ps in high attrition communities to those in low attrition communities, and comparing CHA/Ps with four years or less experience to those with ten or more years of experience.

Based on data collected in this study, the primary factors responsible for the retention or attrition of CHA/Ps include the following:

- Co-worker support – Good communication and teamwork with co-workers helps provide CHA/Ps with empathetic emotional support and improves their ability to share workload and support one another.
- Access to basic training – Newly hired CHA/Ps need to feel adequately prepared and trained for their duties. A fully trained clinic staff helps relieve the workload burden of other CHA/Ps in the clinic as well.
- Fully staffed clinic – A fully staffed, fully trained clinic enables the sharing of the daily workload and on-call duties.

- Community support –Individual community members and tribal councils can do much to make CHA/Ps feel valued and appreciated for their efforts.
- Family support – CHA/Ps need family to help with childcare and eldercare responsibilities, as well as basic household and subsistence activities.

As with Maslow's Hierarchy of Needs, where basic physiological needs must be fulfilled before an individual can consider security, love, esteem, or self-actualization, these five primary factors must be addressed before a CHA/P shifts from being an attrition risk to retention safe.

The data lead to the development of a variety of recommendations that employers, tribal councils, and communities may want to consider.

1. From the Tribal Health Organization

a) Provide team building exercises that support improved teamwork, communication and supportiveness;

b) Provide additional on-call rest benefits, such as time off after a hard night of on-call, or not having to make up on-call after returning from vacation; and

c) Provide additional pay for on-call hours.

2. From the Community and Tribal Councils

a) Advocate for health aides against local gossip or mistreatment;

b) Advocate for health aides to the tribal health organization;

c) Provide mechanisms for regular communication with the village council; and

d) Acknowledge, respect and show appreciation for health aide effort.

3. Training

a) Develop curriculum or training exercises covering coworker support issues at the training center level;

b) Address family issues at the training level. This may include discussing the importance of family support, the difficulty of the job on family members, and ideas for strengthening support from families; and

c) Create additional training slots and evaluate other ways to improve timely access to basic training courses. Findings related to this recommendation support the need for more training opportunities that had been identified previously by CHAP Directors.

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I. INTRODUCTION

Health disparities exist for a number of population groups. They exist for not only racial and ethnic minorities, but also women, children, the elderly, low-income persons, patients with special health needs and people who reside in rural or inner-city locations.[1] Racial and ethnic minorities have well-documented inequities in health status and access to services. African-Americans, Puerto Ricans, Mexican Americans, and American Indians/Alaska Natives have all been shown to have disparities in key health indicators when compared to the U.S. white population. They have been found to have lower life expectancy, greater prevalence of chronic diseases and poorer outcomes for pregnancy than whites. Studies have also shown that they are less likely to obtain some technological and surgical procedures and routine health care preventive services than whites.[2]

The disparities among Alaska Natives are particularly staggering. At birth, Alaska Natives are expected to live almost seven years less than the average lifespan for the U.S. population overall (69.4 years compared to 76.7 years for U.S. All Races), and almost five years less than the average Alaskan (69.4 years compared to 74.7 years for All Alaskans). Alaska Natives are also far less likely to have a high school diploma or bachelor's degree and are much more likely to live below the poverty level (25.7 percent compared to 17.8 percent for U.S All Races and 9.8 percent for All Alaskans). While the overall health status of Alaska Natives has improved substantially over the past several decades, Alaska Natives still suffer from higher rates of cancer, unintentional injury, mortality, and suicide rates than the total U.S. population.[3] Researchers have also noted other troubling health issues among the Alaska Native population – both related to epidemiological findings and access to care. One study found that the prevalence of diabetes among Alaska Natives increased 80 percent between 1985-1998.[4] Others have found that rural asthmatic Alaska Native children are less likely to receive a physician diagnosis of their asthma than children residing in more metropolitan areas.[5]

A. Community Health Aide Program (CHAP)

For the past 35 years, the Community Health Aide Program (CHAP) has provided one major method for working toward diminishing the health disparities of the Alaska Native population by promoting access to health services for Alaska Natives residing in rural and remote communities. CHAP trains local residents, mostly Alaska Native women, to act as non-physician primary care providers in remote tribal communities. These communities are generally too sparsely populated to sustain a physician or midlevel provider. By training local residents to provide basic health care, the program assures that some level of health services are available in the local community from providers who speak the native language and can provide culturally sensitive services.

CHAP emerged from a 1950s program of the Indian Health Service (IHS) that successfully employed the use of local, Native village workers to distribute medications to help combat the tuberculosis epidemic. This successful demonstration of the use of local indigenous peoples as health care providers in the village led to the eventual

formation of the CHAP concept of training local residents as providers of basic health services. While the proposed program model was not without controversy, it was finally determined that such a program was the only way to assure the provision of some level of health services in isolated areas with small populations. After a successful pilot program in the 1960s, CHAP received earmarked funding from the Federal government beginning in 1968. Formalized curriculum and training, which were developed during the 1970s, were designed to help assure that CHA/Ps could receive training with minimal time away from their communities and families.[6]

Today there are approximately 500 Community Health Aide/Practitioners (CHA/Ps) practicing in 178 Alaskan communities. CHA/Ps are employees of tribal health organizations acting as contractors to the Indian Health Service under the auspices of P.L. 93-638 as amended, or the Indian Self-Determination and Education Assistance Act (ISDEAA). Tribal health organizations range from single village systems to large regions responsible for the care of up to 56 villages. In the vast majority of these communities the CHA/P acts as the sole health provider, with the nearest midlevel or physician residing hundreds of air miles away. CHA/Ps provide a broad range of acute, chronic and emergency services. During their 16 weeks of basic training they are taught to recognize and treat minor illness and injury, administer medications according to standing orders or by direction of a physician, deal with emergency situations and refer difficult cases to a physician in a hub community. Within the village, they are generally a patient's first contact with the health system and form the backbone of Alaska's rural tribal health system.

Despite the program's 35-year longevity and success in making health services available to frontier communities, the CHAP program struggles with attrition. In 1988 the program noted a Statewide annual loss of approximately a third of the CHA/P workforce, accounting for over 151 positions[7]. Additional funds were appropriated to the program in the early 1990s creating more funded CHA/P positions, improved equity in CHA/P salaries, benefits, and training, and an increase in training center capacity. CHAP program statistics show that CHA/P attrition decreased during this period – immediately following the increase in funding. However, by Fiscal Year 1999, CHA/P attrition once again became a focal problem, as annual attrition rates climbed to 20 percent.[8]

Because of the unique role of the CHA/P in the community, attrition causes distinct problems. One of the novel features of the program is that CHA/Ps are hired prior to receiving any medical training and receive their 16 weeks of training on an ongoing basis over the first two to three years in their position. Whenever a CHA/P leaves the workforce, a new recruit with no training replaces her. That new recruit must provide some level of services in the community while they are completing their basic training program. When CHA/Ps leave the profession, a wealth of experience and knowledge leave the community until training of the new recruit is completed. As a result, it may take several years to restore the community to a similar level of care.

B. Project Purpose

The purpose of this project was to identify the factors that most impact CHA/P attrition. Based upon a literature review combined with direction from local experts, the researchers identified support structures as particularly important. As a result, the influence of support structures was emphasized; this emphasis included personal support structures, community support, employer support and clinical support. Many of these factors have been demonstrated as important factors influencing retention of rural physicians in other studies. [9,10]

II. METHODS

This research relies on the use of qualitative analytic methods, which allow for the evaluation of a subject in greater depth and detail than quantitative methods permit.[11] This mode of research explores the meanings and characteristics of a topic, as opposed to quantitative research, which measures frequency. Finally, qualitative studies are more open-ended than quantitative studies, guiding researchers into areas of interest on their subject as the research progresses.[12]

In qualitatively examining the issue of attrition, the exact frequency with which health aides report an idea does not determine its level of importance. In fact, frequency is not measured. Instead, the intensity of the experience described, the level of agreement among health aides over an idea, or even the fact that something was mentioned at all gives a topic its importance. This document uses terminology such as “more likely to” or “less likely to,” to convey tendencies of health aides to feel one way or another; however, these trends are not quantifiable in a statistical sense and cannot be interpreted as such.

This study uses key informant interviews of Community Health Aides/Practitioners coupled with field observations. Researchers also interviewed health providers in the village clinic, community members, and leaders in the employing tribal health organizations. These supplemental interviews helped to provide the proper contextual backdrop for the CHA/P interviews. Most of the interviews were conducted in person in the rural villages where CHA/Ps work and reside. This enabled the interviewers to gain a better perspective of local dynamics, facilitated access to community members and allowed interviews to be conducted in the respondents’ own environment. This ethnographic approach was taken so observational fieldwork would allow researchers to witness circumstances firsthand – which when combined with interviews, has been shown to allow researchers a better understanding and more accurate interpretation of findings from key informants.[13] Interviews with tribal health organization employees were primarily conducted by phone.

A. Village Sample

CHA/Ps practice in approximately 178 villages throughout the State of Alaska. ACRH researchers, in collaboration with researchers from Texas A&M University, determined that over sampling low attrition villages relative to high attrition villages would facilitate the identification of retention factors. The team determined, based on funding and geographic distribution of villages, that ten low attrition and five high attrition villages be sampled. To identify the 15 villages for site visits and key informant interviews, the team developed a methodology drawing heavily from the experience of CHAP Directors while assuring geographic and ethnic representation.

In order to systematically differentiate among the 178 CHA/P villages, ACRH designed a rating tool. This tool was developed by inviting CHAP Directors who oversee local CHAP programs to participate in a telephone interview where they identified suspected characteristics and causes of "low" attrition and "high" attrition in their regions. Sixty-one percent (61 percent) of CHAP Directors responded.

The reported characteristics were organized into categories and tabulated. Categories with ten or more responses were labeled "primary factors." *Community support* was an example of a primary factor. Categories with three to nine responses were labeled "secondary factors." *Salary/benefits* was an example of a secondary factor. Those with fewer than three responses were excluded.

The categories were then used to create a rating sheet that would subsequently allow CHAP Directors to prioritize specific villages based on those criteria. A copy of the rating sheet is provided as Appendix A. Directors used this form to rate a maximum of four high attrition villages and three low attrition villages in their region on a scale from 1 to 10 for the attributes listed. This allowed researchers to select specific villages that contained the most attributes of interest to the study, to assure that those villages would be included in the study sample. Each CHAP Director was provided with three follow-up reminders designed to improve the response rate in returning rating sheets. Fifty-seven percent (57 percent) of CHAP Directors completed the rating sheet.

In reviewing the rating sheets to determine the final village selection, special emphasis was given to assure diversity in the employing tribal health organization, the geographic location of the village, and the ethnic makeup of the village. For the purposes of this study, all references to ethnic diversity reflect distinct Alaska Native cultures. These included Athabascan, Inupiaq, Yupik/Cupik, Aleut/Alutiiq, and Eyak/Tlingit/Haida peoples. In addition, because support structures were hypothesized to be a major factor influencing attrition, a special weight was given so that villages with very strong and very weak support structures would be included in the sample. Specifically, the villages rated as having the highest and lowest overall attrition rating from each tribal health organization were selected to move through the first round of cuts. This step helped to account for respondent bias, as well as assuring diversity between employing tribal health organizations. The remaining villages were then rank ordered based on the scores they received for community support, tribal support, and clinical support, creating

a single rank ordered list of the highest and lowest attrition villages within each tribal health organization.

This rank order list formed the general basis for determining the village sample. However, some modifications were made to assure geographic and ethnic diversity. If two villages were from the same general geographic region, the village with the "lowest" community support score was moved to a lower position on the list. A similar modification was made if two villages represented the same Alaska Native ethnic group. Another factor in geographic diversity is road access, as many villages are only accessible by plane, boat or All Terrain Vehicle, depending on location or time of year. Communities located on the road system may have different issues in retaining health care providers. To this end, one high attrition and one low attrition village on the road system were also included in the study. This process resulted in the selection of ten low attrition and five high attrition villages for participation in site visits and key informant interviews. Two villages that made the first cut were replaced later using the same technique – one village was replaced because attrition had caused the village to be without a CHA/P to interview and the other was replaced at the request of the tribal health organization health director. Populations for the selected communities ranged from 131 to 1075 full-time residents. Interviews were performed in each of the selected villages between March and June 2003.

B. Instrumentation

Three separate interview guides were developed. Samples of each are provided in Appendix B. One questionnaire was developed for interviewing CHA/Ps, another for interviewing community leaders, and the last for interviewing leaders within the tribal health organization. Questions were developed from a combination of telephone interviews with CHAP Directors and a review of the literature on health workforce attrition. The questions were approved by the UAA Institutional Review Board. In the telephone interviews, CHAP Directors were asked to describe why certain communities in their regions were identified as "low" and "high" attrition for CHA/Ps. Responses generally correlated to reasons for attrition among other health professionals cited in the literature. These past studies suggested that satisfaction with a profession should be measured separately from satisfaction with a specific job, while also taking into account work values associated with the profession.[14] Studies also suggested the importance of measuring personality factors when assessing job satisfaction.[15] In addition, one study suggested a high correlation between the quality of work environment and the ability of organizations to attract and retain nurses. Based on the factors discussed above, question topics were organized into the following four categories:[16]

- Organizational factors – salary, educational opportunities, retirement benefits, opportunities for promotion, respect of CHA/Ps within the tribal health organization, supervisory style and support.
- Job content – work duties, work autonomy, utilization of abilities, volume of patients relative to staffing, amount of on-call required.

- Work environment – working relationships with supervising doctors, working relationships and support with other health workers in the community, support and relationships from coworkers, support from community, support from village council.
- Personal factors – Childcare responsibilities, elder care responsibilities, family support, ability to participate in subsistence activities.

The ACRH Research Team and a Process Review Team reviewed and edited the instruments. The Process Review Team included a UAA research director, Consultant, CHAP Director, and CHAP Consultant. Instruments were field-tested on three CHA/Ps and a CHA/P Training Center Director.

C. Data Collection and Analytic Technique

All CHA/Ps present and available during the time of the site visit were interviewed.

CHA/Ps and CHAP Directors submitted names of key leaders within each village to be included in the community member interviews. All identified community members present and available during the time of the site visit were interviewed. Approximately five community members were interviewed for each village. Tribal health organization employee interviews included both the CHAP Director and at least one individual identified to be in an executive administrative role within the organization. Responses by tribal health organization and community members were used to validate findings from CHA/P interviews and add perspective to comments received from the CHA/Ps.

All interviews were conducted by one data collection team of three people. Two members traveled to each village, with one person leading the interviews and the note-taker managing the audiocassette. The lead interviewer traveled to all villages, while the note-taker role was shared between the two remaining individuals. This approach ensured consistency in data collection. The lead interviewer is an experienced professional who periodically conducts trainings on this technique. All interviews were recorded on audiocassette, and full transcripts were imported into NUD*IST software for coding and analysis. This qualitative analysis software allows analysts to systematically categorize large volumes of participant responses by clustering words, phrases, sentences or entire paragraphs into nodes or sub-groups. A sub-group is a subset of a node. While not intended for quantitative tabulation, it allows researchers to identify frequently recurring responses, which may be subsequently organized into tendencies and themes.

Analysis involved a team of four researchers, two of whom participated on the data collection team. The lead interviewer and note-taker coded CHA/P responses into over 482 nodes and subgroups to help identify themes of interest. This method ensured the data were coded in a contextually appropriate format.

Next, two researchers not involved in data collection reviewed the analysis separately, and each independently identified apparent tendencies from coded data. A "tendency" was any series of three or more subgroups that differed. The analysts compared findings, and found over a 95% inter-rater reliability. The tendencies that emerged were presented to the analytic team for discussion and tested by reviewing actual interviewee comments. If the tendency held true against actual comments, it was kept. The team discussed the tendencies and organized them into themes.

For example, CHA/Ps, regardless of experience, reported interest in more training. However, many of the participants with less experience referred to basic training and skills for emergencies, while experienced health aides referred to paid access to PA school, conference attendance, and other trainings that were "job perks." These were identified as tendencies. Thus, a theme emerged showing CHA/Ps of different skill levels wanting training, but for very different reasons.

The data were initially sorted by a number of factors. However, two particular comparisons were found to garner the bulk of relevant results. The analysis and findings presented in this report are from those two groupings:

- Responses of CHA/Ps in high attrition communities compared to low attrition communities – Responses from 15 CHA/Ps from high attrition villages and 26 from low attrition villages were compared.

- Responses of CHA/Ps with four years or less experience compared to CHA/Ps with 10 or more years of experience – Responses from 18 interviews with more experienced CHA/Ps and 16 less experienced CHA/Ps were compared. As expected, there was a strong connection of newer CHA/Ps being located in high attrition communities, but there were also some long term health aides in communities with generally high attrition.

III. ANALYSIS AND FINDINGS

A total of 41 health aides from 15 communities participated in key informant interviews. This study included 26 CHA/Ps from low attrition villages, while there were 15 from high attrition villages. Of them, 33 were female, and eight were male. Twenty-three respondents were under 39 years old, eight respondents were 40 to 49 years old, and three were over 50 years of age. Seven respondents did not report their age. 482 nodes (response categories) were developed in response to the interview questions.

This section is organized according to major findings based on specific questions from the CHA/P interview guide.

A. Recruitment / Expectations / Resignations

How CHA/Ps Are Recruited

The top two ways in which CHA/Ps were recruited were through word of mouth or in response to an open job posting. Newer CHA/Ps and those from high attrition communities were more likely to have responded to a posting. Health aides with experience and those from low attrition communities were more commonly invited to become a health aide by someone in a respected position.

What Attracts CHA/Ps to the Job

In general, the same things attracted people to the CHA/P profession, regardless of the type of community or the length of time on the job. The most common reason for applying was that it was a good job/career opportunity and that the individual needed a job. Additionally, respondents were likely to report an interest in medicine, and "just wanting to try it out."

Expectations of the Job

In response to the question, "What are some of the differences between what you originally expected your job would be like, and what it actually is like," many health aides reported that they simply did not know what to expect. CHA/Ps reporting their jobs matched their expectations were split evenly among high and low turnover community health aides.

Current CHA/Ps Who Quit in the Past

There were large numbers of CHA/Ps who quit at some point in their career and then returned to the position.[i] This was found most with health aides who had been on the job for over 10 years, with 11 of the 18 reporting at least one resignation or extended leave during their career. In contrast, only two of the 16 newer health aides had ever left the position. This may be partially explained by more tenured professionals having more time to quit and return than newer CHA/Ps. Nevertheless, the data do suggest that this is a difficult profession. Responses did not differ greatly between CHA/Ps from high and low attrition communities.

Reasons for Quitting

"Personal issues" was the most frequently cited reason why CHA/Ps did or would quit.[ii] Another common reason was the stress, trauma, and burnout caused by the job. In this profession, personal issues and stress are related, especially in high turnover communities. CHA/Ps often discussed how personal issues (such as child care, elder care, taking care of family) were more difficult because of the unique characteristics of

[i] ACRH staff were surprised to find that, when asking CHA/Ps if they had ever quit, there was no easy "yes/no" response. CHA/Ps had often left for a couple months, then returned to work. There appears to be more of a continuum of quitting rather than an easy yes or no decision.

[ii] Comments for "personal issues" included marriage, spouse relocation, family pressure to quit, college, taking care of family or just "personal situation."

the health aide job – such as the on-call requirements. Thus, these two top findings of personal issues and job-related stresses are linked.

Reasons for Returning after Quitting
CHA/Ps returned to the job for a variety of reasons. Encouragement from community members and the need for a job and/or benefits were both heavily cited and appeared to be equally important.

The Rewards of Being a CHA/P
Independent of experience or setting, CHA/Ps overwhelmingly cited patient care and helping other people as the aspect of the job they most liked. For many health aides, this was a passionate mission. Other cited rewards include: the clinical aspect of their work (e.g., drawing blood or performing certain exams); making a positive contribution to the community; the challenge and learning opportunities; the excitement and unpredictability of the work; and simply having a good job in the community.

The Challenges of Being a CHA/P
"Long hours and "being on-call" were the most common aspects disliked about the job.

B. Call / Patient Load
As mentioned above, the long hours and being on-call were the most challenging aspects of the position. Generally, health aides in low attrition communities experienced a less demanding on-call schedule. A complete analysis of CHA/P call schedules for the communities visited is included in Appendix C.

C. Clinical Support
CHA/Ps with more experience, or located in low attrition communities, had more confidence in their own abilities and felt they had gained the trust of other providers in the medical field, relative to newer health aides in high attrition sites. On the other hand, clinics with high attrition appeared to have less staff cohesion, contributing to the feelings of not being supported clinically. Further, these health aides sought greater support from other providers.

The following factors were mentioned by CHA/Ps as contributing to their perception of good clinical support:

- Doctors/midlevels are available, responsive and a resource for learning;
- Respect from doctors;
- Doctors that understand the role of the CHA/P in the community;
- Positive and supportive coworker relationships; and
- Presence of midlevel providers in the clinic.

D. Tribal Health Organization Support

More experienced CHA/Ps, and CHA/Ps in low attrition communities, had higher expectations of their tribal health organizations or employing village council. They were

more likely to comment on specific aspects of tribal health organization support that needed improvement. The most significant suggestion for improvement related to the on-call system, as previously mentioned. Health aides in high attrition communities, on the other hand, pointed to basic needs, such as wanting their tribal health organization to increase staffing.

Low attrition communities were more likely to mention supervisors as a source of support, though health aides in both low and high attrition sites appreciated support from their CHAP Directors and Coordinator/Supervisor Instructors (CI/SI).[iii] Other relevant aspects of tribal health organization support included mental health/counseling services, access to training, time-off and equipment/supplies.

Importance of a Fully Staffed Clinic

Health aides in high turnover communities emphasized the consequences of being understaffed. The remaining health aides in these clinics were extraordinarily busy. Being short staffed meant the remaining health aides could not attend trainings, take leave, and even meant missing their own medical appointments. Further, it is stressful to the community and the clinic when they must rely heavily on itinerant providers.

Support from Health Aide Directors/Clinical Instructors

Based on data from health aides, the characteristics of a good CHAP Director/CI include being readily available, having a sympathetic ear, and keeping in regular contact with CHA/Ps. Some health aides had their supervisor's home number and found this to be comforting in case of emergency.

Mental Health or Counseling Services

Some CHA/Ps described how the availability of mental health or counseling services to manage their personal wellness contributed to the network of support they received as CHA/Ps. Types of services mentioned include the following:

- Post traumatic debriefing sessions.
- Itinerant mental health care providers within the communities.
- Counseling services at the clinic specifically geared for CHA/Ps. Both high and low attrition communities receiving this service actually used it and valued it.

Provision for Training

Training, or access to training, was an important issue to CHA/Ps, independent of tenure in position. However, their needs were distinct. High attrition communities often sought immediate *basic session training*, and expressed frustration with how long it took to access it. In contrast, health aides in low attrition communities generally were more likely to have these needs fulfilled and desired *trainings beyond these basics*. They felt

[iii] The CI/SI role is to supervise and instruct CHA/Ps in the field. They are frequently responsible for ensuring that their learning needs are met between training sessions. They help CHA/Ps keep skills and information current, and act as advocates for CHA/Ps. CI/Sis may be midlevel providers or they may be CHPs. Sometimes CI/SI personnel are administrative, but not clinical. In some agencies they may be called Field Coordinators, Field Instructors, or by other titles.

supported by the tribal health organization when they received training benefits such as tuition repayment for Physician Assistant programs, CHA/P continuing education courses, and tuition repayment for other college credits.

Importance of Generous Time Off
Time off was very important to health aides. "Happy'" clinics were those where the health aides were able to get rest. Health aides in high attrition sites could not take time off because they were compensating for unfilled positions.

Pay and Benefits
Though a good number of health aides in low attrition sites cited pay and benefits as examples of positive tribal health organization support, health aides did not use strong language to emphasize this particular aspect of tribal health organization support.

Feeling Valued by the Tribal Health Organization
Not all CHA/Ps in low attrition communities felt their tribal health organization supported them; however, CHA/Ps that raved about the support given to them by their tribal health organization all felt uniquely valued by their employer. One CHA/P mentioned that her tribal health organization was a true "advocate" for them (she gave an example of high level corporate executives making a visit to her village and having job perks and benefits increased as a result of the visit). Another CHA/P reported that her tribal health organization truly valued each health aide's unique background, and provided counseling, treatment, or whatever was needed to "make their self esteem go higher."

Equipment and Supplies
CHA/Ps' perceptions of their tribal health organizations' support for equipment and supplies did not differ between high and low turnover communities. The primary lesson learned regarding equipment and supplies was that when a tribal health organization periodically denied a health aide's request for certain supplies, the individuals not only felt personally slighted but felt it reflected lack of trust. On the other hand, willingness to take supply requests without asking questions was cited as a major strength that signaled trust in the CHA/P to know what items and quantities the clinic needed.

E. Village Support

The research team selected communities to visit based on their low or high "community support" scores, so it follows that CHA/Ps in low attrition sites had more positive things to say about community support.

More experienced CHA/Ps and those from low attrition sites felt more support from the village in emergencies, felt the community provided more financial or material support to the clinic, felt more respected by the community, cited receiving more kind words and "thank yous," and cited greater responsiveness from the village council.

As was expected, health aides from high attrition communities were not as supported by their villages compared to their low attrition community counterparts. They mentioned

difficulty building trust with the community, the desire for more support with their facility maintenance and equipment, lack of tribal council support, and difficulties with demanding patients. The distinction in comments is not as clear between newer and more experienced CHA/Ps.

Support from Tribal Councils

CHA/Ps provided some clear examples of strong tribal support. They include: 1) advocating for health aides within the community, such as protecting them against village gossip; 2) advocating for health aides to the tribal health organization, such as taking the view that the health aide 'belongs' to the village, and is not an 'outsider' from the larger tribal health organization; and 3) having a standardized procedure for maintaining regular communication with health aides, such as making reports during tribal council meetings.

Interactions with Patients

Health aides in low turnover communities were far more likely to feel appreciated by patients. CHA/Ps from low attrition communities frequently reported that their patients thanked them or complimented them, while CHA/Ps in high attrition communities mentioned this less often.

F. Family Support

Independent of years of experience, health aides cited the need for understanding and encouragement from family as a major requirement for job success, with childcare the second most cited need. More experienced health aides were more likely to cite the challenges of being away from home, and were more vocal about the supportiveness of their families. CHA/Ps from low attrition communities seemed more comfortable talking about family support in general, mentioning both positive and negative aspects. These health aides were more likely to report that their job made it difficult to plan family activities and that necessary training and on-call duties took valuable time away from family.

The Importance of an Understanding Family

Health aides reported that emotional support from other family members was critical to them. They appreciated having family that was understanding and forgiving about the time away from home and the demanding nature of their jobs. Many health aides mentioned that there were other members of their family (mom, sister, mother-in-law) who had been a CHA/P in the past, who understood the demands of the job and offered support.

The Importance of Childcare

When CHA/Ps were asked what kind of family support was the most important, they frequently mentioned childcare issues, regardless of high or low turnover community. Health aides are usually the primary caretaker of domestic responsibilities, including the care of their children. Their job, however, requires them to drop their family

responsibilities at a moment's notice to handle on-call duties. This makes childcare a crucial factor in family support.

G. Emotional Support

More experienced health aides and health aides from low attrition communities relied on support from coworkers (i.e., there appeared to be more staff cohesion in these clinics). Health aides from high attrition communities and more experienced health aides mentioned emotional support from God, as well as support from family. It should be mentioned that without the coworker support, many health aides were left with no way to "vent." Some health aides mentioned patient privacy issues keep them from reaching out to people other than coworkers. Finally, there was a sentiment that only another health aide would understand their situation.

H. Cohesiveness of Staff

As mentioned earlier, the cohesiveness of the clinic staff was an important retention factor in clinics. High turnover clinics were more likely to have problems with staff harmony.

Characteristics of a cohesive staff were found to include the following:

- Regularly scheduled staff meetings – Sites that had especially successful staff cooperation mentioned they had regularly scheduled staff meetings to communicate clinic issues. One site even met on a daily basis.
- Supportiveness in time off – Some clinic staff worked together to negotiate extended periods of leave for each CHA/P sometime during the year. This provided a needed break for the CHA/Ps and alleviated some of the fatigue and burnout. Scheduling such breaks, though, required extensive cooperation from all staff members, and from the employing tribal health organization or village council.
- Experienced health aides teaching the less experienced – Newer health aides in clinics with experienced staff felt that other CHA/Ps were their primary teacher. Experienced health aides who invited new health aides to shadow them won the appreciation of these younger health aides.
- Cooperation to share the burden of the work – Some clinics talked more vocally about CHA/Ps sharing the burden of the village health care among colleagues. Such thinking helped alleviate the stress that otherwise accumulates, leading to fatigue and burnout.

IV. DISCUSSION

This section of the report synthesizes key findings. Primary attrition and retention factors are organized in a manner to elicit a better understanding of their role and

impact in the career of a CHA/P, while contextualizing them into the existing body of literature regarding job satisfaction.

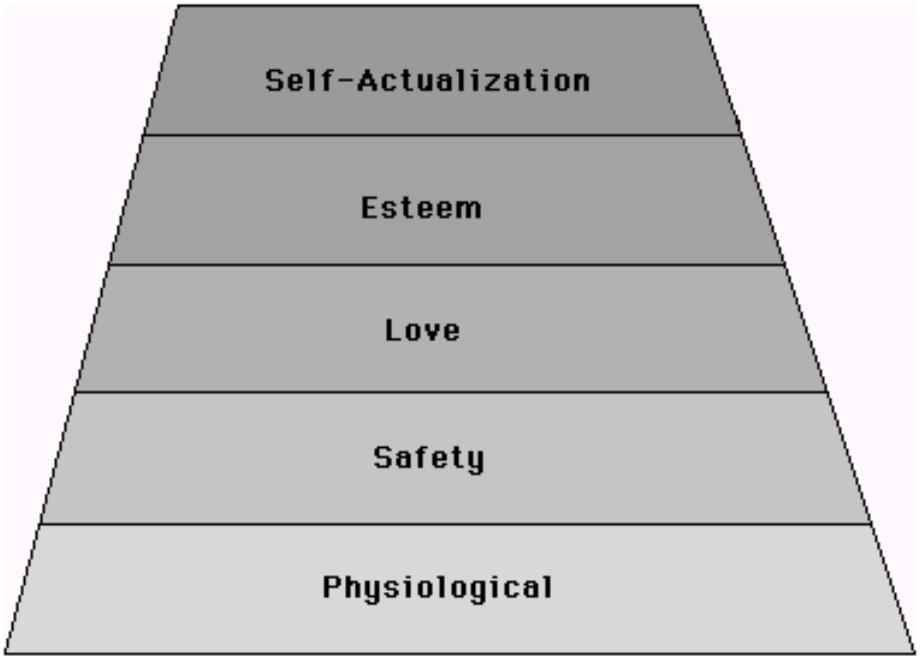
The major theoretical model used to organize our research findings is Maslow's Hierarchy of Needs. Using this model, less experienced CHA/Ps can be understood separately from their more experienced counterparts, facilitating a better understanding of each group's unique needs.

In addition, the key challenges for CHA/Ps working in high attrition communities can be visually organized into a cycle that depicts the role of individual stressors in the decision that many CHA/Ps make to quit. While the cycle is complex and difficult to stop, the visual aid is meant to facilitate an understanding of how individual stresses can compound and add to the creation of new stresses on the CHA/P. Once this cycle is better understood, it can lead to the development of new solutions and approaches to attrition.

A. Maslow's Hierarchy of Needs

Maslow's Hierarchy of Human Needs provides one way of classifying human needs, and has been one of the most influential psychosocial models of the 20th century. It has also emerged as a fairly popular model for explaining job satisfaction factors, partly because it provides a classification system for human needs, but also because it provides concrete implications for managing these needs within complex organizations.[17] This model is shown in Figure 1.

Figure 1. Maslow's Hierarchy of



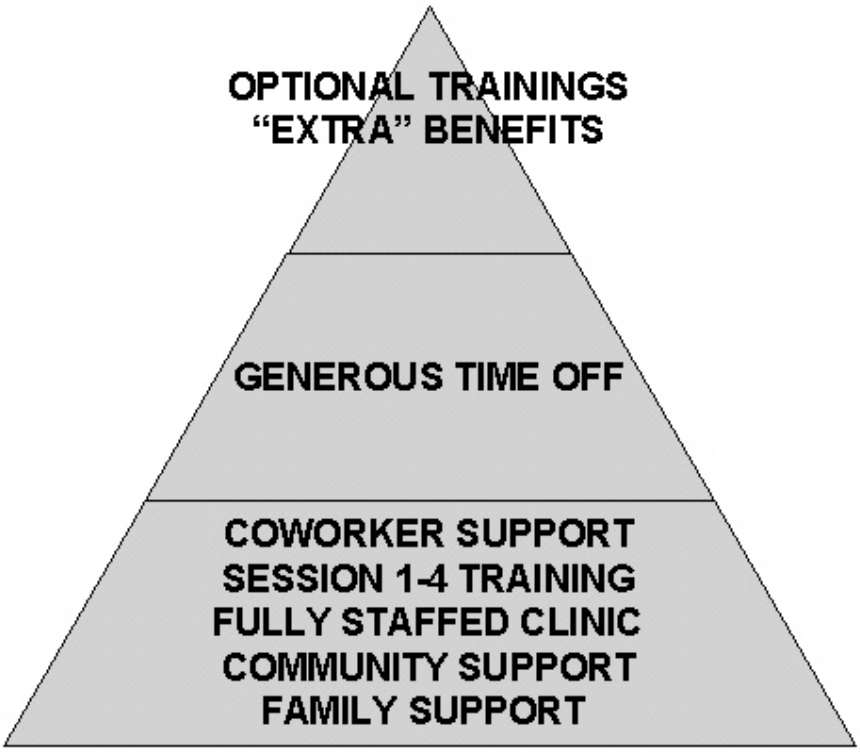
According to Maslow, people are motivated to fulfill their unsatisfied needs, and there are certain lower needs which must be satisfied before higher needs can be fulfilled. Maslow classified needs into general types, including physiological, safety, love, and esteem – arguing that these needs must be met before a person can meet higher needs and be "self-actualized." Physiological needs include air, water, food, and sleep, and form the base of Maslow's pyramid. Safety is next, and includes the need for human beings to feel safe in a chaotic world. The next highest level of the pyramid is comprised of the need for love and belongingness, including the need to feel accepted by others. Esteem includes the need for feeling that essential tasks have been mastered and that others acknowledge their adequacy on the job. Maslow called all of these basic needs "deficiency needs" because humans cannot move toward the higher level of self-actualization, where they can maximize their potential, until these lower cravings have been assuaged.[17]

There are considerable implications with this theory for employer organizations. It can be argued that unless employers provide workers with a means to placate their basic "deficiency" needs, employees will not be able to reach for the higher levels of job satisfaction and self-actualization in the workplace.

B. Maslow's Theory and the CHA/P Profession

This research would indicate that CHA/Ps have a hierarchy of needs within their profession, as well. This model is shown in Figure 2.

Figure 2. Health Aide Hierarchy of Needs



This model uses the Maslow concept that there are basic needs that must be met before CHA/Ps can move toward "self-actualization" or *complete satisfaction* with their career. The research would support the notion that the items on the lowest level of the pyramid (the most basic CHA/P needs) are most likely to be associated with attrition. Items higher on the pyramid are probably not as likely to have a causal relationship with attrition, but fulfillment of these needs can help improve job satisfaction for CHA/Ps. Based on the data, CHA/Ps from low attrition communities, and with more than ten years of experience, appear to function more toward the top of the triangle, while CHA/Ps from high attrition communities, or who have less experience, are more likely to be working to fulfill the five basic needs demonstrated at the bottom of the pyramid. These basic needs include positive co-worker support, timely access to basic training, access to a fully-staffed clinic, support from the community served, and family support.

C. Co-Worker Support

The need for support and cohesion amongst the health aides and clinic staff was a recurring theme brought up by CHA/Ps throughout the interviews. The idea emerged in response to a number of questions on different topics. Data were evenly divided between high and low attrition communities both in terms of the number of comments made by CHA/Ps, as well as interview content. This appears to be a "make or break" area of support – a basic health aide need that can affect attrition.

In general, low attrition community CHA/Ps, and those with ten or more years of experience were much more likely to state that they had good support from the other CHA/Ps in their clinics and to feel that the clinic staff worked in solidarity. When the staff worked well and communicated with one another, the effect translated to a wide variety of areas. It was easier to develop leave and on-call policies that benefited all CHA/Ps, provided more emotional and clinical support during and after trauma situations, and led to a more pleasant work environment. CHA/Ps in low attrition communities also mentioned that working with other supportive CHA/Ps provided an important outlet for emotional support. They pointed out that the isolation and particular challenges of the position made it important to have somebody to share and discuss the job with. CHA/Ps cannot discuss client issues with family or friends due to privacy and confidentiality concerns.

In contrast, a lack of supportive co-workers added to the stresses felt by many CHA/Ps in high attrition communities. CHA/Ps in these communities were much more likely to articulate difficulties communicating and working together with their co-workers. This finding would support the need for communication, team building, and co-worker support structures to be included in basic training and/or on-going field trainings.

D. Access to Basic Training

CHA/Ps from both high and low attrition communities cited the need for training as an important area of support from their employing entity, a need which has already been identified by the CHAP Directors[8]. However, there was a vast difference in the quality of

the comments made on this topic – highlighting the different training needs between newly hired and more experienced CHA/Ps. CHA/Ps with the least experience, and those working in high attrition communities, often cited the need for timely access to basic training. Basic training encompasses approximately 16 weeks of classroom activities and additional supervised fieldwork, emphasizing patient assessment and the identification and treatment of the diseases most prevalent in rural Alaska. Unlike most medical professionals, CHA/Ps are hired and then subsequently trained for their positions. The more experienced CHA/Ps, working in low attrition communities, were able to manage complex cases so that newer CHA/Ps in the clinic were not expected to be the primary responder. However, in communities with high attrition, CHA/Ps often began treating these complex cases earlier in their career, and often before they felt that they had adequate training. For these CHA/Ps, lack of timely access to basic training led to additional job stress. This is supported by Maslow's theory that humans need to feel mastery of their tasks to fulfill their basic esteem needs.

As would be expected, low attrition communities tended to have more experienced CHA/Ps. They also requested training, but were more likely to seek CHA/P continuing education courses or financial support to develop new clinical skills such as a Physician Assistant program. It is the differences in the quality of these comments about training that separated CHA/Ps on the "Health Aide Hierarchy of Needs" pyramid found in Figure 2. Access to continuing education and tuition repayment programs may help assure CHA/P job satisfaction, but lack of timely access to basic training, especially in communities without other experienced health aides to help pick up the slack, is more likely to have a causal relationship to attrition.

E. Fully Staffed Clinic

The long hours and resultant fatigue were the most frequently cited negative aspects of the job in all communities. The problem was felt even more strongly in high attrition communities suffering from frequent position vacancies. The continuous volume of patients in communities that had less than the optimum number of appropriately trained staff led to longer CHA/P hours, both in-clinic and especially on-call. In fact, analysis of reported on-call schedules from all communities showed that CHA/Ps in high attrition communities were generally on-call more often than CHA/Ps in low attrition communities. These long hours, then, contributed to their higher vacancy rates. Meanwhile, disgruntled and complaining patients increased as clinic services were inevitably compromised or reduced outright. The lack of a fully-staffed clinic weighed down on the remaining CHA/Ps in the community, who felt additional stress and pressures as a result of the staffing, and who were therefore more likely to leave themselves. This factor can foster a vicious cycle of attrition, as depicted in Figure 3 at the end of this section.

F. Community Support

CHA/Ps in low attrition communities overwhelmingly cited more positive support from their communities than CHA/Ps in high attrition communities. The more experienced

health aides, and health aides from low attrition sites, were more likely to feel support from the village in emergencies, feel the community provided more financial and material support, feel more respect from the community, receive more kind words and "thank yous," and experience greater responsiveness from their village councils. Although CHA/Ps in all communities mentioned having difficult patients, CHA/Ps in low attrition communities were more likely to overlook these demanding patients because enough positive encouragement from the village was there to counteract it.

In fact, the discussion of community support was the one area where CHA/Ps from high attrition communities had more to say than CHA/Ps in low attrition communities. CHA/Ps in high attrition communities often mentioned the difficulties associated with building trust with the community, the desire for more support with facility maintenance and equipment, and a perception of lack of tribal council support. Further, they were more likely to characterize patients as difficult and demanding of unreasonable services. They were also more likely to feel that patients abused on-call privileges by calling CHA/Ps after hours for non-emergent cases. While it was expected that community support would be a major factor impacting job satisfaction, the degree of its impact on attrition of CHA/Ps was surprising. These data would suggest that communities themselves can play a large role in improving the satisfaction and retention of their CHA/Ps through encouragement, acknowledgement, and appropriate use of on-call systems.

G. Family Support

Personal issues were the most often cited reason for why CHA/Ps quit or consider quitting at some point in their career. This was true amongst CHA/Ps in both high and low attrition communities. The unique demands of the CHA/P job make it almost impossible to succeed without strong support from the CHA/P's family. The average CHA/P is female and has young children at home. Many other CHA/Ps are also primary caretakers of young children or are helping to care for older generations and extended family members within their home. Such stresses can be difficult to manage with any profession, but especially difficult for CHA/Ps who work long and unusual hours as a result of on-call responsibilities. It can be challenging for CHA/Ps with such family responsibilities to leave the house in the middle of the night to respond to emergency and trauma cases without the strong support of other family members who are willing and able to provide child or elder care at a moment's notice.

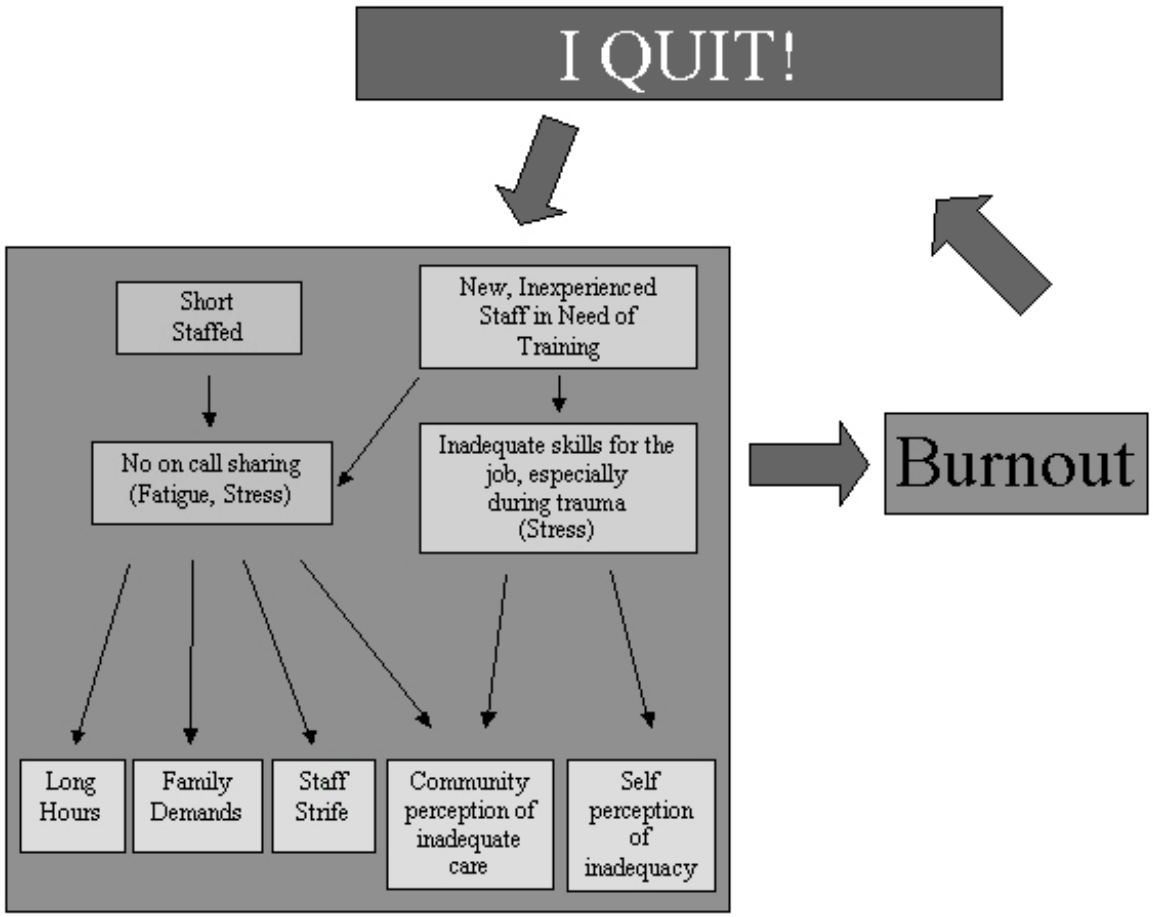
Even CHA/Ps without children or elders to care for discussed the importance of having supportive family members who understood the long hours, fatigue, and stresses of the CHA/P profession. Many CHA/Ps needed family support to help with other household duties, such as cooking, cleaning, and subsistence activities. While other factors such as encouragement from the community or tribal council, or financial need, sometimes were enough to bring a CHA/P back to the job, it was clear that the stress of merging the complexities of the CHA/P job and family responsibilities was often enough to cause CHA/Ps to feel the need to choose between the two.

Fatigue and Stress in the Attrition Cycle

In summary, the following five major areas were found to form the basis of CHA/P retention needs: coworker support, adequate and timely basic training, a fully staffed clinic, positive community support and family support. Although other factors (such as fair wages, good benefits, generous leave policies, adequate clinical support and access to additional training opportunities) were also important issues to CHA/Ps, focusing on them alone without addressing the five basic CHA/P needs is unlikely to positively impact retention.

Each of the five primary factors contributing to attrition affects CHA/P fatigue, stress, and burnout, thus fostering the cycle of attrition in many communities. This feeling of burnout was exemplified by one CHA/P interviewee who told the research team, "They can't pay me enough to do this job." This cycle of attrition is summarized in Figure 3.

Figure 3. Cycle of Burnout



In this cycle, the decision by a CHA/P to quit leads to either a short-staffed clinic and/or a clinic that is staffed with new, inexperienced, and untrained staff members. Both of

these situations lead to inadequate staffing to share job duties, especially complex cases and on-call hours. Therefore, remaining clinic staff members are saddled with an unreasonable burden of patient care, leading to long hours, fatigue, and strife both within their families and amongst the remaining clinic staff. These in turn can lead to perceptions of "poor" quality of care, both amongst community members and by CHA/Ps themselves, if they feel that they must provide services that are beyond their comfort level for the level of training they have completed. Consequently, more CHA/Ps may quit, which then exacerbates and compounds this cycle.

Breaking this cycle is not easy, but developing interventions that solve different aspects of this cycle are what will ultimately bring staffing stability to a community.

V. CONCLUSION AND RECOMMENDATIONS

CHA/Ps practicing in remote locations are an integral part of Alaska's rural tribal health care infrastructure. However, some of the advances in patient access that CHA/Ps have made could be threatened by high attrition rates within the profession.

This research suggests that a number of improvements could be made to the program so that CHA/Ps feel more satisfied in their jobs and acknowledged as an important component of the village and Statewide health system. Tribal health organizations, clinicians, village councils, and community members who strive to meet some of the higher health aide hierarchy of needs — such as providing fair pay and benefits, generous time off policies, optional training support, and more understanding and respect — will help CHA/Ps feel supported in their positions. Addressing some of the more basic CHA/P needs — such as co-worker support, access to basic training, access to a fully-staffed clinic, strong community support, and adequate family support — is especially important for managing CHA/P attrition. Addressing these basic issues will play an important role in helping CHA/Ps to deal with the stress, fatigue, and burnout that is common in the profession. Without addressing these fundamental needs, it is unlikely that other interventions will ultimately reverse the trend of CHA/P attrition.

The research suggests a number of potential solutions for decreasing CHA/P attrition. The recommendations include:

A. Improving On-Call

CHA/Ps had many suggestions for employer tribal health organizations or village councils to improve the CHA/P on-call system. Some suggestions could make CHA/Ps feel more valued and acknowledged for their on-call activities, and others could reduce the actual fatigue that such difficult on-call hours produce. Recommendations that allow CHA/Ps to recover and rest from on-call hours will likely be more productive in reducing attrition. However, it is understood that some recommendations may be unattainable until the clinic is fully staffed and fully trained. CHA/Ps were most likely to suggest the following three methods to improve on-call:

1. Additional pay for on-call hours – Many CHA/Ps did not receive additional pay from their basic salary for hours spent on-call. On-call was figured into their base salary. However, many CHA/Ps felt their on-call schedule was more burdensome as a result of position vacancies or CHA/Ps who had not received adequate training to participate in the call schedule. This resulted in the feeling that they were not fully compensated for the extra hours of work produced by the on-call schedule. Providing additional pay for on-call hours would not resolve the fatigue and stress, but it would help CHA/Ps feel valued for this service and provide a helpful intermediary solution.
2. Paid time off after hard on-call night/s – Many CHA/Ps discussed the difficulties of being up all night working on trauma cases and then being required to show up at the clinic the next morning for their regular shift. CHA/Ps generally felt that they were asked to make an unfair choice in such situations -- either taking leave to rest from their time working the prior night or coming to work fatigued. Providing a policy for paid time off after particularly difficult and traumatic nights of on-call would make CHA/Ps feel more valued.
3. No make-up of on-call after taking annual leave – Inadequate staffing in many clinics makes it difficult for clinics to keep up with call when a CHA/P takes annual leave. As a result, many CHA/Ps are required to "make-up" their on-call time from when they were away on leave, which quickly negates many of the positive soothing aspects of their vacation. While this may not be possible in some clinics due to the low staffing levels, minimizing this practice would likely reduce fatigue.

B. Improving Community Support

Having strong support from village councils and feeling respect and gratitude from community members can make a big difference to overworked, fatigued CHA/Ps. Since the vast majority of CHA/Ps report that their job is very stressful and prone to burnout, local support from the village council and from clinic patients can do a lot to make CHA/Ps feel that the stress is worthwhile. CHA/Ps mentioned the following specific ways village councils can support CHA/Ps.

1. Advocate for health aides within their communities – Some CHA/Ps felt that village councils could do more to protect them against village gossip or from complaining patients. It is not uncommon for patients to take complaints directly to their village council. CHA/Ps need to feel that they are supported by, and working in tandem with, their village council. An illustrative example from a CHA/P interview is shown below:

   I had gone to the city councilman…and told these people I think there were things [gossip] going around. At some point I was only here for the money and I didn't care about the people here. And so I went to the council meeting and I explained to the people who were at the council meeting that, you know, I'm not here just because I'm here robbing you guys of money. I said "you guys are

Inupiat. I'm Inupiat. I'm here because I have a desire to take care of my people. You guys are my people." And then shortly after that I did leave. The council got certain individuals together and had a meeting with them. They pretty much told them that they needed to leave me alone and this committee was in support of me being their health aide. It got better.

2. Advocate for health aides to the tribal health organization – Just as CHA/Ps want to feel that they can trust their village council to stand up for them against complaining patients, they want to feel that the council will advocate for them at the tribal health organization level. In some cases, this might mean advocating for individual CHA/Ps against organizational gossip or for policy changes or benefit issues. The key is for CHA/Ps to feel like they are not alone against their tribal health organization, and to feel that they have strong local support and trust.

   I think [the tribal council members] are [very supportive], and they actually went to bat for us against the corporation back in October. There were two of us that really needed their support. The council did what they could by writing a letter of support saying that the health aides are good, they like them, they trust them, and they do a good job.

3. Provide means for regular communication with the village council – Some communities have standardized procedures for maintaining regular communication with health aides, such as making reports during tribal council meetings. CHA/Ps generally liked and appreciated these forums and felt that they provided opportunities for their needs to be heard.

In addition, support provided directly from patients can help buoy a stressed and tired health aide. CHA/Ps in low attrition communities often discussed how patient acknowledgement and words of gratitude made them feel valued. This would suggest that communities themselves can play a large role in CHA/P retention.

C. Emotional Support

CHA/Ps need strong emotional support to manage the unique stresses of the profession. Finding people outside the clinic with whom to share these stresses can be difficult because of patient confidentiality and privacy issues. Thus, having supportive co-workers to share and vent with can be integral to CHA/P retention. Adding curriculum or training exercises covering coworker support issues at the training center level were seen as likely to be beneficial, although it was recognized that the large number of topics to be covered during the limited training period made adding to the curriculum problematic. Tribal health organization-sponsored team building exercises that encourage improved teamwork, communication, and supportiveness may also provide useful tools to CHA/Ps, particularly in clinics where teamwork doesn't come naturally.

D. Access to Training

Since CHA/Ps are asked to perform some aspects of their jobs before they have completed all of their training, it is crucial to get them through their basic training courses as quickly as possible. Having a fully-staffed, fully-trained clinic team not only helps decrease the stress level of the individual CHA/P (who then feels more prepared to do his/her job), but also helps decrease the burnout of other CHA/Ps in the clinic by providing more people with which to share on-call, trauma and complex cases. The issue of assuring timely, appropriate training is not new and has been discussed by many interested parties in the past. This finding supports data from the CHAP 2001 Update and supports the importance of continuing to evaluate ways of assuring quick and timely access to basic training courses.

Appendix A

CHAP Director Rating Form

Alaska Center for Rural Health - Community Health Aide/Practitioner Program Study

Contact: Mariko Selle PHONE - (907) 786-6591 FAX - (907) 786-6576 EMAIL - mariko@uaa.alaska.edu

Your Region: _____

Please identify 4 "low turnover villages" and 5 "high turnover villages" and rank them on a scale of 1 to 10

for the factors listed, where **"1" is "couldn't possibly be better"** and **10 is "couldn't possibly be worse."**

This information will be kept strictly confidential.

	Low Turnover Villages				High Turnover Villages		
Village	#1	#2	#3	#4	#1	#2	#3
Primary Factors							
Community Support							
Tribal Government Support							
Health Professional Support							
Health Problems in the Community							
Volume Relative to Staffing (either too high or too low)							
Acuity of Health Encounters							
Secondary Factors							
Geography							
Salary/Benefits							
Balance of Power and Authority							
Community Infrastructure							
Training							

Is there a village you believe has made a dramatic shift recently? Either from high turnover to becoming low turnover, or the reverse? Please name the village and explain what has occurred.

Appendix B

Interview Guides

Key Informant Interview Questions
Target: Health Aides
30 – 40 minutes

Introduction

1. What is your most recently completed health aide training session level?

2. How long have you been a health aide, and how long have you worked in this clinic?

3. Have they been a health aide somewhere else? If yes, where? Why did you leave?

Recruitment

4. How were you recruited to be a health aide?

5. What initially attracted you to the health aide job?

Job Pros/Cons

6. What are the things that you like about being a health aide?

7. What are the things you don't like about being a health aide?

8. What are some of the differences between what you originally expected your job would be like, and what it actually is like?

Factors that Affect Retention

9a. Have you ever quit?
If yes - what made you decide to come back?

9b. Do you ever consider quitting?
If yes - What keeps you here?
If no - What do you think are the reasons you've never considered quitting?

10. Is there anything that might cause you to leave your job?

Health Status of the Community

11. What are some of the health care issues in _____?

12. What is your patient load like here?

13. How often are you on-call?

14. How many of the people that you care for have really complex health problems or really serious injuries?

15. How would you describe the overall health of _____?

16. How does all of this affect your job?

17. How can it be improved?

Clinical Support

18. Clinical support is the support you get in the care for patients, from other providers or even other health aides.

How would you describe the clinical support you get?
What specific types of things do your clinical team do to support you? PROBE: how often do doctors call?
How could clinical support be better?

Tribal Health Organization Support

19. Tribal health organization support is the support provided to you from your employer, and can include training, salary and benefits, as well as other kinds of support such as counseling or mentoring to help you in your job.

How would you describe the support you get from your employer?
What specific things do they do?
How could it be better?
Do corporation political struggles or competing interests affect your job, for good or bad? How?

Village Support

20. Village support is the support you get from your community, such as your patients, the people in the community, and members of the village council.

How would you describe the support you get from the village?
What specific things do they do?
How could it be better?
Do village political struggles or competing interests affect your job, for good or bad? How?

Family Support

21. Other health aides have told us that because being a health aide is so demanding, they are sometimes forced to choose between their jobs and their families.

Is this true? Can you tell me about a time you've felt like this?
How does your job affect other members of your family?
What kinds of support do health aides need from their own families?
What kind of support do you get from your own family?

22. We've talked about different kinds of support, including support from the village, your health corporation, and personal/family support. Who do you turn to for other kinds of support - when you're stressed with your job, or something happens that affects you emotionally?

23. What is the most important type of support to you?

Closing

24. Where do you see yourself in 5 years?

25. If you had to do it all over again, would you choose CHA as a career?

26. Would you encourage others to choose CHA as a career?

Key Informant Interview Questions
Target: Community Members
20-30 minutes

Introduction

Thank you for your time. We are interviewing people across Alaska who live in villages where there are health aides. Our goal is to get information that will help improve the health aide program, so there is good quality health care in the communities. _____ recommended we talk to you because of your leadership role in the village.

1. First of all, how would you describe your role in the community (job, tribal government involvement)?

2. What has been your involvement with the health clinic? (Have you been involved in any decisions about the clinic, or anything that may have affected the course of the clinic?)

3. What kinds of services are provided at the _____ (village) clinic, that is, what kinds of things do people go there for?

4. What are some of the health care issues in _____?

5. How is the overall health of this village? PROBE: would you say this was a healthy community?

6. How much do the people of _____ rely on the clinic?

7. What do the people of ____community think about the clinic? PROBE: What is the role of the clinic in _____?

Role of the health aide/Community perception of health aides

I'd like to ask a few questions about the role of the health aides in _____. Health aides in different places assume slightly different roles.

8. First of all, what do you think the benefits are of having health aides in your community?

9. What kind of person makes an ideal health aide?

10. Based on your experience, what attracts people to become health aides?

11. From what you've heard, what are some of the things they like about their jobs?

12. From what you've heard, what are some of the things they don't like?

13. What are some things that make it hard for them to do their jobs?

14. Are health aides quitting a problem in _____? [if needed]

15. Based on your experience, why do you think health aides leave their jobs?

16. What are some of the reasons you think that health aides keep their jobs for a long time in _____?

Support

17. How would you describe the support _____ (village) gives their health aides?

18. How can the support be improved?

19. How is the local community leadership supportive of the health aides?

20. How are the health aides supportive of each other?

21. Do you think people appreciate health aides in ___community? What are some of the ways people show their appreciation?

Improvements

22. Does this community get what it needs from the health aide program? PROBE: Do you have enough health aides, are you getting the type of services you need here?

23. What do you think would improve the health aide program [do we care about improving the "program" or improving the services provided locally?]?

24. Do you have any final comments to make about the health aide program?

Key Informant Interview Questions
Target: Tribal Health Organization Members
20-30 minutes

Interview purpose: to find out what the major roadblocks are for retaining health aides from the tribal health organization perspective.

Introduction

1. Describe your role with _____ (corp.) and your involvement with the CHAP program.

2. What is the process for hiring Community Health Aides at _____?

3. What works well about that process?

4. What needs to be improved?

5. Based on your experience, what attracts people to become health aides?

6. From what you've heard, what are some of the things they like about their jobs?

7. From what you've heard, what are some of the things they don't like?

8. What are some of the differences between what people expect when they first take the job, and the reality of what it's actually like to be a health aide?

Factors that Affect Retention

9. How would you describe the health care system in _____ (village)?

PROBE: What is going on in that village?

10. How would you describe the issue of CHAP turnover in _____ (village)?

11. What are some of the reasons turnover is a problem/is not a problem?

12. Studies have shown that ensuring a good match between the position and the personality of the individual can minimize attrition. When you are looking to fill a health aide position, what type of candidate makes an ideal candidate – the type of person who is likely to stay on, do a good job, and feel good about their job?

13. What are some of the characteristics of health aides of the "20-year" health aides, those who stay long-term?

14. Based on your experience, why do you think CHAPs leave their jobs?

15. Do you have a formal exit process, such as exit interviews?

16. What are some reasons health aides come back after they quit?

CHAP Support Network

Tribal Health Organization Support - general

17. How would you describe the support _____ (corp.) gives to health aides?

    What are some specific things _____ (corp.) has done to support health aides?
    What has worked well?
    Is there anything the corporation might do better?

Tribal Health Organization Support - specific

18. How is the payscale determined?

19. How are salary increases determined?

20. What is the process for health aides to get training?

21. What kinds of advancement opportunities are there for health aides?

22. Do you have a counseling program for health aides?

    How does it work?

23. Does your corporation fund backup health aides?

    How do you determine which villages get backups?
    How many villages have backup health aides?
    How does the presence/lack of presence of back-ups affect CHAP turnover?

24. I've asked you about the ways the corporation support health aides, such as salary, training, advancement, counseling. What could the corporation do better to support health aides?

25. Do corporation political struggles or competing interests affect health aides, and how?

Village Support

26. How would you describe the support _____ (village) gives their health aides?

What are some of the ways they're supportive?
How can the support be improved?

Other Health Professional Support

27. How is the relationship between the health aides in _____ (village) and the other health care professionals that give clinical support, such as the docs and midlevels?

What are some of the ways they're supportive?
How can the support be improved?

28. How are the health aides' relationships with each other?

How are they supportive of each other?
How can their support for each other be improved?

Health Status of Community

29. What are some of the health care issues in _____ (village)?

How often are health aides on-call?
What is the volume of their patient load like?
What about the acuity of health encounters in _____?
How would you describe the overall health status of _____(village)?
How does the health status of _____ affect the turnover of health aides there?

Closing

30. Where do you see the _____ (corp.) program heading in the next 5 years?

31. Is there anything else regarding health aide turnover that you would like to add?

Appendix C

Detailed Discussion and Examples

Detailed Discussion and Examples

A. Recruitment / Expectations / Resignations

1. How Health Aides Were Recruited

The top two ways in which CHA/Ps were recruited were through word of mouth or in response to an open job posting. .However, newer health aides and those from high attrition communities were more likely to have simply responded to a job posting. Health aides in low attrition communities, however, were more likely to have been invited to apply by a respected health aide or community leader, rather than simply reading a posting, or casual suggestion by an acquaintance.

> *"I was with a friend that was sick, and [the health aide] came over. I didn't know that there was a position open to be a health aide, and I didn't have a job in the community. I was born and raised here, so I wanted to stay here, and I needed a job. So, she said, "You know, you should apply for that position."*
> [low turnover site health aide]

> *"There was an advertisement posted and I just applied."*
> [high turnover site health aide]

2. What Attracted Health Aides to the Job

In general, the same things attracted people to the health aide profession, regardless of the type of community or the length of time on the job. People cited a variety of aspects that were attractive about the job, with the most common reason for applying being that it was a good job/career opportunity, and the individual needed a job. Additionally, respondents reported an interest in medicine, and 'just wanting to try it out."

There were only slight differences between groups. For example, the more experienced health aides were slightly more likely to discuss the status of the job in the community and the impact of specific health aide role models in their decision to become a health aide. Health aides from high attrition communities were slightly more likely to think of the health aide job as a "good job in a community where job options are scarce."

> *"I just needed a job. I needed to support my family. That was my main reason.*
> [high turnover site health aide]

> *"First of all I thought that I could never be a health aide. They always looked like they had things together and they were helping people."*
> [low turnover site health aide]

"My grandmother, she was an inspirational guide to me because she was a health care provider back in the olden days…I wanted to be like her and taking care of people was the one thing that motivated me to become a health aide."
[low turnover site health aide]

3. Expectations of the Job

In response to the question, "What are some of the differences between what you originally expected your job would be like, and what it actually is like," many health aides reported that they simply did not know what to expect.

"That's difficult [to answer]…I don't think I even had any expectations…I didn't really know what I was really getting into, I guess."
[low turnover site health aide]

"I had no medical background whatsoever. And I jumped right in and was shown how to give shots into an orange and prepare to deliver a baby through emergency delivery and stuff, and I was right there on-call with the senior health aide. So that I had no clue what I was actually going to be involved in that at least as far as I can remember."
[high turnover site health aide]

Health aides reporting their jobs matched their expectations were split evenly among high and low turnover community health aides. These participants often mentioned that they had been exposed to clinic life previous to their employment or had had a relative that had been a health aide.

"I don't think there was any change because I worked here for so long as a CHR [community health representative], and I went on-calls with the health aides then so I knew what I was getting into."
[low turnover site health aide]

"Yeah, because they shipped my mom to incidents that happened and she used to ask me to go with her to home visit."
[high turnover site health aide]

4. Current Aides Who Quit in the Past

Many health aides had quit at some point in their career and then returned to the position[iv].

[iv] ACRH staff was surprised to find that, when asking CHA/Ps if they had ever quit, there was no easy "yes/no" response. CHA/Ps had often left for a couple months, then returned to work. At best, ACRH staff was consistent in coding responses.

This was found most with health aides who had been on the job for over 10 years, with 11 of the 18 of these long-term health aides reporting at least one resignation, or extended leave, during their career. In contrast, only two of the 16 newer health aides had ever left the position. This may be partially explained with the more tenured professionals having more time to quit and return than newer health aides. Nevertheless, the data do suggest that this is a difficult profession. Responses did not differ greatly between CHA/Ps from high and low attrition communities.

5. Reasons for Quitting

Personal issues were a major determinant for why health aides did quit, considered quitting, or would ever consider quitting.[v]. This was true regardless of the amount of time the health aide had been working on the job, or whether he/she was from a high or low attrition community.

In high turnover communities, however, there was a higher tendency for health aides to quit because the difficulties of their jobs were overwhelming their personal lives. For example, a health aide in a high turnover site described quitting from the stress of a difficult pregnancy while having to take call with only a Session I training. Low turnover communities more frequently cited personal issues such as marriage outside the village, relocation, and higher education as reasons for quitting.

> *"[I quit because] I was seven months pregnant and being on-call -- that's when they were on-call for a week at a time and even though I was Session One, they had me on-call. I was having a hard time with the pregnancy too."*
> [high turnover site health aide]

> *"I told my ex-husband--he's my ex-husband now--that when my oldest child got into first grade, that I was moving. He needed to go to a bigger school with a bigger selection and a wider variety of things going on, so I moved. I left. With or without him, I was moving."*
> [low turnover site health aide]

All health aides, regardless of high/low turnover community, had an extraordinarily difficult job. The stress, trauma, and burnout caused by their jobs was another common reason for quitting. This was true for both new/old health aides, as well as for health aides from high/low attrition communities. Health aides reported having quit because of successive suicides, multiple deaths of young children within days, the stress of constant on-call duties, and having to work with inebriated staff.

> *"After I heard that baby died I just walked out of the clinic. I was too mad, I was everything, I just walked out. I couldn't cope with that pain of losing in a day two four year old boys and a nine-month-old boy."*

[v] Comments for "personal issues" included marriage, spouse relocation, family pressure to quit, college, taking care of family or just "personal situation."

[low turnover site health aide]

"I was burnt out and had odd hours. I went through so much working with a lot of health aides and they would just burn me out. I would always be on-call. The other health aides would be drunk…they used to take advantage of me a lot. Plus, I was at work and practically on-call always. It was not fair."

[high turnover site health aide]

It is worth observing that personal issues and stress caused by the job were interrelated. Health aides often discussed how personal issues (such as child care, elder care, taking care of family issues) were more difficult because of the unique characteristics of the health aide job – such as the on-call requirements. Thus, these two top findings of *personal issues* and *job stresses* appear to be related.

Other reasons for quitting, or considering it, included corporate politics, difficult patients, and abuse by villagers and coworkers. Health aides from low attrition villages, and more experienced health aides, were more likely to cite tribal health organization politics. These health aides may have been more aware of their regional politics due to the longevity of their positions, or because of the absence of other stressors that might have otherwise distracted them away from political happenings. It is also possible that these health aides were more comfortable reporting their political concerns to interviewers.

6. Reasons for Returning after Quitting

Health aides returned to the job for a variety of reasons. Encouragement from community members and the need for a job and/or benefits were both heavily cited and appeared to be equally important reasons.

It should be noted that the reasons health aides returned to work were not linearly related to their reasons for leaving. For example, if she had left because of a problem at home, those issues often remained upon her return (although sometimes they had been resolved) and the stressful nature of the job continued. It is possible that the short period of leave was enough to make these stresses manageable even though they may not have disappeared.

"Encouragement from community members" was found to be a strong factor in getting reluctant health aides to return to the profession, regardless of high/low turnover community. Unlike other professions, a health aide who resigns remains in constant contact with her former clientele and, sometimes, her employers, by virtue of the fact that she is still in the village. Due to this on-going contact, the community is unlikely to forget that a trained provider with whom they are comfortable lives right within their midst. Also, health aides cannot escape seeing the impact their vacancies create in their villages.

"There were people that really wanted me to come back and then our IRA council approved it…During that time even the SI called me and even the family member of

the deceased kept coming to me to give me support. They really wanted me to come back to work and I was a little scared, having cold feet."
[low turnover site health aide]

"They kept asking me before I came back if I would, and at first I wasn't ready to go back. They kept calling me, so I finally said yes. At first, I didn't want it because it was too stressful."
[high turnover site health aide]

Some respondents mentioned that there was no question they would return once their personal situation changed. This supports the concept of quitting as a continuum – they take a break, leave the community, etc. but often only for a short time. This is discussed further in the "Discussion" section of this report.

"We got divorced and I came back in 1992…"
(Was there any question that you would become a health aide again?)
"No, there was no question. I was like, it's my life. Like I said, I wouldn't want to go to another job. When I came back, they made a position for me, because their positions were all filled."
[low turnover site health aide]

"I took a break in 1986 for six months and then in 1996 for six months."
(What was it that made you decide to take a break?)
"I got into mushing."
[low turnover site health aide]

Some health aides, regardless of high/low turnover community, talked about genuinely missing the job as a reason for returning.

"There was part of me missing. When I took my kids to the clinic, I would automatically want to check them myself. I used to do that. I don't know. There is just a part of me that was missing it, so I had to come back."
[high turnover site health aide]

Some health aides reported to have returned to work after a period of time off because they felt restless without a job.

"I got bored. A job popped up here again, so I signed up realizing that I was going to have to take a different perspective of it and not allow myself to get overdrawn like I had."
[low turnover site health aide]

As previously mentioned, financial concerns were another important reason health aides returned to work.

"I needed a job. That was the only skills I had…That is it, I needed a job. I had a husband and a kid, I had to work. He was unemployed."
[low turnover site health aide]

7. The Rewards of Being a Health Aide

Independent of experience or setting, health aides overwhelmingly cited patient care and helping other people as the aspect of the job that they most liked. For many health aides, this was a passionate mission.

"I love being a health aide. I love the patient care. I love the interaction with the patients. I mean, you always have your bad apples, but for the most part, I really enjoy being able to make people well… especially children."
[low turnover site health aide]

"Some of the things I like about being a health aide is having the feeling of having helped someone. That's a really wonderful feeling…I think that's the most important one...that feeling of helping someone. That's what keeps me from quitting. All those other things that happen, all those other bad things that happen in my job, this feeling of having helped someone covers them all."
[low turnover site health aide]

"I like to help people and try to help them live healthy. I encourage the young mothers to take care of their children… I know when I brought my first child in, I was 20, I think. I even brought her in for heat rashes. That always makes me smile when young mothers come in. They usually don't know much about their baby's health, so I try to reassure them that they are okay."
[high turnover site health aide]

"Care for a friend or a neighbor…Seeing patients and then seeing them another day when they are all good, all healthy. Seeing the kids play when they are all done with their personal ills."
[high turnover site health aide]

Health aides also reported to enjoy the clinical aspect of their jobs (taking x-rays or performing certain exams, for example); making a positive contribution to their communities; the challenge and learning opportunities; the excitement and unpredictability of the work; and simply that they had a good job in their own community.

Newer health aides were more likely to mention that they liked the unpredictability of the job. This may be attributed to one of two reasons: (a) newer health aides are generally younger and may be from a generation that appreciates greater unpredictability; or (b) more experienced health aides no longer see the job as unpredictable because they have more experience with a greater variety of clinical cases.

"The kind of rush you get when there is an emergency, kind of an adrenaline rush."
[less experienced health aide]

8. The Challenges of Being a Health Aide

Health aides most commonly reported disliking the long hours and being on-call regardless of whether they resided in high- or low attrition communities.

Health aides from low attrition communities were more likely to mention more job related challenges than health aides from high attrition communities. This indicates that even in communities with better retention of health aides, there are still many things that could be done to improve job satisfaction.

More experienced health aides were also more likely to show a strong tendency to describe the pain related to the death and trauma of the job. This is probably because the longer that a health aide is on the job, the more trauma she or he has seen. It should be noted that this difficulty was also mentioned by younger health aides in high attrition communities. They were likely to be experiencing traumatic cases earlier in their careers, since they generally had fewer people with whom to share call.

"There was a drowning, a young man…I still get mad about it. I was so mad at not having that defibrillator and I was so mad that we couldn't help him…I was trying to accept that it was God's will, but then it's hard sometimes to accept, even though you know."
[low turnover site health aide]

"Dealing with sexual abuse, child abuse, domestic violence, death, and suicides... I think the more contact we have with the patient, it's harder on us when they pass away and we have to keep on going."
[low turnover site health aide]

"It's stressful when you are grieving, silent grieving…"
[low turnover site health aide]

"I was there and I saw what had happened and the immediate family was in shock and I felt like I couldn't do anything for them … The death part was sort of bad and the grief, working through the grief. It's a big challenge."
[high turnover site health aide]

"When we have deaths here … when we prepare the bodies or whatever that's a way that I deal with it because it's helping the family in a way that nobody else can. It's not you saying you're sorry or something that they hear over and over again it's something that somebody else can't do. That's a way that I deal with it."
[high turnover site health aide]

Regardless of high/low turnover community, health aides frequently mentioned the difficulties of providing patient care for family and friends.

"In July, my brother died of cancer. I helped him until he died. That was probably the toughest thing I ever went through. But right after they buried my brother my mom got sick …You have to remember we are working in our own village so most of these patients are our relatives. That is tough."
[low turnover site health aide]

"You could deal with a family member's death and all of that stuff when you are in small place like this. You can't just up and leave or freak out. You have to just deal with it."
[high turnover site health aide]

Regardless of high/low turnover community, all health aides live amongst their patients. Whether they are at the local store or basketball game, they are surrounded by individuals whose health care needs they oversee, and they are often approached about work-related issues after their workday. Therefore, health aides, unlike other health care professionals, can feel like they are on-call all the time. Health aides explained that the only way to feel like they were not on-call was to take respite time by completely leaving their village or to remove themselves from others. This can lead to health aides isolating themselves from their communities. Though the following examples are all from health aides in low turnover communities, this was not a problem unique to low turnover communities.

"To go to Bingo and be bombarded with questions or, 'oh I forgot to call you today,' 'I missed my appointment,' or 'oh can you look at this? This hurts'... And I didn't even go there to play. I went to get change for money. I was there for 15 minutes and I was approached by seven people. And I was out the door. I said, 'I cannot take this. I don't want to give anybody advice.' So, oftentimes I think the health aides get secluded or we isolate… And the only time you really get away from your job… is to leave your community. And then you can feel like you're not working."
[low turnover site health aide]

"And even if you're not working, people will still ask you outside of work. They'll keep calling you and bugging you. You feel like you're still working."
[low turnover site health aide]

"I'm a health aide, that's (an) isolation. You learn to live with being alone a lot."
[low turnover site health aide]

B. Call / Patient Load

Generally, health aides in low attrition communities experienced a less demanding on-call schedule.

All clinics divided their on-call days so their health aides were on-call an equal number of days. The two most common methods of dividing the on-call schedule were by rotating on-call duties every week or every day. The number of days health aides spent on-call each month was dependent on the number of health aides available. Several of the busy clinics opted to rotate their on-call schedule on a daily basis instead of a weekly basis, because when health aides spent their on-call nights bombarded with patient calls, it was difficult to sustain the energy required to keep working all night and all day for consecutive days.

1. Demand of On-call

Regardless of whether the community was a low or high turnover community, health problems, training leave, maternity leave, and inexperience etc. often prevented all hired staff within a clinic to participate in the on-call schedule at any given time.

a. On-call at low turnover sites

Generally, health aides in low turnover communities experienced a less demanding on-call schedule. The following factors contributed to this.

- Even clinics with fewer health aides sharing on-call were often not busy enough to overburden the small pool of health aides. Health aides at these sites were not necessarily "called out" every time they were on-call.
- A busy clinic at a low turnover site was usually staffed with enough experienced health aides to share the burden of on-call.
- Health aides who were on-call for many days a month had other means of getting rest, such as a week off every few weeks, or an extended vacation granted every year.

b. On-call at high turnover sites

High turnover communities generally had very demanding on-call situations.

- High turnover communities were more likely to have newer health aides, which placed greater burden on the more experienced health aide to take on a great share of the on-call.
- Health aides at a busy clinic were highly likely to be "called out" during their on-call duties.

2. On-call schedules

The following lists the various on-call schedules adopted by the sites included in this study. Highly busy clinics often used a "daily rotation" schedule where health aides were only on-call one day at a time, in order to prevent individuals from having to be up all night for consecutive nights.

- Approx. 15 days a month (2 health aides sharing call)
  - ✓ Every other week, for a week
  - ✓ Daily rotate between 2 health aides
- Approx. 11 days a month (3 health aides sharing call)
  - ✓ Every 3rd week, for a week
  - ✓ Every 15 days, for 10 days
  - ✓ Daily rotate among 3 health aides, plus every 3rd weekend
- Approx. 8 days a month (4 health aides sharing call)
  - ✓ Two and a half days consecutively
  - ✓ Daily rotate among 4 health aides
- Approx. 4 days a month (7-8 health aides sharing call)
  - ✓ Daily rotate among 7-8 health aides
- No On-call
  - ✓ Three sites did not have health aides on-call. One clinic on the road system had elected to postpone on-call for health aides temporarily until training needs were met for a newer health aide. One community relied heavily on itinerants and left all on-call duties to the itinerant providers. The other clinic, also on the road system, did not have a permanent health aide so no one was available to take on-call.

3. Improving On-call Benefits

Several comments were made regarding ways the tribal health organization could improve the on-call to make it easier for health aides. It is interesting to note that health aides in high attrition communities did not talk about on-call perks or any other benefits. Again, this may be attributed to the observation that health aides in high attrition communities had a tendency to be too overwhelmed and overworked to consider benefits beyond basic provisions. There were three main suggestions:

- Pay for on-call

  "I would like for us to be paid to be on call. We are not paid to be on call, we are only paid if we actually get called so we are on call all weekend and if nobody calls us then we stay up all night for nothing."

  [low turnover site health aide]

- Paid time off after a hard on-call night/s

  "There are days where that's rough where you are on three or four days in a row and you spend many nights sleepless…you just have to take your annual leave if you're tired which is a bummer."
  [low turnover site health aide]

- Not having to make up on-call after taking annual leave

  "I guess one of my biggest gripes as far as call goes now is when I take annual leave I don't feel that I should have to make up my on call because that's annual leave that I have earned."
  [low turnover site health aide]

C. Clinical Support

Health aides in low turnover sites regarded "clinical support" in a variety of ways, encompassing the quality of relationships with other health aides, midlevels, and physicians, as well as the frequency of face-to-face teaching time provided by higher level providers.

Those with more experience or from low attrition communities generally had more confidence in their own abilities and felt they had gained the trust of other providers in the medical field, relative to newer health aides in high attrition sites. Further, they were more likely to feel that they were learning from other midlevels and doctors.

The smaller pool of low turnover community health aides who sought improved relationships with their physicians and midlevels were likely to mention the need for professional courtesy, and discuss the possibility of increasing the time spent learning new skills under their guidance.

High attrition communities had a tendency to regard clinical support more narrowly in terms of "visits from/contact with doctors." This single category captured most high turnover community health aides' comments regarding clinical support. Further, health aides in high attrition communities were more likely to cite lack of support from coworkers, and appeared to seek increased access to other providers. They were also more likely to cite physician attrition as a problem.

Less experienced health aides focused more on opportunities to learn, such as help and learning from other health aides. More experienced health aides were likely to emphasize the importance of trust with physicians and midlevels, as well as mention specializing tasks among other health aides to utilize strengths.

The following factors were mentioned by health aides as factors contributing to good clinical support:

- Doctors/midlevels are available and responsive – As mentioned previously, health aides frequently cited this as an indication of positive support. Doctors and midlevel providers that were available to respond to health aides' questions, or visited regularly, were found to provide good support. On the other hand, having to wait for extended periods for a doctor or nurse to respond to questions was perceived to be an example of poor clinical support.

  "Normally we have medical traffic once a day but if there is something that needs quicker attention then we just call them directly or whoever is on-call and they just guide us right through whatever we need to do."
  [low turnover site health aide]

  "It can be stressful, but, again, you have the doctors, and you have nurses that you can call in. Any questions that you have, you can call them and ask them…To know you have that resource, it really eases your mind."
  [low turnover site health aide]

  "[It would be better if they had] more than one doctor down there for the radio traffic. When everybody gets sick in the region, you get stuck waiting for the doctor to call. If it's a holiday, then it's extra time."
  [high turnover site health aide]

- Doctors/midlevels are a resource for learning – Health aides talked about how doctors and midlevels were a major resource for them in continuing to learn in their jobs. Individuals from sites where there was an open, information sharing relationship with doctors or midlevels had a positive perception of clinical support.

  "Well, we have the best field doctor. When he comes out, anything we want to know about, we just have to ask him a question. If he doesn't know, he'll tell us he doesn't know and find it out for us.
  [low turnover site health aide]

  "[Our field doctor] is our teacher… Every time he comes here, he teaches us things. He's a good teacher."
  [low turnover site health aide]

- Respect from doctors – Health aides described respect from doctors as an important part of feeling clinically supported. Health aides wanted and appreciated doctors who acknowledged them as capable and knowledgeable health care providers. Especially veteran health aides were aware of their own capacity and had thorough understanding of their patients and the health needs

of their community. They desired to be treated with the professional courtesy their skills merited. As noted above, the importance of professional courtesy was mentioned primarily by health aides from low turnover communities. Health aides from these communities had had both negative and positive experiences with physicians.

"It makes me have a reality check of what if I screw up, these doctors depend on what I do here and what I see, what I smell and they direct me and they believe me. If I tell them there is a respiration of 66 but with the nebulizer treatment it went down to 46 he said, 'I think you should get that lady out here.' No question of 'Are you sure?'"

[low turnover site health aide]

"I've been here for nine years. I know. I'm very comfortable with where I'm at…Some of [the doctors] can be very rude. Granted I don't know all the terminology. I don't know all the tests. That is definitely up to the doctor. I do know a lot about my patients up here and a lot of things that they can't see or that they don't understand. I think it comes from very simple knowledge…I do know what I'm talking about. I can tell you exactly what I'm talking about in a very simple way if they would just take it in. But, some don't. We know our patients very well."

[low turnover site health aide]

"We have people that seem to be bigheaded or have the attitude that 'I'm the doctor, you're just the health aide' thing and that is very, very frustrating."

[low turnover site health aide]

- Doctors that know the role of health aides – In addition to respect from high-level clinicians, health aides discussed the importance of doctors understanding the role of health aides. This was related to physician turnover, as new doctors were often unaware of health aides' training and how to work with them. One health aide specifically suggested physicians get an orientation about the role of health aides. Again, this was mentioned primarily by health aides in low turnover communities. The final example shown below is actually from a health aide in a high turnover community who, despite the problems of her clinic, felt good about the support from her physician, due to his sensitivity for the long hours a health aide puts in.

  "The hospital gets in temporary duty doctors or with the brand new physicians that really don't have a clue as to how the program works, what they should or shouldn't expect from the health aides. Oftentimes we're the ones that are explaining things to them. It could be even how to activate the Medevac service or 'Oh I'm not trained that far along.' …That's very frustrating because when you get somebody that doesn't understand, then you have to spend that much more time on the phone with them."

  [low turnover site health aide]

"A lot of the doctors come and they order all these things and we're like, 'We don't even have that here', you know? Or they don't understand there are health aides that are just Session I training, and they ask them to do a catheter."

[low turnover site health aide]

"There are some doctors that are really familiar with [our village]. It's really good support. When they know we are going to have to stay longer than we usually do they would say that they are sorry but we're going to have to extend the patient care. They actually do feel for us and they even apologize when our time is going to be extended."

[high turnover site health aide]

- Doctors/midlevels know the patients – Another factor related to the longevity of physicians/midlevels was their level of familiarity with the specific patients in the village. A health aide felt well supported clinically when she was able to pick up the phone and call a provider who knew the patients, especially their specific conditions and medications. Because health aides work with their patients routinely, they are very familiar with each patient's health history, diagnosis, and medication, in addition to their family histories, lifestyles, likes and dislikes. If a physician is also very close to the community, a health aide has a higher level of confidence in that physician's medical decisions.

  "You can pick up the phone and talk to them, and they know who you're talking about and what they're on usually. When we'd have a different doctor every time...they would drive us crazy. I mean, we get to know our patients pretty much inside and out. After a while, we know what they're on or what's what."

  [low turnover site health aide]

  "I know that there were a lot of doctors that come and go. They would sometimes hold off on medications for a while, even though we knew what was needed."

  [high turnover site health aide]

- Positive and supportive coworker relationships – Health aides described good relationships with peers as an important aspect of clinical support. Health aides gleaned professional knowledge from their peers, and those who were able to rely on each other had a more positive perspective of clinical support. More on this topic is discussed in a later section of this report.

  "I always just call [the head health aide] because she has got all the standing orders. [The other health aides] are really supportive when we get really busy and stuff and then I start seeing patients and stuff, then I always call them in to double check, listening to lungs and ears."

  [low turnover site health aide]

  "[You want thanks from] your co-worker…My co-worker believed in my ability to effectively report in and do what I'm supposed to do. If she hadn't [acknowledged

that to me] I probably would have had doubts myself…You know how you go through things in your life and you get a high? That kept me going for a long time."

[low turnover site health aide]

"I don't have that much experience under my belt. But, [the other health aides] they've been here a long time. So, if I have questions, they are always good about answering things for me. If I have questions about procedures or something like that, they're really good about that… [The other health aide] says, 'Just call me and I'll come down and give you a hand.' It is nicer when you have somebody else there to help you go through it."

[low turnover site health aide]

- Presence of midlevels – Health aides working side by side with permanent midlevels appreciated their situation. However, no health aides working in 'health aides only' clinics mentioned the need for permanent midlevels.

  "I'm so glad I work in a clinic with mid levels. I'm so glad that I'm not out there by myself."

  [high turnover site health aide]

D. Tribal Health Organization Support

More experienced health aides, and health aides in low attrition communities, had higher expectations of their tribal health organizations or employing village council. They were more likely to comment on specific aspects of tribal health organization support that needed improvement.

The more experienced health aides, as well as those in low attrition sites, were much more likely to report more concerns about their tribal health organization. This included the need to improve on-call, and unresponsiveness and lack of communication with their CHAP director. Their comments implied frustration over lack of tribal health organization respect and appreciation. As in Maslow's "hierarchy of needs," these communities generally had their basic needs met, so they were seeking to fulfill needs on a higher level – need for esteem, for example. Health aides in high attrition communities, on the other hand, pointed to basic needs, primarily being understaffed.

Low attrition communities were more likely to mention supervisors as a source of support, though health aides in both low and high attrition sites appreciated good support from their health aide directors and Coordinator/Supervisor Instructors (CI/SI). Other relevant aspects of tribal health organization support included mental health/counseling services, access to training, time-off, and equipment/supplies.

Health aides in high attrition communities, on the other hand, pointed to basic needs. They spoke in great detail about the consequences of being understaffed. They talked about not being able to go to trainings, not being able to take leave, missing their own

medical appointments, the stress on the community and the clinic when they relied completely on itinerants, and the stress from being constantly busy. The frustration with being understaffed is a "basic provision" issue within the hierarchy of needs, where health aides cannot consider higher needs if they are struggling to survive.

1. Importance of a Fully Staffed Clinic

Health aides in high turnover communities emphasized the consequences of being understaffed. The remaining health aides in these clinics were extraordinarily busy. Being short staffed meant the remaining health aides could not attend trainings, take leave, and even meant missing their own medical appointments. Further, it is stressful to the community and the clinic when they must rely heavily on itinerant providers.

> *"Lack of health aides [is a problem]…I mean we talk to [the tribal health organization] and we ask for staff, but we get held up in so much paperwork it becomes very irritating. Then we start losing people… like last year, I was 32 weeks pregnant and here I was on call alone, no backup. I had a red streak on my arms…and having shortness of breath and stuff like that…and there was no [other] health aide here…"*
>
> [high turnover site health aide]

> *"Patient overload…Here in this clinic we are scheduled every 30 minutes and that's hard to follow the CHAM [Community Health Aide Manual –ed.] question by question. Even a med refill is hard…"*
>
> [high turnover site health aide]

> *"[We need] another body as a healthcare giver...what's hard about itinerants, not just here but [in all villages], is they don't communicate like they should…"*
>
> [high turnover health aide]

2. Support from Health Aide Directors/CIs

Based on data from health aides, the characteristics of a good CHAP Director/CI include: being readily available, having a sympathetic ear, and keeping regular contact with health aides. For example, some health aides had their supervisor's home number.

> *"[My health aide director] made me in my job. She was the only one who believed I could do it. She would come and check on me during my training, she gave me little gifts and encouraged me… I don't want to do anything that would cause her shame as a supervisor, that would disappoint her."*
>
> [low turnover site health aide]

> *"Excellent support, she is always there, we have her home number, work number."*
>
> [low turnover site health aide]

"Our [CI] comes. She's going to come next week she said. Maybe she comes three times a year I think, she comes to be with us. Once a week there is, maybe about two months now, she's called us. We have a teleconference with her and talk to her about things that are stressing us out and stuff."

[low turnover site health aide]

3. Mental Health or Counseling Services

Some health aides described how the availability of mental health or counseling services to manage their personal wellness contributed to their network of support. Types of services mentioned included the following:

- Several health aides appreciated the availability of a post traumatic debriefing session after a traumatic event.

  "I say the biggest one [support] is debriefing the critical incidents, how fast they respond. They always come and debrief us when something critical happens…That's one thing I really like. Whenever something really bad happens, no matter what it is, they always support us and everything."

  [low turnover site health aide]

- Itinerant mental health care providers within the communities were also cited as an example of positive mental health support. The following is one of few high turnover community health aides who expressed appreciation for mental-health related services.

  "The support from the counselors that come here, we talk to them when we need to because we feel we get burnt out, stressed, tired… so to sit and talk to her every now and then when she comes in, so that's very nice."

  [high turnover site health aide]

- A couple of clinics had counseling services specifically for health aides. Both high and low attrition communities receiving this service actually utilized it, and felt it was an important program.

  "[Our health aide director] set up a mandatory counseling [session] …We have to see a counselor together and there we can talk about anything we want to. That's what you don't have, you have these cases and you can't talk to anybody but your boss about and it's really frustrating because you then have isolated yourself because you are a health aide."

  [low turnover site health aide]

4. Provision for Training

Training, or access to training, was an important issue to health aides, independent of tenure in position. However, their needs were distinct. High attrition communities often

needed immediate *basic session training*, and expressed frustration over how long it took to get into that training. In contrast, health aides in low attrition communities had these needs fulfilled and desired *trainings beyond these basics*. They felt supported by the tribal health organization when they provided supplemental training perks, such as paying for PA school, continuing education, and college credits.

The following is an example of a low turnover health aide commenting on a training need.

> *"I would like to see our corporation work on getting some more education for community health practitioners. I don't think there's enough and I don't think that they strive to see that folks that are CHPs who don't have degrees to make that happen."*
>
> [low turnover site health aide]

The following is an example of a high turnover health aide commenting on a training need.

> *"Well, the main thing is the training….If you have training, and if you're faced with a situation, you know what to do and automatically respond to that. But, if you haven't had the training, then you're in as much of a tizzy as the patient is because you're trying to figure out what to do."*
>
> [high turnover site health aide]

5. Importance of Generous Time Off

Time off was very important to health aides. 'Happy' clinics were those where the health aides were able to get a lot of rest. Health aides in high attrition sites were not able take time off because they were compensating for unfilled positions.

> *"With [my son], I was off for three months before he was even born. With [my daughter], I was gone for six months. So, that kind of helped. Sometimes you just need to have that time off. I feel bad for the corporations that don't give their health aides a time off because you need your down time. It makes it a whole lot easier."*
>
> [low turnover site health aide]

> *"It's gotten harder for me to try to leave…before the other health aide came onboard I wasn't able to go on annual leave."*
>
> [high turnover site health aide]

6. Pay and Benefits

Though some health aides in low attrition sites cited pay and benefits as examples of positive tribal health organization support, health aides did not use strong language to emphasize this particular aspect of support. No one made a passionate plea for more

money, and no one said they would quit unless salaries were better. Nevertheless, as previously mentioned, finances were what attracted people into the profession.

> *"I can't lie, financial is one [reason I stay on the job]..."*
> [low turnover site health aide]

> *"I have been requesting a raise but I haven't had that."*
> [high turnover site health aide]

7. Feeling Valued by the Tribal Health Organization

Though some health aides in low attrition communities were unimpressed by the support from their tribal health organizations, those that raved about their tribal health organization all felt uniquely valued by their employer. One health aide mentioned that her tribal health organization was a true "advocate" for them. Her example was of high level corporate executives making a visit to their village, and having job perks and benefits increased as a result of the visit. Another health aide reported that her tribal health organization truly valued each health aide's unique background, and provided counseling, treatment, or whatever was needed to "make their self esteem go higher."

> *"[The high corporate executives], they were here…They really advocate for us. Now we get paid overtime, we never used to get paid overtime…"*
> [low turnover site health aide]

> *"I think it's wonderful support. It's a strong support because they think of our personal being, like if we have an alcohol problem or other kind of problem that's making us not function at work, they can send us to a program where we can gather ourselves and … our self-esteem, they help us make it go higher…they try to help you, and I think that's wonderful. They understand who we are."*
> [low turnover site health aide]

8. Equipment and Supplies

As stated in the narrative, CHA/Ps' perceptions of their tribal health organizations' support for equipment and supplies did not differ between high and low turnover communities. The primary lesson learned regarding equipment and supplies was that when a tribal health organization periodically denied a health aide's request for certain supplies, the individuals not only felt personally slighted but felt it reflected lack of trust, while willingness to take supply requests without asking questions was cited as a major strength that signaled trust in the CHA/P to know what items and quantities the clinic needed.

In the following examples, a high turnover site CHA/P mentioned good support with supplies, while a low turnover site CHA/P mentioned poor support. These examples are not meant to illustrate the difference between high and low turnover communities, but to

show how support in this area can lead to CHA/P's perception of being trusted and valued.

> *"They are supportive in getting us anything that we ask for equipment wise or supply wise. They never question me on my supply orders or my drug orders. They never say, 'No you are ordering too much' or 'you can't have that,' and they never question it. They are real supportive on getting me supplies and stuff…That kind of stuff is a big help."*
>
> [high turnover site health aide]

> *"They'll nickel and dime me about a splint for a patient's knee…then the doctor who comes out here sees this patient - that I've been seeing for a month or two already – says, 'he needs it.'…We send the order over there and the pharmacy says 'so and so has to pay for it.' We send the paperwork to them, 'well, we can't pay for it, so and so has to pay for it'…they are going to nickel and dime us over it until my patient doesn't even get it, until I put it on my credit card for the patient."*
>
> [low turnover site health aide]

E. Village Support

The research team selected communities to visit based on their low or high "community support" scores, so it follows that health aides in low attrition sites had more positive things to say about community support.

More experienced health aides, as well as those from low attrition sites perceived more support from the village in emergencies, felt the community provided more financial or material support to the clinic, felt more respect from the community, received more kind words and "thank yous," and cited greater responsiveness from the village council.

As expected, health aides from high attrition communities felt less supported by their villages compared to their low attrition community counterparts. They mentioned having difficulty building trust with the community, having the desire for more support with their facility maintenance and equipment, sensing a lack of tribal council support, and having difficulties with demanding patients.

1. Support from Tribal Councils

Health aides provided some clear examples of strong tribal support.

- Sticking up for health aides, protecting them against village gossip and difficult patients

  "I had gone to the city councilman…and told these people I think there were things [gossip] going around. At some point I was only here for the money and I

didn't care about the people here. And so I went to the council meeting and I explained to the people who were at the council meeting that, you know, I'm not here just because I'm here robbing you guys of money. I said "you guys are Inupiat. I'm Inupiat. I'm here because I have a desire to take care of my people. You guys are my people." And then shortly after that I did leave. The council got certain individuals together and had a meeting with them. They pretty much told them that they needed to leave me alone and this committee was in support of me being their health aide. It got better."

[low turnover site health aide]

- Advocating for health aides to the tribal health organization – taking the view that the health aide 'belongs' to the village, and not an 'outsider' from the larger tribal health organization.

  "I think [the tribal council members] are [very supportive], and they actually went to bat for us against the corporation back in October. There were two of us that really needed their support. The council did what they could by writing a letter of support saying that the health aides are good, they like them, they trust them, and they do a good job."

  [low turnover site health aide]

  "People call the [tribal council] and complain and [tribal council] contacts [the tribal health organization] and they call us and tell us we are going to do whatever the person complaining wanted, that's our support."

  [high turnover site health aide]

- Having a standardized procedure for maintaining regular communication with health aides, such as making reports during tribal council meetings.

  "We report [to the council] how many patients we saw - but we don't tell them whom - just the amount of people we saw, if there was any problems in the clinic, like we need new windows because it's leaking. We would present those problems to the tribal office. We would present that the eye doctor is coming in June… or that he already came."

  [low turnover site health aide]

2. Interactions with Patients

Health aides in low turnover communities were far more likely to feel appreciated by patients. They frequently reported their patients thanked them or complimented them.

"We've gotten flowers from some people, we've gotten thank you cards, and we've gotten people who pop in and say, "Hey, how you doing? Just stopping by to check on you and give you a hug."

[low turnover site health aide]

Health aides in low turnover sites were also likely to realize that difficult patients exist in every community.

> *"Of course we have our patients who gripe and complain and everything but I think that's in every village. You just let them go."*
> [low turnover site health aide]

On the other hand, high turnover sites were more likely to face genuinely demanding, unreasonable, or abusive patients. Patient conduct was a topic in which health aides in high turnover communities had a plethora of feedback.

> *"I hardly hear 'thank you' from my patients."*
> [high turnover site health aide]

> *"When I first got on here you know they started hollering at me, 'where's my meds, where's my meds! I ordered my meds! Where is it?' 'I don't know, let me go look back there.' The first week I was here it kind of almost drove me away because of that, you know, yelling for their medication. I know they need them and stuff, but right away they start yelling at me, 'I need my meds right now.' It made me feel like it's my fault. I just kind of bit my tongue there a few times."*
> [high turnover site health aide]

> *"There was a death in the town and they blamed it on [the past provider] not following up or not doing something right and they threatened her."*
> [high turnover site health aide]

Though health aides from high and low attrition communities both periodically had patients call them out on non-emergencies, this was a bigger problem in high attrition communities. It should be noted that health aides from high attrition communities often did not have the respect of the community, so it was more difficult for them to stand up to patients. Some did not have policies against non-emergent on-calls, and those with policies did not necessarily enforce them.

> *"I would call [my community] spoiled because all of the years they have been calling the health aides. Like, we'd go home at 5:00, and then we would get a call at 5:30 just because they woke up late or couldn't come to the clinic. So, they would call after hours wanting to be seen. So, we would go back sometimes to see them. They expect that."*
> [high turnover site health aide]

> *"[I wish the community would] not be so demanding and not be so paranoid. I think they take advantage during the week. We're only supposed to be on-call for emergencies, but people that stay up late, they will call us after hours. I think we need to work on that."*
> [high turnover site health aide]

F. Family Support

Independent of years of experience, health aides cited the need for understanding and encouragement from family as a major requirement for job success. Access to child care was the second most cited need. In general, more experienced health aides as well as those from low turnover communities spoke more openly about their family support networks. These health aides reported that their job made it difficult to plan family activities and subsistence traditions. Further, necessary training and on-call duties took valuable time away from family. They were often 'stressed out' and tired when they were home, which affected household harmony. It also compromised their ability to fulfill domestic chores and duties. A small number of the newer health aides suggested that their work did not affect family.

1. The Importance of an Understanding Family

Health aides reported that emotional support from other family members was critical to them. Health aides appreciated having a family that was understanding and forgiving about the time away from home and the demanding nature of their jobs.

> *"My spouse knows that this job has a lot of responsibilities including seeing people in the middle of the night and trusting us that we aren't out to mess around with people. Some women's husbands think that way. They have to trust us that we are seeing people because they're hurt or they need some kind of care. My husband knows and he supports me a lot. He knows that it involves a lot of training…"*
>
> [low turnover site health aide]

Many health aides mentioned that there were other members of their family (mom, sister, mother-in-law) who had been a health aide in the past and understood the demands of the job, offering emotional support or help with family duties.

> *"Now in my situation my mother was a health aide before. She knows what it's like to be a health aide and so I've gotten all the support in the world from her. And my Dad. They get up in the middle of the night to go be with my kids and they're willing to do it."*
>
> [low turnover site health aide]

2. The Importance of Childcare

When health aides were asked what kind of family support was the most important, they frequently cited childcare issues, regardless of whether they resided in a high or low attrition community. Health aides were usually the primary caretaker of domestic responsibilities, including the care of their children. Their job, however, required them to drop their family responsibilities at a moment's notice for on-call duties. This made childcare a crucial factor in family support.

"There was this one big emergency we went to and we didn't even think about our kids until it was like 4:00 in the morning and it just dawned on us, 'where are the kids? Who is with the kids?' Because we had to rush out and we had to get to that emergency, it never really hit us that we just left our kids. His sister knew about the accident, she knew we were going to respond to that so she went and got our kids and brought them to her house. I have been very fortunate to have very supportive parents that will go stay with my children if need be."

[high turnover site health aide]

"Most important support is somebody watching my kids so I can come to work. Without that support I can't make it to work, and without work I can't make any money. Without any money I can't pay the bills."

[high turnover site health aide]

"You definitely need support from your partner who is willing to stay home, especially when you have a young family. Or, you have to have a good, close neighbor that can run over."

[low turnover site health aide]

G. Emotional Support

Overall, health aides in both high and low turnover communities relied on other CHA/Ps and close family and friends for emotional support.

Some health aides mentioned privacy issues keeping them from reaching out to people other than their coworkers. Therefore, those without coworker cohesion were often left with no way to vent. This was characteristic of high turnover communities. There also seemed to be a feeling that only another health aide would understand their situation.

"We can talk to our co-workers over confidential things and that's that, and if there were highly stressful things that happened."

[high turnover site health aide]

Health aides from low turnover sites were far more reliant on their coworkers for this type of support. Though high turnover community health aides also mentioned coworkers (as shown below), they were not an extremely important outlet of emotional support.

"I think that's one thing we are really lucky on because…when something traumatic happens, [the other health aide] and I just tend to talk something to death until we get over it. I think that's one of the things I know really helps me…[the other health aide] and I would just talk about it and talk about it until we just felt like we got it out of our system …I think here in the clinic we have really good support."

[low turnover site health aide]

"My co-workers. I definitely turn to them because they're going to help me more than anybody else. They know and they give great advice…definitely my co-workers are the first people that I talk to."

[low turnover site health aide]

Emotional support provided by family and friends was the second most emphasized support category, regardless of high/low turnover. Even tough specific client-related 'venting" could only occur with coworkers or supervisors, loved ones were nonetheless mentioned as an important source of emotional strength for health aides, regardless of high or low turnover community.

"I think I mostly would turn to my husband. I have to keep the confidentiality of the patients but he is there for me and will run the bath water if he knows that I'm needing time out or whatever."

[low turnover site health aide]

"My mom. She worked for [the tribal health organization] before and she understands the confidentiality so she makes time for me no matter how busy with all her grandchildren, she does make time."

[high turnover site health aide]

The third category of emotional support was from supervisors, which was mentioned more by health aides in low turnover communities.

"[I get emotional support from] the other health aides…or I e-mail [our supervisor]."

[low turnover site health aide]

"Or if nobody else, our .. supervisor…But for most things, I go to [another health aide]."

[low turnover site health aide]

Health aides from high turnover communities relied most heavily on family or friends or on God and prayer for emotional support. This indicates that health aides in high turnover communities were not venting about certain issues, such as stress involving confidential patient matters with another human being who could empathize with their troubles.

"I turn to my husband for some of that. I'm a Christian, so I give my problems to the Lord. I cry out and pray. I go to church."

[high turnover site health aide]

As previously mentioned, health aides in both high and low turnover communities relied on mental health services when they were available.

"We have counselors not only with our employers but the counselors that come up here every so often…"

[low turnover site health aide]

"[Mental health providers], they come out and help."

[high turnover site health aide]

H. Cohesiveness of Staff

As mentioned in a previous section, the cohesiveness of the clinic staff was an important retention factor in clinics. High turnover clinics were more likely to have had problems with staff harmony.

Characteristics of cohesive staff are as follows.

- Regularly scheduled staff meetings -- Sites that had especially successful staff cohesion mentioned they had regularly schooled staff meetings to communicate clinic issues. One site even met on a daily basis to discuss clinic related issues.
- Supportiveness in time off – A fully staffed clinic was important for this as well. But staff that could negotiate taking an extended period of leave needed the cooperation of other staff members in order to coordinate the on-call of the staff that would remain.
- Experienced health aides teaching the less experienced health aides – Newer health aides in clinics where staff support was good discussed that other health aides would be their primary teacher. Experienced health aides who invited new health aides to shadow them won the appreciation of the younger health aides.
- Cooperation to share the burden of the work – Clinics in which health aides talked about how health aides would rely on each other to share the burden of the health care of the village was an example of staff cohesion.

  "I'm thinking because of staff, we always have staff meetings and they talk to each other about their problems here at the clinic. Like if two health aides are having problems, they talk to each other first before they bring it to the SI. Usually here in the clinic, how they work together. They have meetings every week that usually help…We have weekly meetings…[We talk about] problems here at the clinic that can be fixed before they get bad. Like people trying to be off…how to act… like leaving your problems at home, like that."

  [low turnover site health aide]

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