Designing a Home Health Care System for Alaska Natives in Anchorage

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Abstract: Purpose: To design a health care program that allows Alaska Natives to receive culturally appropriate health services in their homes, thus avoiding the trauma of institutionalization and significantly increasing the quality of the patient’s life during the course of the treated illness. Method: Utilizing the culturally appropriate sensitivity that is found within Tribal Health Corporations, Southcentral Foundation is designing a federally based community health care model to bring health support services into the patient’s home. Health Aides and Community Health Representatives play an important role in extending this model into an urban community setting. The cost of care is significantly reduced, as it is more cost-effective to keep patients in their own home environments rather than in institutions. Results: Major outcomes for patients are increased cultural sensitivity to their needs, personal comfort, dignity, and care in their own home surroundings. Outcomes for the federal care system are significant savings and more efficient personalized health care.

Keywords: Alaska; Anchorage; Home health care; Alaska Natives; Cultural values; Health care delivery

INTRODUCTION

There are many patients institutionalized in medical facilities within the United States and other countries who do not need to be treated at such a high level of care. Basically, the concept of home health care is to get each patient who does not absolutely need to be there out of every medical institution. If a patient is evaluated by a team and found to have a condition that does not warrant institutionalization, and his/her condition calls for health-related treatments that may be performed within a patient’s home, then this patient should be treated at his/her home. This is the future of medical care delivery in Alaska, as well as across the United States.

By remaining in the home, patients gain the dignity of being able to stay in their own environment surrounded by loved ones, while receiving the level of home health care they require. Sometimes patients are left longer in an institution, not for medical but for social reasons. For example, we might keep a person in a nursing home for “social reasons” such as that he/she cannot clean the home or prepare meals. Home health care would provide services such as meal preparation, light housekeeping, and other support services to keep the patient home. Institutions would benefit by reducing their operation costs with shorter lengths of stay. The government would save money by paying for lower levels of care. The private sector would benefit by the creation of more jobs in communities. Everyone would in some way benefit from this concept, which has actually been turned into a 30-billion-dollar industry in the United States.

Home health care staffing is provided by a supervising physician, a chief professional nurse, and various aides, as well as specialty staff, depending on the level of care required. This could include a physical therapist, an occupational therapist, a licensed practical nurse, a specialized nurse for intravenous therapy, a consulting dietitian, a geriatric nurse practitioner, a respiratory therapist, and others. There are various levels of home health care, which can include basic medical care, elder care, and home hospice. Other support services require a home health care program administrator, a chief financial officer, a quality assurance manager, and a medical social worker, and may also include directors of patient care, volunteer services, and bereavement services.
THREE COMPONENTS OF A HOME HEALTH CARE SYSTEM

Basic Medical Care
We define as basic medical care that the patient is under the care of a physician, is under a plan of care established and periodically reviewed by the physician and the medical team, is in need of skilled nursing care on an intermittent basis, and is confined to home and needs specialized therapy services. For the government to pay for these services, the patient must be qualified under the federal Medicare or Medicaid programs, Social Security, or other medical insurance programs. Some patients pay through private insurance; others directly out of their own funds.

Elder Care
Substantial numbers of disabled older people now live in assisted-living settings, where they receive individualized personal care in accommodations that offer more privacy, space, and dignity than are typically available in nursing homes and at lower cost. In assisted-living settings, some older people whose disabilities are equivalent to those of nursing home residents receive individualized care in settings more home-like and “normalized” than nursing homes. Assisted-living settings may be board-and-care homes with additional services, residential care units owned by and adjacent to nursing homes, congregate housing settings that have added services, purpose-built assisted-living programs, or the middle level of continuing care retirement communities. Ownership may be either nonprofit or for-profit, the latter including chains of varying sizes.

Hospice
Hospices provide palliative care, as opposed to curative care. Hospice services include supportive, social, emotional, and spiritual services to the terminally ill, as well as support to the patient’s family. The care is primarily provided in the patient’s home so that peace, comfort, and dignity are maintained. Hospice care depends on the combined knowledge and skill of an interdisciplinary medical team that coordinates an individualized care plan for each patient and family. Hospice reaffirms the right of every person and family to participate fully in the final stages of life.

SOUTHCENTRAL FOUNDATION AND NATIVE HOME HEALTH CARE
Southcentral Foundation was incorporated in 1982 as the nonprofit tribal health corporation of Cook Inlet Region, Inc., the Alaska Native corporation representing Southcentral Alaska, including Anchorage. Its mission is to improve the health and well-being of Alaska Natives and American Indians through the development and implementation of comprehensive health-related services which meet changing needs, enhance culture, and empower individuals and families to take charge of their lives. The foundation manages the primary care programs at the Alaska Native Medical Center and also runs several clinical programs, which include dental, optometry, and behavioral health.

Tribes are currently involved in the transfer of many health programs from the Indian Health Service (IHS) to their jurisdiction. In evaluating which programs would be most appropriate for Southcentral Foundation to take on, it was noted that there was a big gap in the continuum of health care services for Alaska Native people in the Anchorage area. The main referral hospital for the Alaska Area Native Health Service is located in Anchorage, as are numerous other private, federal, and nonprofit hospitals and nursing homes. The deficiency we noted was that there was no home health care program available to meet the special needs of Native peoples. Those needs include cross-cultural sensitivity, skills in Native languages, knowledge of traditional medicine, and other special population issues. We felt that not only did the services not exist within the IHS structure, but also there was no model that we could readily adapt for our needs. In particular, we wanted to find a home health care that placed special emphasis on Native peoples and also easily connected to the IHS health statistics computer to provide for third-party billing, to track patients and care given, and to incorporate a follow-up to the individual health care plan, including a flagging system that would alert us when some particular service was due or if a client needed to be seen on a routine basis. We
also needed a program that would be compatible with the Alaska Native Medical Center hospital billing system and would itemize charges between the hospital and the clinic and home health as well as contribute health data for planning purposes. The system needed to be user friendly and conform to all existing Medicaid and Medicare regulations and IHS reporting requirements. We decided that exactly what we wanted did not exist, although parts of it did exist in the private sector.

The purpose of Southcentral Foundation undertaking such a venture would be to restore dignity to the patient to be in his/her own surroundings with their families as much as possible; provide a new source of revenue that could be used to help make up for some of the funding cuts being experienced in many programs across the country; and provide jobs for Alaska Natives and American Indians in the Anchorage area, especially for Cook Inlet Region, Inc., shareholders. We felt that if a client did not absolutely need to be in the hospital, then he should be home. The same was true for nursing homes, when we felt that clients would flourish in a more supportive environment at home.

The task then was to design a program that was for federal institutions, with some private sector aspects in it. Our next step was to approach the Office of the Director of IHS in Rockville, Maryland, where we met with Ms. Cynthia Smith, Senior Advisor to the Director. She called on her colleague, Ms. Joyce Jackson in the Health Care Financing Administration (HCFA), in Baltimore, Maryland, where together they convened a working group to critique a model for community-based health care that could be applied to reservations across the country. The IHS Director had established a steering group in May of 1994 to work with HCFA in many areas of concern common to both agencies. Mr. Harry Rosenswig of the IHS Claims Office in Rockville coordinates the effort for his agency. After several meetings, the group concluded that there were some needs that should be met nationally before the tribal group could begin its demonstration project. Those needs included 1) the necessity of a crossover billing system that could be duplicated in a number of IHS facilities nationwide and could be used in hospitals, extended care facilities, and all tribal health operations, including aspects of community-based home care; 2) the necessity of the billing system to be a simple one that included data from the IHS Research and Planning Management System for planning purposes; 3) a billing system that would be easily adaptable to all tribal groups; and 4) the IHS system to be designed to be the source of teaching and providing technical assistance to all tribes. HCFA has extensive experience with reimbursement systems and could assist IHS in modifying the existing systems to a more user-friendly one. Southcentral Foundation has volunteered to be a test site for the program. The common feeling is that "if it works in Alaska, then it can work anywhere." Alaska is well known for its lack of roads, communications, and basic infrastructure, as well as sporadic breakdowns in electrical and operating systems in general.

The concept of community-based care for Native peoples should include some special emphasis on utilizing the existing special class of Native work force, which we have identified as Community Health Aides and Community Health Representatives. These individuals are specially trained in providing a first line of primary care in rural village settings, where no on-site physician or other health professional is readily available. They conduct sick calls; consult with health care specialists by telephone, radio, or visual images transmitted over phone lines (telemedicine); and make first decisions on what interventions are required for a particular case. They are the first line of medical care for remote areas. For different reasons, a number of them chose to leave the village and come to urban areas, where they find themselves unemployed. We intend to use these same highly trained individuals to provide community-based health care in the homes of Natives requiring their assistance. The question is one of federal reimbursement under Medicaid for their services within the context of community-based health care. Presently, the working group is considering this as well as other reimbursement scenarios, including traditional healers recognized by their tribes. We are not sure if this will require the State of Alaska to apply for a federal
 waiver or not. The program would be licensed and certified by the State of Alaska and would fall under Medicaid and Medicare reimbursement regulations.

Southcentral Foundation is also working with the Alaska Area Office of Community Health, Dr. Tom Nighswander, to develop some urban strategies for providing first-line medical care for Natives. Part of Dr. Nighswander’s vision is to develop a network of urban health aides that would be placed in strategically located areas of high Native populations and who might be employed as a first point of contact with the medical system for local residents. This could prevent overutilizing the emergency room at the Alaska Native Medical Center. Answers to questions such as “Does my baby really need to be seen right now in the emergency room?” could save parents many hours of anxiety as well as potentially free up the emergency room. Furthermore, health aides that have dropped out of the system and are no longer practicing represent a loss of training investment to IHS. We hope to work with HCFA and IHS to assess their current training, future training requirements, and certification for use within the home health care system.

Dr. Nighswander references the fact that we have an increasing number of seniors (over age 65) in our Anchorage population. Between 1990 and 2000, the senior population is estimated to grow by 42% and reach a total of 5,787 by the year 2000. He feels that the Native hospital’s internal medicine service should be in a position to create a home visitation program for follow-up of chronic medical conditions and for monitoring of symptoms, which should lead to earlier discharge of patients from the hospital and more appropriate follow-up.

**TIMETABLE**

At present, Southcentral Foundation is completing its business plan for presentation to its board of directors. It is planned for the program to be in place for the opening of the new Anchorage Native Primary Care Center in the summer of 1997. Meanwhile, the IHS/HCFA committee continues to meet and critique our efforts as we continue to seek input from the Alaska Native Medical Center staff as well as other tribal health organizations.

**CONCLUSIONS/SUMMARY**

Health care for Native peoples today is part of a dramatic restructuring of the whole U.S. medical system. As administrators look for ways to deliver more efficient health care to their clients, the old systems are looking for ways to adapt to new ideas and methodologies. Home health care is a 30-billion-dollar-a-year industry nationally that represents one of the fastest growing components of the economy. Southcentral Foundation is on the cutting edge of this movement, designing a community-based health care system that involves input from various state and federal agencies in order to learn from their experiences so it can design programs to close the gaps in the continuum of care that exist now, not only for the benefit of Alaska Natives, but for the whole Native American community nationwide.

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