

COMMUNITY HEALTH AIDE PROGRAM

FUTURE DIRECTIONS

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September 19, 1989

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INTRODUCTION

The ANHB document, "CHAP IN CRISIS," described a program that was showing signs of fatigue, if not collapse. It is our view that the infusion of new money to CHAP in FY 1989, while improving the situation temporarily, has revealed serious, more deeply rooted problems. More dollars for salaries, more positions and supervision will help, but it is the position of this paper that a thorough and penetrating analysis of the complex and often confusing CHA program, with all of the committees and sub-committees that have some direct involvement in it, must take place. Specifically, this paper will attempt to raise basic questions about the role of the Community Health Aide and about the training curriculum and process that supports that role.

From the standpoint of the Regional Provider Agencies (RPAs) the central question is this: Can the CHAs do what we say they can do? This paper will suggest that formal CHA training time may be too short and our expectations about CHA skill levels (as reflected in current curriculum) somewhat unrealistic for that claim to be made with total confidence. This paper will also suggest that the RPAs, as the primary employers of CHAs, must take major responsibility for defining a more or less standardized CHA role. Finally, this paper will assert the need for establishing an evaluation mechanism that is independent of the existing training structure.

This is a program that has worked remarkably well. The authors of this paper have profound respect for Community Health Aides, for the valiant job they have done and for the many dedicated physicians, trainers and administrators who have worked so hard over the years to make CHAP a success. This paper is offered in a spirit of open inquiry, and with the sincere desire to add to rather than subtract from what has gone before. It was in that spirit that the authors began their study of the CHAP and certainly not without a good deal of "soul searching" about questioning the tenets of a somewhat "hallowed" program.

HISTORY

The Community Health Aide (CHA) concept evolved between 1940-1970 in a time when professional health care providers were struggling desperately with overwhelming health care problems in Alaska Native communities. The program was established formally with Federal funding secured in 1968. By the mid 1970s, the CHA role and training had been pretty well defined and established, more or less in the form in which we know it today. The years 1970-1975 appear, in retrospect, to have been the most critical in terms of defining the program. It was during that time that the CHA role and training were developed and some control of the program development was taken by the Planning and Advisory Committee for Health Problems, Alaska (PAC-HA-PA).

PLANNING AND ADVISORY COMMITTEE FOR HEALTH AIDE PROGRAMS, ALASKA
(PAC-HA-PA)

Between 1973-1975, PAC-HA-PA formed and provided direction to the emerging CHA program. The PAC-HA-PA was a large group with as many as fifty participants at any given time. Membership was diverse and included CHA trainers, physicians, nurses, public health nurses, pharmacists, dentists, health educators, a few CHAs and other interested individuals.

Their main goals were to:

1. Develop a common Community Health Aide manual;
2. Seek college accreditation for the curriculum and work experience of the aides; and
3. Develop continuing education programs for health aides.

PAC-HA-PA no longer exists as an active organization, but they did set the course for the CHA program at a time when the RPAs were only just emerging and developing. To achieve their three goals, PAC-HA-PA had to define CHA scope of practice. From that scope of practice flowed the CHA training program and the training curriculum.

In order to produce the CHA manual the group had to define the CHA role. This was not an easy task and was the basis for many heated debates. Each of the professionals advocated for the CHA role to mirror and support their own professional bias.

The first CHA Manual, Guidelines for Primary Health Care in Rural Alaska 1976, was written by Joseph Whitaker for the PAC-HA-PA. The CHA role, as defined in that first CHA manual, was very broad and actually combined many roles including: physician assistant, public health nurse, health educator, dental aide, clinic administrator, community health service worker, optical aide, mental health counselor, nutrition aide, alcohol counselor, pharmacist, nurse, home health care provider, health services coordinator, travel agent and research assistant.

There is not much evidence to suggest that CHAs had opportunities for meaningful input in that definition of the CHA role or that an attempt was made to prioritize tasks for which CHAs would be responsible. The prevailing attitude at that time was that CHAs were able to and would provide most of those services.

TRAINING PROGRAM

The CHA training program was formalized between 1970-1975. Experiments in training led trainers to believe that CHAs could not leave their villages for long periods of time. Therefore, a training program was designed in which training would require only short periods of time away from home.

By 1975, a training schedule of three sessions lasting four, three, and three weeks respectively was instituted. Each session was to be followed by 200 hours of village based clinical experience in which the CHA practiced the skills learned in the session. After completion of the third session and a total of 600 hours of clinical practice in the village, the CHA was brought to a center and provided with a preceptorship. During the one to two week preceptorship, the CHA worked closely with a midlevel practitioner or physician in a clinical setting to polish CHA skills prior to certification. To attain certification, the CHA then was required to pass a standard certification examination. This same process is used today. Completion of the total process now takes two to four years.

The CHA basic curriculum content was fairly well defined by 1973, prior to the work of the PAC-HA-PA. But the curriculum learning objectives more than doubled in response to the expanded role of the CHA detailed in the 1976 manual and have continued to expand throughout the 1980s. Interestingly, however, the time spent in basic training sessions has remained the same.

UNIVERSITY OF ALASKA

A grant from the Washington/Alaska Regional Medical Program to the Alaska Federation of Natives in 1974 funded a Curriculum Coordinator to work with PAC-HA-PA on development of statewide CHA curriculum and affiliation of the training programs with the University of Alaska (U of A). PAC-HA-PA members believed that University affiliation was desirable in order to secure a greater degree of permanence and stability for the training programs. An additional stated goal was that the University of Alaska Department of Rural Education Affairs would assure fiscal, administrative and academic responsibility for Community Health Practitioner education.

The Alaska Federation of Natives next received a grant from the Robert Wood Johnson Foundation in 1975 to continue the Curriculum Coordinator position through 1976. This position was housed in the University of Alaska Rural Education Administration. The responsibilities of the position included: processing of student paperwork, counseling of students, revision and adaptation of curriculum, assisting in locating local resources for the delivery of advanced level courses and channeling students to Adult Basic Education courses.

The objective of having the University assume responsibility for CHA education never fully materialized even though the University of Alaska has maintained the Curriculum Coordinator position.

ACADEMIC REVIEW COMMITTEE (ARC)

To facilitate interaction between the University of Alaska and the training programs, the Robert Wood Johnson grant created and funded travel for the Academic Review Committee (ARC) something of an outgrowth of and a more streamlined version of PAC-HA-PA.

The ARC meets three times per year. By its bylaws, the ARC consists of twelve members:

1. One CHA
2. One representative from the major training agencies (Kuskokwim College, Anchorage Area Native Health Service, and Norton Sound Health Corporation)
3. Six at-large members from the health corporation Community Health Aide Program
4. The University of Alaska Community Health Aide Program Liaison
5. State Section of Public Health Nursing member.

The purpose of ARC as stated in bylaws is:

1. To plan, develop and update the Community Health Aide Curriculum.
2. To review all permanent catalog courses for Community Health Aide Instruction.
3. To develop a uniform process for certification and achievement of an A.A. Degree.
4. To make recommendations regarding establishment of standards in Community Health Aide education in Alaska.
5. To advise the Chancellor of Community College Rural Education and Extension (CCREE) and the Dean of Rural Education in matters of community health aide education.

ARC continues as an active organization and, besides curriculum development, has been working with the CHAP Directors to develop statewide standards for certification, recertification requirements, state regulations for CHAs, and the development of standards for training centers. Basically, ARC contends with the same fundamental issues with which PAC-HA-PA contended: CHA role and CHA training.

CHAP DIRECTORS

A dramatic contrast to ARC is seen in an emerging group, the CHAP Directors, who began meeting as a group in 1983. These are program administrators responsible for the provision of care in the villages who are concerned with CHA scope of practice and the quality of CHA training. The purpose statement in their bylaws is as follows:

1. Forum for discussion of mutual concerns.
2. Advisory group to make recommendations relating to the Community Health Aide Program.

Not specified is to whom the group makes recommendations and who is supposed to act on those recommendations. The group's function is obviously not entirely clear. However, the CHAP Directors did take the initiative for providing leadership to the CHAP in 1988 with their documentation of problems within the program. Those

efforts demonstrated that the program was severely underfunded and in need of major program restructuring, and led to increased funding for FY89.

Both ARC and the CHAP Directors see themselves as "advisory," although to whom the CHAP Directors are supposed to deliver their advice is as stated above somewhat unclear. One might suppose it would be primarily to their employers, the RPAs.

CHA CURRENT PRACTICE

PERFORMANCE VARIABLES

Fifteen years of experience with the CHA program has demonstrated that CHAs are successful in performing well some of the duties which are outlined in the original CHA manual yet are unsuccessful in some other areas. The areas in which CHAs perform the best are acute care for common ailments and emergency care. They are less successful and/or minimally involved in the provision of preventive care, health surveillance, health education, clinic administration, and outreach programs. Successful performance seems to be related to the following:

1. amount of time available to perform the duties. In many villages, just meeting the acute care needs of the patients forces the CHAs to work well beyond their scheduled time on a daily basis;
2. frequency with which the skill is used;
3. CHA knowledge base in a given area of practice;
4. CHA confidence in performance of the skill;
5. patient demand for the service;
6. complexity of the task;
7. length of experience of the CHA; and
8. competition with others who provide the same services.

Over the years, expectations of CHA performance have changed. Initially viewed as the "eyes, ears, and hands" of the physician or as a liaison between the physician and patient, the CHA seems now to be viewed as a health care provider. Practitioners, trainers, and patients expect the CHA to perform much as a physician assistant (Attachment 1).

CHA current practice is focused on the provision of acute and emergency care, monitoring the care of the chronically ill, and maintaining the village clinic. Though trained and expected to perform public health activities, CHAs tend to take on these responsibilities slowly or not at all.

THE "NEW" CHA MANUAL

In 1987, Robert Burgess, M.D. completed the rather monumental work, Community Health Aide/Practitioner Manual. The materials for this manual were widely reviewed and the finished product has been just as widely accepted. It is, perhaps, the very best "how to" medical reference for paraprofessionals in existence today and has literally enjoyed worldwide exposure.

The new CHAP Manual is the most important reference used by training centers today. While it is not the curriculum, it represents an important standard of care. It forms the basis of CHA practice "expectation" which includes making differential diagnosis of a wide variety of illnesses including heart attack, claudication, thrombophlebitis, bone infection, pneumonia, kidney stone, ulcer, diverticulitis, pelvic inflammatory disease, cholecystitis, bowel obstruction, various sexually transmitted diseases and more.

CONCERNS

HOW DOES CHA ROLE GET DEFINED?

One answer to this question, at least from an historical perspective, might be "by default." As stated earlier, the basic course for CHAP was set back in the early to mid 1970s, at the very time when the new "owners" of CHAP were getting started as organizations. The RPAs were beginning to take advantage of P.L. 93-638 and the CHAP was emerging as a unique, one-of-a-kind program. It quickly became a source of great pride to all who participated including recipients of care, RPAs, Indian Health Service (IHS), public health nurses, the University of Alaska, and the CHAs themselves. The CHA program became a unique "bucket brigade" against the raging fire of unmet health needs in rural Alaska Native communities. Bumper stickers which later proclaimed "We Love Our Health Aides" expressed the high tide of support for CHAP. However, the RPAs didn't look too closely at the program in the ways in which this discussion suggests needs to be done: At that time it was enough to have identified a large "detachable" piece of IHS "substance" that could be taken over. The CHA Program was a way to achieve corporate stability by newly emerging regional tribal entities.

Sadly, within that context, there has been no clear statement from the RPAs of what duties they expect the CHA to perform at any given point in training. Hence the ARC tends to base decisions about curriculum on the CHA, role as it was defined in 1975. In that vacuum, the ARC heeds the opinions of specialists in the major medical centers, the experience of the training center personnel, and some feedback from CHAs and CHAP Directors, although no formal survey of the CHAs or CHAP Directors has been

conducted on curriculum content. ARC has simply had to do the best it could in the absence of more definitive "authority" from elsewhere.

In a sense then, one might conclude that the RPAs, so busy initially with survival, "abdicated" their direct involvement in CHA role determination. One might further conclude that the weighty responsibility for establishing the "right" or "best" role and training would be, at least partially, shouldered by PAC-HA-PA and later by ARC. That is, in fact, what did happen with the unhappy result, in our opinion, that training decisions tended to be driven too much from the locus of training and not enough from the field. The CHA is "taught" a certain subject matter. If the information is taught, the expectation is that it will be practiced in the field. In other words, CHA scope of practice, which should be a product of field experience as communicated by CHAs and their consulting physicians, may not be driving the training.

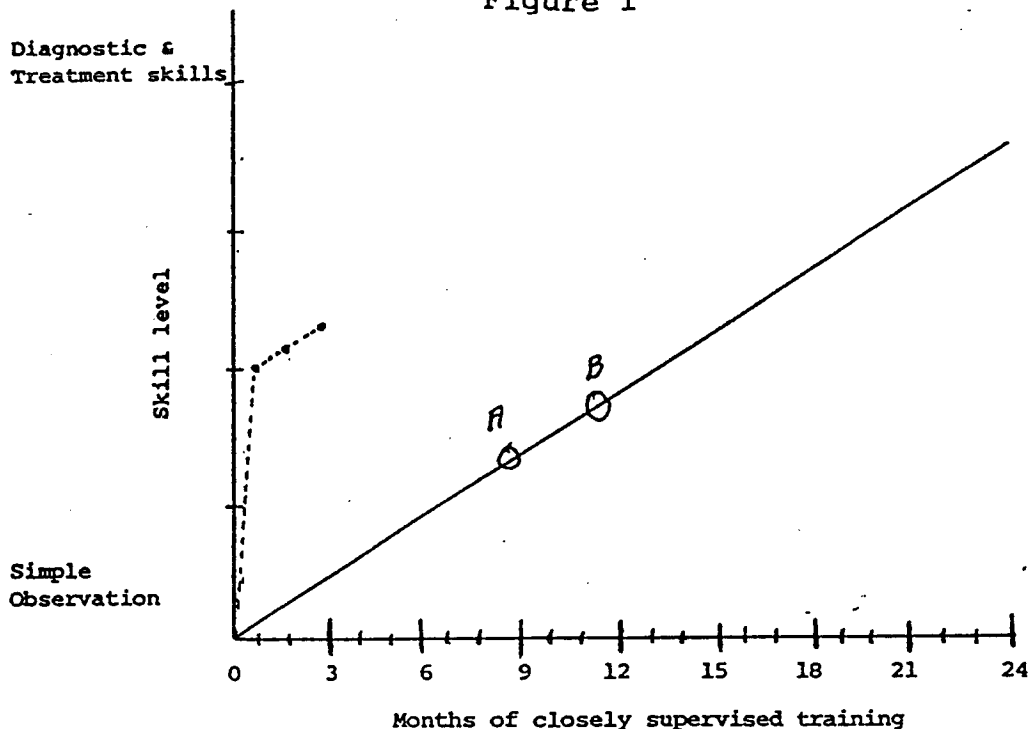
There is by no means universal agreement on this point. In fact, raising the question about how much input to training there has been from CHAs and from consulting physicians in the field is sure to be the occasion of heated discussion.

The advent of the "new comer" group, the CHAP Directors, has not clarified the "authority" issue. Without clear-cut program authority for either ARC or the CHAP Directors, policy questions tend to get bounced back and forth for years, each reluctant to take responsibility to initiate change. No other group has been identified to take this authority. Under these conditions, program problems are not easily addressed; decisions seem to get trapped in limbo.

IS THE INVESTMENT IN TRAINING APPROPRIATE FOR THE PRACTICE EXPECTATION?

It is our view that there is an ideal or appropriate intersection between time and resources invested in training and the skills that are taken into the field. Figure #1 is an attempt to describe those appropriate levels of input and outcome. In changing this paradigm, one has rather limited options. One may scale skill level expectations down to fit the existing training time and resources, or one can increase the training time and resources to get to a higher level of skill in practice.

Figure 1



The solid diagonal line represents a "real time" relationship between two variables, time in training on the horizontal axis and delivery of skills as a product on the vertical axis. The authors believe there is an ideal location on the diagonal (Point "A", Point "B") which represents a "doable" training input to yield an appropriate skill output. The dotted line is our subjective expression of the current situation, to wit, that for three months of training we are getting a skill level that, we fear, may live more in the realm of wishful thinking than in reality.

Mastering the skills of a profession is most certainly a function of the amount of time spent in a learning environment. On the surface, at least, the practice of a CHA is very similar to that of a physician assistant (Attachment 1). It takes the Medex Northwest Physicians Assistant Program twenty-one months to prepare physician assistants (PAs) for the same responsibilities into which the CHA role seems to have evolved. (Attachment 2). The PA is not given the responsibility for the position until after completion of a twenty-one month training program. CHA training at best is 3.75 months long but, as openly conceded by Area CHAP, CHAs must function fairly independently in their communities after Session I.

On the road to becoming certified as a Community Health Practitioner, the CHA must attend three basic sessions, each lasting three to four weeks. Between sessions the CHA is sent back to the village clinic with learning contracts, skills lists and instructions to practice and master skills that were taught

in the session. Little supervision or control is provided during this time that the CHA is alone in the village clinic environment.

Field training and supervision would seem to be at least as serious a problem as that presented in the skill/time paradigm. Coordinator/Supervisor Instructors (CI/SI) whose main responsibility is to supervise, support and teach CHAs, visit each village clinic for two to five day stretches two to three times per year. They observe the CHAs at work in their clinic and sign off the CHA skills lists and learning contracts, among other activities. The number of CHA patient encounters actually observed is limited by the frequency of the CI/SI visit the number of patients who come for care and the number of CHAs in need of supervision and the number of other objectives which must be accomplished on that visit. The CHA trainee may or may not have the opportunity to consult with and learn from other CHAs practicing in the village.

Conditions under which medical consultation is provided to CHAs is less than ideal most of the time. Limited medical supervision is provided to the CHA through daily medical consultation by telephone with a physician or mid level practitioner. The provider, however, only supervises the CHA in the encounters the CHA chooses to report, an estimated 20% of the patients seen. Practitioners are often pushed for time. The CHAs, sensitive to this, respond accordingly by trying to take as little time as possible with the provider, which is not a situation conducive to optional teaching, learning and/or supervision. Since only a small percentage of the patients (about 5%) actually come to a center for evaluation, the practitioners rarely have the opportunity to talk with and examine the patients reported by the CHA to verify the CHAs findings and provide feedback to CHAs on their performance. This is a major complaint voiced by CHAs.

During the several months to several years between each basic session, the CHA may be visited by physicians, public health nurses and others in the village clinic. The focus of the professionals' visit is usually provision of direct patient care; little time is actually spent providing medical supervision and teaching for CHAs. In recent years, some corporations have been encouraging physicians and other professionals to invest more time in these activities on field trips but have had only limited success in investing visiting practitioners in active field training.

Students may fail to develop the necessary skills to provide quality care under the current field training system. Training center personnel are sometimes dismayed that CHAs returning for the next level of training have forgotten much of the material "learned" in the previous session. This information must then be repeated in subsequent sessions. Training centers often fault the RPAs for failing to provide adequate "field follow-up" training for CHAs to solidify skills taught by the centers.

For their part, Regional Provider Agencies wonder how it is possible that a CHA can have "passed" Session I by training center criteria yet not be able to take accurate vital signs on a patient. They wonder about an educational system which certifies CHAs who cannot diagnose or describe accurately common ear problems; a frequently observed condition among the population served. One CHAP Director, in a discussion of CHA training, stated that basically CHAs learn their job through on-the-job training and that he only hopes that they stick with the job long enough to learn the necessary skills.

A preceptorship for the CHA follows completion of the three basic sessions and 600 hours of clinical practice in the village under the conditions described above. The purpose of this preceptorship is to polish CHA skills under the close supervision of a physician or midlevel practitioner, but usually long after the CHA has been fully responsible for patient care. A preceptorship may actually be needed immediately following each session.

CONCLUSIONS

On the question of how the CHA role gets defined, the RPAs are stable now and have demonstrated a remarkable ability to channel resources and provide service. It is time for these "owners" of the CHAP to examine closely this "fruit" of 638 programs that has become the core of their existence.

Clearly, the RPAs, as the primary employers of CHAs in the field, must assume greater responsibility for Quality Of Care provided through the CHAP. Regional agencies must be motivated to take a stronger leadership role because their client populations will increasingly demand a known and consistent level of quality in the CHA practice. It is not in the RPAs interest to promote the CHAP as a program offering quality, comprehensive health care when such confusion reigns about the skills/training paradigm.

The CHAP primary users, "on the ground," simply cannot allow curriculum and, hence, CHA scope of practice decisions to be driven by training interests. Role and curriculum decisions must be driven from the field. In that regard, it is clear that the physicians working with the CHAs on a regular basis, field supervisors and program directors, and CHAs themselves must have a major part in determining what is a "reasonable" CHA role.

It may make some sense to separate the "curriculum developing" role from the "authority" role. ARC, which appears to have been trying to do both, is poorly constituted for both tasks. ARC may be the appropriate agency for constructing curriculum and ensuring its uniformity, quality, etc. but the decision as to what is "right" or "best" for CHAs to do, and what then gets established as the "what" of curriculum in more sweeping terms, must have the authority of the primary partners in P.L. 100-472.

The "owners" of the CHAP system are those parties who carry out the Federal Trust Responsibility. It is the Indian Health Service and the several sovereign nations who agree through contract, what must ultimately be the "what" of CHA curriculum. For, it is they who share the primary burden of tort claims liability and answering to the demands of a constituency.

On the question of the skills/time paradigm, the CHA basic training curriculum may simply be too ambitious. The training centers, covering so much material in so little time, merely serve as the media to expose the CHA to the many things that they will need to know in order to provide quality health care in the villages. For the most part, the CHA trainee practices skills between training sessions alone, in an unsupervised environment, while having full responsibility for the position. Armed with learning contracts, skills lists and a dangerous belief in themselves, CHAs must learn to practice medicine, essentially on their own. Ill prepared for their job, CHAs suffer severely from feelings of inadequacy on the job which contributes significantly to burnout. As one former CHA said, "If the low pay don't get you, the fear will."

In the process of developing this paper there have been suggestions by a surprising number of physicians and other health providers that the CHA role, as currently defined by training expectations is not doable, given the scarcity of training dollars and hours, as well as the relatively limited language, math and science skills with which so many CHAs enter the training program.

Role and training would certainly appear to be areas of great need for evaluation and perhaps some change. For this change to occur, it is our view that a good deal more direction must originate from the RPAs, through their CHAs, CIs, physicians and CHAP Directors.

While it is tempting to declare solutions such as, "increase the number of CIs," we would simply recommend attention be given to the recommendation for independent, outside evaluation of the CHAP.

Preparing the CHA for the responsibilities of their position is a formidable task. CHAs come to the position and training with limited educational resources, little or no experience in the health field, and often using English as a second language. They need to learn a third language (medicaleze), how to operate in a new culture (medical), and how to relate to villages from a new social position. All factors considered, it becomes obvious that we cannot produce a CHA with the skills of a midlevel practitioner/public health nurse/clinic administrator in 3.75 months. We certainly cannot expect the CHA to have these skills after only one short month (Session I). Steps must be taken to

match a reasonable CHA level of practice with a reasonable training level. This can be done through refocusing CHA practice and/or lengthening and altering the way in which CHAs are trained.

RECOMMENDATIONS

1. External review of the CHA program. The objectives of the review should include evaluation of:
 - a. the appropriateness of the current CHA role;
 - b. effectiveness of the current training program in
 - c. preparation of CHAs in that role;
 - d. CHA training curriculum;
 - e. membership and role of the Academic Review Committee;
 - f. role of the CHAP Director organization;
 - g. role of the University of Alaska in the program;
 - h. the means by which training centers will be evaluated;
 - i. recommendations for investment of time and dollars in training in context of that role.

An evaluation team might consist of an educator, the director of a P.A. Program (such as the University of Alaska Medex Program), someone who is providing or is responsible for providing para-professional medical services in third world countries, or someone who evaluates such programs on a regular basis.

2. Regional Provider Agencies must assume major responsibility for direction of the CHAP.

ATTACHMENT 1

Current CHA practice is most closely related to the practice of a physician assistant. Physician assistants' health care functions as identified by the National Commission on Certification of Physicians Assistants, Inc. include:

1. screen patients to determine medical needs
2. review patient records to determine health status
3. take a patient history
4. perform a physical examination
5. perform developmental screening examinations on children
6. record pertinent patient data
7. make decisions regarding data gathering and appropriate management and treatment of a problem or the follow-up evaluation of a previously diagnosed and stabilized condition
8. prepare patient summaries
9. initiate requests for commonly performed initial laboratory studies
10. collect specimens for and carry out commonly performed blood, urine, and stool analyses, and cultures
11. identify normal and abnormal findings on history, physical examination, and commonly performed laboratory studies
12. initiate appropriate evaluation and emergency management for emergency situations (e.g., cardiac arrest, respiratory distress, injuries, burns, hemorrhage)
13. perform clinical procedures, such as:
 - a. venipuncture
 - b. intradermal tests
 - c.* electrocardiogram
 - d. care and suturing of minor lacerations
 - e. casting and splinting
 - f. control of external hemorrhage
 - g. application of dressings and bandages
 - h. administration of medications, intravenous fluids, and
* transfusion of blood or blood components
 - i. removal of superficial foreign bodies
 - j. cardiopulmonary resuscitation
 - k.* audiometry screening
 - l. visual screening
 - m.* carry out aseptic and isolation techniques
 - n. provide counseling and instruction regarding common patient problems

* Duties that are performed by Physician Assistants which are not carried out by Community Health Aides.

ATTACHMENT 2

COMPARISON OF PHYSICIAN ASSISTANT TRAINING PROGRAM

WITH THE COMMUNITY HEALTH AIDE TRAINING PROGRAM

| CRITERIA | *PHYSICIAN ASSISTANT CERTIFICATE PROGRAM | COMMUNITY HEALTH AIDE TRAINING PROGRAM |
|--|--|--|
| Prerequisite for admission | Commitment to the Physician Assistant role | 8th grade education |
| | Minimum of two years recent full time experience in direct patient care delivery or current professional credentials and at least 2 years experience in allied health. | Commitment to the CHA Role |
| | Two college level English courses. | |
| | Completion of two college level science courses (anatomy, physiology, and biology or chemistry. | |
| Length of Program | | |
| a. Classroom, clinical instruction | 9 months | 2.5 months |
| b. Clinical rotations | 6 months | 0.75 months at best |
| c. Clinical preceptorship with sponsoring practitioner | 6 months | 0.5 months |
| d. TOTAL | 21 months | 3.75 months |

*MEDEX North West Physician Assistant Training Program