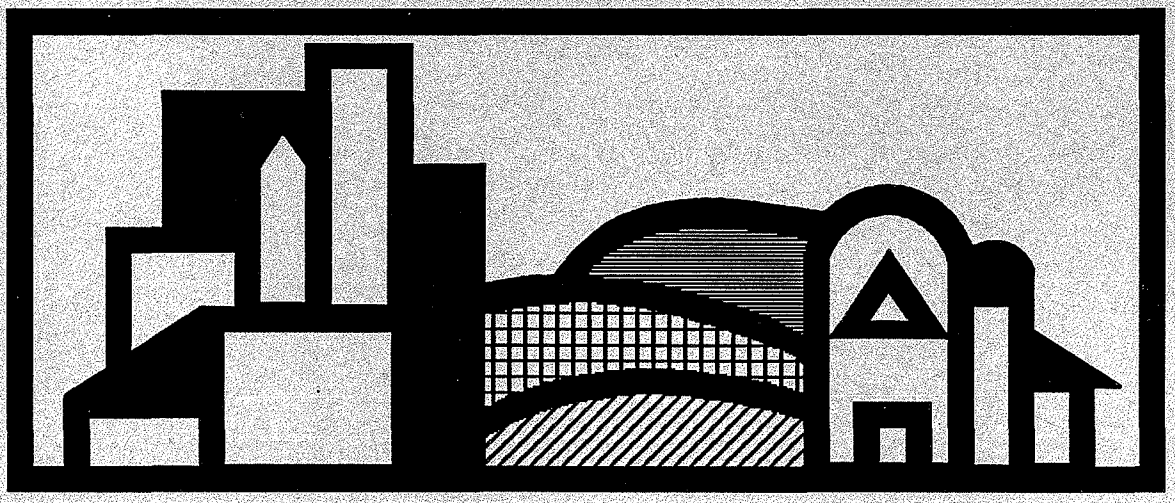
Making Decisions About Home Care: A Guide for Community Health Boards



Minnesota Department of Health

December 1990

Making Decisions About Home Care:

A Guide For Community Health Boards

A Report of the Home Care Subcommittee

of the

State CHS Advisory Committee

December 7, 1990

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to the

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The Home Care Subcommittee Report

*Subcommittee Charge**

As a part of the 1989 Workplan of the State CHS Advisory Committee (SCHSAC) a Home Care Subcommittee was established to complete a review of the existing home care system in order to revise, update and focus them to reflect current home care systems issues. The review was expected to take two years and to focus on three products:

a. A description of the existing home care system and its relation to Home Health Care and other CHS program responsibilities and activities under the Local Public Health Act. Included in this description was a clear identification of issues related to the current home care system in the form of one or more issue papers.
b. A revised and condensed set of Home Care Guidelines for Boards to use both in identifying the Community Health Board's role in planning, coordinating, and improving home care systems and in setting policy related to home care systems issues as those issues relate to the broader responsibilities of the Board.
c. A list of recommended actions for the Commissioner to take in order to encourage and support the development of home care systems consistent with the revised Guidelines.

During 1989, the Subcommittee completed the description of the existing home care system and description of the issues related to the Community Health Board's role in home care (see Exhibit 4). In 1990, the Subcommittee developed a report and recommendations for Community Health Boards and the Commissioner of Health, and a set guidelines for Community Health Boards to use in making decisions about home care. The Subcommittee's report, recommendations, and guidelines are also included in this document.

The Subcommittee met six times during 1989, and seven times during 1990. During 1990, the Subcommittee worked on the Home Care Guidelines, using its 1989 issues paper as background. A preliminary draft of the guidelines were presented to the SCHSAC at its August 22, 1990 meeting. A series of meetings were then held throughout the state to review the preliminary guidelines with Community Health Boards and staff. The final report and list of recommended actions to the Commissioner were approved by the SCHSAC at its meeting on December 7, 1990.

*Updated charge as approved by the SCHSAC at its January 26, 1990 meeting.

Subcommittee Membership

Delores Baumhofer, Chair of the Subcommittee and County Commissioner
Big Stone-Swift-Chippewa-Lac Qui Parle-Yellow Medicine

Nancy Bauer, CHS Administrator
Becker-Norman-Mahnomen

Arnold Biedermann, County Commissioner
Freeborn County

Dorothy Chadwick, Local CHS Advisory Committee Member
Beltrami-Clearwater-Northwest-Lake of the Woods

Lazette Chang-Yit, CHS Administrator
Clay-Wilkin

Cal Condon, County Commissioner
LeSueur-Waseca

Nancy Dagg, Assistant Director, Community Health and Social Services
Anoka County

Fritz Dahling, County Commissioner (left the Subcommittee in 1989)
Goodhue-Wabasha

Gene Dillon, County Commissioner
Redwood-Renville

Bonnie Frederickson, CHS Administrator
Nobles-Rock

Mary Ho, CHS Administrator
Rice County

Randy Rehnstrand, CHS Administrator
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Janet Reigstad, CHS Nursing Supervisor
Stearns County

George Walter, Local CHS Advisory Committee Member
Otter Tail County

Howard Warnberg, County Commissioner
Cass-Todd-Wadena-Morrison

Robert Fulton, CHS Administrator
Ramsey County

Home Care: A Historical and Legal Context

Home care has been a cornerstone of Community Health Services and public health for many years. However, within the past decade, the home care system and the entire system of community based long term care has become increasingly complex in terms of client populations, the range of available services, and financing methods. All of these changes suggested the need to examine the role of the CHS system in relation to home care.

In 1989, the Subcommittee completed a *Systems Description and Issues Report* that described the history of home care within community health services, Community Health Boards' statutory responsibilities for "home health care" under the 1987 Local Public Health Act, and components of the existing home care system and how people gain access to these services. The Report identified the following issues: priority-setting within CHS; interaction between public and private providers; access to services; impact of funding on home care; differing needs in urban and rural areas; and CHS roles in home care. In addition, the Subcommittee's Report declared that the home care "system" was essentially a "non-system" with a confusing array of services, points of access, and funding mechanism.

The Subcommittee's Approach

In developing guidelines that would be useful to Community Health Boards, the Subcommittee chose to address the identified issues through a decision-making approach that incorporates the existing CHS community assessment and planning process. The Subcommittee agreed that the mission of the Community Health Board and the community assessment process are an ideal starting point from which to consider the Board's role in home care.

The Subcommittee called for Community Health Boards to evaluate their role in home care based on a review of their overall mission and an assessment of the need for home care and other community based services. Community Health Boards should consider home care as part of a wide range of services in the entire acute and long-term care system, and they should be a leader in coordinating and facilitating the development of this community based care system.

The Subcommittee also agreed that to assure that ill and disabled people recieve care, direct provision of home care services will continue to be a major role for many Community Health Boards. The Subcommittee neither endorsed nor discredited this role; rather, they recommended that this role be selected based on a process of community assessment and priority-setting.

A Summary of the Guidelines

The Guidelines provide an approach to making important decisions about home care, and are divided into several parts. The complete Guidelines describe each part in detail.

Part One:
The Organization's Mission and Roles

The Guidelines call for Community Health Boards to review their overall mission. The Community Health Board's mission provides a guidepost for determining overall roles of the Board -- such as its responsibility to "protect and promote the health of the general population" (Minn. Stat. 145A.09). A number of ideas on how to develop a mission are included in the Guidelines.

Part Two:
The Community

Decisions made in home health care or any other area must be based on solid information about the community. In order to make decisions about home care, the Community Health Board must look at what it knows about the community as a whole. The Guidelines emphasize the Board's statutory obligation to assess the need for home care services as a part of its community health services planning process.

Part Three
Where Does Home Care Fit?

After assessing the community and identifying problems, the Board must decide what it will do to assure that the problems are addressed. The activities that the Community Health Board or others perform -- for example, coordinating resources, developing referral systems, and providing services directly -- are methods used to address public health problems. In making these decisions, it is necessary to consider home health care, as well as the other aspects of the long term care and the acute care systems. The Guidelines help the Board establish priorities in light of the other services already being provided.

Part Four
Selecting Appropriate Roles and Activities

The Guidelines describe several "alternatives for interaction with other providers" and stress that each Community Health Board could play a variety of roles. Selecting appropriate roles is a policy decision to be made based on the Community Health Board's strengths, and the needs and resources in the community. Examples of roles in home care are provider of direct services, case manager, broker of contracted home care services, consultant to other home care agencies, coordinator of long term care services in the community, advocate for quality care for all persons in need of home

care, and initiator of new services -- alone or with others. A discussion of some of these roles is included in the Guidelines.

Part Five:
Considerations in Decision-Making

The issues that face Community Health Boards in home care are complex and do not lend themselves to simple solutions. In addressing major home care issues, the Board must consider what **options** exist for making changes, what **factors** to consider in making the change, and what the **effect** will be on both its own home care program and on the entire CHS program. The Guidelines give an overview of some options for addressing home care issues and some factors to consider for each option. A case study is also included to illustrate how the approach can be used to look at a specific issue.

Part Six
Resources

Making decisions about home care and acting on the decisions will require resources. The Guidelines acknowledge this, and point out that Community Health Boards have several resources available to them to address home care issues -- including statutory authority, leadership ability, funding, and assistance from other experts. The Guidelines describe these resources and how they can be used by the Community Health Board.

Part Seven
Evaluation - An End and A Beginning

It is also important for a Board to know whether the decisions it has made (or is making) are effective in accomplishing what it wants. When making decisions, the Board should make sure these decisions can be objectively evaluated. The Guidelines provide questions that can be used to evaluate decisions.

The Subcommittee's Recommendations

The Subcommittee's recommendations are divided into two categories; recommendations for Community Health Boards, and recommendations for the Commissioner of Health.

Community Health Boards

1. Community Health Boards should use the home care guidelines as a tool to address home care issues as they arise, and as they develop their community health plans.

   Rationale: The guidelines describe a process for addressing home care issues that can be used both in the formal process of plan development and in addressing specific issues. This process builds on the community assessment process outlined in the CHS Planning and Reporting Manual. The guidelines also stress the importance of considering the overall (written) mission and roles of the Community Health Board in making decisions about home care.

2. As part of the Community Health Services plan, Community Health Boards must assess the need for home care services in their community. Community Health Boards should also determine how to best assure that ill and disabled people can be cared for in the least restrictive environment, within cost limits. Assurance roles may include such activities as planning, developing or fostering development, and coordinating services in the community that relate to home care, and may, but will not necessarily, include provision of direct service.

   Rationale: Community Health Boards have a statutory responsibility to conduct community assessment to identify health problems. This assessment must occur regardless of whether other roles are adopted by the Board. The guidelines describe, in Part Four and in the exhibits, various roles Community Health Boards could assume. The grid in Exhibit 3 also identifies the activities and organizational strengths that would accompany each of these roles. By assuming these roles, Community Health Boards will have a leadership role -- that is, they can have a key role in planning and coordinating the community based care system and be seen as a source of expertise on home care issues.

3. Community Health Boards should develop and implement specific strategies to achieve coordination among all community groups involved in local planning, development, and provision of community based and long term care services, including home care services. Such groups could include county social services, the Area Agency on Aging, school district early learning committees, and others, depending on local resources.

   Rationale: As described in Part Three of the guidelines, home care is one part of a continuum of care for persons who need assistance to live in the least restrictive environment. Although the Subcommittee's charge relates to "home care", it is impossible to look at home care apart from wider range of services

necessary to assure that "problems related to care of the ill and disabled in the least restrictive environment" are addressed. The guidelines describe various possible roles and activities of the Community Health Board in coordinating these services.

Continuous feedback on this coordination effort should be channelled to the Community Health Advisory Committee, so that they can consider community-based care issues in their overall goal of addressing public health problems.

4. Community Health Boards involved in direct or contracted provision of home care should structure their operations to assure the most effective and efficient home care services. Some considerations could include: pooling with several counties for provision of certain services, evaluating staffing patterns, providing appropriate and adequate supervision, considering the advantages and disadvantages of contracted versus direct services, and reviewing arrangements for collection of third party reimbursement.

   Rationale: The guidelines (Part Six and Exhibit 3) describe several steps a Board can take to increase efficiency in provision of direct or contracted services. If a Board is a direct service provider, it will face many time-consuming administrative issues, such as billing clients and third party payers, staff training, and other issues. Improving efficiency of services can increase the "bang for the buck" and may better allow the Board to pursue its overall mission.

Commissioner of Health

1. The Commissioner should take the lead in bringing together key state agencies to work toward a comprehensive strategy of planning and funding for long term care. This would involve joint activities which would promote the effective and efficient delivery of a wide range of services necessary to assure that the ill and disabled are cared for in the least restrictive environment -- from home care through nursing home care. The Commissioner should consider the Community Health Board's role as a leader in planning and coordinating community based long term care services and continue to work closely with the SCHSAC to develop strategies for long term care.

   Rationale: The guidelines describe the relationship of home care to the entire acute and long term care systems. However, as the *Systems Description and Issues Report* states, this array of programs and services is really a "non-system." The guidelines assert that assessment of community problems is a primary role of Community Health Boards, and call for Boards to take a leadership role in developing and coordinating community-based care. However, the Subcommittee believes that Community Health Boards are limited in their ability to make system changes without major changes at other levels of government. It proposes that similar efforts at coordinating planning, as well as efforts to increase funding, occur at the state level. The Subcommittee recommends the following strategies:

a) The Minnesota Department of Health should take a lead role in bringing together the Department of Human Services and the Minnesota Board on Aging to jointly develop, coordinate and implement a long-term care strategy. This approach would encourage more coordination between relevant state agencies and ensure that Community Health Boards are involved in the "front end" of planning and organizing community-based long-term care services, not only as vendors for delivery of home care services. The Interagency Board on Quality Assurance is a potential organization to address these issues.

b) The process described in a) above should be used to study possible options for funding community based long term care planning and services. Some possible funding options to consider are: seek additional funding (through an increase in the CHS subsidy or a separate legislative initiative); assess cost-effectiveness of the way funds are currently used; coordinate funds currently used for long-term care; and increase reimbursement for Medical Assistance and other third party payers to cover the full cost of services.

c) Work with the Legislature and other state and federal agencies to reduce restrictions and create greater administrative flexibility in provision of community based programs (i.e., rule changes, etc.)

d) Consider advocating for legislative or rule changes that would grant greater authority to Community Health Boards for coordination and planning of home care and other community based services.

e) Continue a dialogue with Community Health Boards and County Social Services on the best ways to address these issues. The Interagency Community Health and Social Services Subcommittee is one possible forum for this discussion to take place. However, it is possible that an additional forum may eventually need to be established to address these issues in sufficient detail.

2. Provide administrative and program support from MDH to Community Health Boards in two major areas: assisting Community Health Boards to expand their role as system planner and coordinator; and in addressing the technical aspects of home care. These technical aspects should include, but not be limited to: staff structure, supervision, quality assurance, primary prevention activities that would prevent or reduce the need for home care, and compliance with regulation. This technical support should be provided in addition to the overall planning and program development assistance currently provided through the Section of Public Health Nursing.

Rationale: The guidelines describe the importance of the Community Health Board's role in assessment, planning, coordination of home care services and other community-based services. They also recognize that, due to many of the issues described in the *Systems Description and Issues Report*, many Community

Health Boards will continue to have some role in the direct or contracted provision of home care services. Thus, support from MDH is needed in both of these areas. This administrative and program support can take the form of continuing education, individual consultation, and written materials. (Part Six of the guidelines discusses administrative and program support.)

In the past, the Section of Public Health Nursing provided support in the technical aspects of home care. In recent years, the Public Health Nurse Consultants' role has shifted to providing assistance in community assessment, planning, and evaluation for the overall CHS system. As a result, technical support on home care issues, such as cost-assessment for home care visits, quality assurance standards, record-keeping and billing systems is a lower priority. The Subcommittee recommends that the Commissioner organize her staff to make this support available in addition to the administrative and program support activity currently available through the Section of Public Health Nursing.

MAKING DECISIONS

ABOUT HOME CARE:

A GUIDE FOR COMMUNITY HEALTH BOARDS

December 7, 1990

Part One
The Organization's Mission and Roles

Considering the role of the Community Health Board in home care recalls a story about the late Supreme Court Justice Oliver Wendell Holmes. Holmes once found himself on a train, but couldn't locate his ticket. While the conductor watched, smiling, the 88-year-old Holmes searched through all his pockets without success. Of course, the conductor recognized the distinguished justice, and he said, "Mr. Holmes, don't worry. You don't need your ticket. You will probably find it when you get off the train, and I'm sure the Pennsylvania Railroad will trust you to mail it back later." The justice looked up at the conductor with some irritation and said, "My dear man, that is not the problem at all. The problem is, where am I going?" Perhaps more than in any other program category of CHS, Community Health Boards risk becoming so engrossed in the daily issues related to delivery of home care that they lose sight of their overall direction.

Before a Community Health Board can determine its role in home care (or any of the other program categories), the Board must look at its overall mission, roles, and the community it serves. This is the process outlined in the CHS Planning and Reporting Manual and the series of related workshops held for administrators. However, a brief review of the process as it relates to these guidelines may be helpful.

Mission

The mission of an organization guides its priorities and activities. For example, the MDH mission is "to protect, maintain and improve the health of the citizens of the state through the development and maintenance of an organized system of programs and services carried out by both state and local government with the cooperation of non-governmental entities." In 1990, the SCHSAC also developed a mission statement for community health services that emphasizes the importance of partnerships and community involvement in Community Health Services (See Exhibit 1).

Agreement on its mission leads to a consensus on what the Community Health Board's broad roles should be. Based on this mission, the Board can decide whether it makes sense to allocate resources to a given problem or activity. Although the mission may be phrased somewhat differently and have different meaning for each Community Health Board, there are some similarities in the way missions are developed. The organization's mission can be determined by:

- reviewing statutory and other legal responsibilities;
- examining the underlying principles that govern public health;
- reviewing guidelines and standards published by state and national organizations, and
- using the community assessment process used to develop the CHS plan, as described in the *CHS Planning and Reporting Manual.*

- identifying the basic values and goals on which to base the organization's mission and future activities.

Each Community Health Board's organizational structure also presumably reflects its mission and roles. For example, a Human Services agency may have a somewhat different mission than a single county Community Health Board. Both of these may have somewhat different missions from that of a multi-county Board.

Roles

The mission of the Community Health Board is a guidepost for determining overall roles of the Board. The many specific roles that a Board can have in relation to home health care are a part of its larger role as the entity responsible to "protect and promote the health of the general population" (Minn. Stat. 145A.09).

In the Home Care Systems Description and Issues Report, the following roles are referenced in the definition of community health services contained in the Local Public Health Act:

"* *planning* means assessing community health status and identifying priority needs that can be met either by providing services directly or through arrangements with other organizations. The four-year CHS planning cycle authorized in the Local Public Health Act is the process used for community assessment, identification of needs, and the 'integration, development, and provision of community health services that meet the priority needs of the community health service area.'" (Minn. Stat. 145A.10, Subd. 5.)

* *coordinating* means linking together services that exist in the community through coalition building, sharing of information, and joint projects.

* *developing* means establishing new programs within the CHS system or facilitating other organizations to become viable service providers to meet public health needs.

* *integrating* means making connections between program areas in CHS, including programs provided through other organizations.

* *providing direct service* means providing services directly, either through the Board's own staff or contracted through other organizations.

The Board may have other roles, based on community expectations and on identified community problems. For example, the public often looks to local public health for assistance in the case of a natural disaster. The APEX/PH self-assessment process, which some Community Health Boards may be using in the future, contains another description of the Board's role[1]. The 1981 CHS Home Care Guidelines also describe roles of the Community Health Board.[2]

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[1] APEX/PH *Assessment Protocol for Excellence in Public Health.* (Draft document - Final report is expected to be published in early 1991.) The report describes the roles of local public health as a continuous process of assessment, policy development, assurance, and evaluation. **Assessment** consists of considering community perceptions, demographics, mortality, and other health indicators to identify and analyze priority health problems and develop a plan to address those problems. **Assurance** includes oversight (to determine to what extent needs are being met), advocacy, resource development, projection of future need, and quality assurance. **Policy development** includes decisions that affect the resource allocation and regulation that relate to both public and private sectors of the community. **Evaluation** is an ongoing process of both the plan's success and the health status of the community.

[2] Page A-17 of the *1981 Home Care Guidelines* describe roles of the Board of Health as including citizen involvement; outreach and linkages between home care providers, social services, medical care services, and volunteer groups/agencies; evaluation; and ordinancing authority.

Part Two
The Community

The *SCHSAC Planning and Reporting Manual* outlines a detailed process of community assessment and priority-setting. [3] This process has been described in the planning and assessment workshops conducted by MDH for Community Health Boards. Each Community Health Board completes this process in developing its Community Health Plan every four years.

The following paragraphs are a brief review of that process and should not be construed as an attempt to "reinvent the wheel." For staff, Community Health Advisory Committees, and Boards who have been involved in CHS for several years, the following section may seem redundant. We are reviewing these concepts to reinforce the idea of looking at the results of the community assessment process when making decisions about home care.

Decisions made in home health care or any other area must be based on solid information about the community. In order to make decisions about home care, the Community Health Board must look at what it knows about the community as a whole. Who is your community? What are the demographics of the community? What are the actual and potential problems of the community? In a nutshell, what does your community look like? This overall "community assessment" process consists of several steps: defining the community, identifying potential and actual problems, identifying strengths and resources of the community, and analyzing the community's health status. Although the results of the process must be summarized and included in the CHS plan once every four years, the process is continuous and should also be used in making decisions about ongoing planning.

Defining the Community

The community can be defined as a place, as a social system, and as the people who make up the community. What are the health problems in the community? The CHS *Planning and Reporting Manual* provides a process for assessing health status, using existing health status data such as age, race, income, and occupation. State- and county-wide statistics on morbidity and mortality can then be reviewed to establish a measurement of the leading health problems in the community.

After health problems have been identified, the Community Health Board must ask what activities are taking place in the community to address the identified problems. As part of the CHS planning process, an inventory of the available community resources is conducted.

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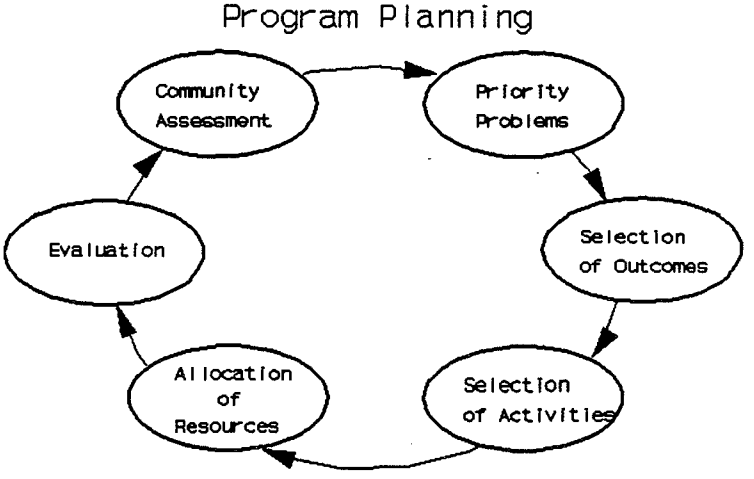
[3] See also Appendix I of *A Guide for Promoting Health in Minnesota: A Community Approach*, Minnesota Department of Health, 1988. This appendix contains a paper on Community organization by Neil Bracht, Professor of Social Work and Community Health Education at the University of Minnesota.

Setting Priorities

After identifying health problems in the community, the next step is prioritizing those problems, since the problems identified invariably exceed the available resources. How does the Board decide which are the most important problems for intervention? Some **measurable** factors are: How severe is the problem? How many other resources are being consumed to fight a problem? How do the resources consumed by a problem compare to those being expended on other problems? Examples of specific criteria related to problems of ill and disabled persons who require health care but do not require institutional care are included in the following section.

In setting priorities for use of its resources, the Board must look at both public health principles and agreed-upon criteria. To decide what these criteria should be and how to apply the public health principles, the Community Health Board looks at what role it should assume based on what activities need to occur and what it sees as its overall mission.

After priorities are established, outcomes and activities are selected and resources are allocated to achieve the outcomes. Finally, the programs are evaluated and the results are built back into the community assessment. The diagram below illustrates this "program planning model".



This model provides a broad-based approach to planning CHS programs that can be applied to all program areas and public health problems. Although it is difficult to look at the "big picture" when faced with a crisis regarding a client, program budget, or staffing pattern, it is easier if the client, budget, or staffing crisis is considered in the context of a complete and accurate picture of the entire community.

Part Three
Where Does Home Care Fit?

Relation to the Long Term Care and Acute Care Systems:

After assessing the community and identifying problems, the Board develops and considers appropriate methods of intervention. In planning interventions, it is necessary to consider not only home health care, but both the long term care and the acute care systems.[4]

Until recently, many lay people and even health care providers thought of "long term care" as nursing home care and "acute care" as hospitalization. With changes in the health care system in recent years, this line has become blurred. The *Home Care Subcommittee System Description and Issues Report* (See Exhibit 4) identifies home health care as one part of the entire **long term care** system, ranging from care provided in the home to nursing home care. Some elements of the long term care system are also concerned with acute care. With earlier hospital discharge and home care of premature and disabled infants, acute care may also occur in the home or community. People who utilize the long term care system may also have acute care episodes. (For example, a person receiving assistance with bathing and meals in the home may break her hip and require hospitalization, then be discharged to a nursing home, and eventually be discharged to home, but require more services than she had received prior to the injury.) The diagram on the next page shows the relationship between **home health** care as a program category of the CHS system and home care as a component of the acute care and long term care "systems." As indicated, home health care is a component of the CHS, long term care, and acute care systems, which may be provided by CHS or other organizations.

The Local Public Health Act requires that Community Health Boards address "home health care." This means that all of the components of the long term and acute care systems should be considered by the Community Health Board in addressing the problems related to "home care" -- not only those components which have traditionally been the direct responsibility of the Board.

Relation to Identified Health Problems in the Community:

All of these components could potentially be used to address identified problems. For example, a Community Health Board might identify the **problem** of ill and disabled persons who need assistance with care in the least restrictive environment.

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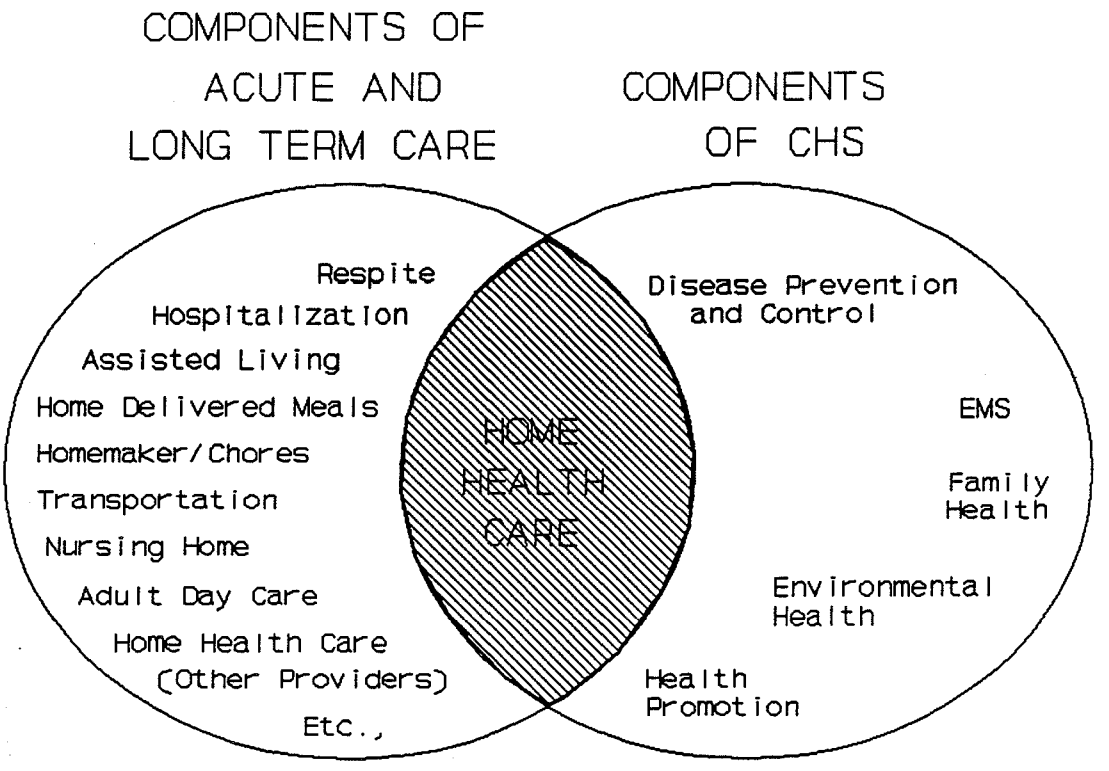
[4] Long-term care is defined as "a set of health, personal care, and social services delivered over a sustained period of time to persons who have lost or never acquired some degree of functional capacity. In layman's terms, long-term care is the assistance that is needed to manage independently and as decently as possible when disabilities undermine capacities." (*Long-Term Care: Principles, Programs, and Policies*. Rosalie A. Kane and Robert L. Kane, 1987.)



The Board would then identify the desired outcome, or goal to work toward.[5] Possible resources that could help address this problem include adult day care, assisted living, hospitalization, home health care, and nursing home care. (Some of these resources may be provided through CHS; some may be provided by other organizations.) The activities that the Community Health Board or others perform -- for example, coordinating resources, developing information and referral systems, and providing services directly, -- are methods used to address public health problems. Community Health Boards may be involved in many of these activities whether or not the Board is providing the services. A decision that Community Health Boards must make early in the process of evaluating where home care fits is: what are the most appropriate activities to address the problems? If home health care is seen as an appropriate activity to address the identified problem (as probably will be the case), the status of home health care in the community must be assessed.

Status of Home Care Currently Available:

To evaluate the status of home care in the community, the Board should consider the following factors:

[5] For example, Goal VI of the 1988 Statewide Goals for Community Health Services, is "to ensure that persons whose illnesses or disabilities require health care but do not necessitate institutional services will regain or maintain the maximum health status for their conditions.

What is the need for home care?

What is the identified need based on the results of the community assessment? Input from community organizations and citizen groups, review of current client records, and analysis of state and national data all help identify the need for home care. Marketing data and other information from private providers can also be helpful. Although obtaining such information from private providers will require that a trusting relationship exists between Community Health Board staff and private provider staff in charge of planning, it is important to make these alliances.

In the 1970s and early 1980s, several formulas were developed by Portland Kaiser-Permanente Group, the University of California at Berkeley, the National League for Nursing, and several others for forecasting demand for home care (See Exhibit 6). These are an additional tool that can be used to help assess need; however, these should be considered as a guide only, not as the bottom line, as local variables may change the final figures considerably. Such formulas also do not include case mix, type of hospital, and type of home care needed. Local CHS staff are encouraged to work with the MDH Public Health Nurse Consultants in using the formulas to arrive at an estimate of need.

Perhaps this question can be answered more fully by looking at the answers to the following questions as well.

1. **What home health care services are available in the community to address the identified problems?**

   The Board should next assess the availability of home health care or other long term care services in the community. It can then determine if there are gaps between the identified need (above) and the level and amount of service available.

   Other providers may also turn to the Community Health Board for information on services available in the community as they are developing their services.

2. **What quality of service exists?**

   Are the services available in the community of acceptable quality? The nature of the Community Health Board's authority in assuring quality varies, depending on whether the Board pays for the service or not. (If the Board is paying for the service, it has more control.) The following are helpful tools for assessing quality:

   - Minnesota state home care licensure rules (The licensure rules are expected to be published in early 1991);
   - Medicare certification and records (The Medicare complaint hot line will provide information on any complaints filed);

- *1981 CHS Home Care Guidelines* home care quality assurance model in Part C[6];
- the National League for Nursing 1988 *Administrator's Handbook for Community Health and Home Care Services*;
- *Code of Ethics: Standards for Home Health Care Providers*
- Home Care accreditation through JCAH;
- National League of Nursing accreditation through the Accreditation Program for Home Care and Community Health;
- any locally developed home care standards and policies.

The MDH Library has these materials available on loan to CHS staff. The Public Health Nurse Consultants can also assist staff in obtaining these materials.

3. How accessible are the current services?

Are services available to people of all income and age levels? Are services available in the more rural areas? Do clients have the option of choosing their own providers, or are discharge planners or physicians automatically referring clients to an agency? Are staff shortages impeding access to services? Are services available when needed (for example, on evenings and weekends as well as during the "normal" work week)?

4. How acceptable are the services currently provided?

Are clients/families satisfied with the level and quality of services currently provided? Is the Community Health Board satisfied with the level and quality of services based on its own identified written standards or on criteria such as that identified above? How strong is community awareness/support for the services available?

Priority in relation to other identified problems:

In the process of assessing community problems and resources, the Community Health Board will ultimately be faced with the dilemma of allocating finite resources. There is never enough money and staff time to deal with all identified problems. Thus, the Board needs to select priority problems and priority interventions. This decision can be made by looking at criteria established and/or agreed upon by the Board. These criteria can be related to either the significance of the problem or the potential success of the proposed intervention. Examples of such criteria for **problems** are:

[6] These Guidelines, although almost a decade old, contain a workable process for assessing quality in a home care agency. The Guidelines suggest assessing three components: structure, process, and outcome in determining quality, and contains recommended standards in each of these components.

- Health factors (premature death, disease and disability, etc);
- Social factors (equity, community concern);
- Consistency with state and national goals;
- Political factors (is the problem perceived as important by the community or by decision-makers?)

After problems have been identified, the most effective interventions must be considered. Examples of criteria for **intervention** are:

- Are there a variety of interventions that can be used to address the problem?
- Are the interventions consistent with the public health principles (see below)?
- Do the interventions have proven effectiveness? (through studies or other historical data?)
- Are interventions politically feasible?

The problems and interventions are then considered together to develop priority problems, for which the Community Health Board develops goals and objectives to address. The chart below shows a matrix for ranking problems based on how important the problems are in relation to how "rich" (politically feasible, proven effective, large number, etc.) the interventions are.[7]

Decision Matrix for Ranking Problems

	VERY IMPORTANT	LESS IMPORTANT
HIGH RICHNESS INDEX	**	*
LOW RICHNESS INDEX	*	-

** Highly recommend to be in plan
* Address in plan if possible
- Continue surveillance; may not address

The following are some examples of public health principles, that can be used in assessing problems and interventions, as described in the CHS Planning and Reporting Manual:

____ Do the interventions focus on aggregates? *(Are people served on a community-wide or target group basis, rather than an individual basis?)*

[7] This model is presented in more detail in the CHS Planning and Reporting Manual.

___ Are the interventions primary prevention activities? *(Do they focus on prevention of disease before it is diagnosed, rather than provision of acute or maintenance care?)*

___ Do the interventions involve organizing community resources? *(Are various groups or individuals in the community brought together to discuss health problems? Is there coordination for best use of resources?)*

___ Do the interventions provide the greatest good for the greatest number of people? *(Are a few people in great need being served, or is a larger share of the population being served? Are there other interventions that potentially could achieve greater benefit to the community?)*

___ Do the interventions do what others cannot or will not? *(Are there others in the community that could perform this intervention? Do public health personnel possess special skills or experience that others do not have in this area? Are groups or individuals being served that would not be served if public health were not involved, either because of costs, distance, or other factors?)*

___ Are the interventions based on scientific principles? (*Are interventions consistent with recommended standards of practice? Are they consistent with what has been found to work through evaluation and research?*)

___ Do the interventions use resources efficiently? (Are *the levels and amounts of resources sufficient, but not excessive, for achieving the desired public health outcome?*)

Although this process may seem clear-cut, it is easier said than done. It is often difficult for Community Health Boards to be aware of all the resources, programs, and organizations that exist in the community. The community assessment is a **process** that must be conducted continuously, not only in preparing the CHS Plan or Plan Update. [8]

Even with good communication in the community, sometimes it is difficult to get all the information necessary to do good planning, such as the number and type of clients served by various organizations. One possible approach is a survey such as that conducted by one Community Health Board and included in Exhibit 5.

Priority-Setting Among Problems and Interventions related to Care of the Ill and Disabled:

In assessing the services available in the community, it is important to look at priority problems and interventions **within** home care in addition to priorities in relation to the overall CHS system. These priorities can be based on the criteria defined above. For example, the Board may identify the specific problem of community-based care for persons who are infected with HIV. Possible interventions may include in-home care, adult foster care, adult day care, or many other options. This specific problem must be weighed in relation to the needs of other home care target populations on the basis of the factors identified above and the "richness" of interventions possible.

[8] The APEX/PH workbook will also provide a simplified method similar to this for use by communities, led by public health agencies, in deciding priorities.

That is, how important is this problem in relation to other "home care" problems, and how likely are the interventions to be successful? This leads to considering and weighing the appropriate roles for CHS in home care, as described in the following section.

Part Four
Selecting Appropriate Roles and Activities for CHS Within Home Care

Community Assessment is a **statutory** role of all Community Health Boards. As a result of conducting community assessment and selecting priority problems and interventions, there are many **possible** roles a Community Health Board can adopt to assure the availability of home care in response to assessed needs. In the *Systems Description and Issues Report* (See Exhibit 4), the Subcommittee identified several "alternatives for interaction with other providers" and stressed that each Community Health Board could play a variety of roles. Selecting appropriate roles is a policy decision to be made based on the Community Health Board's strengths and the needs and resources in the community.

Examples of roles in home care are case manager, broker of contracted home care services, consultant to other home care agencies, coordinator of long term care services in the community, advocate for quality care for all persons in need of home care, initiator of new services, alone or with others, and provider of direct services. A discussion of some of these roles is included in Exhibit 2. Within these roles, there could be many sub-roles. For example, within the role of service provider, a Board may elect to be a provider of comprehensive care, provider of acute care only, provider of maintenance care only, or "provider of last resort" for only those clients with no other funding source.

As in the case of public health problems, a Board may decide to select certain **priority roles** within home care. It will select these roles based on its assessment of community problems, the community's actual and potential resources, and its own organizational capacity (skills and resources) to conduct the activities it deems necessary.

For each role, the Board should consider the activities that would be involved, the resources required, and the skills and knowledge necessary to carry out the activity. (Part 6 contains some suggestions of resources, skills, and knowledge needed for various roles and activities.)

The grid in Exhibit 3 shows some possible roles of Community Health Boards in home care. For each role, some corresponding activities are shown, along with the resources and skills and experience necessary to carry out this activity.

For each role, the following questions should be considered:

- Does this role fit with our identified mission? (This includes both the overall mission of the organization and the goal in relation to home care.)
- Does this role fit with our statutory authority?
- Is it necessary for us to assume this role to assure the level of home care that we have decided is appropriate in our community?
- Is anyone else in the community assuming this role? If so, are they doing an adequate job? (The Community Health Board does not have ordinancing authority for home care, so it may not have access to this information. It can, as part of its community leadership function, informally monitor and encourage other providers to improve the quality of care they provide.)
- Are we the best organization to do this, given our knowledge of the community and our identified mission, or is there someone else who should be doing it?
- Do we have the capacity to fulfill this role within our organization -- that is, do we have sufficient funding, organizational structure, skills, and experience within our staff? If not, are we willing to commit the financial and other resources to attain this capacity? (For more on organizational capacity, see Part Six - Resources)
- If this is a new role for us, how will this change affect our sources of revenue? Will we lose reimbursement or gain additional revenues as we drop some activities and take on others?
- How will we evaluate our new activities?

Part Five
Considerations in Decision-Making

Issues, Options, and Factors

The issues that face Community Health Boards in care of the ill and disabled (home care) are complex and do not lend themselves to simple solutions. In addressing major home care issues, the Board must consider what options exist for making changes, what factors to consider in making the change, and what the effect will be on both its own home care program and on the entire CHS program. For example, if the Community Health Board is concerned with controlling costs for home care, it must look at what options it has to control costs (decrease service, change method of providing service, increase fees, etc.), and how each of these options will affect many factors: quality of care provided, the relationship with other providers, the staffing pattern, the quality of home care available in the community, and the overall mission and roles of the Board.

The following sections give an overview of some options for addressing home care issues and some factors to consider for each option. A case study is included to illustrate how the approach can be used to look at a specific issue.

This approach will not solve all the problems facing Community Health Boards in home care. Instead, it will give Community Health Boards a framework to help them carefully think through issues and make sound decisions.

For each issue, there are several possible alternatives, or **options** to consider.

- Increase services aimed at the identified problem.
- Decrease services aimed at identified problems.
- Make no change in current level or method of service.
- Discontinue services completely.
- Change the method of delivering services, including such methods as contracting for services, making changes in staffing patterns, or making administrative changes to increase revenue.
- Work with the community to find other ways of assuring services or addressing identified problem.

For each option, the Community Health Board must consider certain **factors.** These factors involve looking at the impact of decisions made on the community, the organization, and the clientele. Some factors are:

- What will be the effect on the overall health status of the community?
- What will be the effect on other CHS programs for which the Board is responsible? Will there be fewer or greater resources available for these programs as a result of the decision made?
- How will the decision made affect the quality of home care or long-term care services available in the community?
- How will the role of the Community Health Board in home care, as it is currently defined, be affected?
- What will be the effect on the staff level or pattern currently in place? Will more staff need to be hired, will current staff be reassigned, or will staff be reduced?
- What political considerations exist? Are there "powerful" groups in the community that will be upset or pleased by this change? What influence does this have on the decisions made?
- What effect will the decisions have on revenues? The Community Health Board may no longer be eligible for Medical Assistance or Medicare reimbursement if it no longer provides direct care.
- What will be the effect on overall costs as a result of the change, both to the home care program and to the CHS program? Can funds be found to cover any increase in costs?
- How will the decision affect the relationship with other organizations in the community? Will there be more cooperation, less cooperation, or no change in the relationship?

Although the options and factors to be considered may vary somewhat for each issue, the general pattern for addressing each issue remains the same. Many of the elements affected are the same for all the issues considered: costs, effect on mission and role of the organization, effect on quality of service available in the community.

Case Study: Bloom County Revisited

The following is a case study intended to illustrate how a hypothetical Board worked through the decision-making process for one issue using this approach. The use of this case study does not imply that every community Health Board would address this issue or reach these conclusions; rather, it provides an example of how to work through the process of making decisions

The background:
The Bloom County Community Health Board has traditionally had a strong, comprehensive home care program. The program has expanded steadily since 1965, when Medicare coverage for home care services began, and has grown even more with the expansion of Alternative Care Grant, Medical Assistance waiver programs, private insurance, and local tax dollars. Many of its programs have been developed in response to the problem of the elderly and other adults for chronic maintenance care. Additional problems are increasing numbers of children requiring in-home care and adults discharged from the local hospital in need of follow-up care.

The issue:
In the past three years, all these problems have consumed increasing amounts of staff time. In addition, Bloom CHS has received requests for more complex medical care in the home (often referred to as "high-tech care"), such as IVs, ventilator care, and kidney dialysis. The county does not currently have the staff time to respond to these referrals, nor does it have staff trained in these techniques.

Possible approaches (options)
The Director raised this issue at the Bloom County Community Health Board meeting, reminding the Board that the problem of caring for the ill and disabled at home was explored during the last community assessment process. At that time, community assessment had identified the problem of providing care in the community for persons with complex medical conditions. Based on the statistics on early hospital discharges, numbers in the target populations for home care, and on feedback from the Advisory Committee and other community groups that this was an important issue, the Board agreed that this was a priority problem. However, the Board also wanted to expand its role in community health promotion and its involvement in coordination with EMS based on findings from the community assessment. Therefore, it decided at the beginning of the budget year that it would "hold the line" on local tax dollars for home care services. The Board feared that this policy would actually result in decreases in services, as inflation increased the cost per unit of service and levy limits prohibited raising taxes. Thus, any major expansion of home care services had to come from state or federal funds or from client fees.

The Board asked the Director to work with the Community Health Advisory Committee to examine possible options for addressing the issue of increased demand for complex medical care in the home and to present recommendations at the next meeting. They stressed that they did not want to incur additional overall costs in the home care program, but wished to address this problem if they could do so within the current budget.

The Advisory Committee reviewed the CHS plan items relating to "problems of the ill and disabled." Although the community assessment identified a problem of increasingly complex conditions of clients who require home care, it did not contain specific objectives to address this problem. A survey conducted as part of the planning process indicated that several other providers in the community were delivering some of these services.

Staff presented, and the Advisory Committee addressed, several basic alternatives, or ***options*** *to addressing the problem of demand for complex medical care in the home: examine current agency structure to see if any efficiencies in program operation could be made that would allow service to be expanded without increasing costs, expand staff, contract for the service, coordinate with other organizations to ensure that the service was provided, or decide not to address the problem. The Committee proceeded to address these options one at a time.*

1. *Examine agency operations -* ***considerations/options*** *under agency operations included: examining sliding fee scale to see if it was equitable, yet generated enough revenue; examining fee collection procedures to see if more third party payments could be collected; examining staff structure to see if services could be delivered in a more efficient manner.*

   Discussion: *The Board had revised the agency sliding fee scale less than a year ago and felt it had resulted in more equitable assessment of fees to clients served. In looking at data provided by staff, they realized a large amount of fees assessed were uncollected. They estimated that devoting one-half a clerical person's time to collection of third party payments would increase revenue. The staff discussed with the committee how examining the case loads of staff and examining whether certain duties could be performed by roster nurses rather than staff public health nurses would reduce costs. The Advisory Committee was concerned about how this staff change might affect the comprehensiveness of the service provided in the home, but acknowledged that it was a possible way to reduce costs.*

2. *Expand staff -* ***considerations/options*** *under staff expansion included: What additional skills would be needed by staff to provide these services? Was current staff available to work extra hours or rotating hours? What would be the cost of providing the services? Would the increased revenue generated offset the cost? Was there sufficient volume to justify setting up a separate program component for complex medical care in the home? Another possibility was to limit provision of this complex medical care to only certain procedures -- for example, only IVs. Another consideration was whether directly allocating additional resources to provision of complex medical care was consistent with the mission and roles of the Board as a facilitator and organizer of a broad range of community health services. The Committee had considerable discussion about whether the Board wanted to extend its role as a direct provider of services, and whether its other roles would suffer as a result of that decision.*

Discussion: *the Committee decided that, in order to do more complex medical care in the home with new or existing staff, the staff would have to be extensively trained in IVs and other technical procedures. Also, the staff would have to be paid overtime if they worked hours in excess of the normal working week. Both of these would increase costs. Based on the community assessment conducted for the last plan cycle, the staff estimated that 5% of clients in addition to its current caseload would require complex medical care in the community. The demand was not steady, but seemed to go in unpredictable "waves." Most of the requests would have third-party reimbursement; however, a few would not. Based on the projected number of clients, on estimated third-party reimbursement, and on revenues from the sliding fee scale, staff estimated that the program would result in an additional 10% cost over its current home care budget.*

Current staff was not enthusiastic about working evening hours. Most valued the holistic, generalized nature of the home care more traditionally provided through public health and were not very interested in learning new technical procedures.

3. *Contract for service - the Committee identified the following* ***considerations/options*** *for contracting for home care services: was there a vendor in the area, either an organization or individual, who was qualified and willing to provide the complex medical care in the home and/or evening/weekend services? What would be the additional cost of contracting for these services? Would the public health emphasis on holistic health, on community nursing, and on families suffer as a result of contracting for this service? The Committee also discussed the other concerns (as described in Exhibit 2 of these guidelines) related to contracting.* ***Discussion:*** *the local hospital also had a home care program that provided follow-up care to patients discharged from the hospital. Staff members were also aware of two very small, private home care providers (2-3 staff) who provided home care around the clock. Concern was expressed that these two options did not embody the public health philosophy of client care, as their approach was more episodic and disease-focused than ongoing wellness and family-focused. Direct costs per visit were roughly the same as Bloom County's; however, there would also be some overhead costs involved in monitoring and administering the contract.*

4. *Coordination/Facilitation - the Committee identified the following possibilities for coordination: information and referral to other providers for complex medical care in the home and evening/weekend care (such as those mentioned above), discharge planning with the local hospital to ensure that the clients discharged in need of follow-up care received it, working with the local senior housing complex to encourage them to begin offering these services, and pooling resources with adjacent counties' public health home care programs to provide high tech care in several counties.* ***Considerations*** *in looking at coordination for services included: could the demand for high-tech care be met by encouraging another agency to provide such services without monetary exchange? Would another provider be able to cover the majority of clients in need of service, or would a significant number of clients "fall through the cracks" because of lack of financial resources or geographic distance? What could CHS staff offer in exchange for service provided by another organization, aside from monetary reimbursement? If the Board*

contracted or pooled resources with other counties, what would be the travel costs? Would there be a sufficient volume of clients to justify establishing this arrangement? Some of the questions discussed in considering increasing staff also arose in considering pooling with other counties.
Discussion: *the hospital home care program provides complex medical care for home care clients. The Committee discussed trying to strengthen discharge planning with the hospital so that clients in need of complex medical care in the community were assured of continuity of care after hospital discharge. The Committee acknowledged that some clients would be unable or unwilling to pay for services provided by the hospital's home care program, and lacked third party reimbursement. The Committee discussed working with the senior high-rise to encourage them to become a provider of complex medical care, but concluded that the program would be best used for maintenance care. However, they decided that they could conduct an inservice on using community resources for the high-rise's nursing staff to improve efficiency. The Committee also discussed the possibility of pooling funds and training with two adjacent counties for clients requiring complex medical care in order to increase the volume of cases, but maintaining the public health focus in services provided, but decided that there would not be sufficient volume of cases at this point to justify the increased travel, training, and liability.*

5. *Decide not to address the problem - the Committee explored the option of not addressing the demand for high-tech care.* ***Considerations*** *included the Board's philosophy that they were available to provide holistic care to the greatest number of people, not to only a few in high need, and to use a great deal of resources on a few clients did not fit with this philosophy. In addition, the Advisory Committee questions whether other program priorities, such as environmental health issues, better embodied the public health principle of primary preventing and "the greatest good for the greatest number."*
Discussion: *the Advisory Committee felt it needed to make some attempt to address the problem, as it had identified the problem of care of the ill and disabled in its CHS planning process and other agencies were not meeting all the need. However, it recognized that it could not afford to put a significant amount of resources into this problem at the expense of other programs.*

Advisory Committee Recommendations and Board Decision:
The following are two possible decisions the Community Health Board could have reached:

1. *No role in provision of complex medical care ("high-tech" care): Based on the considerations above, the Advisory Committee recommended to the Community Health Board that Bloom County implement the following internal changes: increase clerical time for fee collection, examine the caseload distribution using a case-mix type system, and further evaluate whether roster RNs could effectively be used to perform certain tasks. It also recommended that Bloom CHS coordinate with other providers for provision of complex medical care services provided in the home, but not contract or add staff time to provide these services. The rationale for this recommendation was that the Board could not afford to be a provider of last resort for this type of service, even on a limited basis, as this would drain resources from its other activities. It felt there were other providers in the*

community who could assume this role, and it was the role of the Community Health Board to encourage them, refer clients to them, and provide them with an assessment of unmet community needs to help them tailor their program.

The Bloom County Community Health Board reviewed this recommendation and approved it. The Board also recommended that staff encourage and offer technical assistance to the new high-rise to strengthen its role in provision of chronic maintenance care. The Board agreed that, by monitoring the need for complex medical care in the community, referring clients to private providers, and encouraging that program's growth, it would strengthen its role as a facilitator.

2. *Contract for complex medical care as a last resort: Based on all the considerations, the Advisory Committee recommended that Bloom CHS coordinate with other providers for provision of complex medical care services provided in the home, but not contract or add staff time to provide these services directly* ***unless*** *there was no other source of reimbursement for these services. In that case, Bloom CHS would enter into a contract with the hospital for certain specified "high-tech" nursing services. The Advisory Committee felt it was not within the scope of its role to become more directly involved in complex medical care in the community, unless there was no one else to take on the cases or no other source of reimbursement. It was also decided that most clients who need care had a reimbursement source that would cover this type of care.*

When the Board received the Committee's recommendations, it specified that the contract with the local hospital be a one-year pilot, with a total cost not to exceed $10,000 (Any revenue gained through sliding fee for these clients would be applied to this project to reduce total costs). After the one-year period, an evaluation of the program would take place to determine if the contract should continue. The Board's decision expressed the philosophy that the Community Health Board is available as a "safety net" for those with no other reimbursement source, but is not a ***competitor*** *in the complex medical care (high-tech) market. The Board reviewed the Advisory Committee's report and recommendations and agreed that, although this solution would not meet the needs of all the target population, it was the best approach for the present.*

Note: For the purpose of illustration, the decision made by Bloom County Community Health Board is less important than the process they used to make the decision. The Board, through its staff and Advisory Committee, examined possible alternatives and the probable effects of each alternative on target home care clients, the home care program, and the overall CHS program. Through this decision-making process, it strengthened its role as a facilitator and coordinator of services and stabilized its role as a provider of maintenance services. This will make it easier to deal with system issues in the future and strengthens the role of the Board as a leader, not only a provider, in this field.

Although the problem the Board faced was considered in a general way in the process of developing the CHS plan, they dealt with the specific decision at a later time, when the Board and community were more ready to examine the issue. They used data collected as a part of the community assessment process and utilized Advisory Committee participation. The process they used could be used for other home care issues as well.

In reaching the decision to coordinate and, in one case, pay for complex medical care services in the home, but not to provide them directly, the Board acknowledged that there would still be an unmet need in the community. By thoroughly considering the

issue of when provision of complex medical care becomes a public health responsibility, the Board, Advisory Committee, and staff were able to articulate and reach some consensus on the Community Health Board's overall role in the community.

Part Six
Resources

Community Health Boards have several resources available to them to address home care issues. The major resources available to the Community Health Board are statutory authority, leadership, funding, and technical assistance. It is important to recognize these resources, because they can be used as effective tools in accomplishing the Boards goals.

Statutory Authority and Leadership

Community Health Boards have the statutory authority for assessment, policy-setting, assurance, and evaluation under the Local Public Health Act. They are probably the only organization in the community with the authority, interest, and ability to do this. All of these roles are necessary to assure and maintain a coordinated home care (and community based care) system within their communities. Because of its involvement in other CHS program categories (health promotion, emergency medical services, environmental health, disease prevention and control, and family health), the Board has the opportunity in the process of addressing home care to address other public health problems as well.

Thus, the Community Health Board should have a leadership role in planning for and coordinating the long term care system, especially as it relates to home health care. This leadership role should consist of the following:

- assessment, planning, and systems management of the long term care system;
- developing policies in relation to home care;
- assuring that quality home care services are available; and
- evaluating the effectiveness of home health care service in relation to the long term care system and the CHS system.

Leadership does not imply that CHS should assume responsibility for the entire long term care system, nor does it assume that CHS is **necessarily** a provider of home care services. However, if the Community Health Board is truly a leader in the long-term care system, other organizations will turn to it for advice or use it as a resource for defining problems and opportunities and deciding on <u>community</u> actions that can lead to improvements. An effective leadership role grows over time and is based on past credibility, professional relationships with other community leaders, and the expectation that the leader can provide useful assistance.

While the Community Health Board has the authority to ordinance for some public health activities (such as nuisance control), the authority to license home care activities now exists at the state and federal levels. Thus, the Board does not completely control the quality of services available in the community. If it is an

effective leader, however, it can provide advice and an example to other providers above regulatory requirements. In fact, being free of the burden of regulatory duties can actually enhance the Board's ability to develop quality assurance and enhancement activities.

Provision of direct service is one way, but not the only way, the Community Health Board has to assure that home care services are available in the community. Assurance can also consist of monitoring existing programs or working with other organizations to develop new programs. The goal of assurance is to meet priority needs, regardless of who the providers are. However, if there are no other organizations able or willing to provide the service deemed necessary by the Board, the Board may decide to become (or remain) a service provider in order to assure availability of service. The Board can then set the standard by example for other home care providers above and beyond any regulatory requirements.

Many different people have leadership roles in the CHS system. Some of these are:

The Community Health Board - The Board should exercise leadership and vision to reconcile the demands for home care with its overall roles in CHS. The Board is ultimately accountable for all of the leadership roles defined above, but it implements those roles through its staff and with guidance from the Community Health Advisory Committee and other groups it charges with these responsibilities.

Community Health Advisory Committee - An Advisory Committee that adequately represents the key elements of the community can bring the interests of CHS and other organizations into a coordinated focus. This focus can help use resources effectively, and increase the chance that all organizations are working together for community benefit. If the committee is representative of the entire community, its advice can help offset narrow political pressure to make decisions based on special interests. The Advisory Committee can be a valuable resource for community assessment, program development, and evaluation. If the Advisory Committee is not effective or representative, the feedback the Community Health Board receives will be based on more narrow interests or tend to reflect primarily the populations currently being served. More suggestions on appropriate ways to work with Advisory Committees will be included in the administrative guidelines currently being developed by the SCHSAC Administration Work Group.

Additional community participation takes place through a long-term care task force or other special task force. However, for the advice given by such groups to be considered in the context of other public health problems, such policy advice should be given to the Community Health Advisory Committee rather than to the Board or to staff.

Staff - CHS Administrators, Nursing Directors, and other management and supervisory staff are also challenged to help separate the community health forest from the many varieties of home care trees. If the Board is involved in the direct or contracted provision of home care, the staff's roles, responsibilities, and skills required will be very different than if it is a coordinator of services.

Whatever the Board's role in home care, the staff involved should have the skills necessary to carry out that role in the most effective and efficient manner to assure high quality service and administration. This can be accomplished through the

structure employed for assigning staff work load/case load, policies for staff orientation, training, and quality assurance review, and fiscal management that maximizes reimbursement. (For more suggestions on program efficiency, see Exhibit 8, a summary of "Stretching the Home Care Dollar".)

The staff person responsible for the home care program should have skills in the following areas: planning, evaluation, community organization, communications, facilitating the public decision-making process, financial management, and supervision. He/she should also have education and experience in public health. If the Board provides direct home health service or contracts for home health service, the direct supervisor of that program should have a baccalaureate degree in nursing with a PHN certificate, with experience in home health care.

Staff structure also affects the effectiveness and efficiency of service delivery. In considering the activities that need to be accomplished for the desired role, the Board must decide on the best mix of staff for each activity. For example, many Community Health Boards have found that their reimbursement is maximized if they have someone other than the staff nurse in charge of fee collections, as long as the client is not a vulnerable adult. Some Boards have used supervised paraprofessional staff or technical staff (LPNs, RNs) to perform certain technical tasks. This strategy may be a good way to increase efficiency. However, it is important to look again at the overall role of the organization in providing public health services and how staff skills and background fit into this structure.

Some examples of ways to maintain staff competence may include the following:

- ongoing inservice training on technical or administrative issues;
- participation in relevant outside workshops and membership in professional associations;
- ongoing discussions with staff on the mission, roles, and direction of the agency;
- a system of record review; and
- a system of levels of care to distribute case load equitably.

The staff qualifications required will depend on the role of the Community Health Board and the activities it decides to assume. The grid in Exhibit 3 gives some examples of the staff activities that correspond to various roles, and the various skills needed to accomplish each activity. If a Board decides to assume a certain role, it has the responsibility to hire and retain staff to carry out the activities that fit that role. It is also responsible for assuring that the staff is trained and supervised to carry out the activities it decides to undertake.

Finally, staff members should be given opportunities to participate in discussions about how home care fits with the entire mission and role of community health services in the community. Understanding of this broader perspective can help staff perform more effectively as they represent the Board in the community.

Other leadership considerations:
In the *Systems Description and Issues Report*, home care and long term care are described as non-systems. Strategies of community organization can be very useful in better coordinating a long-term care system. The model described in the SCHSAC Health Promotion Guidelines[9] can be used with both new and existing groups, with linkages to the Community Health Board and Advisory Committee. Although the Health Promotion Guidelines address chronic disease prevention, the principles and process of community organization apply to home care as well. This approach will help strengthen the Community Health Board's role as a leader in the long term care system, and help dispel the notion that the Board is solely responsible for long term care.

Funding [10]

As described in the *Systems Description and Issues Report*, there are many sources of funding available for home care from all levels of government as well as the private sector. Community Health Boards can and should seek funding from a variety of sources to support home care in their communities. However, they should be aware that all funding sources have strings attached -- local cost-sharing, increased regulations, or other restrictions -- and may add to administrative cost.

The Community Health Board should decide what services it wishes to provide based on the results of community assessment and priority-setting, not only on what funding is available. Even so, funding, and the regulation that accompanies it, cannot help but influence what services are provided in the community and who provides them. Although the Board may be committed to addressing the problem of the need to care for ill and disabled persons in the least restrictive environment, the extent of its role in home care will depend in part on available funding. As reimbursement for direct services fails to keep pace with escalating costs, the Board is forced to decide between offering fewer services, increasing fees, or increasing local expenditures for home care.

Both Community Health Boards and MDH have an interest in a strong home care system. However, as discussed in the Systems Description and Issues Report, reimbursement is primarily available for direct nursing, home health aide, and ancillary services -- what tends to be hands-on, primary care. Reimbursement is usually less available for health promotion in the home, case management, coordination, and community assessment, and system development.

The CHS subsidy is one exception. The CHS subsidy is intended to support the general purpose of the Community Health Board, which is "to develop and maintain an integrated system of community health services..." (145A.09, Subd 1) Conducting planning and community assessment and coordinating services are specific responsibilities of the Board and are appropriate uses of the CHS subsidy.

Changes in the health care system have increased Community Health Boards' responsibility for community assessment, planning for community-based care systems and, in some cases, for service delivery. Yet the subsidy, the primary funder of these activities, has not increased in proportion to these demands, although overall

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[9] *A Guide for Promoting Health in Minnesota: A Community Approach*

[10] For a discussion of issues related to funding see the *Systems Description and Issues Report* in Exhibit 4.

expenditures have risen. In 1988, less than 4% of home care expenditures was in subsidy dollars. CHS reporting data show that expenditures for home health care have increased substantially in the past several years. In 1984, Community Health Boards reported $19,060,326 in expenditures for home health care. Of this, almost $17 million, or 89%, was in local taxes, Medicare, Medical Assistance, and other local sources. In 1988, Community Health Boards reported $41,902,427 in expenditures for home health care. Of this amount, $35,460,800, or 85%, was in expenditures from local taxes, Medicare, Medical Assistance, fees, and other local sources. Of this amount, $7,942,597 was local tax levy.

Although changes in the reporting system do not allow a direct comparison of changes in local tax levies used for home care before 1988, two general observations can be made. One is that expenditures for home health care overall have increased significantly since 1984. The second is that this increase has not been in subsidy dollars, as the home health expenditures from the CHS subsidy increased only minimally from 1984 - 1988 (from $1,366,652 to $1,596,461. Major increases in expenditures appear to be in local and federal funds and such funds as the Medical Assistance Waiver programs.[11]

If community health services are intended to provide an infrastructure for planning and coordination of home care and other services, Community Health Boards and MDH should continue to work for increases in funding for this infrastructure. They should also encourage development or expansion of other funding sources to cover both systems planning activities for home care and the non-medical, health promotion aspects of care provided in the home. In addition, Community Health Boards and MDH should work with other state agencies, especially the Department of Human Services, toward a more comprehensive strategy of funding for long term care. This strategy could include considering how existing home care and other community-based and institutional long-term care should best be funded and administered at the state level, as well as working toward increases in funding.

The Community Health Board must assure that "access to community health services provided by or on contract with the board of health must not be denied to an individual or family because of inability to pay. (145A.04, Subd.4) However, this does not mean that a Board must provide any services at no charge to anyone who asks for them. The Board has the right (and the clear responsibility) to target its resources to address community health problems most effectively. Community Health Boards may address this by implementing a sliding fee scale, setting a cap on the amount of service it provides to any one family or individual, or by limiting the range of hours or type of service it offers.

Technical Assistance

Technical assistance is available from MDH on several facets of home care. The Community Health Services Division of MDH develops a department-wide plan and publishes a calendar of administrative and program support activities based on review of the CHS plans. Through its district office staff (public health nurse consultants and district representatives), the Division also provides assistance in plan development. The public health nurse consultants can also advise local staff about use of formulas

[11] *Community Health Services in Minnesota: An Addendum to the Report to the 1989 Legislature*

to assess need for home care, work through decision-making issues with staff and provide assistance with other administration and leadership issues, or refer these questions to other MDH staff. The district representatives can provide assistance on CHS plan reviews, budget preparation, and provide fiscal, administrative and planning assistance in development of plans, reports, and fiscal data as these relate to home care. The feedback CHS staff provide to the consultants is used in planning administrative and program support.

The MDH Health Resources Division will assist with such areas as home care licensure, how services are regulated, and Medicare regulations.

Technical assistance in other aspects of home care may be available from the Department of Human Services' Long Term Care Management (LTCM) Division.[12] As discussed in other sections of these guidelines, many aspects of home care are changing rapidly. A current knowledge and skill base is very important, especially for those providing and managing direct services. To this end, membership in professional associations and continuing education, to the extent necessary to retain competence in the field, are strongly recommended.

In addition to the completed Home Care Guidelines, the following written publications may be helpful:

- *1989 Community Health Services Planning and Reporting Manual*
- *APEX/PH Assessment Protocol for Excellence In Public Health* (to be published in early 1991)
- *1981 Community Health Services Home Care Guidelines*
- *National League of Nursing Administrator's Handbook for Community Health and Home Care, 1988*
- *Stretching the Home Care Dollar*: a six state survey of home care cost-containment strategies (consult MDH Public Health Nurse Consultants for results of this unpublished study)*
- *The Future of Public Health*, published by the Institute of Medicine, 1989
- *A Guide for Promoting Health in Minnesota: A Community Approach*. Minnesota Department of Health, January 1988.

* Portions of these materials are included in the Exhibits.

[12]The Home and Community Care Section of the LTCM Division provides technical assistance to all providers regarding Medical Assistance Home Care, personal care, private duty nursing,the Children's Home Care Option (TEFRA), and the waiver programs (ACG, CAC, CADI). A new worker orientation for these programs is held twice a year, as well as various other inservice programs.

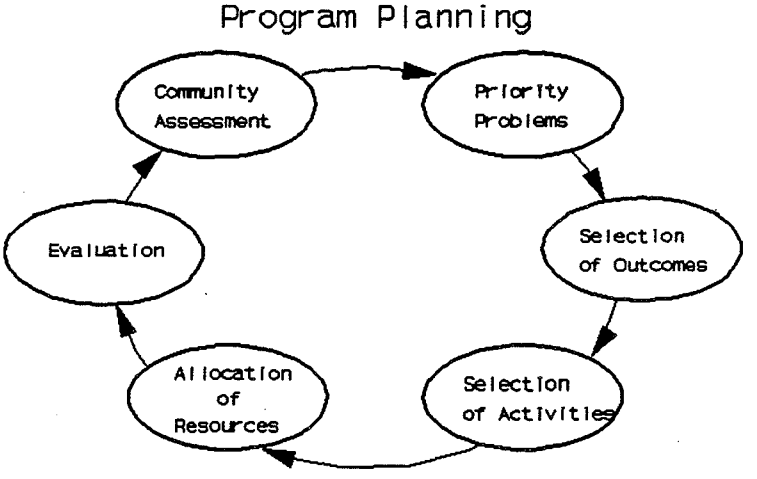
Technical assistance in the form of case management is also available through the Home and Community Care Section of DHS. Regional case management services specialists are under contract with DHS to provide case management to persons with traumatic brain injury and to other persons who receive Medical assistance home care. The CHS/PHN staff may consult with these specialists regarding difficult cases and regarding the coordination of care plans for persons with traumatic brain injury and other Medical Assistance home care clients.

The DHS Division for persons with Developmental Disabilities (DD) provides technical assistance for the MR waiver programs and other services for the DD population (e.g., family subsidy).

Regional case management services specialists are under contract with DHS to provide case management to persons with traumatic brain injury and to other persons who receive Medical assistance home care. The CHS/PHN staff may consult with these specialists regarding difficult cases and regarding the coordination of care plans for persons with traumatic brain injury and other Medical Assistance home care clients.

Part Seven
Evaluation - An End and A Beginning

Evaluation is a way to 1) measure whether program decisions and changes were effective and 2) incorporate changes into the planning process. Thus, evaluation completes the cycle of program planning, as illustrated below:



For evaluation to be effective, goals and outcome criteria must be established with which to evaluate the effect of decisions made in home care. When looking at decisions, the Board should make sure these decisions can be objectively evaluated. Some general factors to consider in evaluating decisions are:

1. Who will use the information from the evaluation? Decision-makers or staff who implement the program?

2. Have ways to collect and analyze data been developed before program changes are made?

3. Will the evaluation conducted be an evaluation of what was done (process), or what the short-term (bridging) or long term (outcome) results were?[13] For example, a process evaluation question might evaluate how many nursing visits to chronically ill patients were conducted, a bridging evaluation question might

[13] From the workshop, "Dispelling the Myths: Program Evaluation is Possible", conducted by the MDH Section of Public Health Nursing. The material on evaluation presented in the workshop will be incorporated into the 1990 CHS Planning and Reporting Manual.

evaluate whether those visits saved money or changed client behavior, and an outcome evaluation question might evaluate whether morbidity and/or mortality was reduced.

4. How will any improvements made be incorporated into next CHS planning process? How will changes be made in day-to-day program operation?

One way to evaluate the outcome of decisions made is to ask whether what you thought would happen, did happen. To do this, it may help to look at the factors considered in making the decision (see Part 5). For example, what was the effect on the overall health status of the community? What was the effect on other CHS programs for which the Board is responsible? How was the role of the Community Health Board in home care affected?

MDH also has a role in evaluating the effectiveness of home care systems, through either monitoring number of visits or assessing the effect of CHS' involvement in the health care system. The statewide evaluation process is one way of evaluating various aspects of home care that could be considered in the future.

Exhibits

The Mission of Community Health Services

The Mission	...The purpose or aim, based on shared values, that motivates and guides future action;
of Community Health Services	...State and local activities designed to protect and promote the health of the general population by emphasizing the prevention of disease, injury, disability, and preventable death through assessment and the promotion of effective coordination and use of community resources, and by extending health services into the community;
is to bring people together	...To develop a system of cooperative partnerships, based on mutual respect, involving professionals, representatives of the community and of state and local government;
to create a healthy future	...To assure that all individuals have the opportunity to achieve and maintain their best level of health and independence, and lead vital, productive lives;
for all Minnesotans.	...All persons on the basis of need. No one shall be denied services because of race, color, gender, age, national origin, religion, sexual orientation, political persuasion, physical or mental ability, ability to pay, or place of residence.

Exhibit 1

Exhibit 2

Possible Community Health Board Roles in Home Care

Contracting Role*

One option for interaction with other providers that has received a great deal of attention involves contracting for home health care services.[14] Boards have explored this option for a variety of reasons: as a way to try to reduce costs, to provide a type of service for which they do not have the expertise or staffing pattern within their own organization, or to help maintain financial stability of other organizations in the community, such as the local hospital. Although many Boards have experimented with contracting for part or all of home care services, data on the effectiveness of contracting in meeting these objectives is not conclusive.

The Board should consider and agree on its major objectives in contracting before the contract is established. This will provide criteria to gauge whether the contract is operating successfully. The main reason to contract may not be to save money. It may be, for example, to ensure a level of care that is not within the Community Health Board's expertise, but that it feels is necessary to have available in the community.

In contracting for home care services, the Board should consider what the effect will be on the elements identified above (overall health status, other roles of the community health board, cost, staff level/pattern, etc.). Whether it provides the service directly or through a contract, the Board has a responsibility to ensure accessible, quality care if it is paying for the service.

Some specific questions that should be asked when considering contracting (and **before** a vendor is selected) are:

1. **Services to be contracted** - Some possibilities are (a) contracting for the entire home care program, including assessment, professional and paraprofessional levels of care, and case management (b) continuing to provide assessment and case management functions, but contracting for the follow-up nursing visits and paraprofessional services, (c) contracting for high-tech professional services only, or (d) contracting for services beyond "normal" working hours, such as evenings and weekends, and (e) contracting for paraprofessional services only. This decision will affect both the cost of the contract and the amount of control the Board retains. In general, the more complex and higher risk the service contracted, the more complex the contract must be.

2. **Type of vendor** - Will the Board contract with individuals or with other organizations? Contract administration and liability will be different depending on the type of vendor selected. The Board should include in the contract its specific expectations for the level and quality of care to be provided. There will also be procedural issues that need to be discussed, such as submitting bills, patient documentation, etc.

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[14] Contracting with the private sector, or "privatization", was a popular concept in the 1980s. For a fuller discussion of the issues involved in privatization (not an endorsement by the Subcommittee), see Exhibit 8, "The Two Different Concepts of Privatization." The article also discusses the public sector as a vendor, an idea not fully explored here.

3. **Cost** - Is contracting as, or more, cost-effective than providing services directly? How will cost-effectiveness be measured? If contracting is not as cost-effective, is the Board willing to incur the additional cost? (The Community Health Board may no longer be eligible for Medical Assistance or Medicare reimbursement if it no longer provides direct care.) What is the method to be used for monitoring costs? (Especially when initially entering into a contract, it may be difficult for potential vendors to estimate the true cost of providing services. Also, start-up costs are different from ongoing program costs.) What will be the effect on the CHS program if the vendor discontinues providing home care service?

   An important consideration in evaluating cost is what is being purchased. If strictly hands-on care is being purchased, the cost should be less than if a more comprehensive service that involves teaching of patient and family and coordination of community resources, similar to that provided by a public health nurse, is being purchased.

4. **Quality** - Is the care provided by the vendor of acceptable quality? Medicare and licensure rules (when completed) will help assure minimal quality; however, the Board can, by contract, set the parameters of quality it deems acceptable.

5. **Quantity** - Is the quantity of service provided by the contracted provider acceptable? Is there a minimum time length for each visit? What is the vendor's geographic scope of services?

6. **Monitoring and supervision** - What monitoring and supervision needs to take place? What staff will be responsible for monitoring? What are the costs of monitoring the contract, and how will this add to the total cost of the contract? In general, the more complex the contract, the more monitoring and supervision will be required.

7. **Legal Ramifications** - What liability issues exist in a contract? When a contract exists, the Board is still liable for the services provided even though its staff is not providing services directly. Liability for services cannot be contracted away.

   Are there antitrust concerns to be addressed when selecting a provider? The Board should consult with its attorney to ensure that antitrust laws are not being violated when selecting a vendor.[15]

   Other legal issues include workers' compensation, unemployment, and malpractice. The Board should contact its attorney when developing contracts to ensure that these issues are addressed.

8. **Administrative issues** - how will the selection of a vendor be made -- request for proposals, single source contract, or some other means? How often should the contract be renewed? Will the process be opened up in the future, or will the Board stay with one vendor indefinitely?

* MDH is currently developing a file of sample home care contracts that will be available for Community Health Board review.

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[15] See Chapter IV of Morrison County Public Health Services' *Risk Taking in Joint Ventures*

Case Manager Role

Case management is defined as "a process by which a home care client receives coordinated delivery of the range of services he or she requires through a process of assessment, coordination of resources, quality assurance, and monitoring cost effectiveness. Services are arranged using a team approach, with involvement of the public health nurse, client, client's family, and often a physician or other professionals."[16] The goals of case management are "to facilitate access to a complete continuum of care, ranging from home care to institutional care; to facilitate choice of the most appropriate service alternatives for the client's and family's unique conditions and concerns; to ensure the coordinated delivery of services to each client and family; and to ensure periodic review of the appropriateness of the service being provided."[17]

As the numbers of providers and components of care continue to expand, case management becomes increasingly important to link clients with the services they require and maintain continuity of care. Even when the Community Health Board is a provider of direct service, clients may move in and out of the public health system and be served by other home care providers as well as other organizations.

Some specific questions for Community Health Boards to consider in their role as case manager include:

1. **Separation of Case Management from Service Delivery** - Is it possible to have some separation of case managers from service deliverers? This can be accomplished either by the services being provided through another agency from where the case management takes place, or by having different staff do direct services and case management. Sometimes this is difficult, especially with a small staff or few other service providers; however, it helps ensure better quality of care and avoids conflict of interest.

2. **Awareness of services and resources** - Is the case manager aware of all the services the client is receiving from other providers? Is the case manager kept up to date on the services available in the community so he/she can best access appropriate services for the client?

3. **Goal of Case Management** - What is the goal of case management for home care clients, and is that the most appropriate goal for every client population? For example, is the goal of case management to act as "gatekeeper" to control overall costs, to monitor quality of care, or to advocate for additional services? Are all staff involved in a case in agreement on what the case manager's goal is?

4. **Case Management and Contracting** - If the Board has or is considering a contract, is the case management service contracted out? In general, contracting for case management gives the Board less influence on the services provided (see "Contracting" above).

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[16] *1989 Home Care Subcommittee Systems Description and Issues Report*

[17] *Community Health Services Home Care Guidelines*, February 1981

Coordinating/Facilitating/Catalyst Roles

Community Health Boards may be involved in coordinating and facilitating resources for home care whether or not they are a provider of services. This coordination can occur at several levels. Coordination can occur at the **client/family** level (to make services available to individual clients) in what is commonly seen as a part of case management. Systems coordination can occur at the **community** level (to put **systems** in place that will better address problems related to the care of the ill and disabled in a community-based environment). On a third level, Community Health Boards would be involved in coordination of the entire acute and long-term care system, not only as it affects home care. This third area is one that may be a larger role for Community Health Boards in the future. In these guidelines, we assume that public health nurses coordinate resources at the client level to address individual problems; the comments here are primarily directed to coordination at the **community** level. By working with other organizations to address community problems, the Community Health Board assumes the role of **catalyst**; that is, it stimulates community change through others.

Ways to coordinate/facilitate/act as a catalyst:

There are many ways the Community Health Board can coordinate or facilitate community resources to assure a more integrated home care system. Examples are:

- Making available and promoting guidelines or standards for quality home care or other alternative care;
- Sharing results of community assessment to let other organizations know about opportunities to develop appropriate new services;
- Providing training to staff of other agencies to teach them new skills, assist with problem-solving on difficult cases, or inform them of community resources;
- Referring clients to other providers;
- Developing coalitions to get new services going or otherwise address public health problems;
- Supporting or working with legislators to introduce legislation to support alternatives to nursing home care;
- Referring clients to other programs;
- Helping other organizations obtain grants for new programs;
- Setting a standard for high quality, comprehensive home care (if the Board is a provider of or contractor for home care services);
- Assisting in development of a network or support system for informal care-givers, such as volunteers or family members;
- An obvious strategy, but an important one, is meeting face to face with providers and planners from other organizations to discuss common problems and possible solutions.

Some questions to consider in facilitating or coordinating home care systems and services are:

1. What are the strengths of your organization - what do you have to offer others? Typical strengths might be emphasis within home care that treats the person, not the disease, knowledge of regulatory systems, and knowledge of community resources.

2. What are the advantages and disadvantages of coordinating/facilitating over working alone? An obvious advantage might be more "bang for the buck"; a disadvantage is the additional time and effort required and the potential "turf" battles.

3. How can you best reduce or eliminate duplication and fill gaps in service?

4. Which staff are involved in coordination of community resources? For example, is this the responsibility of the PHN Director, of all public health nurses who provide home care, or of the CHS Administrator? What is the mechanism for sharing his/her efforts with the rest of the staff, the Board, and the Advisory Committee?

5. How structured will this coordination be? Much coordination may be based on verbal agreement; some time-consuming or controversial efforts may require written memorandums of understanding signed by the Chair of the Board.

6. How are other organizations involved in the development of the community health plan? What other organizations should be involved? Some other organizations responsible for planning for home care services are: the county social services agency, the area agency on aging, the school district (both community education and the Interagency Early Intervention Committee), city planning departments, county extension, and the EMS Regional Project. It may be possible to conduct joint community meetings to gather input, share data, and even develop mutual goals and objectives with those organizations that are responsible for planning and whose problem areas and target populations intersect. (It is important to contact these organizations early, as planning cycles vary.)

Direct Service Provider Role

The role of direct service provider is perhaps the most common role of Community Health Boards in home care. As discussed in the *Home Care Subcommittee Systems Description and Issues Report,* Community Health Boards have historically been providers of home care through their public health nursing services. There are now other providers of home care in many parts of the state. However, these providers may not provide the level or range of service deemed necessary by Community Health Boards; thus, most Community Health Boards continue to be involved in some level of service delivery.

Involvement in direct service involves an additional set of administrative duties for Boards and their staff. At the same time, providing direct service has the advantages of bringing in revenue to the agency, providing a visible service, and potentially creating a valuable link with the medical community. Questions that should be considered by a Community Health Board in direct provision of home care are:

- What type or level of service is provided by others in the community? (This will help us determine what unmet needs exist that we should address.)

- What level of care will we provide (Where will our services fall on a continuum of acute to maintenance care)? How will this decision be made? (see Part Five, Considerations in Decision-Making, of the guidelines)

- What is our philosophy of home health care?

- Where do we see ourselves in relation to other providers - as a provider of a comprehensive range of services, as a competitor for full pay clients, or as a provider of last resort?

- To what extent can we afford to continue to be involved in direct provision of home care, given increased regulation and resulting administrative costs? Given the "social mandate" that exists in many parts of the state, can we afford not to be involved?

- What method will we use for assuring quality care?

- Do we make a financial "profit" by being a home care provider, or do we lose money due to increased administrative costs incurred to meet regulatory requirements?

- **Why** are we providing home care as we currently are? Possible reasons could be because of history, because we provide it better than anyone else, because there is no other provider, because of the revenue it generates, or because it provides a gateway to other public health activities?

- If we provide direct home care services, how can we structure our operations to ensure the most cost-efficient program possible? (Possible areas to consider are pooling with other counties for provision of certain services, billing system, staff orientation and training procedures, fee schedules, staff structure and case load distribution, quality assurance methods, and client record-keeping.)

Grid of Potential CHS Roles in Home Care

In making decisions about Home Care, every Community will be faced with a different set of circumstances and will have a differing set of options. Consequently, each Board may define its role differently. Some Boards will define their role in general terms (i.e. assessment, assurance, and policy development), while other Boards will define their role in terms of specific activities. The following grid provides one approach for defining possible roles, and uses different terminology and a different organizational framework than other sections of these guidelines. This diversity is intentional and is meant to provide a variety of techniques for defining roles. Each Board is encouraged to develop and adapt its own framework to be used for its unique needs in defining its role in Home Care.

For each role, some corresponding activities are shown, along with the resources and skills and experience necessary to carry out this activity. For each role, a number of questions should be considered. A sample set of questions are included in the guidelines on page 14.

Statutory Role	Activities	Indicators of Capacity
Community Assessment and Priority Setting (Required by Statute)	Inventory of community-based care services and resources. Review health status data for target populations. Evaluate quality/scope of service available. Meet with key community leaders to discuss problems related to care of ill and disabled. Review demand forecasting formulas.	Knowledge of community resources. Awareness of effective interventions. Knowledge of Public Health Principles.

Exhibit 3

Grid of Potential CHS Roles in Home Care

Potential Role	Activities	Indicators of Capacity
Assurance: Service Coordination	Survey available funding sources. Develop or compile home health care standards. Share results of community assessment with potential or current service providers. Maintain a data base of services available through home care providers. Conduct outreach to other home care agencies in area. Conduct ongoing discussion, assessment, planning and evaluation. Perform case management. Fill gaps in home health care activities. Continually evaluate services available in the community and means of accessing those services. Link providers of services. Reduce duplication. Publicize community services. Link clients to services.	Knowledge of community (as a place, people, and social system). Communications skills. Team building skills. Awareness of community resources. Negotiating skills.

Grid of Potential CHS Roles in Home Care

Potential Role	Activities	Indicators of Capacity
Assurance: Foster Development of New Services	Provide community assessment data. Quantify target population. Help publicize services. Refer clients. Provide startup funds. Assist in developing support system for informal caregivers.	Community Assessment Skills. Data Analysis. Knowledge of Public Health Data. Public Relations Skills. Connections with influential people in the community. Credibility with client population. Availability of startup funds.
Assurance: Broker/Contract Manager	Develop contracts. Monitor all aspects of contracts. Conduct initial assessment. Develop care plan. Periodic reassessment.	Management Skills. Knowledge of potential vendors.
Assurance: Consultant to Other Home Care Agencies or Providers of Community-based Care	Share expertise in public health philosophy of home care. Assist in developing or accessing standards for high-quality services.	Staff expertise in public health philosophy. Respect from other home care providers. "Expert" status regarding home care.

Grid of Potential CHS Roles in Home Care

Potential Role	Activities	Indicators of Capacity
Assurance: Provider of Direct Services	Conduct assessment/follow-up. Provide direct client care. Maintain client records. Hire/orient/supervise para-professionals. Case management. Conduct client evaluation. Develop parameters of service.	Staff expertise in direct provision of home care. Oral communications skills. Teaching skills. Supervisory skills. Hi-tech skills. Component of well-trained paraprofessional and therapy staff. Access to adequate medical supplies and equipment. Up-to-date policies and procedures.

Grid of Potential CHS Roles in Home Care

Potential Role	Activities	Indicators of Capacity
Acute Care Provider	Conduct Assessment, Case Management. Perform complex medical care procedures e.g. I.V.'s/Oxygen. Maintain client records. Process doctors orders.	Skills in provision of complex medical care. Availability of ongoing staff in service. Access to appropriate equipment.
Maintenance Care Provider	Conduct assessment. Conduct case management. Conduct periodic reassessment. Maintain client records. Conduct health promotion for clients and families.	Family-based philosophy of community health home care. Well-trained paraprofessional staff. Secure funding base.
Provider of Last Resort	Provide care to families that cannot be served by another agency.	Knowledge of other providers. Focused mission statement. Adequate funding base to cover indigent care or difficult cases.
Comprehensive Provider	Case management. Fill gaps in home health care activities. Provide a wide range of home care services for families referred to agency.	Full component of nursing, ancillary, and paraprofessional staff. Staff with broad training in public health. Secure funding base. Clear mission statement.

Exhibit 4

State CHS Advisory Committee

Home Care Subcommittee

Systems Description and Issues Report

September 25, 1989

TABLE OF CONTENTS

Introduction

"Planning without action is useless; but action without planning is futile." [1]

Home care has been a cornerstone of Community Health Services and public health for many years. The Local Public Health Act defines home health care, as "activities intended to reduce the ill effects and complications of existing disease and to provide suitable alternatives to inpatient care in a health facility. These activities include the coordination or provision of health assessment, nursing care, education, counseling, nutrition services, delegated medical and ancillary services, case management, referral and follow-up." (Minn. Stat. 145A.02, Subd 14) This definition includes only part of the range of services (mostly those that are health-related) necessary to keep individuals in their own homes. Home care can also include health, social, and support services designed to foster a continuum of care. A package of services tailored to the needs of the individual and family are planned, coordinated, and made available by providers organized for the delivery of home care. Public health nursing services and Community Health Boards have developed sophisticated systems of care to enable elderly, disabled, and other individuals to remain at home independently. However, several changes have taken place in recent years within the home care system and the Community Health system. A few examples of the changes are:

* large numbers of acute care cases are being treated in the home as well as the more traditional chronic care cases;

* complicated distinctions are made in reimbursement between health and other home care services;

* many more providers are delivering home care services;

* the legislature has required licensure of home care agencies;

* preadmission screening programs and alternative care grants have been instituted; and

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[1] Chuck Nelson, Centers for Disease Control, at a recent Minnesota Cancer Prevention Conference.

* the demand for home care services continues to grow.

All of these changes suggest the need to examine the role of the CHS system in relation to home care.

In 1989, the State CHS Advisory Committee decided to address the issue of home care in its 1989 Work Plan. As described in the 1989 SCHSAC Workplan, the review was to be aimed at "revising, updating, and focusing the 1981 Home Care Guidelines to reflect current home care systems issues - in particular, how home care fits into the overall community health system and the intent of the Local Public Health Act." The Subcommittee's products are expected to be:

> "1. A description of the existing home care system and its relation to home care and other statutory CHS program responsibilities and activities under the Local Public Health Act, along with a clear identification of issues related to the current home care system;
>
> 2. A revised and condensed set of guidelines for boards to use in both identifying the Community Health Board's role in planning, coordinating, and improving home care systems issues as those issues relate to the broader responsibilities of the Board, and;
>
> 3. A list of recommended actions for the Commissioner to take in order to encourage and support the development of home care systems consistent with the revised Guidelines."

To accomplish these objectives, a fifteen-member subcommittee was established representing SCHSAC members and alternates throughout the state. The Subcommittee's goal is not to create a "how-to" manual for developing a home care program. Rather, its charge is to develop a tool for local decision-makers to use in deciding future directions for home care within their own community. This paper is intended to provide a framework for discussion of the charge and help identify other areas that should be addressed.

HOME CARE SYSTEMS DESCRIPTION

Before beginning a description of the home care system in Minnesota, it may be helpful to describe how home care as a component of CHS is implemented at the local level through the structure of Community Health Services in Minnesota. The following narrative highlights the legislation that led to this structure.

I. LEGISLATIVE HISTORY OF COMMUNITY HEALTH SERVICES IN MINNESOTA

The 1976 Community Health Services Act established a voluntary subsidy program by which local government could organize a local board of health or a joint powers board of health. Local governments serving a combined total of 30,000 or more people that established a board of health were eligible for a subsidy which was allocated on a formula basis and were required to meet a minimum local match. The premise of the Act was that local governments were best able to examine needs of and assume responsibility for planning, assessing, and delivering needed public health services in local communities. The CHS Act was intended to reorganize all local public health authorities and to increase local control over health decisions. Within nine years of its enactment, all 87 Minnesota counties and five cities were participating in the program.

The CHS Act was revised in 1987 to become the Local Public Health Act (Minn. Stat., Chapter 145A). The purpose of the Act was to "develop and maintain an integrated system of community health services under local administration and within a system of state guidelines" (Minn. Stat. 145A.09, Subd. 1).

The Local Public Health Act did not make major changes in the goals, organization, and financing of the CHS system; rather, its purpose was to make clear the continuing authorities and responsibilities of local government for public health.

The Act requires Community Health Boards to submit to the Commissioner a written plan, which "...must provide for the assessment and provision of community health status and the integration, development, and provision of community health services that meet the priority needs of the community health service area." (Minn. Stat. 145A.10, Subd. 5). Among other things, the plan must include the process used of assessing community health status, statement of

goals and objectives according to priority, and description of rationale for proposed goals and objectives". The Act defined community health services as "activities designed to protect and promote the health of the general population...by emphasizing the prevention of disease, injury, disability, and preventable death through the promotion of effective coordination and use of community resources, and by extending health services into the community" (Minn. Stat. 145A.02, Subd 6). The Community Health Board balances the goals and objectives of the plan with available resources to determine the level of health care programs that will be available in the community. Typically, the plan addresses community needs by providing, developing or integrating existing public health programs. Program categories of community health services include disease prevention and control, emergency medical care, environmental health, family health, health promotion, and home health care (Minn. Stat. 145A.02, Subd 6).

Minn. Stat. 145A.02, Subd. 14 defines home health care as "activities intended to reduce the ill effects and complications of existing disease and to provide suitable alternatives to inpatient care in a health facility. These activities include the coordination or provision of health assessment, nursing care, education, counseling, nutrition services, delegated medical and ancillary services, case management, referral and follow-up."

Home health care is the biggest single program expenditure category in CHS in Minnesota. To understand how the role of home care evolved in many Community Health Boards, it may be helpful to examine the development of home care within the historical context of public health nursing in Minnesota.

Home care has been a visible part of services provided under the umbrella of local public health nursing services for many years. However, the emphasis on home care in relation to other services is a relatively recent phenomenon. Public health has long been involved in other areas as well; in fact, it is only in recent decades that home care programs within public health have become as prominent as they are today.

II. DEVELOPMENT OF HOME CARE OF THE ILL AND DISABLED IN MINNESOTA [2]

Since the early years of public health in Minnesota, State and local officials have made plans and allocated resources

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[2] This section is a summary of remarks presented by Ann Moorhous at the April 14, 1989 Subcommittee meeting.

to do what was needed to meet home health care needs. The basic functions of home health care of the ill and disabled through the years have been nursing care, other professional care, and personal care, demonstration of care to family members, and emotional support for caregivers. These functions were delivered in various ways and degrees through the years depending on need and resources available.

A. The Early Days of Public Health

Public health began in Minnesota in 1858. In that year the first session of the Minnesota Legislature gave towns and cities authority to make regulations concerning contagious disease and quarantine in the towns and five miles beyond. There was no provision for organized public health activity beyond the five mile limit. In 1866 the Legislature empowered township boards to act as Boards of Health.

In 1904, the first public health nursing services were financed by Red Cross and Christmas Seals. The services provided were mainly school nursing, communicable disease control, and infant welfare. Care of the sick at home was accomplished by demonstration of care to family members.

In 1919, legislation gave local units of government authority to fund Public Health Nursing services, replacing Christmas Seals and Red Cross as sources of revenue. In the 1940s, a typical county public health nursing service provided maternity services, health supervision of infants and children, communicable disease control with immunization for diphtheria/tetanus and smallpox, and bedside nursing on a demonstration basis. At that time public health nursing services provided mainly health promotion services and care of the ill and disabled by demonstrating care of families. Since most counties had only one nurse, the resources were not available to provide the full range of home health care services. Public health nursing services grew slowly in the 1950s, when only fifteen counties had more than one nurse. Legislation passed in 1955 allowed counties to adopt a sliding fee scale to employ RNs or LPNs to assist public health nurses in home care. In 1963, legislation permitted counties to employ home health aides. Even though this legislation existed, for over a decade there was little development of organized home care programs with a wide range of services. The home care delivery programs that did exist, however, were located in public health nursing services.

B. Advent of Medicare

In 1966, an event occurred which has had a major impact on the role of public health nursing and on home care

services. Federal Medicare legislation passed, providing payment for home care of ill and disabled over age 65 in their own homes. People eligible for service were eager to begin receiving it. Public health nursing services were seen as the most appropriate service-providers for several reasons. County public health nursing agencies had a well-developed system of providing services to people in their own homes. Public health nursing (including needs of the ill and disabled at home) had historically been a major public health focus of county commissioners. Through the years, public health nurses had made major decisions about how to care for individuals with conditions such as cholera, smallpox, measles, and how to deliver maternity service in the home. Also, Public Health Nursing Agencies were the only service providers interested in becoming Medicare-certified for home health care. This interest, coupled with longer hospital stays and the availability of reimbursement through the new and then-liberal Medicare payment for home care, contributed to the rapid expansion of home care services. By 1968, there were 77 county public health nursing services in Minnesota; 43 of them were Medicare certified for home care. County public health nursing services became more responsive to the need for care of the ill and disabled, and some health promotion activities had lower priority.

In the late 1970s other providers began developing home services. This trend began in the more population-dense areas with services developed by hospitals, non profit groups, and proprietary agencies, and it soon spread to rural Minnesota. Presently, there are 204 Medicare certified home care agencies in Minnesota. More than half of these are in agencies other than Community Health Service Agencies.

In the early 1980s, Minnesota began to move toward providing long term care support services based in the community as an alternative to institutionalization. There were various reasons for this movement: the philosophy that people should be able to be in their own homes as long as possible, a need to find the most economical means to provide long term care, a shortage of nursing home beds, and an aging society.

C. The Medical Assistance Waiver Programs

In 1980, the Minnesota Legislature established a "Preadmission Screening and Alternative Care Grant Program" (PAS/ACG) for the elderly. Funded through a Medical Assistance waiver, the program initially provided funding for screening and in-home services for individuals 65 years and older who were eligible for Medical Assistance, or who would have been eligible for Medical Assistance within 90

days of being admitted into a nursing home. A county screening team, composed of a public health nurse and social worker team, assessed the individual to determine if his/her care needs could be best met in a nursing home or in his/her own home. The Alternative Care Grant part of the program provided money for care in the individual's own home and included case management, adult day care, homemaker service, home health aide, foster care, personal care and respite care. This PAS/ACG program has continued through the years with several Legislative changes. In 1985, preadmission screening was expanded to include boarding care homes. The screening is now mandated for anyone considering entering a nursing home.

One effect of the PAS/ACG program has been to increase demand for home care services, largely because it has improved case-finding, increased families' awareness of community alternatives to institutional care, and (for some people) provided another means to pay for that care.

In the 1980s, sources of payment for home care for those under age 65 also became available. There are Medical Assistance waivers that provide payment of home care services for the chronically ill under age 65 at risk for hospitalization (CAC), for disabled under age 65 (CADI) and for persons with mental retardation or related conditions (MR/RC).

D. Recent History

The entire system of delivery and payment of home health care has become much more complex in the last ten to fifteen years. There are a variety of payment sources, each with different eligibility criteria, payment criteria, and of course paperwork.

Many of the changes that have occurred in health care in the 1980s have been results of efforts to reduce costs. Since October, 1983, there have been dramatic declines in the length of hospital stays and increases in the acute home health care needs for individuals at home. These changes in stays and corresponding increased demand for home health care are related to prospective payment plans for hospital inpatient care. "Diagnostic Related Groupings" (DRGs) for elderly patients initially accounted for much of the change to the system, but most major users of the system (i.e., HMOs and health insurance plans) now use some form of prospective payment plan for inpatient hospital care. The result has been not only that more people require home care, but also that the actual care given in the home has become much more complex. People of all ages, from newborn to elderly, go home from hospitals with acute care needs which sometimes require high technology equipment.

Currently, home care is the largest single expenditure

category of the CHS program categories, comprising 29.2% of total expenditures from all sources in 1987. The following table illustrates changes in service levels over the past five years.

CHS HOME HEALTH CARE SERVICE LEVELS [3]

1983 - 1987

YEAR	NURSING VISITS	HHA* VISITS	HHA CLIENTS
1983	273,571	288,552	**
1984	283,669	335,204	8447
1985	292,398	392,474	11,720
1986	296,935	404,020	11,631
1987	288,684	436,681	10,841

* Home Health Aide
** Data not available

From 1983 through 1987, there was a 5.24 percent increase in the number of nursing visits provided through CHS. Home health aide visits rose almost 34 percent during that time period, and home health aide clients rose approximately 22 percent. Thus, even with other providers serving many of the acute care clients, CHS case loads have continued to increase. The greatest increase is the number of home health aide visits. This indicates either that more maintenance care is being provided by CHS or that more acute care due to earlier hospital discharge is provided, requiring more frequent visits by home health aides.

III. FACTORS AFFECTING THE NEED FOR HOME CARE

The 1981 Guidelines defined the home care target population as the elderly and disabled. Since that time, the target populations for home care services have expanded. Some of the factors contributing to this expansion include:

* a moratorium enacted by the State Legislature on building new nursing home beds;

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[3] Community Health Services in Minnesota: Report to the Legislature, 1983 - 1987

* implementation of a prospective payment system for hospital costs, resulting in many acute care patients being discharged from the hospital still in need of care. This has also created economic problems for many rural hospitals that are struggling for survival;

* the AIDS epidemic has resulted in a new population of people who need maintenance care to enable them to live at home;

* there has been a trend toward care of the terminally ill in the home;

* care of handicapped/chronically ill children in the home;

* increasing numbers of elderly, especially the "frail elderly" over 75 (between 1980 and 2000 the population aged 75-84 is expected to increase by 21.6%, and the population 85+ is expected to increase by 22%. Some studies estimate that one in seven elderly will need assistance to maintain them at home);

* increased consumer preference for home care services as opposed to institutional care;

* expanded public funding of programs for home care of elderly, disabled, and handicapped children;

* entry of mentally handicapped into the community, with the trend toward deinstitutionalization;

* pressure placed upon the informal family care available, due to changing family structures;

* the ever-increasing expansion of services, including services formerly provided in institutions;

* the increasing involvement of private providers in the home care market;

* continued efforts by government and private insurers to control health care costs through less institutional care.

IV. GOALS OF THE HOME CARE SYSTEM

The Commissioner's 1990 Statewide Goal for home care is "to ensure that persons whose illnesses or disabilities require

health care but do not necessitate institutional services will regain or maintain the maximum health status for their conditions." The rationale states that "the availability of effective and efficient home health services helps to ensure that members of the community are able to remain in the place of choice, as free as possible from institutional constraints. The home and family become part of the health care system, resulting in a situation that is more humane and often less costly than institutional services."

V. THE SERVICE DELIVERY SYSTEM TODAY

A. What Is a "System", Anyway?

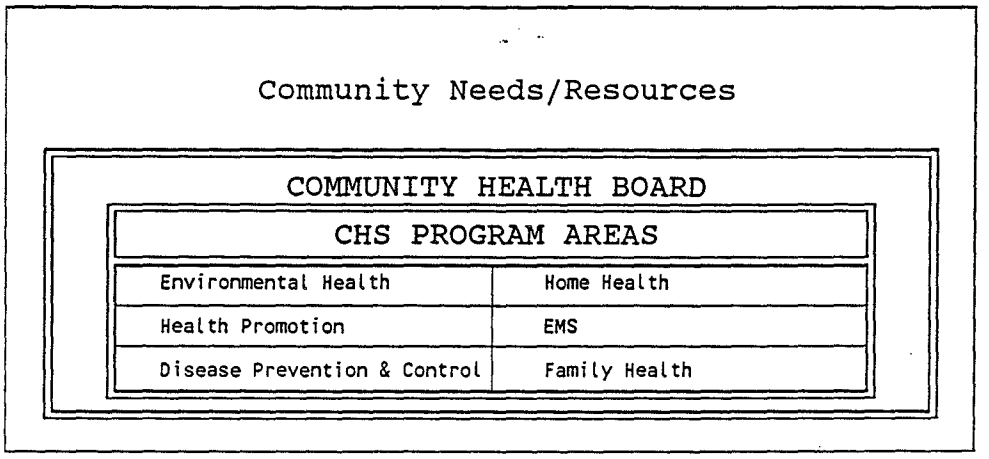
In discussing health and social services, the term "systems" is sometimes used very loosely. However, it may be useful for purposes of discussion to identify some commonalities of all systems. Braden and Herben, in their book, Community Health: A Systems Approach, identify the following criteria for all systems: they function as a whole, there is a nucleus or focal point, there is interrelatedness or interdependence of the variables within the system, and they are governed by some "laws" of operation. They cite as examples the physical sciences, such as physics and astronomy, and biologic systems. In health and human services fields, a fully coordinated system would link services provided, providers and planners, and financing in a clearly discernable pattern.

B. The Community Health Services System - Where Does Home Care Fit?

The community health services system identifies public health problems and then addresses them within six CHS program areas. These categories include home health, disease prevention and control, health promotion, emergency medical services, environmental health and family health. In addition to the Community Health Board's role in addressing services in these six areas, the Board has statutory responsibility for such areas as public health nuisance control, and the authority to enter into agreements to ensure the public health. When we discuss home health care within the community health system, we are referring to the planning and implementation process that addresses home health care as one component of a collection of CHS program responsibilities. The Community Health Board's role in home care involves not only "extending health services into the community", but also includes "the promotion of effective

coordination and use of community resources."

The following diagram illustrates the community health system, of which home care is a part:



C. Home Care - System or Chaos?

The home health care arranged or provided through CHS is a subset of a local public health system and of a community-based long-term care system, sometimes loosely referred to as the home care system. This home care or community-based system is comprised of a large number of providers that interact in a variety of ways. This system goes well beyond the provision of various in-home services which are normally provided by CHS. The community-based care system also includes programs organized, financed, and provided by other organizations, whether under the direction of the local Community Health Board or operating independently.

After discussing the CHS role in home care and how CHS interacts with other providers, the Subcommittee concluded that what exists in community-based care today is not a system, or is at best a very fluid system. Certainly it is a very open system as defined by the criteria above. While there are indeed many diverse parts, they do not function as a whole, there is not a nucleus, and they are not governed by the same laws of operation. Moreover, the "system" is constantly changing, primarily due to changes in the funding sources available to support various programs. There are multiple decision-makers in the home care environment. No one organization has access to information about all services that are available or controls people's access to them. Even so, there are some aspects of this community-based long-term care environment that can be identified and analyzed.

1. Elements of the Home Care Environment

Systems are sometimes described utilizing a two-tiered approach: first, analyzing the system elements, and second, reviewing how these elements interact to meet community needs. (This approach was used in the 1988 SCHSAC document, A Guide for Emergency Medical Care) A chart of the system elements is included in appendix A. However, the elements of the system are constantly changing, primarily due to the changing reimbursement available for health care and other related community-based services. Because of this, the way the system functions, or the pathway to receiving services, is likewise constantly in transition. What is available today will not necessarily be available tomorrow, or it may be provided by another organization.

The following are the elements that are present in the home care environment.

* Target populations
* Needs (of target populations)
* Components (health services and related services)
* Providers of home care
* Providers of related services
* Funding

2. How Do People Enter the Home Care System?

a) Generally:

How people access services is a major point of confusion in the present home care system. Possible entry points are at discharge from a nursing home or hospital, upon referral from a family member, physician, neighbor, social service agency, or school system, or when considering entering a nursing home. The entry point depends partly on which target population a client falls. Where a person goes to receive home care services also varies depending on who makes the referral, to what agency the client is referred, and what source of payment is available.

b) Within CHS:

The "point of entry" for home care services is no longer always through the public health system. For instance, many Community Health Boards have seen their acute care service

referrals drop as hospital and clinic-based home care programs automatically receive referrals of clients discharged from these facilities. In some cases, the CHS home care program receives service referrals for home care cases only when sources of payment for care are exhausted by another agency that has initially been providing care. Public health home programs receive all **assessment** referrals from other providers for PAS/ACG clients; however, they frequently receive further service referrals for only some PAS/ACG clients. In some cases, public health conducts the assessment, provides referrals, and provides much of the service.

Within the public health system, there are some common principles under which services are arranged. Central principles of home care within public health are the family's involvement in the client's health status, a philosophy of self-responsibility for health (including the client's right to refuse services), and the use of community resources to meet the client's need.[4] These principles influence the assessment process and the way resources are organized in the provision of home care through public health. Although there is a great deal of variation throughout the state, the following generally describes what happens when a referral is accepted by a public health home care program.

Initially, an assessment by a professional nurse in a public health agency is performed to determine what level of care the person requires and what resources are available within the family and community to provide that care. Usually, a public health nurse is designated as a "case manager" or case coordinator.[5] This case manager, in conjunction with the client, family, and physician, develops a plan of care designed to allow the individual to function most independently at home. The goal may range from restoring functional status to maintaining a given level of functioning to slowing the decline of a person's health status.

The care plan can include any of the service components

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[4] Commonly accepted public health principles are listed in appendix B.

[5] The term "case management" has various definitions depending on the discipline or regulator of services. For our purposes, case management is defined as a process by which a home care client receives coordinated delivery of the range of services he or she requires through a process of assessment, coordination of resources, quality assurance, and monitoring cost effectiveness. Services are arranged using a team approach, with involvement of the public health nurse, client, client's family, and often a physician and other professionals.

described in the chart under "home health services" or "related services." Depending on the framework of services available in a given community, care may be provided through a "lead agency", other home care agencies, or a variety of other organizations (as listed under "home care providers" and "related providers" in the chart). The person's financial status is discussed, and the case manager, client and family together find the most appropriate payment arrangements. (Funding may come from any of the sources listed under "funding" on the chart, or from a variety of these sources.) The individual continues to receive services as specified under the care plan, with the case manager monitoring the client's health status and making changes in the care plan as necessary. This plan of care can continue for as short a time as a few days or weeks, or as long as many years, depending on the person's health status and family and community support system. Sometimes the client may decide to refuse services if she/he does not see a need for care or if she/he perceives that the level of services required will be too costly.

3. Target Populations for Home Care

Based upon the factors described in the earlier sections, the current target populations for home care are:

* elderly in need of chronic care;

* other chronically ill adults and children;

* physically disabled adults;

* mentally handicapped;

* persons in need of acute care;

* terminally ill;

* handicapped children;

* family and other informal caregivers

These are the clients who need to be served by the current system, and it is likely that their numbers will increase. Estimates of the size of the target population can be made using a variety of formulas and looking at state and federal statistics. (Various formulas for making these estimates have been developed by the Department of Health and Human Services, Kaiser Permanente, National League of Nursing, the Ohio Department of Health and are available from MDH.) Perhaps the most valuable estimates can be made

through an assessment of the local community, including a review of past cases, local demographic patterns, and other factors. Such data have typically been included in the CHS plan.

4. Service Components of Home Care

a) Generally:

Two general kinds of services have been identified as necessary to meet community based care needs:

Home Health Services: including nursing, home health aide, physical therapy, occupational therapy, respite, in-home hospice, case coordination/management, speech therapy, medical social services, personal care assistance, respiratory therapy, nutritional/dietician services, (these services may be provided directly or under contract with other providers) and

Related Services: including mental health counseling, home delivered and congregate meals, transportation/escort, companionship, support groups, money management, adult day care, home maintenance, homemaker, assisted living housing, telephone and related reassurance programs, and care provided through informal support systems, such as neighbors and families.

b) Within CHS:

The mix of services clients and families receive will vary depending on their needs at any point. Public health has traditionally provided, either directly or through contract, a range of those components included in the "Home Health Services" section directly above. However, public health through its case management/coordination function has also facilitated access to the services listed under "related services".

Throughout the state there is a wide range in comprehensiveness of services available. Some Community Health Boards may have many of the services defined under "Home Health Services" available within their own agency; other agencies, especially those in rural areas, may provide only nursing, home health aide, and homemaker, and may not have access to other services, such as therapies. In some areas, many of the services described are not available within CHS, nor are they available within other organizations.

It is the Community Health Board's responsibility to look at the total home care environment, identify the extent of unmet need, and decide how to best facilitate its

community needs within the context of the Board's other responsibilities. Often, this varies not only from client to client, but from week to week as eligibility requirements or availability of funding changes.

D. Who Provides and Manages Home Care at the Local Level?

As indicated under "providers of home health services" and "providers of related services" in the chart in Appendix A, there are many organizations involved in planning and delivering home care services at the local level. These agencies may provide home care services directly or provide supportive services. Provider organizations include nursing homes, hospitals, public health and social services agencies, private independent agencies, and private individual providers. As indicated in the chart, volunteers, neighbors, and family caregivers also provide a great deal of care in the home on an informal basis; in fact, a 1985 study by the Wilder Foundation indicated that up to 80% of the care provided is contributed by family members.

As mentioned in the history of the development of home care services since the time Medicare coverage of home care began, public health had for many years been the only organization providing nursing and home health aide services in many areas of the state. Information on the number of clients served through public health and the number of public agencies providing service is available to organizations conducting planning and research. Information is not as widely available on private home care providers and the number of clients they serve.

In 1987, legislation was enacted requiring licensure of home care and hospice providers. The law requires that anyone who provides hospice services, or is regularly engaged in providing home care services in a residence for a fee to any person whose illness, disability, or physical condition creates a need for the service, must register with the Department of Health, and later must be licensed. The law was passed in response to the perceived vulnerability of home care consumers to abuse as well as a perceived need to have more public information on all providers available. At this time, the report of the Home Care Advisory Task Force offering recommendations for regulation of home care providers has been completed, and the rules are being written.

Since registration of home care providers was required a year ago, there are some data available on all registered providers. There are 460 providers registered in Minnesota. 200 of these providers are Medicare certified, and the rest are non-Medicare certified. The Health Resources Division of MDH is developing a database covering those agencies

registered with the Minnesota Department of Health whereby anyone calling for information on home care can receive information on the type of organization, location, the territory it serves, the number of FTE staff, the source and size of its budget, and the name of the administrator.

E. What are Some Alternative Models for Interaction with Other Providers?

Because CHS is structured differently and has a different "mission" from other organizations that provide home care services, the role of CHS in relation to home care may be different from that of other organizations. For example, a private home care provider may have the provision of home care for profit as its primary organizational "mission." One of the primary "missions" of a hospital is to provide quality health care, especially acute care, to its community while maintaining financial stability. A hospital may well see home care fitting into its mission if it sees home care clients as a continuing source of revenues.

The Community Health Board, in contrast, has as its mission "to develop and maintain an integrated system of community health services..." (Minn. Stat. 145A.09, Subd.1) The concepts of primary prevention, organization of community resources, and the health needs of aggregates are underlying principles to guide how this mission is accomplished.[6] How a Community Health Board translates these broad principles into more specific priorities determines what arrangements it will make for ensuring availability of home care services.

The Community Health Board must weigh whether it has a role as primary service provider and if so, how this role is related to its role as a planner and integrator of all public health services. If the Board's primary goal is one of fostering the development of a full range of services, the decisions made about client care, the range and scope of service provided, and relationships with other providers will be quite different than those of an agency that exists primarily to provide home care services.

Public agencies have often found their role in the home care system has changed during the last decade as a variety of other providers enter the home care market. The existence of other providers has been an opportunity for public health to respond in a variety of ways, including exploring other arrangements for assuring services. The following are some options utilized by Community Health Boards for ensuring availability of home care in Minnesota. A Community Health Board may use one or more of these arrangements for attempting to ensure that home care is

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[6] See Public Health Principles, Appendix B.

adequately available, depending on the Board's perception of its role in home care.

1. Primary Provider

Some Community Health Boards/Boards of Health are the primary provider of most home care in the community. There may be some competition from private providers, but no formal arrangements exist with the private organizations in relation to services usually performed by public health. In these cases, the public agency provides the direct care, serves as case manager, and to a large extent, controls the home care environment.

2. Case Manager/Coordinator

Some Community Health Boards/Boards of Health (usually through their public health nursing services) are coordinators of client care, or case manager, for most home care services. However, these Boards have contractual arrangements with private providers for direct provision of some services, such as home health aide and nursing services. A few Community Health Boards/Boards of Health contract for all home health aide, homemaker, or all home care services. These arrangements are entered into with a variety of expectations: the perception that services will be provided in a more cost-effective manner, that competition and duplication of services will be reduced, that a consistent quality of services will be maintained, or because of a philosophy that provision of direct care is not the major emphasis of the public health agency.

3. Provider of Limited Service

Some Community Health Boards provide home care services primarily to those clients who have inadequate financial resources. Clients who are covered by private insurance, Medicare, or other sources are seen by private agencies, and referred to public health when those benefits are depleted. Some Community Health Boards have made the policy decision to be the "provider of last resort", and some have inadvertently assumed this role due to competition.

4. Broker

A few Community Health Boards/Boards of Health contract with another organization for all Community Health Services. The contractor provides home care as a part of that contract, and the Board's responsibility is to monitor the contract,

continue surveillance of community need and service gap, and subsidize services.

5. Facilitator

In this option, Community Health Boards/Boards of Health encourage growth of high quality services that will improve access to home care services by working with other home care providers and providers of related services. This cooperation could take the form of cross-referrals, assisting in case problem-solving, or fostering development of new services.

6. Purchaser of Contracted Services

In some cases, contractual arrangements exist back and forth between public and private providers. Hospital-based agencies may contract with the Community Health Board/Board of Health for home health aides, and the Community Health Board/Board of Health may contract with hospitals for various therapies.

7. Partner in a Joint Venture

At least one Community Health Board/Board of Health has considered dividing responsibility for services with another organization by entering into a joint venture as an equal partner.[7] This arrangement potentially allows Boards to "specialize" in certain services, fill service gaps in the community without competing for clients, and avoid establishment of a two-tier health care delivery system. This option has various legal implications, including the possibility of antitrust violations if the joint venture partnership and the partners' relationship to the rest of the community are not carefully considered.

These arrangements are not mutually exclusive. A Community Health Board may use several alternative arrangements for home care services. For example, some Boards may never enter into contracts but act as a primary provider of direct service as well as a facilitator of service. The arrangements will vary depending on what the Board sees as its role, based on its view of its mission and the other resources available in the community.

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[7] See Risk-Taking in Joint Ventures, published by Morrison County Public Health Services and Unity Family Healthcare, 1989.

VI. FINANCING FOR HOME CARE SERVICES

There are many different sources of funding for home care services from several levels of government as well as private insurance and fees. As indicated in the History section, the number of funding sources available has increased significantly in the past decade, particularly funds provided under the Medical Assistance waiver programs. The "Funding" column on the chart in Appendix A lists the funding sources available for home care. Appendix C provides a breakdown of funding sources for home care by program and eligibility.

Home care continues to be the area of greatest expenditures of the CHS program categories. Community Health Boards reported expenditures of $34,739,294 for home care in 1987. This includes funds from several sources, including the CHS subsidy, Medicare, PAS/ACG, Medical Assistance, and private fees. This figure represents a 45% increase since 1983. The percentage of total revenue derived from federal revenue sources, such as Medicare and Medicaid, has decreased in the last few years, while the percentage derived from county taxes, fees, and some state funds have increased.[8] According to the CHS expenditure reports, home care is also the largest revenue-producer of all programs; much of the $20,243,591 in fees for CHS activities comes from fees and private insurance for home care services.

Problems related to funding for home care services are addressed in the "Issues" section of this paper. However, the following observations can be made here about funding for home care:

* There are numerous funding sources for home care, each with differing eligibility and reporting requirements.

* Reimbursement is largely based on an acute care medical model; thus, adequate third party reimbursement may not be available to cover maintenance care. Funding from many third-party payors is available primarily for acute or episodic care.

* There are often numerous payment sources even for a single client, and the payment source may change several times during the course of a client's care.

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[8] Community Health Services in Minnesota: Report to the Legislature 1983 - 1987

* Funding is insufficient to meet the demand for home care services.

* Although a third-party reimbursement source may be available, it is usually insufficient to cover the entire cost per visit. This may be partly because home care within public health provides a different kind of service than a strictly "medical model" of care, as mentioned earlier. The teaching and coordinating of community resources that takes place in public health home care is usually not reimbursed.

* The expansion of home care services, both through CHS and through the private sector, has been directly related to the expansion of available funding.

* The trend is toward increased regulation of home care services. For example, the Department of Human Services in Minnesota has influenced much of the home care that public health provides both through funding and its associated regulation (for example, through the Medical Assistance waiver programs.) Community Health Boards are affected by this regulation, but they do not have a formal way of channeling their concerns to DHS to influence regulation. Regulation usually increases the amount of paperwork required and may limit the amount of staff time available for direct care.

VII. FUTURE TRENDS

Projections based on demographics indicate that home care will continue to be an area of high demand. For example, by the year 2030, one in three persons is expected to be 55 years or older and one in five will be 65 and over. Studies conducted in 1984 showed that 23% of the population 65 and over living in the community had difficulty with one or more of the seven personal care activities, or activities of daily living. (from "Aging America: Trends and Projections, 1987-88 edition). Additionally, the 85+ population is expected to nearly quadruple in size between 1980 and 2030. This growth of the older population and their accompanying personal care needs will have an impact on the amount of maintenance care that CHS will be expected to provide.

Acute care needs will probably also increase. As hospital use declines, home care is predicted to grow at an

annual rate of up to 20% nationwide.[9] Pressures to control costs will push hospitals and HMOs to move toward more "managed care", resulting in still earlier hospital discharges.

Numbers of individuals in other target populations, such as handicapped children and HIV patients, are increasing as well.

Technological advances have made possible in-home care of respirator-dependent patients and patients receiving intravenous treatments. The Office of Technology Assessment predicts that the number of "technology-dependent children" (defined as children who require special equipment and medical services beyond the normal capabilities of untrained families) appears to have been increasing over the past ten years. This is due primarily to increased survival of very-low-birthweight infants and increased survival of children with certain inherited and congenital chronic disorders. In 1960, only three of every ten very-low-birthweight newborns survived for at least a month; by 1980, nearly twice as many were surviving. Some estimates place the numbers of children currently in this group as high as 100,000 nationwide; adding other disabled children will boost that number still higher. Changes in legislation affecting services to handicapped children is resulting in pressures on public health nursing services to become involved in implementation of the Individual Education Plan (IEP) in the home. Public health is seen as a natural source of assistance for the teaching and rehabilitative functions of the IEP, especially in the summer months.

A recent AIDS activity survey conducted by MDH indicated that 30% of counties have provided services to someone with AIDS and 19% have provided services to someone with HIV. As the number of HIV positive individuals in Minnesota increases, their needs for home care will increase as well.

Finally, due to decreasing hospital census counts, it is likely that there will be more rural hospitals closing in the future. This will affect both continuity of health care and access to care near individuals' homes.

In addition to increased demand for home care services, there are demands on Community Health Boards in other areas as well. Pressures to utilize their ordinancing authority to deal with public health nuisances, to develop community-wide health promotion programs to deal with chronic disease

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[9] The Nation's Nurses: a credible profession doing an incredible job. Governing Board of the National Commission of Nursing Implementation Project, 1988.

issues, and to expand their roles in environmental and mental health issues have increased. Increasingly, Community Health Boards are expected to provide expertise in addition to being service providers in a wide number of public health areas. The wide range of topics discussed by the State Community Health Services Advisory Committee in recent years offers testimony to these broader expectations. It may be beyond the scope of this Subcommittee's charge to project all the public health needs of the future; however, it is necessary to recognize that expectations of the community health system overall are growing.

MAJOR ISSUES TO BE ADDRESSED BY THE SUBCOMMITTEE

The Subcommittee has identified many issues related to effective planning and delivery of home care. Many of these issues also addressed the role that home care plays in relation to other activities of the community health board and to the effect home care has on the ability to plan for all community health services. After reviewing the home care environment (or system) as described in previous sections, the Subcommittee concludes that new guidelines developed should address the issues described below.

I. PRIORITY-SETTING WITHIN CHS

Probably the most important issue is the question of how to set priorities within the CHS system as a whole, given the many changes and increased demand in the home care program. Home care is a popular program to the Community Health Board, for the following reasons:

* It takes care of community members who need the assistance - home care has met an acknowledged community need.

* It is highly visible; almost everyone has a relative or knows someone who has been served by home care.

* The results are measurable in terms of number of visits, hours of service, and outcome achieved. This is not as true of some other public health programs, in which the outcomes may not be evident for years or may not be as directly attributed to the public health intervention.

* There is some funding available in addition to the CHS subsidy, whereas there may not be such funding for other public health programs.

* Most public health programs have developed a reputation for providing good quality, comprehensive care.

* Many Community Health Boards believe home care is an obligatory program because "we've always done it".

Home care has given publicity and acceptance to public health programs overall and, in many cases, has increased awareness of the CHS system. Because of the success of home care delivered through public health, there may be increased willingness to invest in less visible public health programs. Home care has provided a "gateway" to development or expansion of other CHS programs.

To some extent, however, the success of CHS home care programs also limits the objective assessment of other community needs. The CHS planning guidelines have provided a structure for objective assessment and weighing of community needs and resources. The community health plan ranks problem areas and thus detemines program priorities. In using this process, Community Health Boards and their staffs are presented with the dilemma of weighing their investment in well-known, highly successful programs like home care against new endeavors or areas where the results are less tangible.

Sometimes the focus on home care can impede the consideration of other public health problems as priorities for intervention by the Community Health Board. Occasionally, home care has emerged as a mid-level, rather than high, priority in the CHS planning process. When this has happened, special interest groups have sometimes objected to attempts to reduce the resources that go into the program. In some cases, the Community Health Board has identified higher program priorities in its community assessment and community health plan, yet home care still consumes the largest share of the Community Health Board's resources.

Although the home care target populations may be a minority of the CHS service area population, they often consume resources out of proportion to their numbers. The decision to fund all these needs is usually made in order to meet the needs of a vulnerable population who would not otherwise be served. Even so, many Community Health Boards are beginning to suspect that endless resources can be expended in home care without meeting all of the need.

II. INTERACTION BETWEEN PUBLIC AND PRIVATE PROVIDERS

The entry of other providers into the home care field has changed the work done in public health agencies in a variety of ways. Some have seen a decline in client population overall as clients are referred to private agencies. Others have seen a growth in the nonpaying or sliding fee patients, while clients with other reimbursement sources have been referred to private agencies. Still others have seen case loads decline for a time, only to have to absorb a sudden increase when the private agency goes out of business. In some cases, public agencies provide the maintenance care,

while the private agencies handle the acute care. The latter is more often reimbursable. In such cases, a client could conceivably receive care from two or more agencies at the same time. Sometimes one agency provides the acute care while another provides the maintenance care, or in some cases a client may be transferred back and forth between providers as reimbursement sources shift.

The 1981 Home Care Guidelines state, in the listed "Assumptions", that one agency should be designated as the lead agency for home care in the community. In many communities, this has traditionally been the accepted province of public health. Case management, or case coordination, has been a key method to ensure adequacy of care as well as to ration care and to provide quality assurance. With many points of entry into the home care system, it is more difficult than in the past to ensure that there is an adequate level of care in the community.

A. Concerns regarding multiple providers of home care

Concerns expressed by public agencies over the issue of multiple providers include decline in revenues, concern over the provision of a strictly "medical model" of service as opposed to a holistic family-centered approach, coordination issues, and questions about the appropriateness of continued community health services involvement in home care when other providers are present.

As mentioned in the "Alternative Arrangements" section of the system description, Community Health Boards have addressed these problems in many different ways. Some have actively competed for all home care clients, some have selected a certain "niche" of home care clients to focus on, such as those requiring chronic care (leaving the acute care clients to private providers), and some have entered into contractual arrangements with private providers for the provision of some or all home care services. Some have interpreted the public health principle that public health does "what others can not or will not" to mean they will "come in and pick up the pieces" when private home care is discontinued or when no one else will take on a difficult case. One of the most controversial approaches has been to shift responsibility for all of home care or even all of community health services to another organization through a contract.

B. Issues involved in contracting for services

Even though the Community Health Board may be purchasing a service, it still has legal responsibility for how it is provided. Contracting for provision of services raises many

questions. Among them are:

* Is contracting more cost-effective?

* Is the quality of care provided similar?

* What orientation and training needs to take place?

* What monitoring needs to occur?

* Are there antitrust concerns to be addressed in selecting a provider?

* Are there other concerns beyond medical and fiscal that must be considered when contracting?

With the advent of private involvement in home care, Community Health Boards must evaluate through what arrangements they can best continue to meet their public health responsibilities.

III. ACCESS TO SERVICES

The Local Public Health Act states that "the community health board must ensure that community health services are accessible to all persons on the basis of need. No one shall be denied services because of race, color, sex, age, language, religion, nationality, inability to pay, political persuasion, or place or residence." (Minn. Stat. 145A.10, Subd.7) This statement does not mean that the Community Health Board is required to provide services in all six CHS program categories, nor are they required to provide a certain level of service. However, if a service is provided, it must be uniformly accessible.

A. Ability to pay

The concept of "inability to pay" is difficult to apply in practice. As private agencies handle the more "desirable" situations, public agencies are faced with clients who need more long-term maintenance care, more intense care, or live farther out in the country, thus increasing the cost per visit. Handling high cost cases limits the total number of clients who can be served. In some cases, this may also result in fewer resources for other programs. If the Community Health Board decides to raise fees to increase revenues, it must also decide whether it is limiting access to those who feel they cannot afford to pay.

B. Dealing with increased demand

Another access issue is the increased demand for various amounts and levels of care due to the factors described earlier. Demand for evening and weekend care has increased due to earlier discharge from acute care facilities. Providing this level of care may increase staff costs and liability. Demand has also increased from a more "high-tech" level of care than has previously been provided by many CHS home care programs, from longer hours of care in the home to treat the terminally ill, from earlier hospital discharges, and from other more intensive care cases. Community Health Board must decide whether "access to service" means that anyone who asks for service will receive it, or whether limits must be placed on the amount and type service provided. If so, the Board must evaluate what these limits will be and the basis for limiting the services.

C. Right of the client to choose his or her provider

Another concern related to access is the ability of the client to choose his or her provider. Controlling the cost of care sometimes limits these choices; for example, HMOs will only refer to certain home care providers. When services are arranged by a third party payor or discharge planner, the selection of provider is made by the agency that first receives the referral. Unless the agency making the provider-client arrangements does a comprehensive care care plan that considers all community resources, patients are likely to get only those services provided by that agency or provider. When those choices are made by someone other than the client, those services may be less than, or different from services the client would choose herself.

D. Staff shortages

The shortage of nurses and other professionals and paraprofessionals will also affect both the quality and amount of care delivered by both public health and other providers. Inadequate salaries, demanding care responsibilities, and increased administrative tasks have resulted in high turnover in many areas. Staff may also lack the high-tech expertise necessary to handle the acute care situations that arise as a result of earlier hospital discharges. The scarcity of experienced staff raises concerns about the ability of all providers, including the Community Health Board, to ensure provision of high quality services. Higher salaries may attract staff, but Community Health Boards sometimes fear that they may also limit the

money available to serve clients or meet other identified CHS needs.

IV. DIFFERING PHILOSOPHIES OF HEALTH CARE

The features that historically distinguish home care provided through public health from other home care providers are: a focus on continuous versus episodic care, an emphasis on teaching, on the entire family as client, on wellness as opposed to illness, on coordinating community resources, and on moving the client toward greater independence. One public health goal is to meet the needs of the patient and family with the least intervention, thus encouraging the greatest possible independence. Other providers may not share this goal and may actually encourage more services, either because those are the services that can be reimbursed or because providing services maximizes revenues while encouraging independence does not. Although the initial reason for a home visit may be for skilled nursing care or maintenance care, there may be other concerns, such as nutrition or family communication issues, that need to be addressed in addition to these physical symptoms. Public health nurses view their entry into the home as an opportunity to offer health promotion to the entire family. If a Community Health Board contracts for services with a private agency, it should be aware that the contracted staff may not share this community-based perspective. The increased demands for acute care may leave little time for the teaching and holistic emphasis valued in the public health field. Each Community Health Board must evaluate to what extent it will be involved in a medical model of high-technology care in addition to a community focus of home care. Such a decision has implications for staffing levels, inservice and training provided, and comprehensiveness of service offered.

V. THE IMPACT OF FUNDING ON HOME CARE

A. Funding influences what is provided.

Financial reimbursement for home care influences the care provided by CHS and other providers. Although decisions are made based on the client's needs, they are also determined by the parameters of the available reimbursement sources.

As indicated in the history of home care, funding for

home care is probably one reason that this program is such a sizable part of public health nursing and CHS. In many cases, home health care has provided a steady source of revenue for public health programs, whereas other programs, such as health promotion, are not typically revenue-producing.

If the Community Health Board is receiving less third-party reimbursement because there are fewer paying home care clients, it will either have to raise more revenues from local tax dollars, decrease the amount of service it provides, or shift dollars from other programs into home care. This struggle to maintain the level of home care service provided in the past may make it more difficult for CHS to expand or maintain other program areas, as there may be less local money available for other program categories.

B. Funding influences the local economy

Funding for home care is also sometimes connected to the fate of the local hospital. For example, hospitals sometimes see home care as an integral part of their survival. The survival of the local hospital, with its physicians, emergency and ambulance services, is seen as important to the health of the entire community. In turn, a hospital's survival is often tied to the economic health of the community as people see that community as a trade area for shopping and entertainment as well as health care. This may result in increased pressures from the community to the county board to see that the hospital survives, making it more likely that the Board will support any efforts to establish a hospital-based home care program in the local community.

The community's economy also influences the scope of home care that can be provided by local government. For example, a poor local farm or business economy may mean less revenue from private-pay patients is available to the home care program. It may also result in increased pressures to keep property taxes stable, thus limiting the amount of revenue available to meet inflation or to expand programs.

C. Funding for home care is still poorly coordinated and inflexible.

Reimbursement is a key factor in determining where, when, and how much home care is provided. Partial reimbursement from third party payors has been available for home care and not for other CHS services. Home health has probably grown faster than other public health programs because it has been a revenue generator. The idea that "public health" programs should pay for themselves has sometimes prevented the

expansion of both home care and other public health programs.

In spite of the growth of funding from a wide variety of sources, the funds have been insufficient to keep up with the demand for home care services. Also, funding is volatile; the criteria for services reimbursable through Medicare, for example, changes almost daily. Funding comes from many government and private sources, each of which has its own requirements. Some funding sources determine what will be paid by categorical funding, some determine what will be paid through a means test, some are short term, and some require that clients meet certain disability criteria. No funding source is comprehensive enough to meet all the identified home care needs of the clients in a given community. Moreover, most sources are insufficient to cover the entire cost of providing service on a per visit basis. Thus, additional outside funding for home care may result in additional local costs.

In some areas, there has been little local money put into home care because there has always been third party reimbursement available. As those sources of revenue diminish, either because clients who use those reimbursement sources are seen by other providers or because increased regulation results in "less bang for the buck", some Boards have to face the prospect of putting additional money into home care in order to **maintain** the level of service they have always provided.

Efforts to control costs at the state and federal levels have sometimes resulted in costs being shifted to the local level. Medicare and Medicaid efforts to control inpatient hospital and nursing home costs (which are largely paid by federal and State dollars) often move patients and clients into the community where they receive home care (which requires a much higher local contribution than inpatient services.) Also, as regulations for Medicare reimbursement, Veteran's Administration, Medical Assistance waiver programs, and other programs are tightened, fewer clients may be eligible for service - and tighter regulation usually means the cost per client also increases because of increased paperwork requirements. If amount reimbursed per client by various state and federal programs goes down or remains stable, local governments will have to pick up the cost in order to maintain the same level of service.

VI. DIFFERING NEEDS IN RURAL AND URBAN AREAS

Rural and urban areas face both similar and different issues in home care. Although home care is popular in both areas for the reasons discussed earlier, the arrangements for ensuring provision of home care services vary considerably

between rural and urban areas.

Many of the issues described in this paper - access to services, impact of funding, dilemmas in setting priority-setting - may be intensified in rural areas. Whereas urban and suburban areas may have many other potential home care providers, the Community Health Board/Board of Health in a rural area may be the only provider. Thus, while problems in urban areas may focus more on coordination of resources, rural areas may be addressing development of needed services. Because there are fewer providers of both home health care and related services, home care available in rural areas is often less comprehensive than that in metro areas. Thus, Community Health Boards in rural areas are more likely to assume a larger role in direct provision of home care services - to "be all things to all people" in the area of home care. Rural areas may also have to rely more extensively on the informal care network, placing more pressures on family caregivers.

Another factor that may complicate home care delivery in rural areas is the closing of some rural hospitals due to declining inpatient hospital use and reimbursement constraints. A 1989 study by MDH indicated that over half of the State's less than 25-bed hospitals are financially stressed.[10] This may affect the comprehensiveness of services available in the community, since Minnesotans may lack access to high-technology care and emergency care services in the future. If this care is not available on an inpatient basis, rural Community Health Boards may feel obligated to provide some of that care in the home, thus stretching their resources even further.

VII. CHS ROLES

A. Statutory Roles

The Local Public Health Act emphasizes the role of the Community Health Board in planning and integrating community health services in order to "develop and maintain an integrated system of community health services under local administration and within a system of state guidelines and standards." (Minn. Stat. 145A.09) In addition to weighing public health program priorities, Community Health Boards must determine how best to address their priorities by considering its various statutory roles. These roles are consistent throughout each of the six CHS program categories. The following roles are referenced in the

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[10] See Access to Hospital Services in Rural Minnesota, Minnesota Department of Health, March 1989

definition of CHS contained in the Local Public Health Act:

* *planning* means assessing community health status and identifying priority needs that can be met either by providing services directly or through arrangements with other organizations. The four-year CHS planning cycle authorized in the Local Public Health Act is the process used for community assessment, identification of needs, and the "integration, development, and provision of community health services that meet the priority needs of the community health service area." (Minn. Stat. 145A.10, Subd. 5.) Effective planning "sets the stage" for meeting public health needs. Examples of planning are the program planning required in the four-year CHS plan, as well as strategic planning to identify the purpose of the agency, and comprehensive planning, which establishes long-range goals and outcomes.[11]

One example of planning within the program area of home care is evaluating to what extent the Community Health Board should be involved in providing high-tech care. Examples of planning in other program categories could include decisions on whether to enter into or expand environmental health delegation agreements or disease prevention and control agreements with MDH, whether involvement with a regional EMS Board is appropriate, and a wide range of other public health activities related to "developing and maintaining" an integrated system.

* *coordinating* means linking together services that exist in the community through coalition building, sharing of information, and joint projects.

One example of coordinating within the home care program category is working with a local hospital on discharge planning. Examples within other CHS program categories could include participation in a school early learning committee to develop education plans for handicapped children, working with a local ambulance service to offer joint CPR programs, or helping a school district find resources to implement an AIDS education curriculum.

* *developing* means establishing new programs within the CHS system or facilitating other organizations to become viable service providers to meet public health needs.

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[11] Minnesota Department of Health Community Health Services Planning and Reporting Manual, November, 1988

One example of developing within the home care program category is working with a local nursing home to help them establish an adult day care program. Examples within other CHS program categories could include working with a local community education program to set up a fitness program, encouraging area physicians to become a referral source for a WIC clinic, and encouraging local fire departments to get involved in EMS education efforts.

* *integrating* means making connections between program areas in CHS, including programs provided through other organizations.

One example of integrating within the home care program category is establishing linkages between prenatal classes and postpartum in-home visits. Examples within other CHS program categories could include the HIV resource person and local hospital personnel collaborating in training first responders regarding their risks of contracting blood-borne infections, and helping local sanitarians, public health nurses, and planning and zoning staff to work together on public health nuisance control.

* *providing direct service* means providing services directly, either through the Board's own staff or contracted through other organizations.

One example of providing within the home care program category is home visits to the target populations identified in earlier sections. Examples of providing within other CHS program categories could include conducting well water testing, immunization clinics, and new mother-baby visits.

For Community Health Boards on a limited budget, weighing these roles is a constant struggle. For example, the Community Health Board, in developing its four-year plan, may identify community organization for health promotion as a high priority. However, if the agency is structured so that the same staff is simultaneously responsible for both home health care and health promotion, the planning responsibilities may get put on hold when urgent patient care responsibilities emerge, or when revenues are reduced because staff are not making "billable" visits. Thus, the ongoing demands of home care services can challenge the ability to implement the community health plan, even when other priorities are clearly established.

B. Administrative Roles

The Community Health Board is the legal entity responsible for implementation of the Local Public Health Act. As such, the Board is also responsible for whatever role it decides to assume in home care. The Community Health Board delegates responsibility for carrying out this responsibility to staff: the CHS administrator, a Public Health Nursing Director, and other direct service staff. Although these parties all have a different level of involvement in the roles described above, they are all affected to some extent by the issues raised here. With the many changes in the home care system, persons involved with local public health are obligated to look at the community health system as a whole, facilitate community involvement in public health, identify how home care fits into that system, and how that vision affects the day-to-day activities of the organization. In implementing the community health system it has deemed appropriate for its community, the Community Health Board must determine the complement of staff skill, experience, and training necessary to achieve that system.

C. State Roles

Much of what happens at the local level is affected by decisions made by state and federal agencies in their regulation of funding requirements for home care services. The Department of Human Services administration, reimbursement, and regulation of several home care programs influences the activities of Community Health Boards. State agencies need to establish a process for jointly reviewing the impact their regulations and other activities have on community health services. The Minnesota Department of Health must also consider how it can best provide administrative and program support for CHS in both technical training and the assessment, planning, and program skills discussed above.

How a Community Health Board views its overall purpose, or mission, determines to a large extent its role in home care services. If the Board views its major role as community planner, integrator, or facilitator, the resources allocated and the decisions made about the problems discussed in this paper will be different than if its major role is provision of primary care services. Each Community Health Board must look at and interpret its role by examining local needs and utilizing public health principles.

A recently published Institute of Medicine study

concluded, "Balancing public health prevention activities with primary care is a difficult and challenging problem which must be resolved." It is difficult for the Community Health Board to "step back" from its pressing role as provider of primary services to look at the larger needs of the community, but this is a necessary part of its public health responsibility.

8/22/89
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Appendices

HOME CARE SYSTEM ELEMENTS

Target Population	Needs	Home Health Services	Related Services	Home Care Providers	Providers of Rel Serv	Funding
elderly in need of chronic care	skilled nursing	skilled nursing	mental health counseling	Medicare certified providers (includes most CHS, hospitals, and nursing homes, and some independent agencies)	public and private social service agencies	Medicare
other chronically ill adults and children	personal care	home health aide/homemaker	home delivered and congregate meals	social services agencies	senior centers	Medical Assistance
physically disabled children/adults	nutritous meals	physical therapy	transportation/ escort	public and private non-Medicare certified (including individual paraprofessionals)	congregate dining sites	county taxes
mentally ill	socialization	nutritional/ dietician	companionship		volunteer, church, civic organizations	federal grant programs
acute care	rehabilitative services	respite	support groups		assisted living (housing) programs	MA waiver programs (PAS/ACG, CADI, MR/RC, CAC)
terminally ill*	money management	in-home hospice	money management		CAP agencies	Medical Assistance
caregivers	household maintenance	case coordination/ management	adult/child day care		mental health centers	MCH Grants
	emotional support	speech therapy	home maintenance		schools	Children's Health Plan
	caregiver relief (respite)/support	occupational therapy	homemaker			Veteran's Assistance
		medical social services	assisted living/housing			CHS
		personal care assistance	telephone and related reassurance programs			insurance/HMOs
		respiratory therapy	neighbors and families			fees
			emergency medical services			United Way/other local funds
						CSSA

* includes HIV infected

Appendix A

Public Health Principles

Public health has been defined as "The Science and Art of (1) preventing disease, (2) prolonging life, and (3) promoting health and efficiency through organized community effort for (a) the sanitation of the environment, (b) the control of communicable infections, (c) the education of the individual in personal hygiene, (d) the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and (e) the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity."

Commonly accepted public health principles include:

- planning and interventions are focused on the health needs of aggregates

- primary prevention is given priority over secondary and tertiary prevention

- community resources are organized to meet health needs.

- consideration is first given to interventions that provide for the greatest good for the greatest number of people

- public health interventions do what others cannot or will not

- public health interventions are based on scientific principles and epidemiology is the method of inquiry.

- public health interventions use resources efficiently.

POTENTIAL FUNDING SOURCES FOR CHS FOR HOME CARE SERVICES FOR CARE OF ILL AND DISABLED *

FUNDING SOURCES	ELIGIBLE PERSONS	COVERED SERVICES
MEDICARE	A. 65+ in need of acute care. B. Some disabled under 65 in need of acute care. C. Homebound	A. Intermittent skilled nursing. B. Some personal care services covered by HHA. C. Therapies - PT, OT, speech, medical social services, medical supplies and equipment. Need MD's orders.
PRIVATE INSURANCE	A. Varies depending on individual policy coverage.	A. Varies depending on policy coverage.
SLIDING FEE	A. Clients with no other 3rd party payment source who meet criteria for services.	A. Local discretion.
MCH BLOCK GRANT	A. Children with handicapping/ chronically ill conditions. B. Antepartum patients with complications.	A. Skilled nursing/ health promotion. B. Personal care. C. Health Promotion (with HHA) D. Respite. E. Therapies (P.T., O.T., S.T.).
CHILDREN'S HEALTH PLAN	A. Children with income below 100% of poverty not covered by MA or health insurance. Age 1-8 (1/1/91 to age 18.	A. Skilled nursing. B. Therapies. C. HHA for personal care.

* Some funding sources are more restrictive than others. A single client may utilize many pay sources.

FUNDING SOURCES FOR HOME CARE

FUNDING SOURCES	ELIGIBLE PERSONS	COVERED SERVICES
SERVICES FOR CHILDREN W/ HANDICAPS	A. Eligibility requirements for SCH - income and conditions.	A. Limited skilled nursing. B. HHA and therapies by special agreement.
CHS SUBSIDY	A. Local discretion based on established priorities.	A. Skilled and maintenance nursing care. B. Assessment. C. Therapies (P.T., O.T., S.T.) D. Case Management. E. Referral. F. Follow-up. G. Others as defined in LPHA.
COUNTY TAXES	A. Local discretion.	A. Local discretion.
VETERAN'S ADMINISTRATION	A. Veterans meeting eligibility criteria. Usually service connected condition.	A. Nursing.
MA WAIVER PROGRAMS	A. See Appendix D.	A. See Appendix D.
MEDICAID	A. Income - eligible.	A. Skilled nursing. B. Therapies. C. Medical supplies and equipment. D. Personal care assistance. E. HHA F. Case Management for AIDS clients. G. Health Promotion.

FUNDING SOURCES FOR HOME CARE (Cont'd)

FUNDING SOURCES	ELIGIBLE PERSONS	COVERED SERVICES
T III *	A. 60+; must be for a new service or expansion of existing service.	Categorical grant program covers services identified in grant could include: A. Personal care. B. Nursing C. Respite. D. Housekeeping/chore. E. Transportation and related services.
CSSA	A. Local discretion.	A. Volunteer services. B. Chore services. C. Others as determined by local discretion.
SILS	A. Handicapped adults.	A. Personal care. B. Housekeeping services. C. Teaching independent living skills.

* There are also other federal and foundation grant programs that serve the identified target populations.

MA Waiver Programs

	PAS/ACG	MR/RC	CAC	CADI
Covered Services	A. Regular MA services. B. Case Mgmt. C. Adult Day Care. D. Respite. E. Homemaker F. Home Health Aide. G. Foster Care. H. Personal Care Assistant	A. Regular MA services. B. Case Mgmt. C. Day Habilitation. D. In home family support E. Respite. F. Homemaker. G. Adaptive Aids. H. Supported Living Services.	A. Regular MA services. B. Case Mgmt. C. Respite. D. Minor adaptations to the home. E. Family counseling and Training. F. Foster Care. G. Homemaker. H. Extended MA.	A. Regular MA services. B. Case Mgmt. C. Adaptations. D. Homemaker. E. Respite. F. Adult Day Care. G. Family Counseling & Training H. Independent Living Skills I. Extended Home Health Services. J. Extended Personal Care Assistant.
Related Programs	ACG under 180-day eligibility Community Health Services Title XX/CSSA Title III	Family Subsidy SILS (Semi Independent Living Services) Title XX/CSSA Children's Home Care Option	Title XX/CSSA Services for Children With Handicaps Community Health Services Children's Home Care Option	Title XX/CSSA Community Health Services Disease related organizations Children's Home Care Option
State Administrative Contact	Wally Goettl 612/296-2213 Gina Grannes 612/296-2862	Bob Prouty 612/296-2136 Wes Kooistra 612/296-1146	Phyllis Zwieg 612/296-2916 Cathy Griffin 612/296-2917	Lynda Adams 612/296-1551 Cathy Griffin 612/296-2917

	PAS/ACG	MR/RC	CAC	CADI
Eligible Persons	A. Age 65 or over. B. Applicant to a nursing home who is at risk of SNF or ICF placement. C. Eligible for MA. D. Has been screened by PAS. E. Individual chooses community care. F. MA community costs < MA institution (individual)	A. Any age. B. Individual diagnosed with MR or RC and at risk of ICF/MR placement. C. Eligible for MA (deeming waiver). D. Has been screened by MR/RC screening team. E. Client/gaurdian chooses community care. F. MA community costs < MA institution (state average)	A. Under age 65. B. Resident of a hospital or at risk of inpatient hospital care. C. Eligible for MA (deeming waiver). D. Parent/Guardian/Individual chooses community care. E. MA community costs < MA institution. (individual)	A. Under age 65 B. Applicant to or resident of a nursing home. C. Requires an SNF or ICF level of care. D. Eligible for MA (deeming waiver E. Certified as disabled. F. Has been screened by PAS. G. Individual parents, spouse or guardian chooses community care. H. MA community costs < MA institution. (individual)
Average Annual cost for Community Based Services (rounded to the nearest dollar)	FY 89 $2,914 FY 90 $3,055 FY 91 $3,201 FY 92 $3,354 FY 93 $3,516	FY 88 $18,054 FY 89 $19,733 FY 90 $21,542 FY 91 $22,682 FY 92 $23,874	4/88-3/89 $186,145 4/89-3/90 $199,766 4/90-3/91 $203,579 4/91-3/92 $206,177 4/92-3/93 $209,861	10/87-9/88 $14,119 10/88-9/89 $14,825 10/89-9/90 $15,566

SAMPLE

Exhibit 5

HOME CARE AGENCY SURVEY *

NAME OF AGENCY: _____

DATE OF SURVEY: _____

Type of agency: (Governmental, Non profit, etc.)

1. Please indicate the type of services your agency provides, either through your staff or through other arrangements:

	Own Staff	Other
Skilled Nursing Care Specify: IV, ventilators,etc.	_____	_____
Home Health Aide	_____	_____
Homemaker	_____	_____
Personal Care Attendant	_____	_____
Physical Therapy	_____	_____
Occupational Therapy	_____	_____
Speech Therapy	_____	_____
Nutrition Counseling	_____	_____
Pharmacy	_____	_____
Equipment	_____	_____
Chore Services	_____	_____
Maternal/Child Health	_____	_____
Health Promotion	_____	_____
Disease Prevention (TB)	_____	_____

Other: _____

_____

_____

Senior Companion Station, Home Delivered Meal Assessments, Child Care, Transportation (arrange or provide), Private Duty Nurse, B.P. Screenings, Diabetic Screenings, Immunization Clinics, Toenail clinics, Respite, Day Care, etc.

2. What are your sources of revenue: (Check all that apply)

Medicare ___ Private Pay ____ Medical Assistance___

Insurance___ Grants ____ Other ___

3. What is your criteria for accepting clients?

4. What are your fees for service? (Please attach a fee schedule).

a. How do you determine finances?

b. What type of financial intake do you do?

5. Who does the financial intake?

6. What is your service area?
   Just Moorhead?
   How many miles outside of Moorhead will your agency travel?

7. Length of time per visit? (Hour, day, week, etc.)
   Frequency of visits?

8. Do you utilize other community resources?

   Which ones:

9. What determines the discontinuance of client care?
   Goal obtained _____
   Funding depleted _____
   Agency policy/procedure _____
   Transfer to another agency _____

10. When are clients transferred to another agency?

11. How many uncompensated cases have you cared for in the past year?

12. Do you provide acute care?

13. Do you provide health promotion services?

14. Do you provide maintenance care?
   Frequency of visits: Nurse _____
   HHA _____

15. What type of training do you require of your paraprofessionals?

16. Do you provide inservice to your employees?
   Which employees _____
   How often _____

17. What do you see as the strengths of your agency?

18. What do you see as the limitations to your service?

19. What do you see as your specialty areas?

20. What do you see as the role of public health?

21. How frequently do each category of employee receive direct supervision?
RN/PHN_____ HHA/HM _____ PT/OT_____

22. Do you actively advertise your service? ___Yes ___No
If yes: ___Newspaper ___TV ___Brochure
_____Other:

23. How many visits or hours of service per day do you feel professional staff need to make per day to be cost effective?

Is it acceptable with you to share the results of this survey with other agencies or interested parties other then the Clay County Health Department.

___Yes ___No

_____ _____
Signature Date

* This survey was developed by the staff of the Clay-Wilkin Community Health Board.

Exhibit 6

Macro Formula-Based Home Care Demand Forecasting Models

Various agencies and organizations have published models that forecast overall home care demand on the basis of population in a given area. The figure below shows examples of commonly used home care planning formulas. The forecasts that result from these formulas vary widely, as these forecasts are for a particular organization in a specific geographic location. Home care is a rapidly changing industry and is highly dependent on local attitudes and the reimbursement climate. Consequently, wide geographic variations in market potential exist. Further, these macro models predict overall demand for home care, rather than the demand for individual lines of business. Also because these models are historically based, they do not reflect the recent changes in the market, such as the impact of Medicare prospective pricing. In spite of these shortcomings, these models provide a quick and easy starting point for estimating market potential.

Using a combination of the three types of forecasting and tailoring the analysis to the particular organization should result in a good understanding of the marketplace. The external and internal factors provide tools for analyzing the attractiveness of the market and the hospital's potential for success in the various segments.

Author	Formula
Department of Health, Education, and Welfare	.067 x population over 65
Kaiser Permanente System	.07 x hospital discharges
Southwestern Pennsylvania HSA	.04 x hospital discharges x 2
Piedmont HSA	(.07 x population over age 65) + (.005 x population under age 65)
National League for Nursing	(.026 x population over age 65) + (.013 x population under age 65)
Ohio Department of Health	(.002 x population under age 14) + (.0115 x population 15-64) + (.118 x population age 65 and over)
Georgia Department of Human Resources	(.14 x population 65-74) + (.25 x population age 75 and over)
New Jersey/Pennsylvania HSA	(.06 x population age 65 and over) + (.08 x hospital med/surg discharges) + (.5 x nursing home discharges)
University of California	(.118 to .160 x population over age 65) + (.15 to .30 x nursing home population) + (.03 to .09 x hospital discharges)

Management of Increasing Home Care Expenditures

A Six State Study

Introduction

The amount of county and state dollars spent for home health services has grown dramatically over the course of the last twenty years. In 1988, more and more county commissioners and public health nursing directors were asking the question "How can we continue to keep people in their own homes through home health services while slowing the growth of expenditures?" Several of them approached the public health nursing staff of the Minnesota Department of health for assistance. In discussing this issue repeatedly the question arose "How have other public health agencies managed this type of situation?" In order to answer that question a survey of all public health nursing and visiting nurse associations in six upper midwestern states was conducted.

In order to slow the growth of tax expenditures a manager must either increase other revenue or decrease cost. When a manager decreases cost it may affect the quality of care. These assumptions served as the bases for the type of questions asked in the survey. Managers were asked to identify what strategies they had used to increase revenue, decrease cost and maintain quality. Since their responses may have been influenced by the environment in which they operated, managers were also asked to supply information on the socio-economic situation in which they operated.

Most Frequently Used Strategies

Many agencies used a variety of strategies. On average 3.96 cost reduction strategies, 3.28 revenue strategies and 3.34 quality assurance strategies were used. The following table list the number of agencies using a strategy with the most frequently used strategies listed first.

See table on next page.

STRATEGIES USED BY THE 129 AGENCIES (IN 6 STATES) THAT REPORTED INCREASED DEMAND FOR UNCOMPENSATED CARE

Type of Strategy	Strategy	Agencies Using Strategy #	Agencies Using Strategy %
Decrease Costs	Revising caseload assignment to reduce travel time.	88	69
Increase Revenues	Establish more aggressive collection procedures.	75	59
Quality Assurance	Conduct joint supervisory home visits with staff.	74	58
Increase Revenues	Increase utilization of local tax dollars.	69	54
Decrease Costs	Developing streamlined record-keeping system.	71	55
Quality Assurance	Conduct regular client satisfaction studies.	67	57
Increase Revenues	Expectation that nurse is aware of payment source prior to developing plan of care.	62	48
Decrease Costs	Increasing productivity expectation.	62	48
Increase Revenues	Intensifying marketing activities.	60	47
Quality Assurance	Establish quality assurance committee.	57	45
Quality Assurance	Establish peer review process.	58	45
Increase Revenues	Increase solicitation from expanded sources of outside funding.	55	43
Quality Assurance	Provide for expanded or modified orientation of new employees.	48	37

Table continued on following page.

STRATEGIES USED BY THE 129 AGENCIES (IN 6 STATES) THAT REPORTED INCREASED DEMAND FOR UNCOMPENSATED CARE

Type of Strategy	Strategy	Agencies Using Strategy #	%
Quality Assurance	Hire better prepared staff.	45	35
Increase Revenues	Expectation that plan of care is developed according to parameters of coverage set by payor.	41	32
Quality Assurance	Provide for increased amount of staff development.	40	31
Decrease Costs	Cutting overhead costs.	39	30
Increase Revenues	Expectation for quality care change from ideal to less than ideal but safe.	39	30
Quality Assurance	Provide for increased supervisory time.	38	30
Decrease Costs	Increasing staff generalization.	28	22
Decrease Costs	Increasing staff specialization.	22	17
Decrease Costs	Substitutions lesser prepared, lower cost staff.	26	20
Decrease Costs	Establishing productivity standards or standards on direct vs. indirect time.	20	16
Decrease Costs	Transferring relationship with staff from employee to contractor.	20	16
Decrease Costs	Eliminating high-cost services such as high-tech procedures.	16	12
Decrease Costs	Tying compensation to volume of visits made.	10	8
Decrease Costs	Establishing a utilization review committee.	9	7

Differences on Use of Strategies According to Agency Characteristics

The data revealed voluntary agencies were using more of the strategies than were the public agencies. It was also found that small agencies tended to use fewer strategies than there larger counterparts.

There was a trend toward small agencies being less likely to use the certain strategies, including efforts to:

* compensate employees on the basis of volume of visits;
* reduce staff support;
* establish productivity standards and expectations;
* increase staff specialization;
* streamline record-keeping;
* increase solicitation for outside funding;
* establish more aggressive collection procedures;
* develop a plan of care according to payment source;
* establish quality assurance committees;
* conduct regular client satisfaction studies; and
* expand or modify orientation of new employees.

A possible reason for small agencies using fewer strategies is the smaller size of their management staff. Implementation of any of these strategies would require management to spend time on planning and supervising the enactment of the strategy. Managers in smaller agencies also maybe less able to attend conferences or workshops where strategies are presented and thus maybe less aware of their possible use.

Other Findings

One method to cope with fiscal problems is to increase productivity. When the data from the 203 responding agencies was examined it was found that between 1982 and 1987 productivity for nurses and home health aides decreased. This may be because during that same time hospitals were under financial pressure to dismiss patients earlier in their recovery process. This resulted in more acutely ill patients receiving home health services. At the same time payers of services were demanding more documentation of the need for and descriptions of services provided thus increasing paper work demands on home health agency staff.

Another method of reducing fiscal problems and increase productivity is to reduce staff. The majority of public agencies and half of the voluntary agencies increased administrative staff, nurses and home health aides. These findings are not surprising in view of the above described changes in the home health field. An additional finding which would appear to justify the addition of staff was the fact that the majority of agencies experience a dramatic increase in the demand for visits between 1982 and 1987.

Adding to the fiscal problems of many agencies was an observed shift in source of payment. The majority of agencies saw a decrease in Medicare as a source of payment and an increase in other payment sources. Since the inception of Medicare it has tended to be a preferred source of payment since is covers more of the agencies actual cost than do many other payment sources.

This finding is consistent with the report by 129 agencies that they were experiencing an increase demand for uncompensated home health services. Small agencies were more likely to experience an increase demand for uncompensated home health services.

Summary

In summary the data reveals that there are many management strategies that agencies are using to reduce cost, increase revenue and to assure quality. Public agencies and small agencies tended to use fewer of these management strategies. These same agencies were also experiencing an increase demand for uncompensated care.

CURRENTS and SOUNDINGS

The Two Different Concepts of Privatization

Ted Kolderie, University of Minnesota

■ *The usefulness of much of the current discussion about privatization is impaired by a basic confusion about definitions and concepts. In particular, many observers fail to distinguish between the primary policy decision of government to provide a service and the secondary decision to produce a service. Either function or both may be "turned over" to private parties. In the latter case, the efficiency and effectiveness of government may be improved. In the former, the objective of social equity may be put seriously at risk.*

Privatization is currently a hot topic, much in discussion and highly controversial.

Professional journals and business magazines have been filled with articles about it. Whole books have been written about the idea—some boosting it, such as E.S. Savas' *Privatizing the Public Sector* or Stuart Butler's *Privatizing Federal Spending;* some condemning it, such as *Passing the Bucks* by the American Federation of State, County and Municipal Employees. Centers are being formed to study or to promote the cause. Privatization now threatens to displace "partnerships" as the number one topic where people gather to talk about the contributions which business can make to the solution of problems which beset government.

Privatization is a live issue on the agendas of state, county, and city governments. It is becoming an issue in political campaigns. During the past year some particularly unusual and controversial proposals—especially, involving prisons—have brought privatization more to the attention of the media and of the general public. It is closely covered now, for example, by the *New York Times* and has become a favorite target for newspaper and magazine columnists, who tend to treat proposals for privatization as assertions that the market can replace government.

The discussion, the reporting, and the comment would be more helpful if there were some clarity about what the term privatization means. Much of the discussion is quite unclear—largely because two quite different ideas are being expressed by the use of the same word, and very different interests with very different implications for public policy are represented by those different ideas.

This article is an effort to sort out those two conflicting definitions of privatization.

What Are We Talking About Privatizing?

Typically in a discussion about privatization it will be said that the Postal Service, or transit, or the fire service, or some other service should be "turned over to" the private sector. No useful discussion is possible in these terms. What does "turned over" mean? What precisely would be "turned over"?

Government performs two quite separate activities. It is essential to be clear which activity would be dropped under privatization. Is it the policy decision to *provide* a service? Or is it the administrative action to *produce* a service? Is government to withdraw from its role as a buyer? Or from its role as a seller?

We cannot talk simply about a public sector and a private sector. Only a *four*-part concept of the sectors—combining providing and producing, government and non-government—will let us have a useful discussion about the roles of public and private and about the strategy of privatization.

An example will help. Let's take the service called security. There are two pure cases and two mixed cases.

Case 1: Government does both—The legislature writes the law and provides the money; the Department of Corrections runs the prison. Neither function is private.

Case 2: Production is private—The City of Bloomington decides to provide security when the high school hockey teams play at the city arena, and it contracts with Pinkertons for the guards.

Case 3: Provision is private—Government sells to a market of private buyers. The North Stars hockey team wants security at Metropolitan Sports Center, and it contracts with the Bloomington city police.

Case 4: Both activities are private—A department store decides that it wants uniformed security and employs (or contracts privately for) its own guards. Government performs neither activity.

Case 1 is the pure-case public sector. The policy decision is governmental. A public bureau, at the same or at a different level, produces the service.

Case 2 is immediately recognizable as the—still controversial—system of contracting.

Case 3 is less familiar, although examples of government agencies selling to private buyers are in fact fairly common.

Case 4 is, again, well understood as the pure case of private agencies selling to private buyers.

The vocabulary *can* be confusing. Nothing is as troublesome as the ambiguous use of the word "providing." Some people talk in one breath about society providing medical care for the elderly and in the next describe doctors as the providers. Avoid such confusion: That way madness lies.

Nothing is as troublesome as the ambiguous use of the word "providing."

One distinct activity of government is to *provide* for its people. In other words: policy making, deciding, buying, requiring, regulating, franchising, financing, subsidizing.

A second and distinctly separate activity of government may be to *produce* the services it decides should be provided. In other words: operating, delivering, running, doing, selling, administering.

Each activity can be broken down into several parts; each of which might be privatized separately.

The *production* of a service is the less complicated of the two. It can be divided, for example, into the line service and into the support service; into the labor and into the equipment and facilities; into the work itself and into the management of the work. Any of these can, in turn, be divided into parts; the way a city might divide its refuse collection among several haulers or the management of its pension funds among several banks.

The *provision* of a service is more complicated. A service is publicly or socially provided (a) where the decision whether to have it (and the decisions about who shall have it and how much of it) is a political decision, (b) when government arranges for the recipients not to have to pay directly for the service themselves, and (c) when the government selects the producer that will serve them.

The service is privately provided (a) where individuals and nongovernmental organizations make their own decisions whether or not to have it, (b) where, if they choose to have it, they pay for it in full out of their own resources, whatever these may be, and (c) where they select the producer themselves.

Clearly there can be mixed cases. Government may make a service available but let citizens decide whether to use it; or the financing may be shared between public and private, with users paying a part and government paying a part of the cost; or some individuals may be asked to pay the cost in full themselves while government pays the full cost for others; or government may pay the cost but allow the user to select the vendor, and so forth.

Services provided publicly may be financed through taxes, as schools are. But government also uses nontax devices. One of these is regulation: Government provides us with clean restaurants by requiring their owners to clean them at their own expense. Franchising is another: Government provides to all parts of a city a uniform level of service by creating a monopoly that permits a utility to average its prices, overcharging some residents so as to subsidize others.

With this distinction clear, we can now look separately at what it means to privatize both provision and production.

Privatizing Production

Let's begin with the simpler activity of service production. Here privatization means simply that a governmental agency that had been producing a service is converted into, or is replaced by, a nongovernmental organization. This can occur either where the agency is selling to private buyers or where it is selling to government.

The British Example

In Britain privatization means transferring to private parties the ownership of a state industry that had been producing very largely for private buyers.

Over the years a number of private industries had been socialized by successive Labor governments, becoming British Steel, the Coal Board, British Gas, British Air, British Telecom, etc. These state industries served each other and the government, of course, but did business very largely with private firms and private households.

These are now being sold; sometimes to other firms, sometimes (through a stock issue) directly to individuals, sometimes to the workers. This "selling off the family silver" has been both popular (especially the sale of public housing units to their occupants, which has transformed tenants into owners) and profitable for the government.

As state industries, these enterprises had been under pressure to hold down their prices. Thus, year by year, deficits arose which the government had to cover. Year by year, the effort to limit the subsidy, as a way to force these industries to reduce their costs, had failed. So the Thatcher government decided to privatize these service producers. As private organizations, these industries will have to earn their revenues and will be forced to control costs and improve services in ways that, as public organizations, they were not.

The American Application

A few proposals for the sale of government enterprises have appeared here. Conrail is to be sold. President Reagan has proposed the sale of others, including power distribution facilities and selected petroleum reserves. But in this country (though called public utilities) the major energy, transportation, and communications systems (except for the Postal Service, TVA, and such distribution systems as Bonneville

Power) have been in private ownership. The scope for the kind of privatization under way in the United Kingdom—transforming government-owned sellers of private services back into privately-owned sellers of private services—is limited in this country.

Here privatization has come to mean mainly the government turning more to private producers for services for which government remains responsible and which government continues to finance. It has become simply a new name for contracting.

Contracting itself is not new in American government. It is traditional in public works at all levels, and it has been common in the rapid growth of human services since the 1960s. What is new is the proposal now to expand the practice and to apply it to service areas in which it had not previously been considered. There are proposals, for example, that a county board might privatize its hospital by turning over the management (or ownership) to, say, Hospital Corporation of America; or that a city might retain a private firm to finance and to operate, as well as to design and to build, a new waste-water-treatment plant; or that Tennessee might bring in the Corrections Corporation of America to run its state prisons.

These facilities and services would be turned over to private organizations in the sense that private organizations would run them (that is, become responsible for service production). But the responsibility for provision, the policy side, would remain governmental.

Issues in Privatizing Production

The debate about this idea of privatizing production is now fully under way. While it has its ideological side, most of it is intensely practical. It is very much a clash between competing producers, both of which want the government's business.

The organizations of government employees, which would like to hold on to the business, say privatization will mean poorer service at higher cost. The American Federation of State, County and Municipal Employees has been running ads in the magazines read by city public-works directors, warning about the dangers of contracting, and has mailed copies of *Passing the Bucks* to 5,000 government officials.

Private firms that would like to get into the business say that privatization (contracting) offers better service at lower costs. In 1985 a number of firms created the Privatization Council, with offices at 30 Rockefeller Plaza, New York. The council sponsors conferences and publishes a journal, the *Privatization Review,* to promote this concept of privatization.

The problem is complex, falling roughly into six parts.

The Question of Competition

What actually happens as a result of a shift to contracting depends largely on whether the change is only the substitution of a monopoly private supplier for a monopoly public bureau or involves also the introduction of competition among producers.

If the change is simply from one monopoly supplier to another, then neither cost nor performance is likely to change very much. The government as buyer is still caught with a sole source arrangement. Some of the privatization in Britain has been of this sort. British Telecom has been sold to private owners, for example, but other communications companies have not been allowed to enter the market freely to compete with it. It is privatization without competition.

An argument can always be heard for this. Private and public organizations alike are quick to tell you how much better they could serve you if only they did not have to compete for your custom. But an effort at privatization should try to make the producers competitive. (Efforts are needed periodically to make even *private* industries competitive. The deregulation of railroads, aviation, over-the-road trucking, banking, health care, and telecommunications in the 1970s and 1980s was such an effort.)

The Question of "Creaming"

A common charge against privatization is that it will result in service going only to the easy and profitable customers, while the difficult and unprofitable customers are neglected.

This reflects a failure to distinguish between providing and producing. Creaming is a problem when producers sell to private buyers. It should not be a problem where government is the buyer. Government can get the service it wants to pay for. It will have to pay for what it wants. But if government wants rockets to the moon, it can get rockets to the moon. If it wants daily mail delivery to Lost Butte, Montana, it can get daily mail delivery to Lost Butte, Montana.

Government *will* have to be a smart buyer. Creaming, like corruption, *can* occur if the government is careless. Private contractors and public bureaus alike may tend to avoid the difficult work required in the poorer neighborhoods of a city. The government must be careful to specify the work it wants done, and it must inspect the work to make sure it gets what it wants.

The Question of Corruption

When a government buys from private producers, efforts must be made continually to detect and suppress anti-competitive behavior and the use of public office for private profit. The same is true when the producers are public.

We tend not to talk about corruption in the relationship between elected officials and their bureau. But this is also a noncompetitive arrangement, with the potential for problems (if, for example, wage increases are exchanged for contributions at campaign time). One good way to protect the public interest is to separate the governmental provider from its producers—public bureau or private contractor—through free-choice-of-vendor or voucher arrangements.

The Question of Cost

Where competition is introduced, costs are normally expected to fall. Thus, privatization of the producer side should be appealing not only to business firms eager for a chance to sell to the government but also to managers frustrated by a costly and unresponsive public bureau and to citizens eager to see service made more effective without an increase in their taxes. And probably competition does reduce costs per unit.

As the discussion goes along, however, concern is arising about a cost-*increasing* effect of contracting. This comes through strongly in the book, *Privatizing Federal Spending* by Stuart Butler, head of domestic policy studies at the Heritage Foundation in Washington. He argues that contracting expands "the spending coalition" that drives up the federal budget.

Moving the supply (producer) function out of government may replace a muted bureaucratic pressure for bigger programs with a well-financed, private-sector campaign. This significant drawback means that contracting should be viewed with caution as a means of privatization. Contracting can lead to more efficient government, but it does not guarantee smaller government.

How you view contracting depends on what you are trying to do. If you think programs ought *not* to be expanded, you will probably want to resist its use. If you favor larger public programs, you may find it highly strategic to expand the use of this form of privatization.

A good example of this just now is in the field of corrections. One group wants to put more people behind bars and is advocating contracts with private firms to build and operate state prisons. Another thinks the industry of locking up people (especially, kids) has already grown too large and wants to block contracting. The two groups disagree—except in their belief that contracting would mean more jails.

The Question of Control

Opponents of contracting argue that a government has better control when it *owns* its operations; that is, when the workers are permanent employees. Proponents argue that control is better when operations are handled by contract, because on contract—since an affirmative decision is required periodically to continue the relationship—the producer is always at risk.

The Question of Community

The term privatization—even if only of service production—suggests to some people that the public purpose of a program is somehow lost. Proposals are quickly drawn into an ideological debate—attacked as further eroding the sense of community in contemporary society and for intensifying the individualistic ethic of our time.

Here again the error lies in confusing production with provision. So far we have been talking only about a privatization of the *producer* role. The sense of community is not lost in this kind of privatization—unless the public character of a service depends on its being delivered by a specifically governmental producer. In some service areas and for some people, it may. This is clearly a reason for the resistance to contracting of prison services. Also, to most people, public education means a school run by government.

On the other hand, no strong feeling exists today that the public character of the program is lost if people needing medical care do not go to the county hospital or if people needing housing are not required to live in the project owned by the local housing authority.

When we're talking simply about nongovernmental *producers,* the social commitment to a program is generally maintained and, as we have seen, may even be enlarged. Hence, this kind of privatization does not put community seriously at risk.

The danger to community comes from the other major concept of privatization, to which we now turn.

Privatizing the Provision of Service

It is quite possible, of course, to privatize the public role in the provision of benefits and services. Government would simply withdraw from (or reduce) its role as buyer, regulator, standard setter, or decision maker. People (or certain people for certain services thus privatized) would then be on their own to decide whether or not to have a service and to pay for it should they decide they want it.

Since the essence of government lies in this first function, of deciding what it will provide—what it will require and buy and make available; where and when and to whom and to what standard—*this* is the real (as Butler says, complete) privatization.

For those who care about government maintaining a strong policy role, health care is not privatized when the county board contracts the management of the public hospital to a private firm, when it sells the hospital to a private firm, or even when it closes the hospital and buys care from the other hospitals in the community. The responsibility to provide is truly privatized when the county board says it will no longer pay for the care of the medically indigent.

The Methods for Privatizing Provision

Government can withdraw from the provision of service in a variety of ways.

First, it can withdraw from the production of a service and not at the same time redesign that program into a purchase-of-service arrangement. This is load shedding, in the vocabulary of alternative service delivery. A city that simply stopped plowing snow out of alleys or stopped inspecting restaurants would be privatizing production and provision simultaneously.

Sometimes this occurs. Sometimes it does not. When government reduced its role in the production of housing (i.e., stopped building more housing projects), it redesigned public housing into a program in which it

pays the rent for low-income families in privately-owned houses and apartments.

Second, government can reduce or withdraw from its role as provider by introducing fees and charges for a service it continues to produce. In many cases the financing responsibility will still be shared between taxpayers and users. But the proportion paid by users will rise. It is a kind of creeping privatization.

Charges can be introduced at a flat rate for all, regardless of ability to pay. Or they can be introduced for some people and not for others, or set at a higher rate for some than for others. Discount transit fares for the elderly, sliding fee scales for day care, and checks to some people for winter heating bills (while other people pay full rate) come quickly to mind.

A similar privatization occurs as tax liability is extended to cover the cash payments received and the cash value of services received under benefit and entitlement programs. Above a certain income level, for example, social security payments are now taxable, and Colorado's Governor Richard Lamm has suggested this as a general policy where the pressure to offer services and benefits universally in the first instance cannot be resisted.

The Reasons for Privatizing Provision

Who would want to do anything so cold-hearted?

Actually, two very different interests, both deeply concerned about equity and about community, are coming together to reduce or limit the role of government as provider in America and in other western countries.

The first of the two efforts to limit the scope of government rises mainly from social and political concerns. In recent years some representatives of the poor and disadvantaged have increasingly resisted government housing, health care, and other social-welfare programs. For them effects are what count; not intentions. For the people they represent, programs have too often operated mainly to enlarge the income, status, and power of the industry of bureaucratic and professional service producers, whether governmental or private.

These advocates resist the idea that we find our community through politics and resist the extension of law and regulation that steadily deprives nongovernmental and nonprofessional institutions of the right to care for themselves and for each other in ways that private communities always have. Their efforts to maintain these rights for individuals, families, and voluntary organizations form an important part of the support for privatization.

The second and more conspicuous of the forces arises from the effort to restrain public expenditure—to relate needs and wants to what the city, state, or nation can realistically afford to pay.

The combination of client advocates, the media, and the political process has worked powerfully to turn needs into rights, rights into entitlements, entitlements into programs, and programs into budgets. At the same time, the combination of international and interstate economic competition, taxpayer resistance, and the need to stimulate entrepreneurship and investment has worked powerfully to constrain the resources that come into the economy and the amount available for public service provision.

In almost every country, public services have come under pressure. Something has had to give. One response has been to reduce services across the board, making no distinctions among users. Another is to shift from a universalist to a selective approach in social policy—that is, from a policy that makes services available to everyone at no charge regardless of ability to pay to a policy that asks those who can afford to pay to do so and reserves the limited public resources for those who genuinely cannot.

The latter approach, privatization, enhances equity better than an across-the-board reduction in service levels. It also eases the concern about what could happen to democratic institutions in a society in which more than half of the people have their incomes politically determined.

The people who want to limit what government provides are not necessarily cold-hearted. They are skeptical about public officials' tendency to justify programs in terms of intentions. They worry about government's ability to drive out its competitors with the offer of free services. They seek to reduce the proportion of decisions made in a political process which they see as incapable, realistically, of resisting the pressure for irresponsible decisions to pay for services with other people's resources and to increase the proportion of decisions made in a process where private parties make responsible decisions about the use of their own resources.

The clear requirements for the success of a social policy of this sort, however, are almost certainly the provision of an adequate income to the poor—through transfers or through work—and the maintenance of community standards to those whose service is being paid for socially. It is hard to see that the effort at privatization is yet adequately sensitive to the practical and ethical importance of this idea of social equity.

A Reasonable Program for Privatization

Privatization can serve a useful purpose. It also carries some dangers. The effort should be to secure the former while avoiding the latter.

A reasonable program would involve some privatization of service production combined with some privatization of service provision.

Implementation of such a strategy would focus mainly on (a) maintaining the right and enlarging the responsibility of people to provide for their needs privately, where they can and where they wish; and, where government *is* responsible, (b) enlarging the opportunity for elected officials and for citizens to secure those services from private producers as well as from public agencies if they wish.

First, in the area of service *provision,* such a program would involve:

• Being selective. *Targeting eligibility* to those in need.

• Continuing to use *fees and charges with income offsets* for people of low income.

• *Taxing benefits,* where benefits are granted universally in the first instance. (All of the above will privatize financial responsibility and thus help restrain expenditure.)

• Fixing—*appropriating—the revenues* for programs and managing the eligibility as demand for the service changes. Commonly, today, programs fix the eligibility so that with a rise in demand it is the appropriation that becomes the variable.

In this country, privatization has come to be simply a new name for contracting.

• *Introducing voucher systems* or other user-side subsidies that privatize and thereby depoliticize the vendor-selection decision where the service is governmentally paid and even where it is governmentally produced. This will guard against the problems that can arise in contracting, where elected or appointed officials select the vendor. It will also indicate more clearly the sort of service people really want.

Second, in the area of service *production,* such a program would involve:

• A policy to *avoid sole sourcing,* whether the supplier is governmental or private. This will ensure competition. A public-bureau arrangement is essentially a long-term, noncompetitive, sole-source contract. (Note that it is possible to have competition without privatization. A government can contract with other governments, and free-choice-of-vendor arrangements can be introduced where the choice is simply among public agencies. Governor Rudy Perpich's proposal in 1985 for open enrollment among public school districts in Minnesota is an example of the latter.)

• An effort to *disaggregate the elements of a service.* Breaking up a service into pieces will enlarge the opportunity to use different kinds of suppliers. This will allow changes to occur more gradually and thus lower both the political pain and the risk involved in service redesign.

• *Divestiture.* A public policy body that serves also as the board of directors for the public agency producing its service is caught in a dual role which can at times become a conflict of interest. Separating the roles of provider and producer can make it easier to privatize production. This will be useful even in a general-purpose government organization, freeing the elected board to concentrate on policy and on ways to reduce the cost and to increase the quality of service. It is especially needed in single-purpose agencies such as transit commissions and public school districts.

• *Capitation.* Paying the producer a lump sum, up front, and allowing that organization to keep whatever it does not need to spend introduces an incentive for producers to innovate. Teachers, for example, say that if given this incentive they would move quickly toward peer-teaching, independent study, parent involvement, the use of community resources, differentiated staffing, and new learning technology.

• *Co-production.* In voucher arrangements clients can do much of the work themselves. They need not be required to spend the money on professional service. This will encourage strategies of prevention and self-help that can be, at the same time, less costly for payers and more supportive for users.

In Conclusion

Such a program ought to be possible.

For the moment, however, both the private leadership and the political leadership are mired in the old ways of thinking. Both are bogged down by traditional concepts of government that are insufficiently sensitive to needs for economy and responsiveness and by concepts of a private role that are insufficiently sensitive to the need for equity.

A new concept, combining equity in the provision of services with competition in their production, has yet to be articulated politically.

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References

Much of the literature on privatization is in articles and papers. A particularly extensive and useful bibliography can be found at the end of the generally negative view of privatization, in the article by Paul Starr, "The Meaning of Privatization," in: *Project on the Federal Social Role, Working Paper 6* (Washington: The National Conference on Social Welfare, 1985). The Local Government Center, a project of the Reason Foundation (1018 Garden Street, Santa Barbara, CA) keeps track of examples of efforts at privatization.

In many respects the fullest, most politically sophisticated, and therefore most important treatment of the subject is in: Stuart Butler, *Privatizing Federal Spending, A Strategy to Eliminate the Deficit* (Washington: The Heritage Foundation, 1985). Another effort to

clarify the meaning of privatization, following the distinctions made by Vincent and Elinor Ostrom, is: E.S. Savas, *Privatizing the Public Sector* (Chatham, NJ: Chatham House, 1982).

Two particularly sensible comments by persons long in and around government and public administration are: Alan K. Campbell, *Testimony Before the Texas Commission on Economy and Efficiency* (Austin, TX: January 23, 1986), and Dick Netzer, "Privatization," in *Setting Municipal Priorities* (New York: Columbia University Press, 1985).

A summary of the varying approaches to privatization, in Britain and in other countries, appeared in *The Economist,* (December 21, 1985), p. 71.

Exhibit 9

LIST OF ACRONYMS USED IN THE HOME CARE GUIDELINES

ACG	Alternative Care Grant
AIDS	Acquired Immunodeficiency Syndrome
APEX/PH	Assessment Protocol for Excellence in Public Health
CAC	Community Alternative Care
CADI	Community Alternatives for Disabled Individuals
CAP	Community Action Program Agencies
CHS	Community Health Services
CPR	Cardiopulmonary Resuscitation
CSSA	Community Social Services Agency
DD	Developmentally Disabled
DHS	Department of Human Services
DRGs	Diagnostic Related Groupings
EMS	Emergency Medical Services
FTE	Full time employee
FY	Fiscal Year
HHA	Home Health Aide
HIV	Human Immunodeficiency Virus
HM	Homemaker
HMO	Health Management Organizations
ICF	Intensive Care Facility
IEP	Individual Education Plan
IV's	Intravenous feedings
JCAH	Joint Commission on Accreditation of Hospitals
now known as	
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LPHA	Local Public Health Act
LPN	Licensed Practical Nurse
LTCM	Long Term Care Management
MA	Medical Assistance
MCH	Maternal Child Health
MDH	Minnesota Department of Health
MR/RC	Mental Retardation/Related Conditions
OT	Occupational Therapy
PAS/ACG	Preadmission Screening/Alternative Care Grant
PHN	Public Health Nurse
PN	Practical Nurse
PT	Physical Therapy
SCHSAC	State Community Health Services Advisory Committee
SILS	Semi-Independent Living Services
SNF	Skilled Nursing Facility
ST	Speech Therapy
TB	Tuberculosis
TEFRA	Tax Equity Fiscal Responsibility Act (Federal)
also known as	
CHCO	Children's Home Care Option. The acronym is pronounced like "cheeco."
WIC	Women/Infants/Children---Nutrition Program