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Benchmarking Home Health Care and Public Health Nursing Services

Indian Health Service, Billings Area Indian Health Service, Public Health Nursing Division.

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BENCHMARKING HOME HEALTH CARE AND PUBLIC HEALTH NURSING SERVICES

June 1995

Submitted to:

**Billings Area Indian Health Service
Public Health Nursing Division**

Prepared by:

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EXECUTIVE SUMMARY

The Billings Area Indian Health Service (IHS) serves approximately 60,021 Native American people living in Montana and Wyoming. Ambulatory, emergency, dental, environmental health, community health and preventive services are generally available on the Service Units (SUs). However, for many eligible Native Americans in the Billings Area, home health care services are lacking. IHS does not have any formal home health care programs that are consistently provided across the nation. This is especially a problem in the Billings Area IHS. Some of the units have home health care services provided by private agencies, while in other areas the public health nurses are responsible for home health care services along with providing other general community health services. Consequently, home health care needs are not being adequately met in all Service Units in the Billing Area IHS.

The aims of the project are to: 1) develop a current profile of existing public health nursing and home health care services on each reservation in the Billings Area IHS, 2) develop a profile of successful home health programs on reservations in the United States (US), and 3) integrate the two profiles to identify factors contributing to success and failure of home care programs. Benchmarking, a key tool in Total Quality Management (TQM), was used in this project. Benchmarking is a search for and implementation of industry best practices. Several phases are undertaken in a benchmarking process: planning, analysis, integration, action and maturity. This project focused on the first three phases. In future phases of the project, action plans will be implemented and new practices fully integrated into the organization.

Findings

The first step of the project was deciding what was going to be benchmarked. For this project, the Technical Advisory Committee members defined home health care primarily as "skilled" home health care. Home health care includes the following components: 1) skilled nursing care as the primary health service provided, 2) a registered nurse (RN) to evaluate the home situation and resources needed to promote clients optimal level of well-being, 3) a designated RN to act as a multidisciplinary coordinator or manager who directs and plans care with an emphasis on optimizing client outcomes, and 4) a designated RN to promote continuity of care and collaborate daily with the multidisciplinary team with representatives as necessary from medicine, occupational therapy, physical therapy, social services, discharge planning, and personal care services. The family's understanding of and ability to assist in care is important in producing positive outcomes. Home health care services are intermittent and part-time, and are provided in the current residence of the client.

The second step in the benchmarking process was developing a profile of the eight Billings Area IHS Service Units. In general, the user populations of the SUs are small ranging from approximately 3,700 to 10,400 persons. The proportion of the population that is elderly has been used as an indicator of home health care need. The SU

populations are relatively young with a high percentage of residents under age 5 and a relatively low percentage of residents over the age of 55.

The leading diagnoses of persons using home health care include heart disease, musculoskeletal disease, injuries and poisonings, neoplasms, respiratory disease and endocrine disorders (Dey, 1995). Heart disease, accidents and neoplasms are leading causes of death for the SUs. In addition, the most common diagnoses for outpatient visits and hospitalizations include a variety of acute and chronic illness frequently encountered in home health care: diabetes mellitus, hypertension, musculo-skeletal problems, and respiratory disorders.

Currently, the availability of home health care resources on the SUs varies widely. All SUs have public health nursing services, however, most of the PHNs are only able to provide minimal home health care services. At least one home health care agency is located nearby all of the SUs. Some of these agencies provide care on the reservation, and some do not. In addition, the availability of specialty home health care, such as hospice, durable medical equipment, and oxygen, is variable.

The next steps in the benchmarking process involved identifying and visiting benchmarking partners. Four sites were visited for one day by one of the consultants and two or three members of the technical Advisory Committee: Fort Belknap/Phillips County Home Health in Montana, Min-no-aya-win Public Health Nursing Department/Home Health Agency (PHN/HHC) in Minnesota, Cherokee Nation Home Health Care in Oklahoma, and Rehoboth McKinley Christian Hospital Home Health in New Mexico. These four agencies were selected because they represented different approaches to meeting skilled home health needs of Native Americans. Home health care is provided on the Fort Belknap SU through a contractual arrangement with a private, Medicare-certified home care agency, Phillips County Hospital Home Health Care. At the Min-no-aya-win PHN/HHC, home care services are provided by the tribe through a IHS 638 contract; currently they do not receive Medicare reimbursement. The PHN/HHC department is part of a human services division with ambulatory care and social services. The Cherokee Nation provides home health services through a free-standing, Medicare-certified agency that is administered by the tribe. Finally, Rehoboth McKinley is a private, hospital-based, Medicare-certified agency that includes the Navajo reservation in its service area.

Recommendations

The above four agencies represent different approaches to providing home health care services in the Billings Area. These approaches could be adopted as described in this report or a combination of these approaches could be utilized. In order for any new endeavor to be successful, the following components must be present: commitment, support, communication, leadership, and autonomy.

In adopting any of these approaches or a combination of these approaches several issues must be considered. The populations of the SUs are very small and it may be difficult for one agency to have an adequate caseload to support the organization. In addition, most of the SUs are geographically isolated and travel distances between homes

and to other health care are long. If a collaborative arrangement is sought, private agencies must be available and interested. Provision of home health care services by the tribe or IHS necessitates being able to attract health care professionals with knowledge and experience in home health care, as well as attract personnel knowledgeable about billing, medical records and perhaps even grant writing. Initiating a home health care agency also may require significant tribal administrative and financial support, and home health care would need to fit within tribal priorities.

Each service unit will need to establish the appropriate model to meet the needs given the resources available. Based on the size of the reservation and the needs and commitment of the tribes, any one of the above approaches would be an option. Finally, the efforts begun by the SUs should continue. In some cases, these efforts are only in the initial stages. Collaboration and networking need to continue.



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INTRODUCTION

Across the nation hospital stays have shortened as persons go home after hospitalization "quicker and sicker". Needs for skilled nursing by home health care clients has risen substantially (Shaughnessy & Kramer, 1990). Combined with this is the continual increase in the proportion of population 65 years of age and older. Both of these have stimulated an impressive growth in home health care services. Although many elderly people are healthy, the number of frail elderly requiring home health care services has increased. Approximately three-quarters of home health care discharges are for people 65 years of age and older (Dey, 1995). Services once only provided in an acute care setting can now be provided in the home often at a lower cost. Physical therapy, speech therapy, intravenous infusion, complex respiratory therapy and a variety of other "high tech" services can all be provided in the home.

However, for many Native Americans these home care services are lacking. Indian Health Service (IHS) currently does not have any formal home health care programs that are consistently provided across the nation. This is especially a problem in the Billings Area Indian Health Service. Some of the units have home health care services provided by private agencies while in other areas the public health nurses (PHNs) provide some home health care time permitting. IHS currently pays for some home health care service, but this is on a case-by-case basis. Consequently, in general, home health care needs are not being adequately met in the Billings Area IHS.

The Billings Area IHS serves approximately 60,021 Native American people living in Montana and Wyoming. Seven Service Units (SU) are in Montana and one is in Wyoming (see Table 1). Two of the Service Units have compacted: Flathead and Rocky Boy. Ambulatory, emergency, dental, environmental health, community health and preventive services are available on all Service Units with the exception of the Flathead Service Unit which provides direct pharmacy, dental services and limited physician services. Other services are provided through contractual arrangements. Blackfeet, Crow and Fort Belknap Service Units have both outpatient and inpatient hospital services.

Aims of the Project

The aims of this project are as follows: 1) develop a current profile of existing public health nursing and home health care services on each reservation in the Billings Area IHS, 2) develop a profile of successful home health programs on reservations in the US, and 3) integrate the two profiles to identify factors contributing to success and failure of home health care programs.

Methods

Benchmarking, a key tool in Total Quality Management, was used in this project. "Benchmarking" is a search for and implementation of industry best practices. The process is used to accelerate the rate of improvement, establish goals and performance measures that reflect an external or client focus, plan for the future, and promote a team

approach to change that is driven by data from successful organizations. Several phases are undertaken in a benchmarking process: planning, analysis, integration, action and maturity. This project focused on the first three. During the planning phase, what is to be benchmarked and comparative organizations are identified, and the data collection method is determined. Following data collection, analysis of the data is done. The current performance "gap" is identified and future performance levels developed. During integration, benchmark findings are communicated and functional goals developed. Development and implementation of action plans occurs during the action phase. Progress is monitored and recalibration of the benchmarks is done as necessary. Finally, during maturity, the new practices are fully integrated into the organization.

Table 1. Billings Area Indian Health Service Units

Service Unit (S.U.)	State	Tribe(s)
Blackfeet	Montana	Blackfeet
Crow	Montana	Crow
Flathead Tribal	Montana	Confederated Salish & Kootenai
Fort Belknap	Montana	Gros-Ventre & Assiniboine
Fort Peck	Montana	Sioux & Assiniboine
Northern Cheyenne	Montana	Northern Cheyenne
Rocky Boy	Montana	Chippewa-Cree
Wind River	Wyoming	Arapahoe & Shoshone

Home Health Care

The first step in the benchmarking process was deciding what was going to be benchmarked. The focus of the project was on home health care, however, there are many different aspects of home health such as acute, skilled home care vs. long-term personal care services provided in the home. The Technical Advisory Committee members felt the biggest gap was in skilled home health care services and decided upon the following definition of home health care. Home health care includes the following components: 1) skilled nursing care is the primary health service provided, 2) a registered nurse (RN) to evaluate the home situation and resources needed to promote clients optimal level of well-being, 3) a designated RN to act as a multidisciplinary coordinator or manager who directs and plans care with an emphasis on optimizing client outcomes, and 4) a designated RN to promote continuity of care and collaborate daily with the multidisciplinary team with representatives as necessary from medicine, occupational therapy, physical therapy, social services, discharge planning, and personal care services. The family's understanding of and ability to assist in care is important in producing positive outcomes. Home health care services are intermittent and part-time, and are provided in the current residence of the client.

Profile of Existing Billings Area Services

The second step in the benchmarking process was development of a profile of the eight Billings Area IHS Service Units focusing on home health care services and related health care resources. The following information was gathered: public health nursing mission and philosophy; public health nursing staffing; core public health nursing services provided; availability of skilled home health care services and personal care services; availability of any specialty services such as hospice, durable medical equipment (DME), intravenous (IV) companies, hospice, etc.; availability of other special IHS programs, such as diabetic programs, dialysis, etc.; availability of long term care; objective/subjective data on home health care need; previous home health care attempts on the SU; and potential financial resources for home health care.

Identification of Potential Benchmarking Partners

The next step in the process was identifying potential benchmarking partners. Administrators in IHS were polled to see who they perceived to be providing excellent home health care services. A list of approximately 10 potential sites was developed. Each of these sites was contacted by phone by one of the consultants, and, if possible, a Technical Advisory committee member, to determine whether they provided skilled home health care. In addition, the administrators were asked about the following for their agency: basic organizational structure, revenue sources, size of staff, length of operation, availability of 24 hour coverage, characteristics of the clientele served, Medicare certification, licensure and accreditation, provision of "high-tech" home health care, and definition and measurement of success in their agency.

Based on the information gathered during the phone interviews, the Technical Advisory Committee selected four sites to visit: Fort Belknap/Phillips County Home Health in Montana, Min-No-Aya-Win Public Health Nursing Department/Home Health Agency (PHN/HHC) in Minnesota, Cherokee Nation Home Health Care in Oklahoma, and Rehoboth McKinley Christian Hospital Home Health in New Mexico. These four agencies were selected because they represented different approaches to meeting the skilled home health needs of Native Americans. Home health care is provided on the Fort Belknap SU through a contractual arrangement with a private, Medicare-certified home care agency, Phillips County Hospital Home Health Care. At Min-no-aya-win PHN/HHC, home care services are provided by the tribe through an IHS 638 contract; currently they do not receive Medicare reimbursement. The PHN/HHC department is part of a human services division with ambulatory care and social services. The Cherokee Nation provides home health services through a free-standing, Medicare-certified agency that is administered by the tribe. Finally, Rehoboth McKinley is a private, hospital-based, Medicare-certified agency that includes the Navajo reservation in its service area. Currently, no formal contract exists between Rehoboth McKinley and the Navajo Tribe in relation to home health care services.

Site Visits to Benchmarking Partners

Each site was visited for one day by one of the consultants and two or three members of the Technical Advisory Committee. Key people at each site were

interviewed as appropriate including the director, tribal council representative, financial manager, patient care manager, and nurses and other staff. Information on the following was obtained: structure and mission of the agency, services provided, other area resources, population served, regulatory issues, goals for organization, financial management, patient care, staff orientation and development, and factors contributing to success and/or failure. One or two site visitors focused primarily on administrative issues while the other visitors focused on clinical issues. If possible, one site visitor went on home visits with a staff member from the organization.



FINDINGS

Description of Billings Area IHS Service Units

Demographic Characteristics

The total user population for the Billings Area IHS was 60,000 in 1993 (see Table 2). Populations for the Service Units range from just under 3,800 in Rocky Boy to almost 10,400 in the Blackfeet SU. The projected 1995 user populations are somewhat different than the actual populations in 1993 with a decrease in all except Crow and Flathead. This is particularly so for the Blackfeet, Ft. Belknap, Ft. Peck, Northern Cheyenne and Wind River SUs.

A key factor in determining home health care need is the number of people who are elderly. In general, the Billings Area IHS has a young population (see Table 2). The percent of the population four or younger is high ranging from 11.2% at Flathead to 15.2% at Ft. Peck. This compares to 7.3% for the US. The percent of the population 65 and older ranges from a low of 3.4% at Crow and Rocky Boy to a high at Fort Belknap of 6.0%. This compares with 12.5% for the U.S. as a whole. Finally, the Billings Area IHS is evenly split between men and women.

Table 2. Demographic Characteristics of Billings Area Service Units

Service Unit	User Pop FY 1993	Projected User Pop FY 1995	% ≥ 65 yrs of age	% ≤ 4 yrs of age	% women
Blackfeet	10,398	8,335	5.7	13.8	50.4
Crow	9,794	10,424	3.4	13.8	50.4
Flathead	7,817	8,771	5.1	11.2	50.4
Ft. Belknap	4,314	3,382	6.0	14.2	50.5
Ft. Peck	8,333	7,272	4.3	15.2	51.5
Northern Cheyenne	6,191	4,308	3.6	15.1	50.1
Rocky Boy	3,780	3,464	3.4	13.4	51.1
Wind River	9,394	7,308	4.3	13.2	49.3
Total: Billings	60,021	52,264	4.5	13.5	50.4

Health Status

Infant mortality rates often are used as a measure of a population's health. In general, the infant mortality rates are higher for the SUs than for the national average which was 10.0 per 1,000 in 1988. The highest 5-year rate, 27.5 per 1,000, is in Rocky Boy's Service Unit. The lowest, 6.2 per 1,000, is in Fort Belknap Service Unit. Fort Belknap is the only SU that is below the national average. The other SUs are in between Rocky Boy and Fort Belknap: Blackfeet 10.4 per 1,000; Crow and Northern Cheyenne 13.2 per 1,000, Flathead 14.9 per 1,000; Ft. Peck 20.8 per 1,000; and Wind River 13.5 per 1,000.

Heart disease, accidents and neoplasms are the leading causes of death for the Billings Area SUs (see Table 3). Chronic liver disease, diabetes, respiratory disease, cerebrovascular disease, influenza and suicide also are leading causes of death for some of the SUs. These findings are noteworthy. In home health care, the leading diagnoses in elderly persons include heart disease, musculoskeletal disorders, injuries and poisonings, neoplasms, respiratory disease, and endocrine disorders (Dey, 1995).

Table 3. Cause Specific Mortality Rates for Billings Area Service Units, 1988-1990, Rates per 100,000 Population

Service Unit	Leading Causes of Death
Blackfeet	Heart Disease: 139.3 Accidents: 123.4 Neoplasms: 99.5 Chronic Liver: 99.5 Respiratory Disease: 47.8
Crow	Accidents: 161.8 Heart Disease: 135.7 Neoplasms 109.6 Chronic Liver: 46.9 Respiratory Disease 46.9
Flathead	Heart Disease: 153.4 Neoplasms: 144.1 Accidents 144.1 Cerebrovascular Disease: 51.5 Respiratory Disease: 37.2
Fort Belknap	Heart Disease: 273.2 Accidents: 220.7 Neoplasms: 157.6 Respiratory Disease: 52.5 Cerebrovascular Disease: 52.5

(Cont. on next page)

Service Unit	Leading Causes of Death
Fort Peck	Heart Disease: 226.1 Accidents: 226.1 Neoplasms: 99.9 Respiratory Disease: 84.1 Chronic Liver 73.6
Northern Cheyenne	Accidents: 161.8 Heart Disease: 135.7 Neoplasms: 109.6 Chronic Liver: 46.9 Respiratory Disease: 46.9
Rocky Boy	Heart Disease: 128.4 Accidents: 128.4 Neoplasms: 117.7 Respiratory Disease: 107.0 Influenza: 53.5
Wind River	Accidents: 220.9 Heart Disease: 160.2 Neoplasms: 104.9 Respiratory Disease: 77.3 Suicide: 71.8
Billings	Heart Disease: 130.6 Neoplasms: 111.4 Motor Vehicle Accidents: 83.0 Liver Cirrhosis: 43.3 All Other Accidents: 36.2 Diabetes Mellitus: 32.1

Existing Home Health Care Resources

Currently, the availability of home health care on the SUs varies significantly. For some of the SUs, the PHNs provide some home health care, on others private agencies are providing care, while on at least one SU no home health care is available. However, a variety of resources exist on or nearby all of the SUs that support and/or complement home health care.

IHS/Tribal Resources

Each of the SUs provide public health nursing services. The newly adopted mission statement for Public Health Nursing in the Billings Area IHS is in the box on the next page. The focus is primarily on community level assessment and intervention. The primary goal is high level wellness. Consequently, home health care services, especially acute-focused services, may be difficult for the PHNs to provide due to increasing high tech needs, frequent visits, unpredictable staffing requirements and conflicting responsibilities and priorities.

At Crow Reservation, the PHNs provide patient and family counseling, education and community assessment focusing on five major areas: maternal child health, communicable disease control, childhood and adult immunizations, chronic diseases, and elderly health needs. Similarly, at the Northern Cheyenne Reservation, well child clinics, immunization programs, communicable disease control, prenatal education, prepared childbirth classes, postpartum and newborn follow-up, and chronic disease control and maintenance are program priorities. In addition, the PHNs provide support to families experiencing a terminal illness, provide fitness and wellness programs, and facilitate school health. At Rocky Boy's, communicable disease, immunizations and performing medical outreach are primary foci of the community health nursing program.

Public Health Nursing Mission

Our main purpose is to improve the health of the Indian community. Public Health Nursing practice is autonomous and based on a synthesis of community need, existing public health nursing resources, and public health program priorities. We achieve this through a program of continuous community assessment and evaluation of needs of Indian people in the communities served. We accomplish this through individual, family and community education, case management, and advocacy. We provide these professional public health nursing services in a variety of settings and in collaboration with others for the goal of promoting high level wellness.

Most of the PHNs provide "minimal" home health care services (see Table 4). On the Blackfeet SU, the PHNs provide home health care services because there are no other agencies providing home health care services on the reservation. However, this may be changing in the near future as an nearby agency is beginning to provide some home health care on the reservation.

Similarly, each SU has a quite a few CHRs, however, for the majority of the SUs, the CHRs are providing minimal or no home health care. Again, Blackfeet SU is the exception with two CHRs providing home health care. Very few of the CHRs are trained as CNAs.

Finally, a variety of special programs are available on some of the SUs that complement home health care. These include diabetic programs, dialysis, foot clinics, respite care, and perinatal services. These could clearly be a source of referrals for a home health care program.

Other Health Care Resources

In addition, to what is available from IHS or Tribal Health, a variety of programs provided by private agencies are available on the SUs. At least one home health care agency is nearby each of the SUs (see Table 5). However, the amount of care provided on the reservation by these private agencies varies from very little at Blackfeet to over 120 visits per month at Fort Belknap. Personal care appears to be provided more

consistently. WestMont, a private agency which is state regulated, provides personal care on most of the reservations in Montana.

Table 4. Indian Health Service and Tribal Health Care Resources

Service Unit	PHN Services	CHRs	Special Programs
Blackfeet	4 PHNs Provide HHC	20 CHRs: 1 CNA, 1 LPN 2 provide HHC	Diabetic Program Meals
Crow	4.5 PHNs 2 new PHNs with new hospital No HHC	No formal HHC services provided	Handicapped persons advocacy Respite Care Dialysis - old hospital
Flathead	6 PHNS Minimal HHC	10 CHRs: 7 generalists, 3 specialists No formal HHC	NA
Ft. Belknap	1 PHN, 1 LPN All non-Medicare/non- Medicaid HHC patients seen	12 CHRs: 1 CNA, 1 LPN. No formal HHC	Diabetic Task Force Pregnant Woman's Program
Ft. Peck	6 PHNs Minimal HHC	8 CHRs: No formal HHC	NA
Northern Cheyenne	3 PHNs Minimal HHC	NA	Diabetic Program
Rocky Boy	1 RN 1 LPN Provide HHC	NA	NA
Wind River	4 PHNs: 1 LPN Limited HHC	15 CHRs No formal HHC	Prenatal and postpartum follow-up Diabetic program

Note: NA = Not Available

Table 5. Other Non-IHS, Non-Tribal Home Health Care Resources

Service Unit	Home Health Agencies	Personal Care	Specialty Home Care
Blackfeet	1 agency nearby; doesn't provide services on reservation	WestMont	Home oxygen No IV, DME or hospice
Crow	2 agencies nearby: 1 provides care if 3rd party payer; the other plans to start service	WestMont Respite and advocacy provided through tribe	Home oxygen, DME, IV services. No hospice
Flathead	2 agencies: 10-16% of visits to Native Americans	WestMont Health Care Givers (Private) CS&K Tribes	Home oxygen, IV, DME, hospice available off reservation
Ft. Belknap	1 agency serving reservation through contract with tribe	WestMont	Home oxygen, IV, DME, hospice available off reservation
Ft. Peck	1 agency nearby: 50% of caseload Native American	WestMont	Home oxygen, DME. No hospice IV
Northern Cheyenne	1 agency 100 miles away	WestMont	Home oxygen, DME. CHRs do hospice.
Rocky Boy	1 agency; have served several clients on reservation	West Mont	Home oxygen, IV, DME from Helena
Wind River	2 agencies providing some HHC on reservation	Through HHC agencies Senior citizen program: limited	Home oxygen, DME and hospice services available on reservation

The availability of specialty home health care services is variable. Home oxygen, DME, hospice, and IV therapy are generally available off the reservation, but not necessarily on the reservation. Wind River is the exception to this in which all of these are available on the reservation. Similarly, nursing home care is generally available off the reservation, but not always on the reservation (see Table 6). For acute care, three of the SU have PHS hospitals while the other SUs have contract care available off the reservation. Out-patient clinics are available on all the reservation.

Table 6. Other Non-IHS, Non-Tribal Health Care Resources

Service Unit	Long-Term Care	Acute Care	Out-Patient Care
Blackfeet	1 nursing home	Blackfeet PHS hospital: 27 bed Contract care: Kalispell or Great Falls	Blackfeet Clinic Heart Butte Health Station: Open 3 days/week, staffed by PA
Crow	None on reservation. Several nearby: Hardin 70 beds; Red Lodge 110 beds; Roundup 37 beds; Billings 695 total beds	Crow PHS hospital: recently completed Contract care: Billings or Sheridan	Crow Clinic Lodge Grass Health Center: 5 days/week with after hours care. Pryor Health Station: open 5 days/week
Flathead	2 Medicare certified nursing homes 6 near the reservation	Contract Care: Missoula	St. Ignatius Health Center: limited medical, pharmacy, mental health, psychology and social services.
Ft. Belknap	5 nursing homes utilized. Tribe has formed Long-Term Care Facility Committee to explore development of nursing home on reservation	Ft. Belknap PHS hospital: 12-bed Contract Care: Havre	Fort Belknap Clinic Hays Health Station: 2 days/week staffed by MD
Ft. Peck	3 nursing homes nearby; approximately 120 beds total	Contract Care: Poplar and Wolf Point	Vern E Gibbs Health Center Chief Red Stone Health Center
Northern Cheyenne	Congregate housing for seniors. 695 total nursing home beds in Billings	Contract Care: Billings and Sheridan	Lame Deer Health Center with 24 hr. emergency care
Rocky Boy	Residential center for 8-10 persons (no skilled care)	Contract Care: Havre or Great Falls	Chippewa-Cree Health Center
Wind River	3 nursing homes in county. IHS patients also in other homes around state	Contract Care: Lander, Riverton and Thermopolis	Ft. Washakie Health Center Arapahoe health Center

Need for Home Health Care

Little patient satisfaction or needs assessment data is available for the Billings Area SUs regarding the need for home health care. Functional assessment is one of the best ways to determine need for long-term and home health care. This information is not currently available for the Billings Area IHS. In a national study, approximately one-quarter of Indian elders reported that their health interfered with their ability to perform daily activities (Indian Health Service, 1995). More rural elders, and most of the Billings Area is rural, were less able to perform daily activities independently than urban elders. Whether these findings hold true for the Billings Area is not known.

Subjective Data

On the Fort Belknap reservation, members of the Geriatric Task Force and Diabetes Task Force have identified the following needs: diabetics who need help with insulin and blood sugar monitoring; dressing changes; terminal care -- hospice; and dialysis. PHNs working on the Blackfeet SU have identified the following needs for patients currently being seen by PHNs: dressing changes, pain management, intravenous therapy, weekly injections, lab draws, oxygen therapy, teaching, blood pressure monitoring, blood sugar monitoring, medication management, colostomy care, catheter care, and physical therapy. On the Crow Reservation, the PHNs perceive that approximately three to four cases are followed each month that need skilled home health care. At Fort Belknap, approximately two to three patients per month are seen by PHNs rather than by the home health agency because no third party payment for home health care is available. Tribal Health officials on the Northern Cheyenne SU perceive unmet needs for home health care and are pursuing some sort of a collaborative arrangement with a home health care agency in Miles City. This collaboration is still under negotiation. Finally, a need for home health care is not perceived by the PHNs at the Wind River SU.

Objective Data

Another indicator of home health care is age of the population; the majority of home health care clients are 65 years of age and older. As noted earlier, the Billings Area SUs tend to be younger than the general population (see Table 2).

Given the lower numbers of older adults, the assumption could be made that the need for home health care is less in the Billings Area. However, when other data on health status are examined, the picture is much different. Table 7 contains the leading diagnoses for outpatient visits in general and for persons 65 years of age and older. Acute and chronic illnesses that are common in home health care are evident, especially for those 65 years of age and older. For example, diabetes mellitus, hypertension, musculo-skeletal problems, and acute and chronic respiratory disorders are relatively common. In addition, some of the visits are for hospital follow-up. Whether these persons could have been better served in their homes is not clear, but it remains a possibility.

Table 7. Outpatient Visit Leading Diagnoses for Billings Area and Service Units

Service Unit	All Ages	Persons 65 years and older
Billings	<ol style="list-style-type: none"> 1. Diabetes Mellitus 2. Otitis Media 3. URI 4. Hypertension 5. Prenatal Care 6. Pharyngitis/tonsillitis 7. Other respiratory 8. Mental 9. Other upper respiratory 10. Allergy/asthma 	Not available
Blackfeet	<ol style="list-style-type: none"> 1. Diabetes Mellitus 2. Otitis Media 3. URI 4. Hypertension 5. Prenatal Care 6. Spine disorders 7. Other respiratory 8. Allergy/asthma 9. Alcoholism 10. Other musculoskeletal 	<ol style="list-style-type: none"> 1. Diabetes mellitus 2. Hypertension 3. Other respiratory 4. UTI 5. Other musculoskeletal 6. Other endocrine 7. Spine disorders 8. Allergy/asthma 9. Dislocation/sprain 10. URI
Crow	<ol style="list-style-type: none"> 1. Otitis Media 2. Diabetes Mellitus 3. Prenatal care 4. Alcoholism 5. URI 6. Pharyngitis/tonsillitis 7. Other upper respiratory 8. Other respiratory 9. Mental 10. Allergy/asthma 	<ol style="list-style-type: none"> 1. Diabetes Mellitus 2. Hypertension 3. Other respiratory 4. Urinary tract infection 5. Other musculo-skeletal 6. Skin disorders 7. Mental 8. Spinal disorders 9. URI 10. Abdominal pain
Flathead	<ol style="list-style-type: none"> 1. Diabetes Mellitus 2. URI 3. Hypertension 4. Infection/parasites 5. Gastritis/duodenitis 6. mental 7. Drug dependence 8. Allergy/asthma 9. Other endocrine 10. Otitis Media 	<ol style="list-style-type: none"> 1. Hypertension 2. Diabetes Mellitus 3. Metabolic disorders 4. Gastritis/duodenitis 5. Allergy/asthma 6. Other endocrine 7. Arthritis 8. Nutritional disorders 9. Other musculo-skeletal 10. Vitamin deficiencies

(Cont. on next page)

Service Unit	All Ages	Persons 65 years and older
Ft. Belknap	<ol style="list-style-type: none"> 1. Otitis Media 2. URI 3. Diabetes Mellitus 4. Hypertension 5. Pharyngitis/tonsillitis 6. Drug dependence 7. Other respiratory 8. Other mental 9. Other endocrine 10. Allergy/asthma 	<ol style="list-style-type: none"> 1. Diabetes Mellitus 2. Hypertension 3. Other respiratory 4. Other endocrine 5. Skin disorders 6. URI 7. Other upper respiratory 8. Neurosis 9. Drug dependence 10. Allergy/asthma
Fort Peck	<ol style="list-style-type: none"> 1. URI 2. Otitis Media 3. Diabetes Mellitus 4. Pharyngitis/tonsillitis 5. Prenatal care 6. Hypertension 7. Other respiratory 8. Neurosis 9. Allergy/asthma 10. Other musculo-skeletal 	<ol style="list-style-type: none"> 1. Diabetes Mellitus 2. Hypertension 3. Other respiratory 4. Neurosis 5. Other musculo-skeletal 6. Other endocrine 7. URI 8. Allergy/asthma 9. Mental 10. Spinal disorder
Northern Cheyenne	<ol style="list-style-type: none"> 1. Mental 2. Otitis Media 3. URI 4. Immunizations 5. Prenatal Care 6. Diabetes Mellitus 7. Environmental problem 8. Hospital follow-up 9. Hypertension 10. Pharyngitis/tonsillitis 	<ol style="list-style-type: none"> 1. Hypertension 2. Diabetes Mellitus 3. Environmental problem 4. Hospital follow-up 5. Other respiratory 6. Other preventive care 7. Immunization 8. Other musculo-skeletal 9. Refractive error 10. URI
Rocky Boy's	<ol style="list-style-type: none"> 1. Diabetes Mellitus 2. Hypertension 3. Otitis Media 4. URI 5. Pharyngitis/tonsillitis 6. Other respiratory 7. Other endocrine 8. Adjustment reaction (adult) 9. Bronchitis 10. Other musculo-skeletal 	<ol style="list-style-type: none"> 1. Diabetes Mellitus 2. Hypertension 3. Other respiratory 4. Other endocrine 5. Other musculo-skeletal 6. Bronchitis 7. URI 8. Spinal disorder 9. Mental 10. Pharyngitis/tonsillitis
Wind River	<ol style="list-style-type: none"> 1. Diabetes Mellitus 2. Otitis Media 3. Other respiratory 4. Hypertension 5. URI 6. Other upper respiratory 7. Prenatal care 8. Pharyngitis/tonsillitis 9. Other endocrine 10. Allergy/asthma 	<ol style="list-style-type: none"> 1. Diabetes Mellitus 2. Hypertension 3. Other respiratory 4. Other GI tract 5. Skin disorders 6. Urinary tract infection 7. Other musculo-skeletal 8. Other endocrine 9. Other bone, joint 10. Spinal disorders

Similarly, hospital admission diagnoses include many that are seen often in home health care (see Table 8). Chronic problems, such as heart disease, neoplasms, musculo-skeletal, and diabetes mellitus, are common. In addition, acute problems that may require home health care also are evident: fractures, myocardial infarction, and pneumonia/influenza.

Table 8. Leading Hospital Admission Diagnoses for Billings Area Service Units

Service Unit	PHS Hospital	PHS Contract Hospital Care
Blackfeet	<ol style="list-style-type: none"> 1. Respiratory disorders 2. Mental disorders 3. Complications of pregnancy 4. Accidents, poisonings 5. Digestive disorders 	<ol style="list-style-type: none"> 1. Fractures 2. Neoplasms 3. Gallbladder 4. Other respiratory 5. Medical/surgical complications 6. Cardiovascular disease 7. Esophagus disorders 8. Other musculo-skeletal 9. Diabetic complications 10. Acute myocardial infarction
Crow	<ol style="list-style-type: none"> 1. Respiratory disorders 2. Complication of pregnancy 3. Digestive disorders 4. Genitourinary disorders 5. Misc. symptoms 	<ol style="list-style-type: none"> 1. Fractures 2. Neoplasms 3. Diabetic complications 4. Gallbladder 5. Medical/Surgical complications 6. Appendicitis 7. Septicemia 8. Other respiratory 9. Acute myocardial infarction 10. Osteoarthritis
Flathead	Not applicable	<ol style="list-style-type: none"> 1. Fractures 2. Medical/surgical complications 3. Gallbladder 4. Complications of delivery 5. Neoplasms 6. Alcoholism 7. Female genitalia disorders 8. Psychotic conditions 9. Pneumonia 10. Asthma

(Cont. on next page)

Service Unit	PHS Hospital	PHS Contract Hospital Care
Fort Belknap	<ol style="list-style-type: none"> 1. Respiratory disorders 2. Mental disorders 3. Digestive disorders 4. Misc. symptoms 5. Accidents, poisonings 	<ol style="list-style-type: none"> 1. Fractures 2. Medical/surgical complications 3. Female genitalia disorders 4. Diabetic complications 5. Acute myocardial infarction 6. Osteoarthritis 7. Uterine scar 8. Joint disorders 9. Psychotic conditions 10. Cerebrovascular disorders
Fort Peck	Not applicable	<ol style="list-style-type: none"> 1. Alcoholism 2. Respiratory symptoms 3. Digestive disorders 4. Diabetic complications 5. Cellulitis 6. Pneumonia 7. Kidney, ureter disorders 8. Cerebrovascular disorders 9. Other respiratory 10. Cardiac dysrhythmia
Northern Cheyenne	Not applicable	<ol style="list-style-type: none"> 1. Respiratory symptoms 2. Appendicitis 3. Gallbladder 4. Pneumonia 5. Other respiratory 6. Cellulitis 7. Medical/surgical complications 8. Fracture 9. Diabetic complications 10. Arthropathies
Rocky Boy's	Not applicable	<ol style="list-style-type: none"> 1. Digestive disorders 2. Respiratory disease 3. Accidents 4. Neoplasms 5. Infection/parasites
Wind River	Not applicable	<ol style="list-style-type: none"> 1. Digestive disorders 2. Gastritis/duodenitis 3. Pneumonia 4. Gallbladder 5. Fracture 6. Pancreas disorders 7. Cellulitis 8. Gastroenteritis, colitis 9. Asthma 10. Diabetic complications

Other indicators of home health needs also are available including recent applications for and/or approvals for certificates of need (CONs) for home health care. In the Fort Belknap area, an organization (New Horizon) has submitted a CON to provide personal care and skilled home health care to Blaine County. Part of the Fort Belknap Indian Reservation is in this county. Big Horn County Memorial Hospital just received a certificate of need. This CON includes part of the Crow Indian Reservation. In the Flathead area, a CON is currently being done for Lake County.

Previous Home Health Care Attempts

Other attempts have been made to provide home health care on some of the Billings Area SUs. On the Crow Indian Reservation, Big Horn County and Yellowstone County have both tried to provide services in the past. Big Horn County was never greatly committed to serving distance parts of the county or the reservation. Yellowstone County formed a five county regional home health agency and stills tries to honor that agreement, but only if third party payment is available. The agencies have attempted to hire local nurses to minimize travel costs, but this has not been successful because of low and unpredictable caseloads.

On the Blackfeet reservation, an unsuccessful attempt was made to start home health care. The former director of the program identified several factors that were related to the failure of this program. She emphasized that there was commitment for the program on the part of the staff and tribal health, however, this was not enough to sustain the organization. She felt that the organization was understaffed especially in relation to medical records and budgetary issues. Ten to fifteen clients were seen daily. The agency accepted Medicare and Medicaid reimbursement, however, some client were without any payment source. At that time, IHS was not paying for any home health care and was not perceived to be supportive of the program. The debt of the agency continued to climb until it was necessary to stop the program. She felt that she and the agency lacked an adequate network to help solve problems. In addition, she had difficulty calculating an accurate cost estimate for the agency services to boost the reimbursement rate.

Other Issues

During the assessment of the Billings Area SUs a number of issues were raised regarding the feasibility of providing home health care. The first is a personnel issue. Are enough trained personnel available to provide clinical services as well as provide management skills in the area of billing and reimbursement? Second, as with many rural areas, geographic distances present a problem on all of the SUs. This is compounded by fluctuating caseloads and conflicting priorities that make staffing difficult. Third, and this issue was raised repeatedly, is the lack of reimbursement of home health care by IHS except for on a case-by-case basis. Fourth, Tribal Employment Rights Opportunities (TERO) requires nontribal organizations to pay a fee on money earned on the reservation. If contracts are made with private organizations off the reservation to provide home health care, how does TERO affect these contracts? Finally, home health care may not be readily accepted. This is a new service and many tribal members as well as health

care providers may not be aware of what home health care entails, how it is paid, what services can be provided, the difference between home health care and public health, etc.

Site Visits

Four sites were visited to gather more extensive information. Location, structure, and size are summarized in Table 9. Each is discussed separately in the following pages.

Fort Belknap/Phillips County Home Health, Montana

Agency Overview

Fort Belknap is part of the Billings Area IHS. In the 1980s, Fort Belknap Tribal Health obtained a CON to provide home health care services on the reservation. For 14 months they advertised for an RN to organize and manage the agency. However, they were unsuccessful in their attempts. In 1986, the Director of Tribal Health began talking with the Director of Phillips County Hospital Home Health Care (PHC). A resolution was drafted to "subcontract" with Phillips County for home health care services. This agreement is renewed each year and has been continuous since that time. The original CON is still in existence in the Tribe's name and is only for the reservation.

Home health care services are arranged through a contract between Fort Belknap Indian Reservation and Phillips County Hospital Home Health Care. PHC provides the nursing director and office space, hires and pays the staff (RN, licensed practice nurse [LPN], home health aide [HHA]), pays mileage and expenses for staff, does third party billing, and reports semi-annually to the tribe. According to the contract, case conferences between the two agencies are required weekly by phone or in person. Two Fort Belknap members are to serve on the professional advisory committee. The contract is to be reviewed annually and can be terminated by either party. If a profit is realized a method of sharing that profit will be determined, however, according to Emory Champagne, Tribal Health Director, this has never been addressed. The focus of the agreement is on those living on the reservation, not off-reservation persons. Tribal Council has been supportive; renewal of the contract has always been unanimous.

PCH is a private Medicare and Medicaid certified home health agency and is part of a private nonprofit hospital, Phillips County Hospital, which has approximately 20 beds and a busy out-patient department. The usual hospital census is about two to three patients per day. The director of PCH is an RN. Her immediate supervisor is the Phillips County Hospital administrator. She spends one half of her time on the services for Fort Belknap. Phillips County Hospital does the billing and payroll for the home health program. PCH has its own medical records, however, some technical assistance is provided by Phillips County Hospital. The records of the persons seen on the Fort Belknap Reservation are kept at PCH. The philosophy of PCH is to pick up everybody on reservation who qualifies and needs home health care to free up tribal health dollars. An attempt is made to hire nurses from the Fort Belknap area. Because PCH is a hospital-based agency, there is some overlap between the home health care staffing and hospital staffing.

Table 9. Benchmark Site Characteristics

	Cherokee Nation Home Health Care	Min-No-Aya-Win PHN/HHC	Fort Belknap /Phillips County Home Health	Rehoboth McKinley Christian Hospital
Location	Talequah, Oklahoma	Cloquet, Minnesota	Fort Belknap and Malta, Montana	Gallup, New Mexico
Size of Population Served	170,000	6,000	3,323	105,000 persons
Size of Service Area	Cherokee Nation Indian Reservation	Fon du Lac Indian Reservation and urban Indians living in Duluth	Agreement covers just Fort Belknap Indian Reservation	60 mile radius of Gallup 35 miles radius of Grants 50 miles west of state line into Arizona
Type of Organization	Free-Standing Tribal Corporation Medicare/ Medicaid Certified	Tribal Health, part of Human Services Organization	Contract between Tribe and Phillips County Home Health Care	JCAHO Accredited, Private Medicare/ Medicaid Certified Home Health Agency
Staff Size	1 RN adm. 12.5 RNs 3.5 LPNs 6.5 HHAs 4 support 1 PT (position vacant)	8 RNs 2 LPNs 3 HHAs	1 RN adm 1-2 RNs	13 RNs 1 LPN 6.5 HHAs 1 PT 4 ST 2 MSW 3 Support
Contact Person	Susan Fisher, RN Talequah	Mike Snesrud, Director, Cloquet	Emory Champagne, Tribal Health Director, Fort Belknap	Linda Wenger, RN Director Gallup, New Mexico

Complementary health care services are available on and off the Fort Belknap Indian Reservation. Home oxygen, IV therapy, DME and hospice are available off of the reservation. Five nursing homes are located around the area. A PHS Indian Hospital and part-time outpatient clinic are available on the reservation.

Clients

Currently PCH has a monthly caseload of about 80 persons. Of these, approximately 16 to 20 are Native Americans on the reservation. Of those seen on the reservation, 10 to 11 per month have Medicare and six to nine have Medicaid. PCH does 135 to 271 visits per month on the reservation. Of these, 45 to 179 are Medicare visits and 47 to 103 are Medicaid visits. Between zero and three persons who live on the reservation are discharged from PCH monthly. The caseload has been relatively stable after a surge several years ago.

Typical clients have congestive heart failure, diabetes mellitus, chronic obstructive pulmonary disease or open wounds. Typical services include skilled observation and assessment, dressing changes, teaching, and oxygen saturation assessment using pulse oximetry. WestMont is used to provide personal services.

A variety of needs still exist on the reservation according the Tribal Health Director and the Director of PCH. The biggest gap is for those who do not have a third party payer. The PHNs only provide care if it can't be done by PCH because of lack of insurance coverage. Currently, the public health nursing office is only budgeted for one RN, one LPN and a secretary, and providing home health care services is difficult for this small staff. In addition, the tribe has had difficulty filling all of these positions. Clients who have no payment source tend to only be seen in a crisis. CHRs may follow them, but consistent nursing assessment is not done. Other needs identified include the following: dressing changes, diabetic monitoring and insulin preparation, monitoring of those with hypertension during medication changes, intravenous therapy, dialysis, personal care, and "night" care for persons needing nighttime supervision.

Monthly Tribal Resource County Meetings are held in which the cases of elders on the reservation are discussed. This involves the director of PCH, Tribal Health Director, an IHS physician, CHRs, WestMont program director, and chemical dependencies counselors.

Budget Implications

Due to the nature of the contract, the direct costs to the tribe are minimal. The primary costs are for the Tribal Resource County Meetings which are held monthly to review elderly clients on the reservation. PCH provides the nursing director and office space, hires and pays the staff, pays mileage and expenses for the staff, and does third party billing. Staff are paid hourly which includes visit time, travel time, and pre- and post-time. Mileage (28 cents/mile) also is reimbursed.

Strengths and Weaknesses of this Approach

The Tribal Health Director identified several strengths of this approach to providing home health care services on the Fort Belknap Indian Reservation. First, the services have been continuous and have, in general, met the needs of the elderly on the reservation. Overall, satisfaction with the program is high. The Tribal Health Director receives few complaints about the program and those that she does receive are generally related to not understanding the program. An advantage to the tribe is that no billing is done by the tribe. All billing is done by PCH. In addition, all personnel matters are dealt with by PCH. Finally, tribal members are employed to do the home visits.

However, this approach is not without disadvantages. The Tribal Health Director does not have direct supervision over the staffing or the care provided. She has to work through the Director of PCH. The good communication between the organizations helps to facilitate this, but it still remains a source of potential problems. For PCH, there are also disadvantages. Under Medicare, patients need to be homebound, however, PCH has trouble making home visits because persons are not at home. In addition, hiring staff has been problematic. The caseload fluctuates and does not necessarily ensure full-time work for the staff. Consequently, finding registered nurses (RNs) can be difficult. This has a significant impact on continuity of care as different RNs provide services at different timepoints. This problem was identified by persons at Fort Belknap and by the staff of PCH. As with many other agencies, nurses, physicians and families have misunderstandings about home health care: what services can be provided, how the services are provided and when the services can be provided. Finally, despite monthly meetings to coordinate care, gaps exist. For example, home health care patients are discharged by the IHS hospital and PCH is not notified of the discharge. At times it has been hard for PCH employees to negotiate the IHS system to obtain medical records on home health care clients. This is made more difficult by the geographic separation of the reservation from the home health care agency.

Keys to Success

A variety of keys to success were identified by both the Tribal Health Director and the Director of PCH. First, good communication between Fort Belknap and PCH has been critical. The monthly meetings help facilitate communication, plus the two directors talk frequently by phone. Second, both directors are dedicated to meeting the needs of elderly on the reservation. They identify this as one of their main goals. Third, both directors have felt that education of the tribe is important. They do this yearly at tribal council meetings and through regular reports about the services being provided on the reservations. Finally, external support by both the tribal council and the hospital administration is critical. The tribe and hospital administration have consistently renewed the contract each year.

Cherokee Nation, Oklahoma

Agency Overview

The Cherokee tribe is a self-governance tribe. Within the Health Services Division is the Office of Professional Services which has a Medical Director. Nursing services are part of this Division and are divided into two separate entities: public health and home health (see organizational chart in Appendix A). The Cherokee Nation Home Health Agency (CNHHA) is a tribal corporation which has been in operation for 5 years and has Medicare and Medicaid certification. Two IHS hospitals and five tribally operated clinics are in the tribal area. There is considerable home health competition in the area. A for-profit home health agency has moved into a store front office next to the Cherokee Nation agency administrative offices in the past several months. A nearby community has 16 home health agencies. However, CNHHA still projects that they will double the number of visits they make in the next year.

The administration of the program is done out of a central office in Talequah. There are three satellite offices which cover 14 counties within the nation. The average travel radius from each office is 30 miles. In an average day, each nurse visits five patients. A typical day is seeing a diabetic patient prior to reporting to the office, doing early morning office work, planning and case management, conducting four more visits, and then reporting back to the office at the end of the day. Nurses currently carry beepers and CNHHA is planning to switch to cellular phones. Many clients do not have phones making it difficult to contact physicians and other providers when out in the field, and to maintain contact with the central and satellite offices should that be necessary. The agency has a professional advisory board which meets quarterly and consists of an RN, MD, medical social worker (MSW), and a consumer.

Cherokee Nation uses a variety of marketing strategies to enhance business. In the past they have done the following: 1) held open houses, 2) developed balloons and key chains with their logo, 3) had luncheons for MDs, 4) developed brochures to give to families and other health care professionals, 5) made business cards for the employees, and 6) published articles in tribal newspapers about home health care services. The CNHHA has been innovative. Staff are able to do all charting in the home. The nurses all get a copy of the *Handbook of Home Health Standards* by Murell (2nd edition from Mosby published in 1994). A calendar is used in the back of the chart in the central office to check frequency and actual visits. Finally, the home health aides wear scrubs.

Cherokee Nation Home Health Care has been exploring a number of options for the future. The possibility of developing a contract with a health insurance company for providing home health to their beneficiaries is under consideration. In addition, they would like to contract with an pharmaceutical company to provide intravenous (IV) therapy on the reservation.

The agency is relatively large. There is one administrator who is an RN. Twelve full-time RNs, one part-time RN, three full-time LPNs, one part-time LPN, six full-time home health aides and one part-time home health aide provide direct care. Four support

staff help with billing, purchasing, data entry, and medical records. In the past they have had one contract physical therapist, but this position is currently open.

Clients

In 1994, 148 new clients were admitted. A total of 9242 skilled nursing visits were made and 6789 HHA visits were made. Diabetes, CVD and hypertension are the three primary diagnoses. Many clients have open wounds and amputations. Ninety percent of clients are 65 years of age and older.

Nurses travel up to 100 miles per day. The length of each visit is 30 to 45 minutes. The expectation is that the visit not exceed 45 minutes. If more indepth nursing is needed, the PHN will be involved. IVs are done if they can run within a day. The agency provides 7 day a week, day time coverage. There is no budget for 24 hour in-home coverage. This is seen as a deterrent to greater growth.

Documentation is done in the home and a "field chart" is left in the home. After the nurse, HHA or therapist has made the visit and documented, the patient signs the form. A copy of this is submitted for billing with an additional form which specifies length of visit and supplies used. Each chart is checked prior to going to billing as to appropriateness of care, documentation and length of time nurses have spent in the home.

Budget Implications

CNHHC has undergone lots of changes in the last few months including administrative turnover and consideration of collaborating/joining a large national home health care agency. Consequently, we were unable to get specific information from the agency. They do receive reimbursement from Medicare. They have been getting VA referrals for the past five years. They also bill Medicaid when possible, however, the State of Oklahoma only pays for 12 visits per year.

Strengths and Weaknesses of this Approach

Independence from IHS was seen as a strength of this approach. In addition, the CNHHC has well organized administration and nursing and support services. Computerized billing also was a strength of this organization. This shortens the time from billing to reimbursement to the agency.

Despite relative independence, this is still a tribal corporation with money generated going into the Tribe's general fund. This limits options for allocating those funds and makes calculation of costs difficult. In addition, improved communication and coordination with the PHNs were needed. Home health and public health are part of the same division, however, coordination between these programs could be enhanced.

Keys to Success

Recommendations based on the combined 10 years of experience of the administrator of nursing service and home health services were very candid:

- Get commitment from the community and area physicians.
- Work with the area public health nurses.
- Start with a small business loan to develop an enterprise that is separate from the tribe. The administrators and others at Cherokee saw some problems working with the tribal system. First, 14.9% of income goes to the tribe for indirect costs the home health agency would prefer to manage such as accounting, marketing, personnel and purchasing. Second, money goes into general fund and it is difficult to extract costs for Medicare report. This deflates their cost/visit.
- Hire Indian and bilingual staff, but be sure they are adequately trained. They presently provide experience for student nurses from area universities.
- Clearly state the reason and goals of the agency to consumers, health care providers and discharge planners.
- Use an administrative consultant/legal consultant who is knowledgeable about home health.
- Hire a nurse administrator who is committed to home health care and has experience in the area.
- Budget for involvement in National Association of Home Care nationally and regionally. Networking and updating is essential to successful administration, program implementation and financial viability.
- Coordinate with other tribal programs, e.g., IHS, local discharge coordinators, AIDs coordinator, Public Health Nurses, and CHRs.
- Hire full-time and part-time personnel and limit the number of contracts to essential services, e.g., PT, SW.
- Use computerized billing because payment can be within 14 days of filing. In addition, corrections can be made on line.

Rehoboth McKinley Home Health Care, New Mexico

Agency Overview

This private JCAHO accredited, Medicare/Medicaid certified home health agency is associated with a 100-bed hospital (see organizational chart in Appendix B). It has been in operation for 10 years and began with one RN and a home health aide. A satellite office is located in Grants which is approximately 60 minutes from Gallup. In response to a request from IHS, they have recently crossed state lines to serve the Navajo population in eastern Arizona. The estimated population served by the entire agency is 105,000 persons with about 50% Native American. Visits are made within a 60 mile radius of Gallup and a 35 mile radius of Grants. It is not unusual for staff to travel 200

miles per day. Much of the travel is on jeep roads so the agency owns four-wheel drive jeeps equipped with two-way radios. There are no other home health agencies in Gallup, but they do have competition from other agencies in the Grants area which is closer to Albuquerque.

Nine RNs work out of the Gallup office while four RNs work out of the Grants office. The agency also employs one private duty LPN, six full-time and 1 part-time HHAs, one PT, four STs, and two medical social workers (MSWs). The home health aides are paid well and receive 72 hours of didactic courses at the local community college. Competency evaluations and skills check are done and the aides must speak Navajo. Three support staff do secretarial work, data processing and billing. The Director is recruiting an additional physical therapist to work in the Grants office. This will markedly increase the caseload for the satellite office. The agency does extensive searches for professional employees.

The agency employs a variety of different marketing strategies: 1) plastic drug boxes have been produced with the agency's logo and phone number, 2) the nursing administrator is highly visible through activity in regional and state home health organizations, 3) the agency has a close association with the hospital discharge coordinators, and 4) they have developed a reputation for culturally sensitive care. The agency has a very spiritual mission and philosophy statement. Both are printed on the back of the staff nametags and are published on agency pamphlets.

Clients

In 1994, 12,552 patient visits were made. This is up from 8,546 in 1991. In 1992, they opened a satellite office and total visits jumped to 11,229. An average of five clients are seen daily. Many visits are made jointly with the home health aides. Less than 10% of Navajo clients speak English and the aides act as interpreters. This is an additional expense which drives up the cost per visit. Because the majority of the clients do not have phones, the rate of "not at home" visits is high (25% of visits). It is difficult to provide high-tech care because many homes lack running water and electricity. The HHAs must carry hot water on many visits.

Probably because of their close association with a private hospital, this agency follows more diverse age groups than other home health agencies. They assess infants needing apnea monitors and bilirubin lights. They have purchased bilirubin lights and apnea monitors so they can provide this service. However, 73% of their caseload is over the age of 60. Primary diagnoses seen are heart disease, open wounds, diabetes mellitus, multiple sclerosis, quadriplegia, and cancer. Dialysis patients are seen if they have problems unrelated to the dialysis.

Multiple cultural barriers exist to providing optimal care. Many common diagnoses/conditions, such as cancer, tuberculosis and death, are considered "bad words". Some procedures and treatments are not well accepted including phlebotomies and oxygen use. Many traditional Navajo males reject personal care by female providers. After hospitalization a period of mourning occurs when the Navajo patient will leave home to purify him- or herself before returning home. This delays the initial visit.

Budget Implications

Gross revenue for Rehoboth McKinley increased from \$400,000 in 1991 to \$882,920 in 1994. In 1994, departmental expenses totalled \$572,240. Medicare is the primary source of revenue. The agency charges \$110 per skilled nursing visit and are reimbursed \$95. They estimated that the average cost per visit is actually \$112. The higher cost is due to the fact that they cannot bill for an HHAs acting as an interpreter, the extended travel times and the need for car radios and four-wheel drive. This deficit has occurred in the past two years with additional expenses attributed to opening the satellite office and expansion activities in the Gallup office.

For the Navajo tribe, there are essentially no real costs, other than coordination costs for making referrals and follow-up on care.

Strengths and Weaknesses of this Approach

The strengths of this approach include successful networking with the IHS system, a highly visible nursing administrator within the region, increasing numbers of appropriate referrals, and a culturally sensitive home health care mission. There are weaknesses to this approach mostly related to coordination of care. Despite successful networking, there are barriers to working with IHS. The IHS hospital is within walking distance of the home health care agency. Many patients are referred by specialty physicians who are unwilling to deal with other primary care problems the patients may have. This has resulted in the agency being unable to provide care for some patients. Recently physician members of the advisory committee have tried to negotiate with IHS to improve this problem. Within the IHS system the definition of the varying roles of home health and public health nursing are unclear and confusing for both providers and patients. No statistics are available on the number of IHS patients that are not referred for home health care because of lack of reimbursement for care, but administration assumes this occurs because they had only one IHS patient covered by contract care in five years. Subsequent discussion with an IHS discharge coordinator at the IHS hospital in Gallup indicated that contract care for home health care can be arranged if approved by the medical director. Finally, Rehoboth has a high cost per visit with reimbursement less than cost.

Keys to Success

There are several keys to success evident in this private agency. The agency uses very aggressive marketing. In addition, the administrator is politically active locally and in the region. Finally, the agency attempts to make cultural sensitivity a key aspect of their care.

Min-no-aya-win Public Health Nursing Department/Home Health Agency, Minnesota

Agency Overview

The Fon du Lac tribe is a self-governance tribe, the 23rd tribe in the country to compact. Public Health Nursing for the Fon du Lac tribe is within a department of the

Human Services Division (see Appendix C). The coordinator of the program is responsible for many traditional public health programs. Home care nursing is one aspect of the overall nursing program. The PHN is often visiting a family concurrently with a nurse from a home health agency that may be providing high tech care to a tribal member. The nurses are involved with discharge planning for clients who have been hospitalized and assess the need for skilled care and for home health aide visits. Although skilled nursing care is provided, the agency is not certified by Medicare and a recent decision was made not to renew JCAHO accreditation. All required services are in place to meet the requirements of JCAHO and Medicare certification, but it was decided that tribal monies adequately support the programs and the agency's desire to establish their own standards and maintain those at a high level is greatly valued. Accreditation was not perceived to add to the existing high standards. Additionally, the cost of the accreditation was projected to be \$17,000 and the director felt that this was a big expenditure without providing much return on the investment.

Thus, nurses fulfill the role of home health and public health with favorable outcomes. The agency provided care five days per week for eight hours until just recently when RN and HHA services became available in the evening, on weekends or during holidays. In addition, until recently, if greater than three visits per week were indicated, the client was referred to a home health care agency. However, now the number of visits that can be provided is unlimited. A great deal of prevention is done to lower the incidence of accidents in the home and to change health risk status by altering lifestyle as well as providing skilled nursing care. Public health nursing has two service centers, one in Cloquet, a rural community on the reservation, and another approximately 15 miles East in Duluth, an urban community. The nearest IHS hospital is 100 miles away although there are four non-Indian hospitals which are accessible to tribal members within five to 20 minutes. The agency is the 2nd largest employer in the county.

There is pride in the success of this agency without the assistance of IHS. The Tribal Council is very involved in all stages of the programs and the obvious success of public health and clinic programs is largely due to an adequate budget. The administrator has been in his position since the outset of the program. The administrator and the program directors have been successful in writing grants (the PHN director wrote 18 grants in the past year). Gaming enterprises have brought many dollars to the tribe with allocations that help fund Human Services. The clinic, offices, and senior apartments are well maintained and supplied with up-to-date equipment. A priority of maintaining Indian culture is obvious in literature, videotapes, and the decor of the clinical offices and waiting rooms. A very impressive senior apartment complex is staffed by an LPN from 2:30 to 10:30 daily. She has an office with a dental chair for providing foot care and maintains computerized health records on all residents.

The Min-No-Aya-Win programs also use lots of marketing techniques. Their logo is on all agency publications. They have an in-house printing department which is used to produce publications for the various programs. Monthly calendars are published with particular emphasis on programs for seniors. A 1995 calendar was published promoting regional art and acknowledging supporters.

Min-No-Aya-Win has been innovative in implementing plans to develop personnel and to develop a strong team spirit. Activities include:

- A 2-day retreat in the fall.
- Staff are recognized with awards.
- Spring and Christmas gatherings, involving country line dancing, and pumpkin carving, have been used.
- Hard core topics that need discussion are combined with entertainment.
- Monthly staff meeting include an agenda item focusing on praise for peers.
- Meyers-Briggs personal profiles has been used for team building.
- Newsletters are sent to tribal members and each department submits an article.

There are eight FTE PHNs, two LPNs, and 3 CHRs. In this agency, the CHRs are cross-trained as HHAs. PT, OT, and speech therapy (ST) services are contracted for it needed. As of April 1, 1995, the PHN/HHC department has received additional funding from the tribe. These funds have been used to hire an additional BSN-educated RN, 2 half-time LPNs, 2 HHAs, and 1 health care associate. They also have changed the role of the home health aide; HHAs will now have a combined role of CHR, HHA, and homemaker. This is intended to reduce the number of people visiting elders in their homes. The director anticipates doing some billing under the Medicare and Medicaid programs, however, this is still in the exploratory phase.

Clients

A criteria for accepting home health referrals has been that less than three visits/week are required. There are 11 home health agencies in the area who can provide care 24 hours/day, 7 days a week. These agencies have been used when clients need more intensive services. However, recently services were expanded and no limitation is placed on the number of visits per week that can be provided to a client.

Many diabetics are followed. They see an "occasional" amputation and they have no dialysis patients. In 1994, 6693 individual client contacts were made and approximately 8000 group contacts. However, home health care is not coded separately from other types of community health services. Any service provided in the home is considered home health.

Budget Implications

The overall budget for the integrated public health nursing and home health care budget is approximately \$975,000 for the 1995 FY. Approximately \$194,000 of this comes from the IHS self-governance compact. As of April 1, 1995, \$112,000 has been allocated from tribal elder care expansion funds. The rest of the money comes from multiple grant sources including the Council on Aging and the State of Minnesota.

Advantages and Disadvantages of this Approach

Advantages of this approach include an critical integration of public health and home health care. These two aspects of community health are often separate although

caseloads may be overlapping with clients having needs for both public health and home health care. Another advantage is not having to follow Medicare/Medicaid guidelines such as the homebound requirement for Medicare. In addition, paperwork can be kept to a minimum. However, this is a disadvantage at the same time; an additional source of revenue is not accessed.

Keys to Success

To be successful, the following recommendations were provided by people from the Min-No-Aya-Win PHN/HHC:

- Tribes should develop home health programs on their own.
- Developing staff "esprit de corps" is critical to success and provision of quality services.
- Work with mentoring programs, such as Protect program and In Med, which orient adolescent tribal members to human service professions to increase the numbers of Indian providers.
- Needs assessment and client evaluations should be done every two years. In 1995, the needs assessment was mailed out with the newsletter to 1000 randomly selected members of the tribe.



CONCLUSIONS AND RECOMMENDATIONS

Home Health Care Need

The need for home health care in the Billings Area varies. Despite lower percentage of older adults in the Billings Area, acute and chronic illnesses, such as cardiovascular disease, that would most likely be appropriate for home health care are very prevalent. In addition, staff on some of the SUs perceive unmet home health care needs, e.g., clients needing skilled care, but without third party payers so they are not seen by a home health care agency. If a decision is made to pursue developing some mechanism to provide home health care on any of the SUs, more definitive estimates of home health care need may be required. In general, home health care has expanded rather dramatically across the country due to increasing proportion of older adults, increasing prevalence of chronic illness, and changing reimbursement and treatment patterns. However, whether this holds true for the Billings Area IHS is not known.

Wind River and Fort Belknap have been able to meet the home health care needs of their residents, with the exception of a minority who have no source of payment, through formal or informal arrangements with private agencies. Contract care for home health care is an option to cover those without other payment sources. On the other hand, the perceived need for home health care is high on several SUs, especially Blackfeet and Northern Cheyenne SUs. Both of these SUs are in the process of exploring mechanisms to meet the needs of their residents.

Several unsuccessful attempts to establish home health agencies have been made in Montana including efforts by Blackfeet and Crow. Some of the barriers to success are experienced by agencies that are presently operating such as those confronted by Phillips County Hospital Home Health Care. The barriers include inadequate resources for staffing, travel distances, personnel budget to include administration and billing, and technology to speed the flow of money.

Keys to Success

A variety of keys to success in providing home health care services to Indians are evident from the site visits. Commitment to meeting home health care needs is required. This came up repeatedly in our observations. For example, at Fort Belknap and Phillips County Hospital Home Health Care, both directors voiced a strong commitment to meeting the needs of Native Americans and were willing to try different strategies in order to do this. This dedication was necessary to continue services despite barriers to providing home health care.

Keys to Success

- Commitment
 - Support
 - Communication
 - Leadership
 - Autonomy
-

Support is also critical. For example, at Cherokee Nation Home Health Care and Min-No-Aya-Win PHN/HHC financial and administrative support from Tribal Health is crucial for the long-term maintenance of these programs. Support is needed from a variety of different sources including tribal health, administration, and IHS. In addition, use of outside support from fiscal intermediaries and home health professional organizations locally and nationally is important. Use of these sources of support are dependent on time and an adequate budget for travel, conference fees and membership dues.

Open and continual communication is necessary for success in whatever approach is taken. This requires good communication with the tribe, referral sources such as IHS hospitals, and other home health care resources. Both directors of Fort Belknap Tribal Health and Phillips County Hospital Home Health Care reported that the good communication between the two agencies was fundamental to the success and continuity of the contract. However, at several of the sites problems in this areas were identified, such as communication with IHS regarding personnel, budget management and payment for uninsured clients, that were perceived to be barriers to providing quality services.

Aggressive leadership is needed especially in areas of high competition. But good leadership is also needed in other arenas as well, e.g., willingness to explore different options, collaborate with others, etc. This type of leadership was evident at Rehoboth McKinley Christian Hospital Home Health in which the director has developed a large geographic service area with varying populations in Western New Mexico and Eastern Arizona.

Finally, autonomy is critical to success. Several sites strongly recommended establishing independence early on from other organizations such as tribal health or IHS. At Cherokee, for example, the home health care administrator had difficulty determining costs because the home health care revenues were part of the tribe's general fund.

Home Health Care Options

The four agencies visited as part of this benchmarking project represented different approaches to meeting the skilled home health care needs of Native Americans. These approaches could be adopted individually, or perhaps a combination may be a possibility in which aspects of two or more are adopted. Home health care is provided on the Fort Belknap SU through a contractual arrangement with a private, Medicare-certified home care agency, Phillips County Hospital Home Health Care. At the Min-No-Aya-Win PHN/HHC, home care services are provided by the tribe through an IHS 638 contract; currently they do not receive Medicare or Medicaid reimbursement. The PHN/HHC department is part of a human services division with ambulatory care and social services. The Cherokee Nation provides home health services through a free-standing, Medicare-certified agency that is administered by the tribe. Finally, Rehoboth McKinley is a private, hospital-based, Medicare-certified agency that includes the Navajo reservation in its service area. There is not formal contract between it and the tribe in relation to home health care services.

Fort Belknap/Phillips County Hospital Home Health Care

The approach taken by the Fort Belknap requires a nearby health care organization willing to contract with the tribe, and take on the bulk of the responsibility for providing home health care services. Low financial and administrative commitments are required. PCH is responsible for hiring staff, providing care, maintaining medical records, and billing third party payers. Consequently, the tribe doesn't have to worry about these. This approach does require coordination between Tribal Health and the private agency. At Fort Belknap, monthly meetings are held to discuss the care of older adults on the reservation.

This approach would be an option for the rest of the SUs in the Billings Area because home health care agencies are located nearby all of the SUs. There may be some problems with geographic service area and whether the reservation was included in the area served by the private agency. In addition, this approach does not meet all the home health care needs on the reservation. Persons without a payment source, such as Medicare, are not necessarily seen by the private agency and the PHNs on the reservation may still be required to follow these individuals unless contractual arrangements with IHS can be negotiated.

Rehoboth McKinley Christian Hospital Home Health Care

This approach differs only slightly from the Fort Belknap/Phillips County Hospital Home Health Care. Rehoboth McKinley is a private agency providing services on the Navajo Reservation, similar to Phillips County Hospital Home Health Care. However, no formal contract exists between Rehoboth McKinley and the Navajo tribe. Rehoboth McKinley has a very spiritual mission which includes an emphasis on providing culturally sensitive to Native Americans.

This approach could potentially be an option for some of the SUs if a private agency exists that wants to take on the responsibility for providing care without the formality of the contract, such as that developed by Fort Belknap and Phillips County Hospital Home Health.

Min-No-Aya-Win Public Health Nursing Department/Home Health Agency

Essentially, in this approach to providing home care the current services of the public health nursing department are expanded to include home health care. This approach allows for continued integration between public health nursing and home health care. Through grants and tribal money, the clinic has provided home health care for patients needing three or less visits per week until recently when home health care services were greatly expanded. The agency has elected not to utilize third party payers feeling that payment sources limit their options in providing services to those who need home health care.

This approach could be an option for most of the SUs, however, the ability to do this will depend on tribal budgetary priorities and adequacy, and the monetary resources of the tribe. In addition, despite the benefits of combining public health and home health

care, these are different programs with, in some instances, incompatible priorities. This incompatibility may present some problems in the implementation of the program.

Cherokee Nation Home Health Care

Cherokee Nation opted to develop its own tribally run home health care agency. Similar to Min-No-Aya-Win PHN/HHC, this approach requires more significant financial commitment by the tribe. The tribe is required to set up the administration and structure of the agency. Therefore, the tribe needs to be able to recruit and retain personnel with experience in health care, billing, budgeting, etc.

This approach potentially is an option for most of the SUs. But, just as with Min-No-Aya-Win PHN/HHC, the decision to go forth with such a strategy would depend on the tribe's budget and budget priorities.

Factors to Consider

A variety of factors must be considered when deciding what approach to take to meet the home health care needs in the Billings Area. The SUs are diverse and, therefore, different approaches may be needed. First, population size is an important variable to consider. Cherokee Nation Home Health Care and Rehoboth McKinley Christian Hospital Home Health Care both served very large populations. The population of the Rehoboth Service Area was around 105,000 persons. This is larger than the population of the entire Billings Area IHS. The individual SUs in the Billings Area range from 3500 to 10,000 in population. These populations are similar to those served by the Min-No-Aya-Win PHN/HHC and the Fort Belknap/Phillips County Hospital Home Health Care Agreement.

Second, the majority of the SUs are geographically isolated. Some are close to large population centers, such as Billings, Montana, where large private agencies may be located. Rehoboth McKinley is an example of this. Although the reservation it serves is fairly isolated, the agency is located in a relatively large population center with a continuum of health care services. However, some of the other SUs are not close to large cities or home health care agencies. Consequently, meeting home health care needs with a large private agency may not be possible.

Third, both the Rehoboth McKinley and Fort Belknap/Phillips County models rely on the availability of other home health care resources off the reservation. For all of the SUs, private agencies are located nearby the reservations. In some cases, the private home health care agencies are already providing services on the reservations, e.g., Wind River. In other cases, the relationships between IHS, the tribe and the private agencies have not been optimal and the agencies have not been providing care on the SUs. Whether these home health care resources would collaborate with to meet needs should be examined on an individual basis considering such factors as interest on the part of the private agency and service area resources.

Fourth, in contrast to the Rehoboth McKinley and Fort Belknap/Phillips County models which rely on private home health care resources, both the Cherokee Nation and

Min-No-Aya-Win models require tribal resources. Consequently, the availability of third party payment and other funding sources, e.g., IHS and the Tribe, need to be explored. At Fon du Lac, the Min-No-Aya-Win PHN/HHC is funded in part by tribal monies which come from gaming dollars. In addition, the PHN/HHC has relied heavily on grants. Third party payers such as Medicare and Medicaid are not currently used. On the other hand, Cherokee Nation receives reimbursement from Medicare and Medicaid. The financial commitments of this approach are much greater than that required by the Fort Belknap/Phillips County Model in which the tribe has relatively little financial investment in home health care. The financial burden rests on the private collaborating home health care agency.

If third party payers are the main source of revenue, these sources need to be adequate to maintain the viability of the agency. This was clearly a factor in an early attempt to develop a tribal home health care agency at Blackfeet according to the former director. Some of the clients did not have any source of payment at all. In a small agency this uncompensated care can have significant financial implications for the agency. In this case, the amount of debt carried by the agency continued to grow until it became impossible to continue the program.

Fifth, as above, both the Cherokee Nation and Min-No-Aya-Win models required considerable technical competence in a variety of areas such as billing, medical records, and grant writing. Currently, billing for third party reimbursement is complex in home health care and requires someone with training in this area. The manuals supplied by the Health Care Financing Administration in relation to billing and medical records are huge. Both Cherokee Nation Home Health and Rehoboth McKinley have three to four support staff members. In the early failed attempt to delivery home health care services at Blackfeet, inadequate technical competence was identified by the former director as a factor in the demise of that program. She felt that the agency was understaffed and did not have enough employees with responsibility for billing and medical records who were adequately trained. Computer support services to enhance the documentation, the billing process and cost analysis are fairly sophisticated. Systems can be put in place with networking to share services in small agencies. The capability to document patient care using hand-held and laptop computers is available. These systems could eventually decrease the amount of documentation time and increase the time spent in providing patient care.

Sixth, if the Cherokee Nation or Min-No-Aya-Win models are used, professional resources are necessary. Health care professionals (nurses, home health aides and possibly therapists) are needed who have adequate education or experience in home health care. The agency needs to be able to pay them an appropriate salary and have a caseload large enough to provide them with enough work hours. Phillips County Hospital Home Health Care is a small agency in a rural community. One of their problems, especially in relation to providing services on the Fort Belknap Reservation, is attracting and retaining adequate nursing staff. The agency seemed to be able to provide the care that was needed, but, according to several people, continuity of care was negatively affected by the turnover in RNs.

Summary

As part of the benchmarking project, visits were made to four model agencies. The various models that were studied included:

- 1) Free Standing, Certified, Tribal Home Health Agency
- 2) Traditional PHN agency providing limited home health care and referring for high tech care or frequent visits (until recently when home health care services were expanded)
- 3) Non-profit, Certified, Private, Hospital-based Home Health Agency providing services on the reservation
- 4) Certified, Private, Hospital-based Home Health Agency providing contractual care on the reservation.

Each service unit will need to establish the appropriate model to meet the needs give the resources available. Based on the size of the reservation and the needs and commitment of the tribes, any one of the above approaches would be an option. Other approaches might include providing care through IHS or the tribe and contracting with another agency or entity to handle billing and some administration. Or computerized billing and other services could be shared with larger service units. In smaller reservations where home health care agencies exist nearby, collaborative efforts with established agencies to improve referral processes and coordination of care seems reasonable. Concentrating on improving access to care for persons on the reservation by developing satellite offices, perhaps subsidized or provided by the tribe and staffed by Indian personnel, also may be an option. As tribes compact, budget allocations could be set aside for clients ineligible for third party reimbursement and case management could be used to manage the care of these high risk individuals.

Given the demographics of the SUs, providing home health care to younger populations should be considered. Pediatric home health care has been growing gradually and this is a potential area of need in the Billings Area. Finally, the efforts begun by the SUs should continue such as those progressing on the Northern Cheyenne and Blackfeet Reservations. In some cases, these efforts are only in the initial stages. Collaboration and networking need to continue.



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APPENDICES

Appendix A
Cherokee Nation Home Health Care
Organizational Chart

Health Services Division

Office of Executive Director
Executive Director

Executive Secretary

Special Assistant

Staff Devel. & Trng. Officer

Office of Program Operations Management
Senior Associate Director

Office of Administration and Fiscal Management
Senior Associate Director

Office of Professional Services
Medical Director

Office of Health Policy Planning & Evaluation
Director

Medical Services

- W.P. Markiller Hlth. Clin.
- Redbird Smith Health Ctr.
- Salina Community Clinic
- Sam Hider Jay Com. Clin.
- Nowata Clinic
- Emergency Medical Svcs.
- Eye Care Services

Behavioral Health Services

- Mental Health
- Social Services
- Substance Abuse
- Adult Treatment Ctr.
- Employee Asst. Program

Jack Brown Center

- STEPP
- First Offender

Community Health Service

- Community Health Reps.
- Health Education
- Development Disabilities
- Vocational Rehabilitation

Food & Nutrition Services

- WIC
- Food Distribution

Biomedical & Facilities

- Property Management
- Budget

Contract Compliance

- Information Systems Mgmt
- Billing & Collections

Quality Improvement

- Nursing Services
- Public Health Nursing
- Home Health Agency

Clinical Services, BHS

- Preventive
- Clinical

Credentialed Medical Svcs.

- Pediatrics
- Primary Provider
- Emergency Medical
- Mid-level Provider
- Credentialed Adjunct Svcs.

Recruitment

- Health Prom/Disease Prev
- Robert W. Johnson Grant
- AIDS

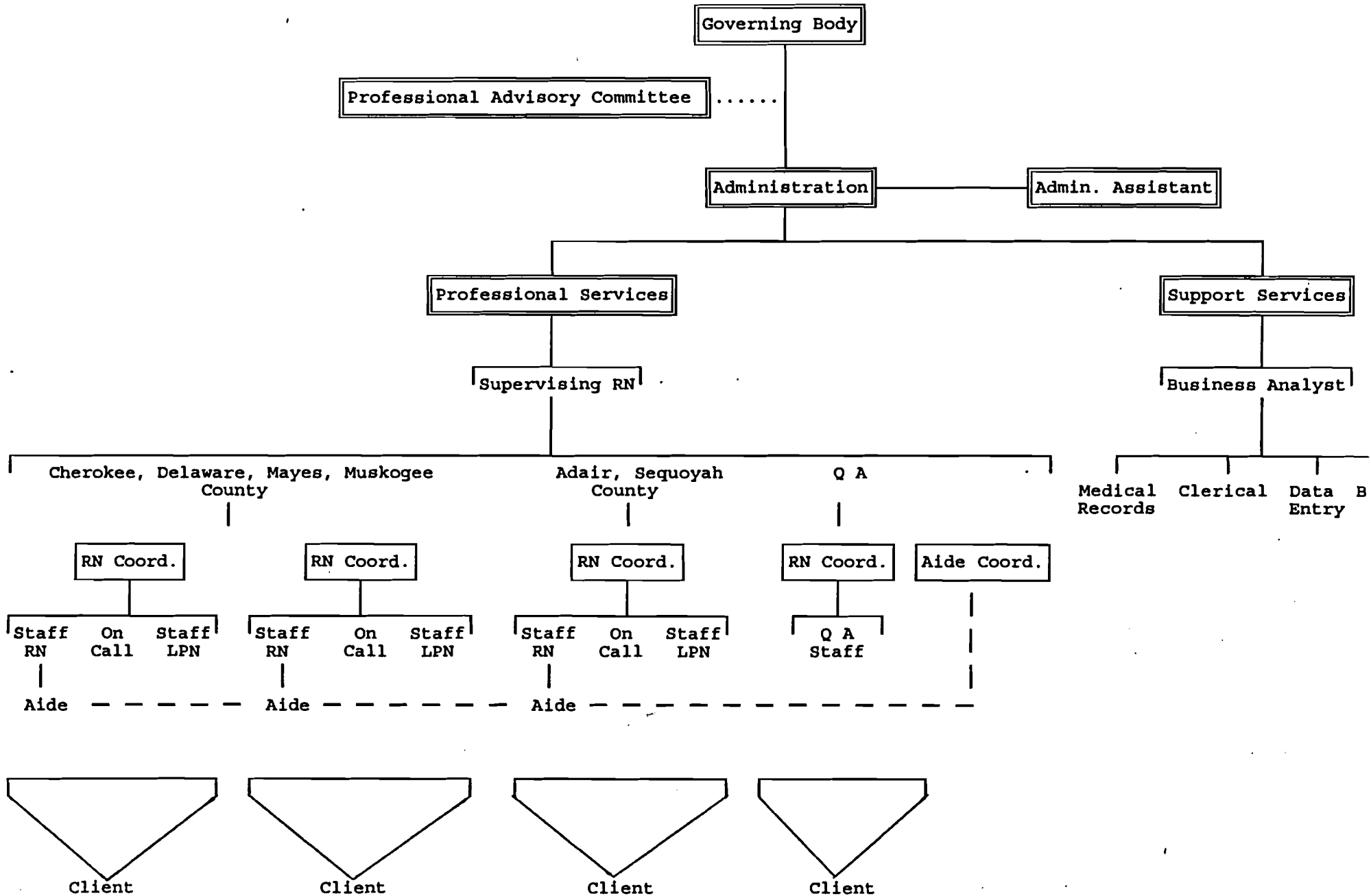
Ancillary Services

- Lab/Radiology
- Pharmacy
- Medical Records
- Alternative Medicine
- Nutrition

Network Development

- Epidemiologist

Health P
Finance

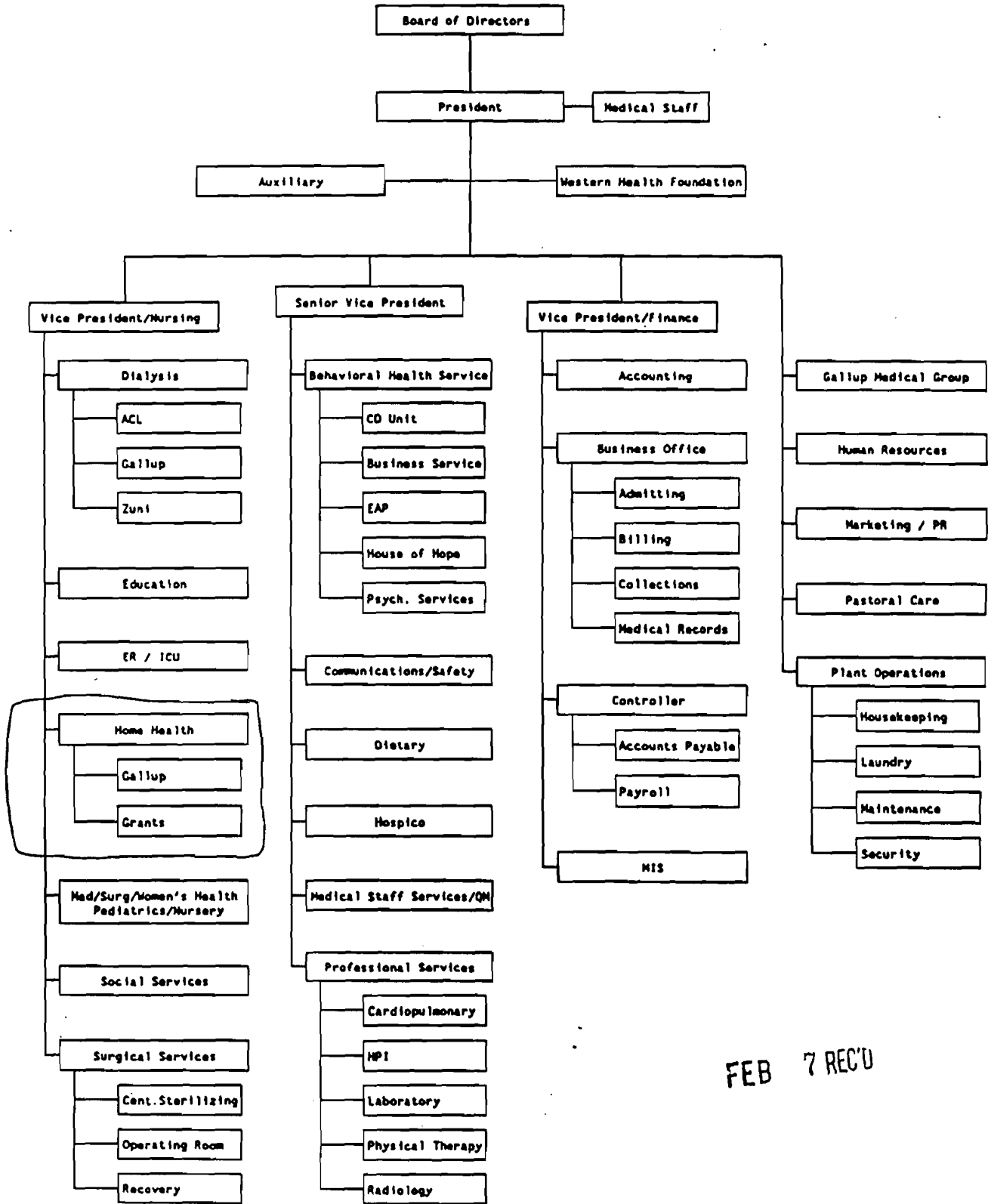


Appendix B
Rehobath McKinley Christian Hospital Home Health Care
Organizational Chart

Rehoboth McKinley Christian Hospital

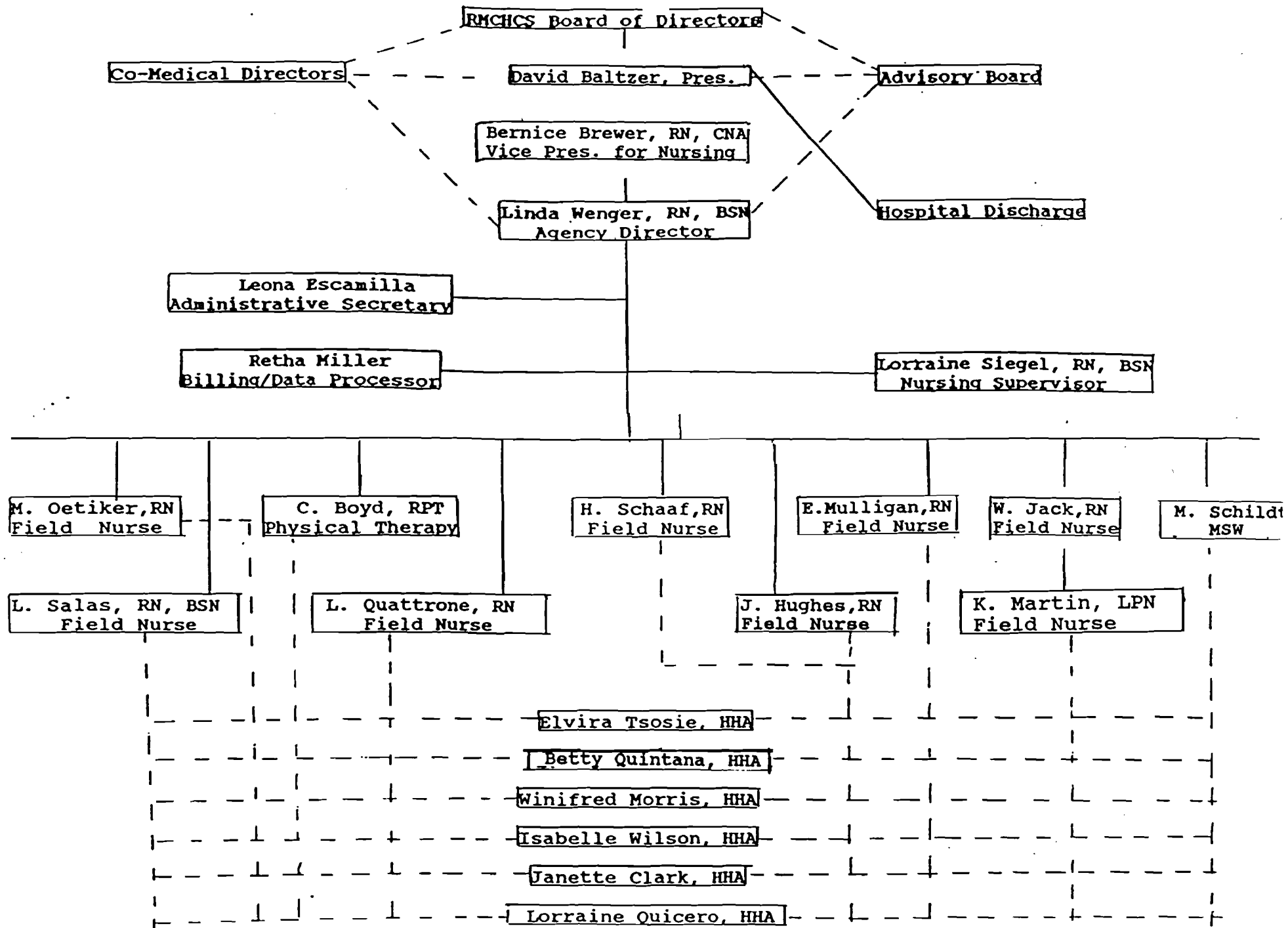
Gallup, New Mexico

TABLE OF ORGANIZATION



FEB 7 REC'D

APPROVED:
David Baltzer 2/3/95
David J. Baltzer, President Date



RMCHCS Board of Directors

Co-Medical Directors

David Baltzer, Pres.

Advisory Board

Bernice Brewer, RN, CNA
Vice Pres. for Nursing

Linda Wenger, RN, BSN
Agency Director

Hospital Discharge

Leona Escamilla
Administrative Secretary

Retha Miller
Billing/Data Processor

Lorraine Siegel, RN, BSN
Nursing Supervisor

C. Carlton, RN, BSN
Field Nurse

P. Gutierrez, RNC
Field Nurse

J. Sibley, RN
Field Nurse

C. Johnson, P.T
Physical Therap

J. Wauneka, RN
Field Nurse

C. Martin, HHA

C. Becenti, HHA



Fond du Lac Reservation
Human Services Division
 Flow Chart

