BHA Models of Success Study: Review and Discussion of Phase 1 Findings

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CENTER FOR ALASKA NATIVE HEALTH RESEARCH

NORTHWEST INDIAN COLLEGE

WICHE Western Interstate Commission for Higher Education

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- Dena'inaq elnen'aq' gheshtnu ch'q'u yeshdu. (Dena'ina)
  - *I live and work on the land of the Dena’ina. (English)*
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Overview

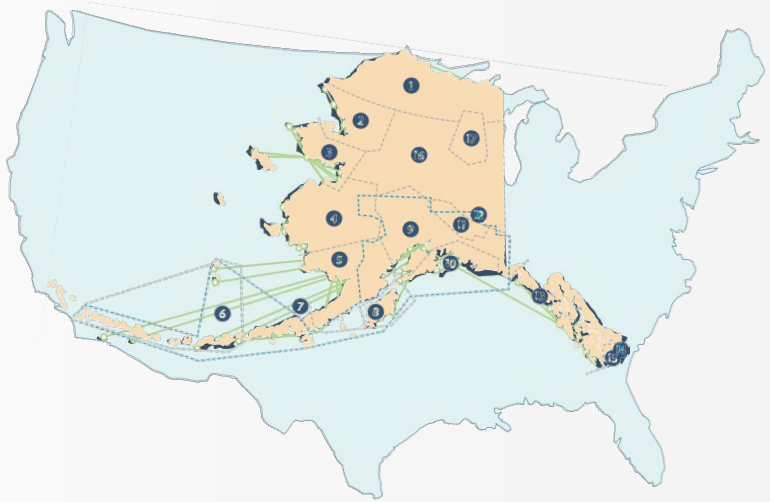
- Background & context of Health Aide programs
- Key components of the BHA Model
- *BHA Models of Success* research project
- Phase I findings & implications
- Discussion

Alaskan Context

Alaska’s geographical, historical, and cultural contexts contribute unique challenges and opportunities for meeting the behavioral health needs of its communities.

Geography & Population Demographics

- Alaska's area: 570,641 square mi.
- Total Alaska population: 737, 354
  - Alaska Native/American Indian population: 143,367 (19.4%)
  - Median age: 26.8 years
- Diverse Alaska Native cultural groups
  - 11 distinct cultures
  - 11 different languages, 22 different dialects



Same-scale comparison
Alaska vs continental United States




Strengths of Alaska Native Communities

Studies have documented the preventative and healing power of Indigenous cultural knowledge, traditions, ceremonies, and relational networks, demonstrating how "culture is medicine"[5],

Indigenous cultural interventions have been shown to reduce alcohol use and suicide risk among youth and adults[6], treat addiction[7], and improve physical health outcomes[8].

5. Ayunerak et al., 2014; Brady, 1995; Kaholokula et al., 2017; Pomerville & Gone, 2019; Schiff & Moore, 2006
6. Allen et al., 2023; Bogic et al., 2024; Cwik et al., 2016
7. Rowan et al., 2014
8. Kaholokula et al., 2017

Culturally-Grounded Interventions

- Indigenous scholars continue to call for an investment in culturally-grounded interventions vs. those adapted from other (e.g., Western) paradigms
- Despite demonstrated efficacy, funding for culturally-grounded intervention development and evaluation has been limited
- Programs often face early termination, preventing a full understanding of long-term impacts.[9]

9. Kapelow, 2024

History of Alaska's Community Health Aide Program

1960s

Community Health Aide

2000

Dental Health Aide

2009

Behavioral Health Aide

Assess and provide emergent, acute, and chronic care (well child visits, immunizations prenatal exams)

Diagnosis and treatment planning, cleanings, sealants, fillings and extractions

Prevention, early identification, screening, assessment, treatment, and recovery

BHA/P WORKFORCE

Behavioral Health Aides and Behavioral Health Practitioners use a combination of Western and traditional-based practices to provide behavioral health prevention, treatment, and recovery services to Alaska Native populations in the Alaska Tribal Health System.

Core Components of BHA Workforce & Certification

These foundational elements provide guidelines defining what is essential for maintaining fidelity to the BHA model

- Person-First Employment – Tribal Health Organizations
- Training and Certification for a Broad Scope of Practice
- Practicum, Competencies, and Continuing Education
- Supervision and Support
- Emphasis on Holistic Wellbeing

Person-First Approach to Employment

Grow-your-own philosophy

- Community-engaged process to identify/ inform selection
- Hired based on unique characteristics/ qualities

Work, Earn, Learn, Certify

- Training / practicum are embedded into the employment (formal and internal to org)

Sustainable practices

- Integrated into system
- Specific role and scope of practice
- Funding and reimbursement to employ/retain

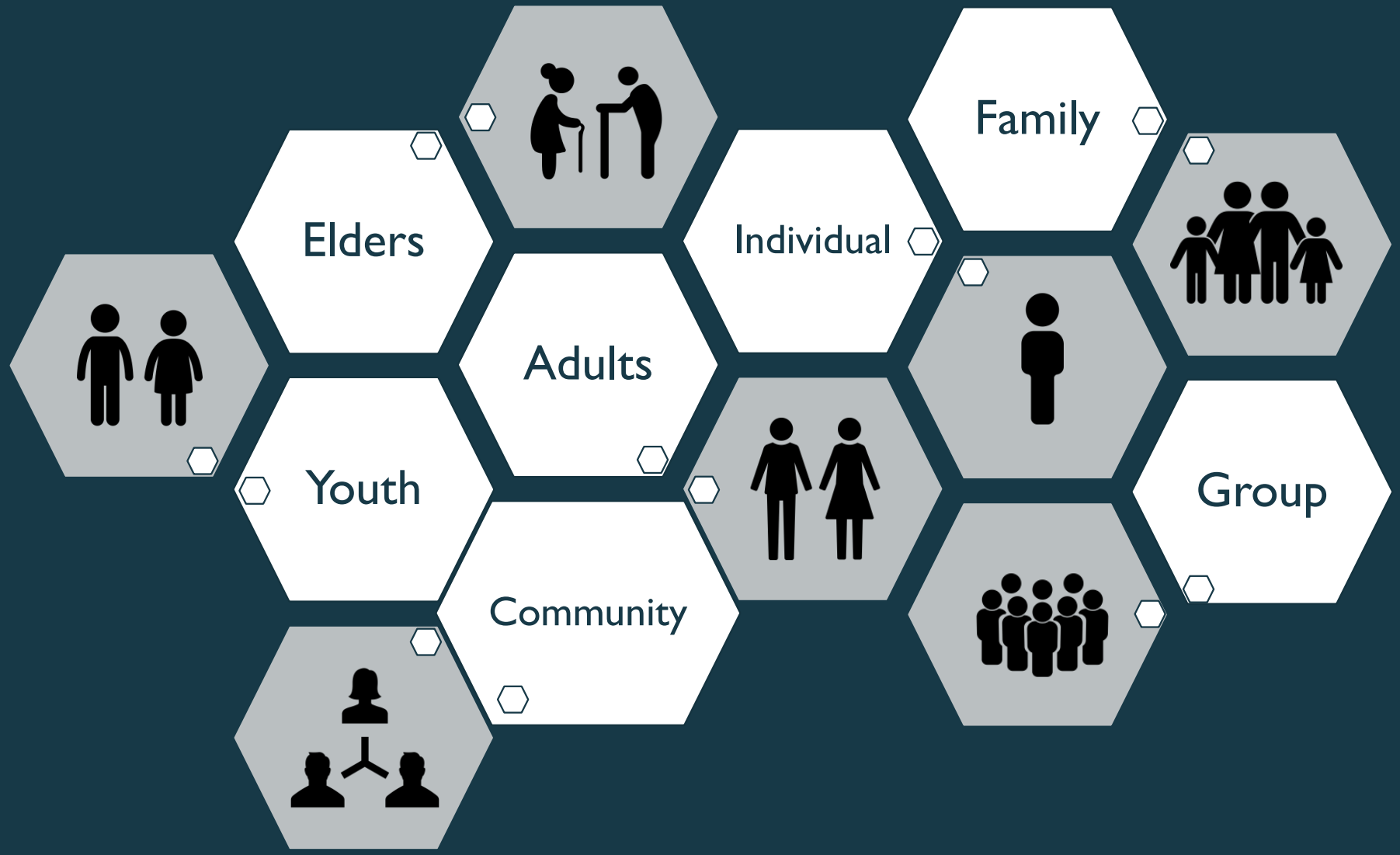
- Position is designed to fit within sociocultural and geographical contexts.
- Internal career pathway
  - Informed by THO and personal goals/capacity
- Creation of practical and accessible pathways to BH careers in rural and remote areas.

CERTIFICATION BOARD

Standards & Procedures

- Clinical oversight
  - Program responsibility
  - Qualifications
- Levels of Supervision
- Scope of practice
- Training & related curriculum
- Practicum
- Work experience hours
- Competencies
- Continuing education

BHAs work with people across the lifespan to address a variety of presenting problems and manage common BH symptoms and diagnoses.



	BHA I	BHA II	BHA III	BHA/P
Scope of Practice	• Wellness Promotion • Education • Advocacy • Community Needs Assessment • Screening • Intake • Referral • Crisis Management • Case Management • Life Skill & Resource Development • Medication Education • Psychoeducation • Individual & Group Interventions	• Substance Use Disorder Assessment & Diagnosis • Substance Use Disorder Treatment Planning • Substance Use Disorder Treatment Implementation • Community Readiness Assessment • Individual, Group & Family Counseling	• Treatment/ Aftercare of Co-Occurring Disorders • Child/Youth Services • Clinical Case Review • Quality Assurance Case Review	• BHA Mentoring • Child-Centered Interventions

Behavioral Health Aide (BHA) Research Project

The Research Team

- Alaska Native Tribal Health Consortium (ANTHC)
- Western Interstate Commission for Higher Education (WICHE)
- University of Alaska – Fairbanks (UAF) - Center for Alaska Native Health Research (CANHR)
- Northwest Indian College (NWIC)

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BHA Project Purpose

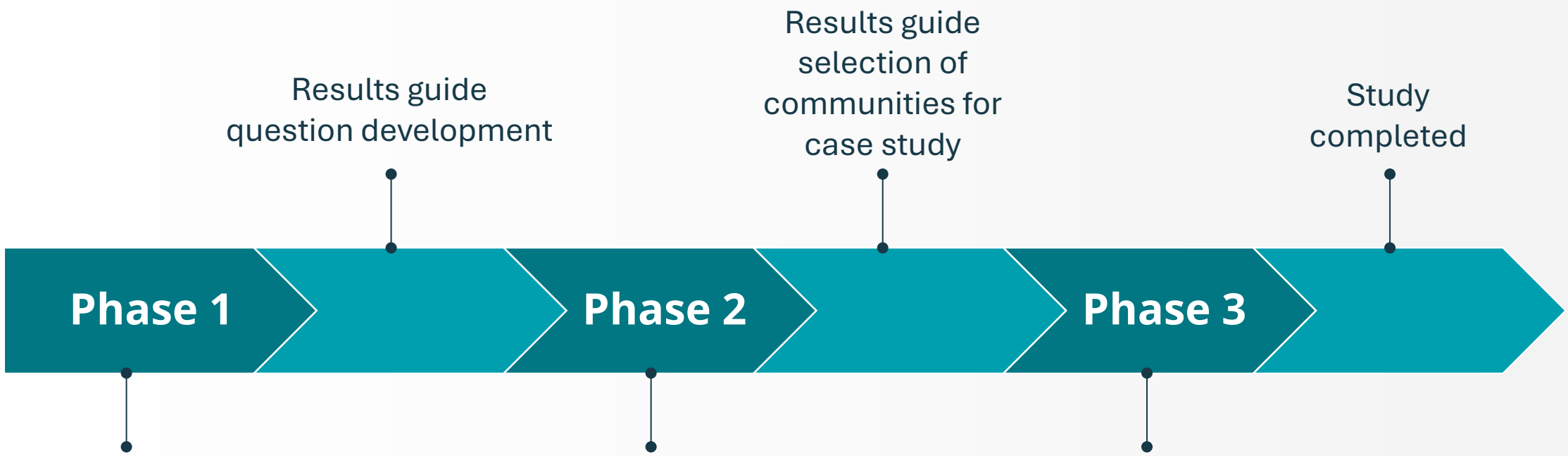
The Alaska Behavioral Health Aide (BHA) Research Project includes three phases that aim to:

- Examine the **implementation** of the BHA model in Alaska
- Explore the **effectiveness** of the BHA training program in building provider competencies
- Describe the core facets of the Alaska BHA Program to help **guide potential adoption and implementation** of the program in the lower 48
- Build the **research capacity** of Alaska Native research partners & institutions

Indian Health Service (IHS) has embraced the BHA model for replication in tribal health settings across the U.S.

To date, no implementation science studies have been conducted to inform this technology transfer and adoption process

Study Phases



Phase 1 Research Questions

What are the **characteristics of BHAs** in current services, geographic distribution, demographics, qualification, and training levels?

What are BHAs' **primary service and practices areas**?

What do BHAs identify as their **competency level** in their primary service and practice areas?

How do BHAs perceive the **supervision, support and training** provided to them in their BHA role?

Phase 1 Design & Methods

- Online survey of individuals employed as a BHA and/or working towards certification
- Recruitment via email distributed to ANTHC BHA Program listserv
- Inclusion criteria
  - 18 or older
  - Employed as a BHA at or working toward any level of certification
- Approved by
  - Alaska Area IRB
  - Alaska Native Tribal Health Consortium Health Research Review Committee
  - Southcentral Foundation Research Review Board

Phase 1 Results

Demographics of BHAs (n = 66)

Age	N (%)
18-34	21 (31.8)
35-44	20 (30.3)
45-54	10 (15.2)
55+	13 (19.7)

80.3%
Women

18.2%
Men

Education	N (%)
High School or GED	18 (27.3)
Associates	12 (18.2)
Bachelors	17 (25.8)
Masters	12 (18.2)
Other	7 (10.6)

Racial & Ethnic Identities of BHAs
(Select all that apply)

Race	N (%)
Alaska Native or American Indian	**37 (56.1)**
White	32 (48.5)
Hispanic/Latino/a/x	5 (7.6)
Other*	10 (15.2)

26% Multiracial - selected multiple categories

**"Other" includes the following: Asian or Asian American, Black or African American, Native Hawaiian or Pacific Islander, Race Other, and Prefer not to answer.*

BHA Certification

59%

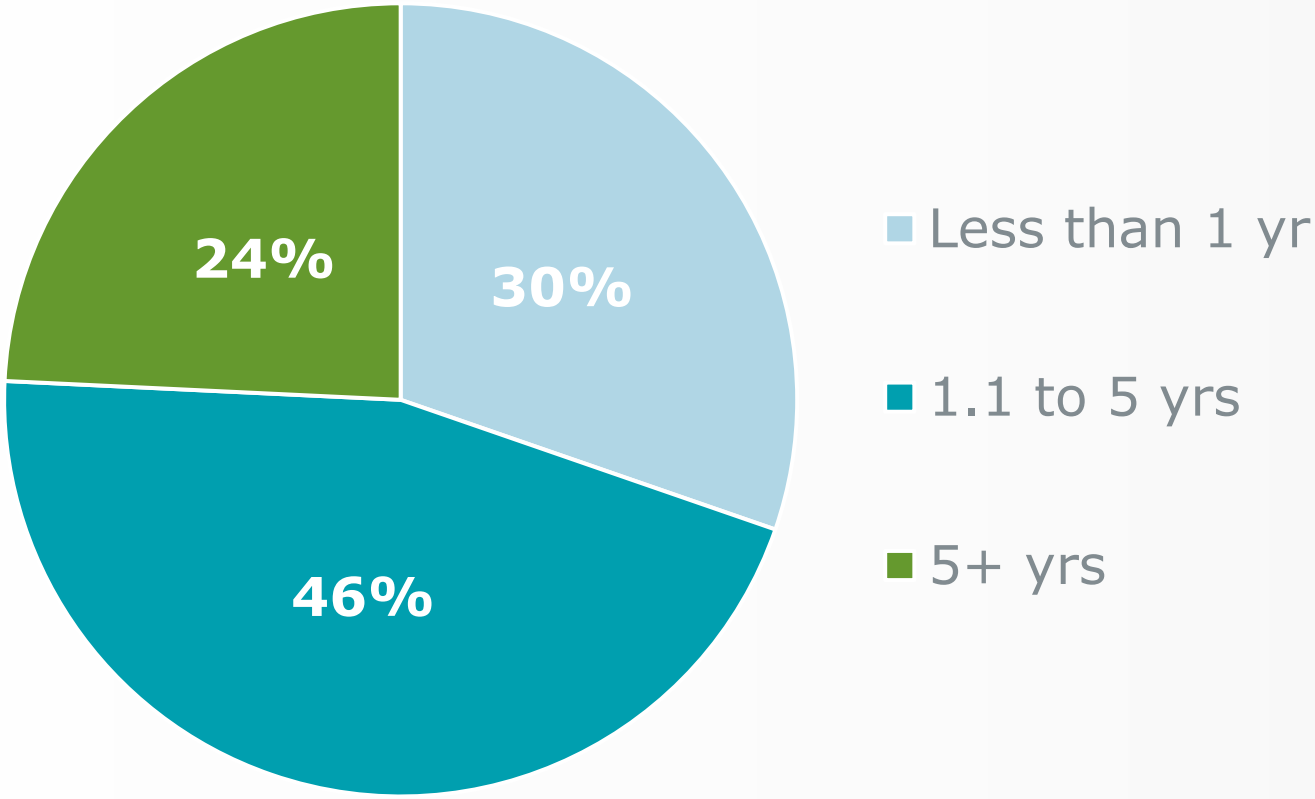
Certified

73%

Working toward certification (initial or advanced)

Current Certification Levels	N
BHA I	13
BHA II	11
BHA III	7
BHP	8
Total	39

Length of Employment as BHA



BHA Service Modality

In-person & Telehealth

27%

Provided in-person services to multiple villages

74%

Provided telehealth (phone/video)

61%

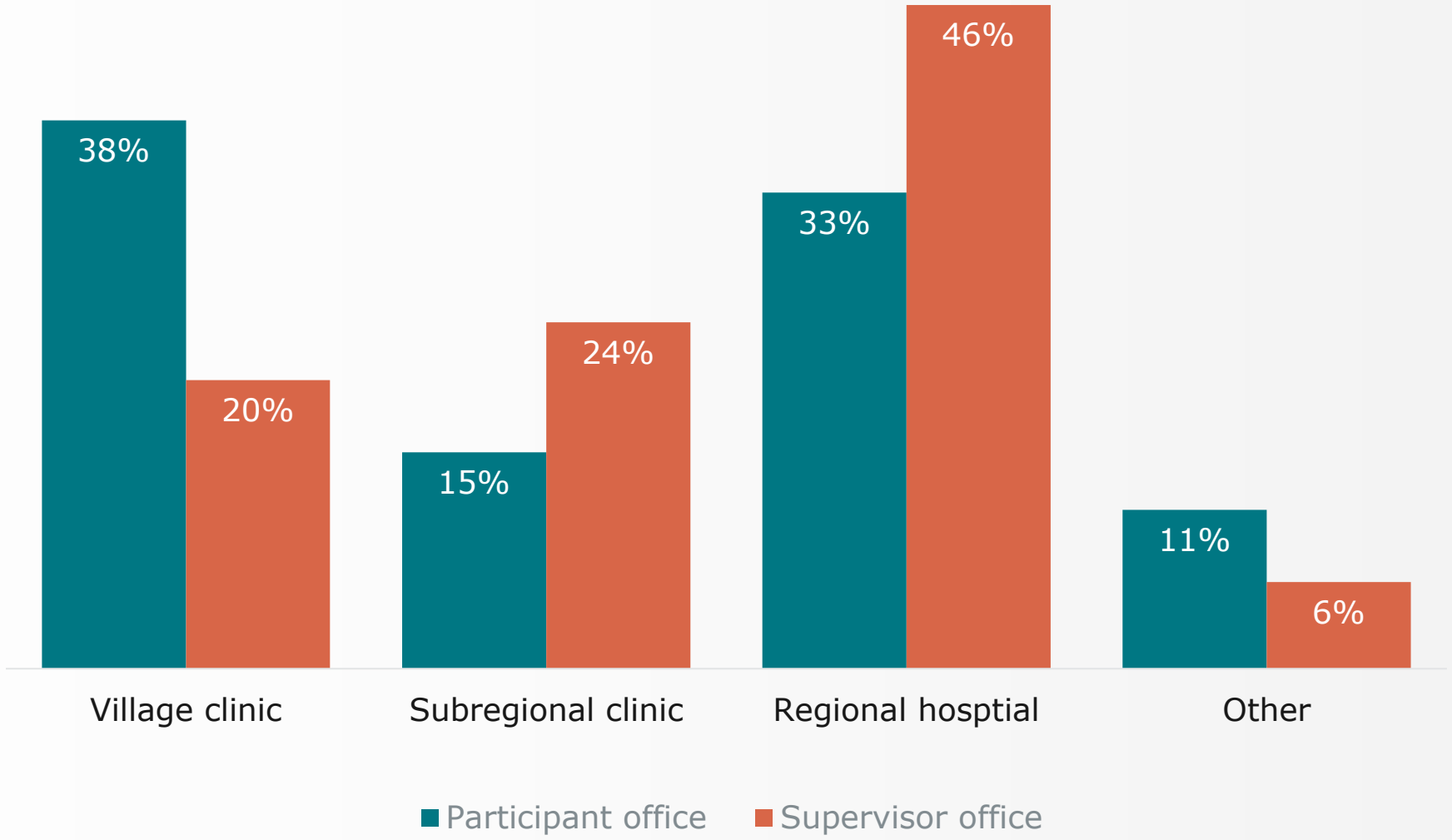
Provided telehealth to multiple villages

BHA and BHA Supervisors

Office Location

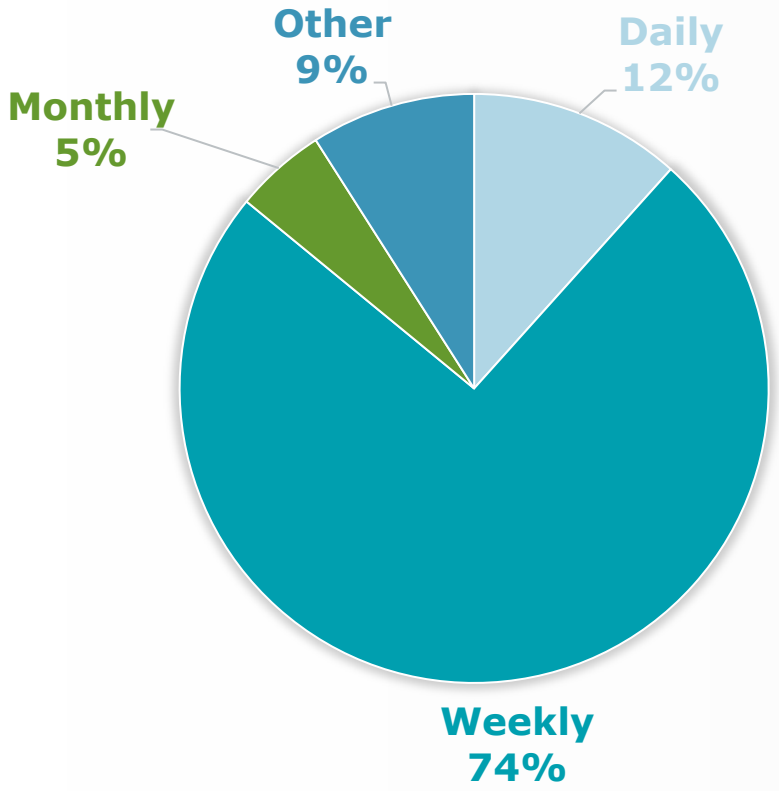
70%

Received in-person supervision



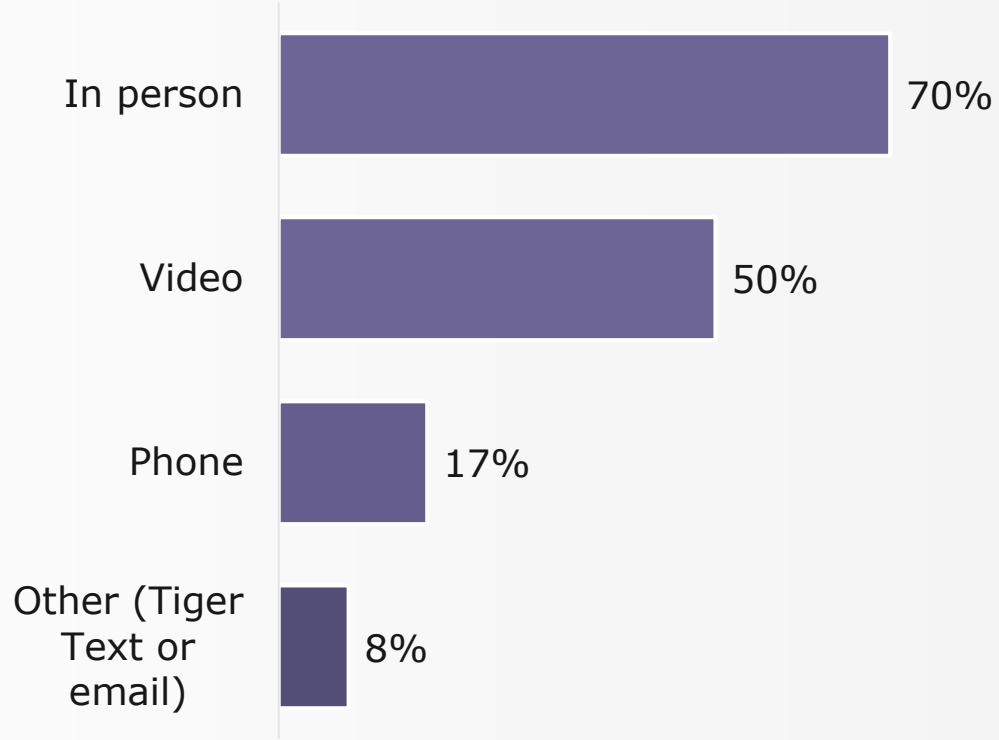
Supervision

Frequency of Supervision



Meeting Type

(select all that apply)



Perceptions of Training

87%

Satisfied or Very Satisfied with training received through ANTHC

TRAINING LOCATION	%
ANTHC BHA Training Center	80%
My organization	27%
My university	20%
RADACT	33%
Other or Prefer not to answer	5%

Perceptions of Supervision & Support

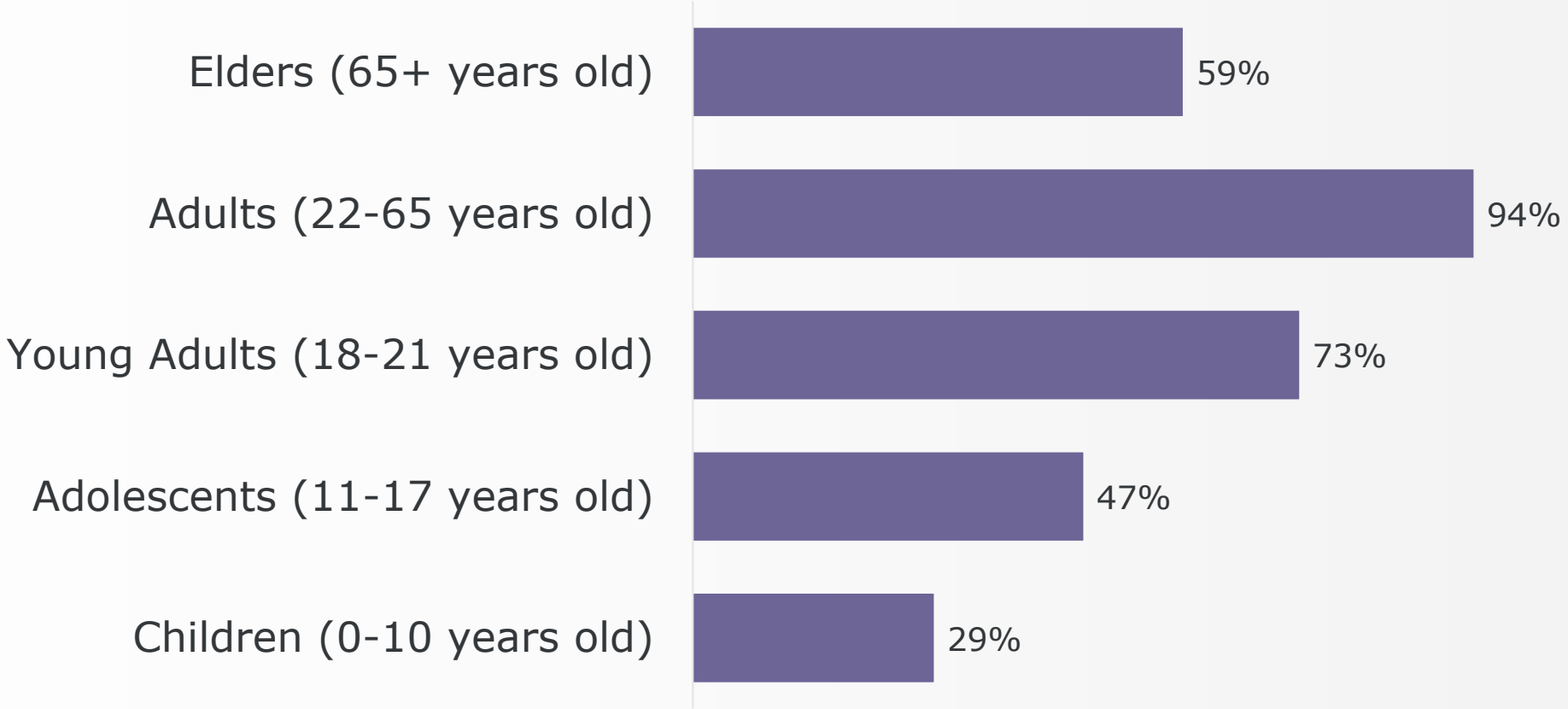
% Who Agreed or Strongly Agreed*	
81.1%	I receive the supervision I need to be successful as a BHA/P
81.1%	I feel strongly supported by my organization/employer
79.7%	My training prepared me for my role as a BHA/P
78.2%	My community values the work I do as a BHA
76.8%	I feel like I am doing the job I was trained to do
75.4%	I am making a positive impact on my community

**Levels of disagreement were low (ranging from 2.8% to 8.7%). 10-14.5% of participants selected the "neutral" option for each question*

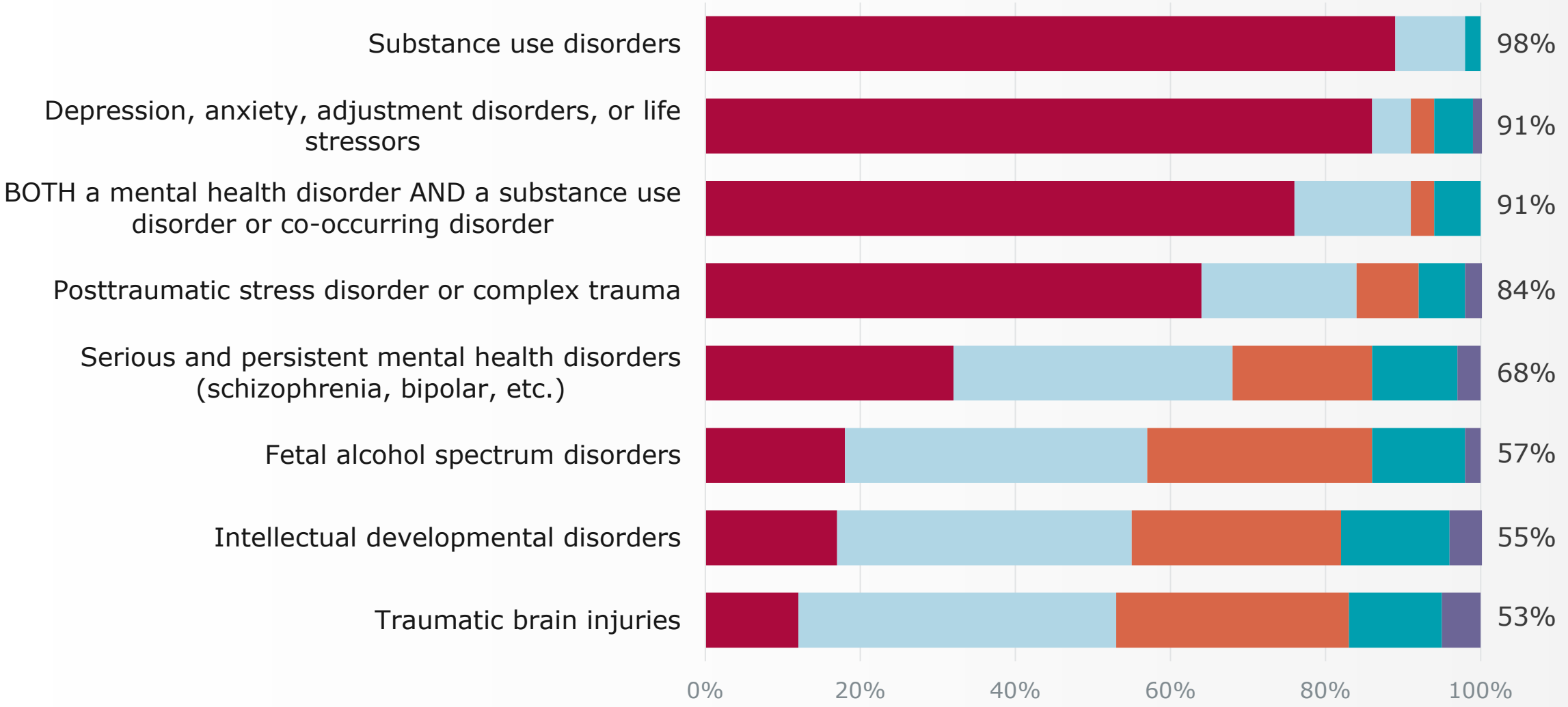
Populations Served by BHAs

- Individuals (95%)
- Groups (56%)
- Families (30%)
- Couples (12%)

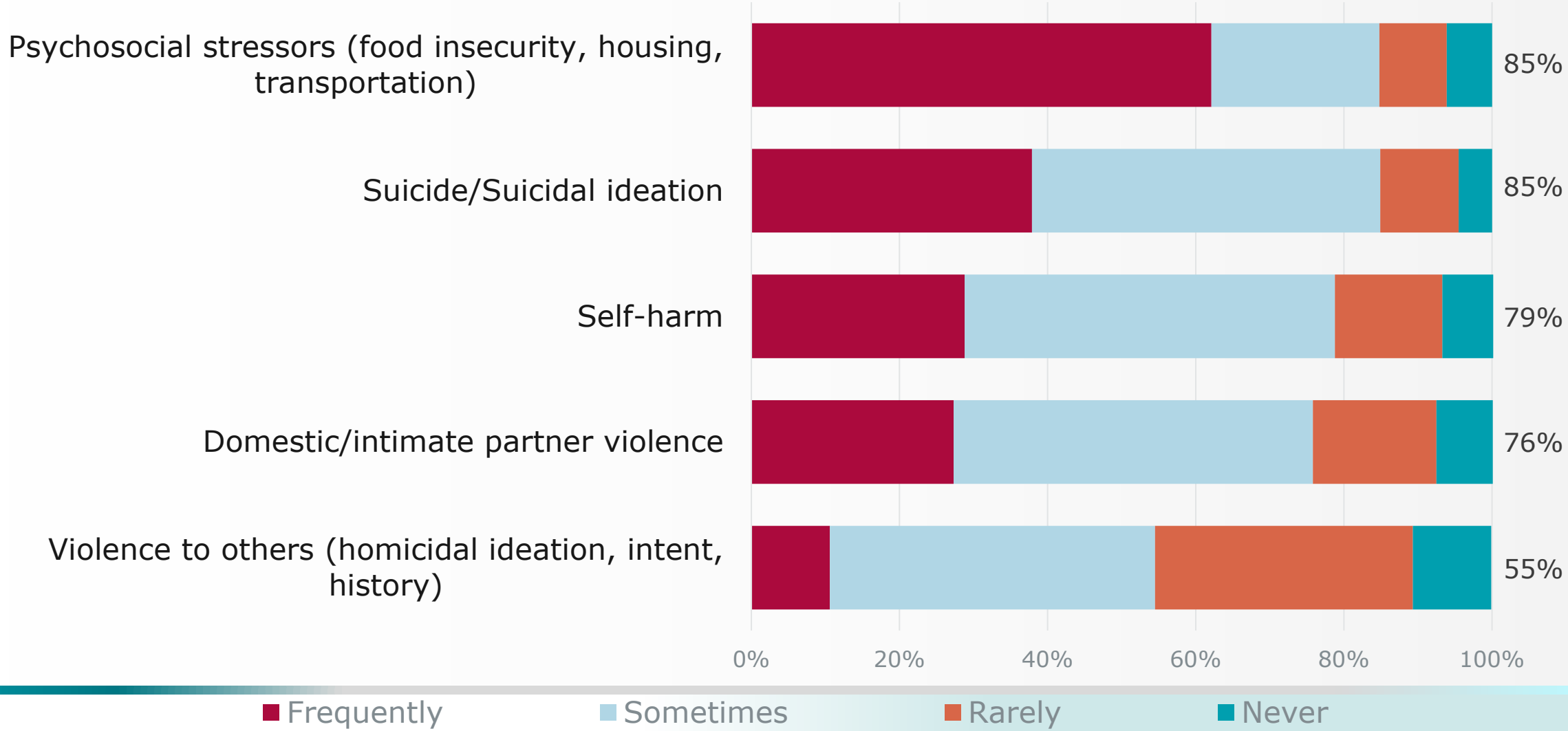
Age of Caseload



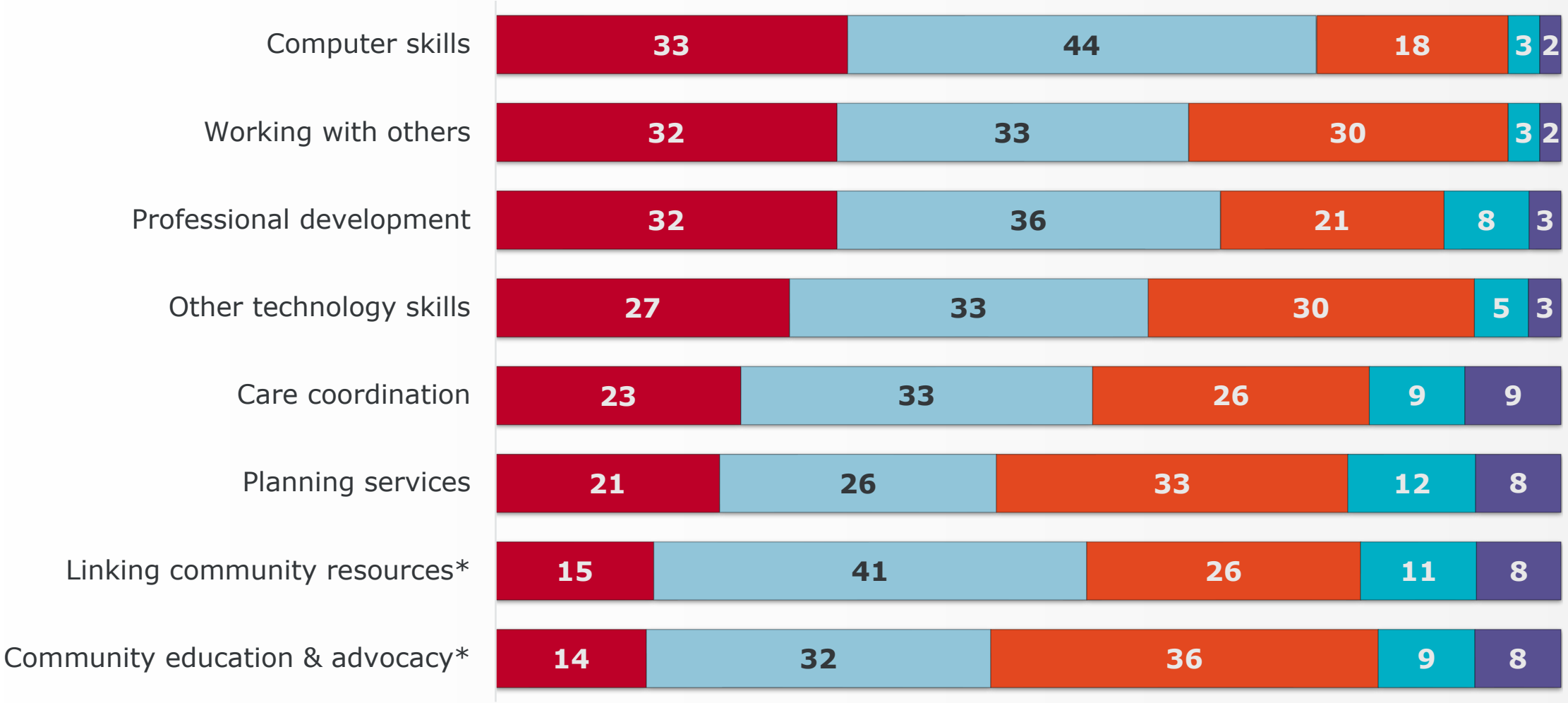
Frequency of Client Engagement by Diagnosis



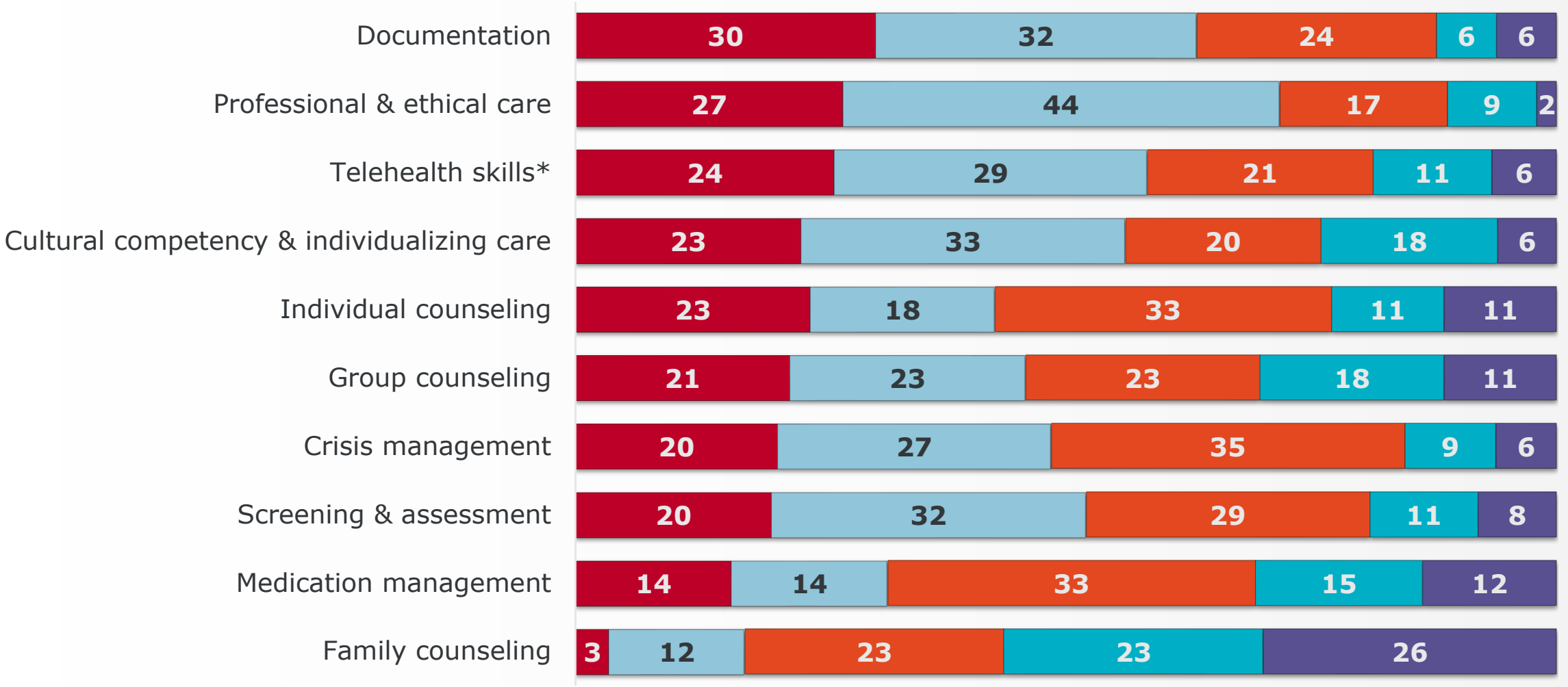
Frequency of Engagement by Presenting Concern



Level of Competency
Non-Clinical/Professional Skills



Perceived Level of Competency



Limitations

- Sample size (response rate ~30%)
- Self-selected sample, non-representative
- Self-report
- Limitations of survey design

Next Steps

- Explore implications of the data
- Share Phase I data/findings with participants and communities
- Phase 2 in Data Analysis
- Phase 3 IRB in process
- Finalize Phase 1 publication to inform adoption and implementation of the BHA model in other settings

Evidence-Supported Strengths of the BHA Model

BHAs…

- Are a workforce model that prioritizes employment-first, which reduces barriers to workforce participation.
- Serve a broad spectrum of people across the continuum of care.
- Are a workforce that can relate greatly to the people they are serving. They are familiar with the strengths and the struggles within the community.
- Are capable of delivering essential healthcare services in rural and remote communities, often with minimal on-site support.

Discussion of Findings

- Demographics and characteristics of BHA workforce
- Clients served
- Supervision locations and modalities
- Perceptions of supervision, support, and training
- Primary areas of practice
- Frequent presenting concerns and diagnoses
- Levels of competency

Conclusion

The strength of the BHA model lies in its capacity to deliver essential healthcare services despite the significant challenges of serving rural and remote communities.

The BHA program provides a model for other communities that fit local cultural, social, and geographical context, particularly in settings where there are currently little or no services.

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