COMMUNITY HEALTH REPRESENTATIVES (CHR)

Indian Health Service

Preventive Health	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Community Health Representatives:					
Budget Authority	$46,380,000	$48,061,000	$49,789,000	+$3,409,000	+$1,728,000
Number of CHRs	1,612	1,612	1,612	0	0
# of Tribally Operated Svcs Provided	2,200,000	2,200,000	2,200,000	0	0

PURPOSE AND METHOD OF OPERATION

Program Mission/Responsibilities

As tribally contracted and compacted programs, the 215 Community Health Representative (CHR) programs are tribally administered outreach programs. They are based on the concept that American Indian/Alaska Native (AI/AN) community members, trained in the basic skills of health care provision, disease control, and prevention, can successfully create change in community acceptance and utilization of Western health care resources. The Indian Health Service works with tribes and provides leadership and guidance to the CHR program.

The CHR Program plays an important role in the successful implementation of IHS/Tribal health promotion/disease prevention initiatives and efforts to improve access to medical services. CHRs are indigenous people well positioned within their communities to provide the needed educational and related services that can result in healthier lifestyles and early treatment and lower morbidity among their people. The CHRs are proven effective outreach health care providers and have established an efficient network system through which health promotion/disease prevention and health care access are being delivered to the AI/AN people.

ACCOMPLISHMENTS

The Community Health Representative program has developed two reporting methods to record the services provided by CHRs: the RPMS/PCC Direct and the RPMS/PCC Remote Reporting. The IHS encourages tribes to report data such as the number of client-patient contacts and the number of service hours spent on health education, case management, patient care, case finding, monitoring, and transporting patients in the health areas of diabetes, hypertension, health promotion/disease prevention, alcohol/substance abuse, cancer, communicable diseases. However at this time, complete data is not available.

The Community Health Representative Program launched a new CHR Web Site providing access to a CHR Newsletter. Future capabilities will permit

us to download local and regional reports from the RPMS/PCC Direct and the RPMS/PCC Remote Reporting as well as other general information about the CHR program.

In consultation with the Tribal CHR program, a major focus is on training. The CHR Program provides 3-Week CHR Basic training sessions to assist Community Health Representatives to obtain health and medical education appropriate to the CHR program. The CHR program also provides CHR Refresher training sessions for those CHR staff that have been employed by the local CHR program for more than two-years.

The CHR Program also revised the curriculum for the 3-Week Basic training manual as well as the CHR Refresher training manual. The manuals were distributed to all 215 CHR tribal programs.

The Community Health Representative Program has joined partnership with the Environmental Protection Agency to develop culturally appropriate training materials for use in educating Native American and Alaska Natives on the subject of Indoor Air Quality.

The Community Health Representative Program continues to maintain a close working relationship with the National Association of Community Health Representatives joining forces to elevate the health status of Native Americans and Alaskan Natives to the highest possible.

PERFORMANCE PLAN

The performance indicators are included in the IHS FY 2002 Annual Performance. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN. At the FY 2002 funding level, IHS would be able to accomplish the following:

Indicator 2: During FY 2002, continue the trend of improved glycemic control in the proportion of I/T/U clients with diagnosed diabetes.

Indicator 8: During FY 2002, increase the proportion of AI/AN children served by IHS receiving a minimum of four well-child visits by 27 months of age by 2 percent over the FY 2001 level.

Indicator 23: During FY 2002, increase the proportion of AI/AN children who have completed all recommended immunizations for ages 0-27 months (as recommended by Advisory Committee on Immunization Practices) by 1 percent over the FY 2001 level.

Indicator 24: During FY 2002, increase pneumococcal and influenza vaccination levels among adult diabetics and adults aged 65 years and older by 1 percent over the FY 2000 level.

Following are the funding levels for the last 5 fiscal years:

1997	$44,973,000	12	
1998	$44,312,000	13	
1999	$45,960,000	5	
2000	$46,380,000	0	
2001	$48,061,000	0	Enacted

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $49,789,000 is an increase of $1,728,000 over the FY 2001 enacted level of $48,061,000. The increase includes the following:

Built-in Increases: +$1,728,000

The request of $1,728,000 for inflation/tribal pay cost would fund the built-in increases associated with on-going operations. Included is the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

Maintaining the current I/T/U health system by ensuring access and continuity of care is necessary in eliminating disparities in health status between AI/AN and the rest of the U.S. population.