League of Women Voters of Minnesota Records

Copyright Notice:

Version 3
August 20, 2018

6/3/82

These are ann
Pugliese's records
from the Kedette Care
Study (now dropped by
LWVUS from program)
talk to me about this.
Do we keep? throw all?
keep some?

TO: Local League presidents

FROM: Joan Newmark, Voter Service Chair

RE: Debates '82

DATE: May 21, 1982

Plans are well underway for our October 1982 debates between major candidates for Minnesota's governor and U.S. Senator. Sponsor of Debates '82 is the League of Women Voters of Minnesota. Co-sponsors are Common Cause of Minnesota and the Augsburg College Public Affairs Forum.

The gubernatorial debate is tentatively set for 7 p.m. October 24, and the senatorial debate for 7 p.m. October 25, thus providing an opportunity for two consecutive evenings of public affairs programming to maximize voter interest the week before the general election. Both will be held at Augsburg College in Minneapolis.

WCCO-TV is planning to carry the debates, providing feeds to other stations on a cost-shared basis.

Other stations which have expressed interest in carrying the debates are as follows:

KEYC (Ch. 12) in Mankato
KDLH (Ch. 3) in Duluth
KCMT/KNMT (Ch. 7 & 12) in Alexandria and Walker

A list of radio stations interested in carrying the debates is included. We have sent a second letter to several other stations hoping to generate their interest in carrying the debates. Please check the attached list of stations and encourage these stations to carry the debates if you live in their broadcast area.

[redacted]e in an area where you will not be able to receive the [redacted]ven if the listed stations carry them, please let us [redacted] any suggestions regarding contacting the stations [redacted]i to hear from you.

[redacted] announced thus far have been informed of our [redacted]es. Debates '82 has developed a set of cri- [redacted]ch candidates to invite to participate. (See

[redacted]has pledged a major contribution to the [redacted]more donations are expected in the next

What changes should be reported?

You should notify your worker immediately if:

- your check, GAMC Identification Card, food stamps, or identification is lost or stolen
- your income changes
- your address changes
- you get a job or your job changes
- your income increases or decreases
- the number of persons living in your home changes
- any of your children, age 14 or older, leaves school or finds employment
- your marital status changes (you get married, divorced, separated, or widowed)
- if anything else happens which you feel might affect your situation.

Information is kept strictly private

All information you provide or that is obtained through other sources is private, as are all welfare department case records.

What do you do if you have a complaint?

Any applicant or recipient who feels s/he is discriminated against in any manner in the handling of a public welfare application or payment because of race, color, national origin, religion, sex, age, marital status, or because of a physical, mental, or emotional disability may file a complaint with the Minnesota Department of Public Welfare, Centennial Office Building, St. Paul, MN 55155; the Minnesota Department of Human Rights, 240 Bremer Building, 7th and Robert Streets, St. Paul, MN 55101; or the U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201.

DPW-2063
(3-79)

[1977]

GAMC

GENERAL ASSISTANCE MEDICAL CARE — Minn. Dept. of Public Welfare

GENERAL ASSISTANCE MEDICAL CARE

The State of Minnesota, in its concern for its citizens, has instituted laws providing financial assistance and social services to persons in need of them through the following welfare programs:

Aid to Families with Dependent Children (AFDC)
Child Welfare Assistance (CWA)
Food Stamps
General Assistance (GA)
General Assistance Medical Care (GAMC)
Medical Assistance (MA) and
Minnesota Supplemental Aid (MSA)

This brochure is about the General Assistance Medical Care program. This outline provides only general information. More specific and detailed information regarding GAMC or other assistance programs and services is available at any local county welfare or family service office.

What is General Assistance Medical Care?

This program is designed to assist people in meeting the cost of necessary medical care. It was created to include those who are not eligible for other state and federal programs such as AFDC, MA, MSA, and Medicare.

What services are covered by General Assistance Medical Care?

GAMC covers a wide range of medical expenses such as:

- hospital care
- outpatient and clinic care
- laboratory and x-ray services
- doctors services
- dental care
- nursing home care
- physical therapy and related services

Who is eligible for General Assistance Medical Care?

You may qualify for this program if you:

- live in Minnesota;
- are currently receiving General Assistance;
- own property with an equity of not more than $28,500;
- own personal property worth less than $750 if you are single ($1,000 for a married couple, plus $150 for each child);
- own life insurance with a cash surrender value not over $1,000 per insured person;
- have only one family automobile, regardless of value;
- have a yearly personal income of less than $2,868 if you are single, $3,600 for two family members, $4,368 for three family members, $5,088 for four family members, $5,724 for five family members, plus $696 for each additional child under 18;
- prepaid funeral contract of $750 + $200 accrued interest per person.

How does the General Assistance Medical Care Program work?

The General Assistance Medical Care Program is administered by your local county welfare agency. The workers in your welfare agency will help you apply for General Assistance Medical Care.

Your Worker helps by:

- explaining your rights and the requirements of the program
- reviewing your application for completeness
- alerting you to other programs for which you may qualify
- informing you of program changes
- pointing out health and social services available to you.

You help by:

- filling out the application form
- discussing your situation with the worker fully and frankly
- furnishing proof of information you supply, if requested
- informing your worker of any changes in your situation.

Prompt Reporting Prevents Trouble

It is very important to immediately report any change in your situation. Failure to do so could result in:

- having to pay back money you were not entitled to receive
- receiving less money than you were entitled to receive
- possible charges of fraud.

Dear Ann -

This bill - Senate File 234 is for information only regarding education but has opposition! Will be heard Fri 1:00 PM Room 118 Capitol before Higher Ed. Sub Committee.

Anne Stakowski - Chair 296-4192

A call to her, if you agree with the bill, would be helpful.

Sincerely

Carol Fuller

[1980?]

QUOTATIONS TAKEN FROM STUDIES AND ESSAYS IN LEADING MEDICAL JOURNALS

ON THE SUBJECT OF FAULTS IN MEDICAL EDUCATION

WITH SPECIAL ATTENTION TO DEPARTMENTS OF MEDICINE

"Departments of medicine are commonly described as the linchpins of medical schools. They are the largest departments in the medical school and often the largest in the entire university. They have the primary responsibility for the education of medical students, they retain the largest house staff, they train the greatest number of research and clinical fellows, and in most institutions they do the most research. Most have major service responsibilities....Moreover, because of their diverse functions, they are more vigorously buffeted by change...."

"Finally, departments of medicine must engage in a rational process of long-range planning. In many visits to various departments, I found none --including my own--that did anything but approach its problems in an ad hoc fashion."

Robert G. Petersdorf, M.D., department head, U. of Washington

"Most teachers of family practice residents come from internal medicine departments."

Robert H. Moser, M.D., exec. vice-president of the American College of Physicians

"College, medical-school, and house-officer education now each go their own way without really understanding what the others are doing.... Some understanding exists between medical schools and teaching hospitals; little exists between colleges and medical schools."

Ludwig W. Eichna, M.D., department head, State University of New York

Compiled by Carol M. Fuller - 429-3916

Robert G. Petersdorf, M.D. Departments of Medicine, New Eng. J. of Med. Aug, 29,1974
and Evolution of Departments of Medicine, NEJM, , Aug. 28, 1980

"Departments of medicine are commonly described as the linchpins of medical schools." Rest of quote on the title page

Problems arise because of "the degree of overspecialization that has become characteristic of departments of medicine. This is reflected in complaints by surgical departments that they cannot get a "good medical consult"; all that seems to be available is a group of specialists. In a specialized setting, medicine on the wards is often practiced by a committee of consultants, and service in the general medical or internal medicine clinic is considered a drag. This poses a serious problem for departments of medicine because in the face of a demand for more generalists by the community, they have few role models in their own departments to supervise the training of generalists. Moreover, even if a department turns out good generalists from its training programs, it has great difficulty in retaining them."

"A universal problem for all faculty members, particularly the young faculty, is the demand on their time. For a variety of reasons, the senior faculty has taken on obligations that often take him 'out of town', leaving the junior faculty behind to do the teaching and take care of the patients. This presents a most serious problem to the young investigator, who....cannot find the time to get to the laboratory. In addition to the frustration engendered by this enforced absence from the bench, these faculty members pay a price because promotions based on teaching and patient care, rather than research, often come more slowly.

"Despite these difficulties, faculty members whose primary interest and activity is in clinical investigation remain fairly secure whereas those whose primary activity consists of clinical work and teaching are uniformly worried about their academic futures. They like the academic world....but worry about promotions, tenure, and attainment of other criteria that have been used to characterize the successful academician. Departments of medicine have not yet found a way to accord appropriate recognition to the scholarly clinician....
1974

"It is easy to promote the researcher who has written a great many papers; it is much more difficult to give a similar accolade to the clinician who excels at instruction and patient care. Yet this is precisely the type of faculty member whom we must encourage if we wish to meet our obligations to our students and patients. 1980

Allan S. Brett, MD, Primary Care: Controversy and Necessity, The Forum on Medicine, May 1980

"It is unlikely that new internal medicine graduates will feel comfortable as generalists unless they have the opportunity to observe generalists." He says that young doctors in training seldom work with generalists in the care of patients.

Robert S. Lawrence, M.D., Internal Medicine News, June 1, 1979

"The way we train residents in internal medicine is like having people who want to become forest rangers spend all their training time in a lumber yard."

Ludwig W. Eichna, M.D., Commencement Address, The Pharos, Summer 1980

Dr. Eichna, head of the department of medicine, State University of N.Y. at Downstate Medical Center, says he became increasingly disturbed over the product of medical education until, when he retired, he reentered medical school in order to find out where the problems lay. He was a full-time student for four years performing exactly as other students and passing all examinations. He delivered the commencement address to his class and some of what he said follows.

"There is an increasing, almost obsessive use today of laboratory tests and procedures.....It is this surrender to "the numbers" that so inflates medical costs. Yet, medical education today rarely calls upon us to justify the tests done....We are being taught to treat "the numbers" not the patients. It was commonplace for residents upon approaching a patient to turn immediately to the intern and ask, "What are the numbers today?" not, "How is the patient?"

"Let us be clear. We absolutely need laboratory tests and special procedures; they are essential for good patient care. What we need is to perfect clinical skills that will permit the use of only the necessary tests in a proper, thinking sequence..."

"What of clinical skills? They are poorly taught. Rarely is the student actually observed taking a history or performing a physical examination... Today, physicians are being trained who have never been observed in the actual performance of basic clinical skills--not in medical school, not as house officers, not in certifying examinations, and no longer in specialty board examinations."

"Now I come to medical ethics. The downgrading of clinical skills (and note that it is clinical skills that bring a physician into close contact with patients) have led to the teaching of bad medical ethics..... Today, we look too much upon patients as resources for our own development; our needs, not the patients' are now our outlook....Our outlook has been patterned upon that of our teachers. The house officers are the worst offenders, and note that the student lives with them all day, every day. Self-centered in their development they neglect patient concerns. Faculty, concentrating on teaching, pay too little attention to patients as people."

Faith T. Fitzgerald, M.D., The Clinical Examination, A Dying Art?
The Forum on Medicine, May 1980

"The history and physical examination, properly done,.....provide 90% of the diagnoses....." However, those she teaches seem not to like to interview and examine patients. Why has this happened?

"The history and physical examination as currently taught are dull"..... "undirected", do not emphasize good journalist principles, and are perceived by the students as less "reliable" than the laboratory test.

"By what evidence is a well-described physical finding less "scientific" than a computer generated number? Why should clinicians abdicate their diagnostic responsibility to machines and operators who do not know the patients..."

Frederick W. Platt, M.D. and Jonathan C. McMath, M.D., Clinical Hypocompetence: The Interview, Annals of Internal Medicine, 1979:91:898-902

They made a study of the way teachers, house staff and students conducted patient interviews (300 interviews studied), and found a high frequency of defects. These fell into five types. (1) Personal thoughtlessness and brusqueness, (2) Inattention to symptoms, (3) High control style not allowing the patient to fully relate the story, (4) Not going beyond the patient's telling of what other doctors have said and done (hearsay), and (5) Not thinking through the data and developing a hypothesis before moving on to testing or treatment.

"To our surprise....physicians at all levels who had previously been thought quite competent appeared defective in their interactions with patients."

"Repeated observations have shown great consistency."

George L. Engel, M.D., Are Medical Schools Neglecting Clinical Skills? Journal of the American Medical Association, August 16, 1976

"The dehumanizing effects of technology are well recognized. Less appreciated is the extent to which dependence on technologic approaches in medicine has impeded the education of physicians in the application of the scientific method to the study of disease and the care of patients, the prime objective of the Flexner reforms. Ironically much of Flexner's work has been undone by the triumph of technology."

"Clinical observation and clinical reasoning have been debased."

"In informal inquiries of medical students at more than 50 North American medical schools visited since 1960, this writer has encountered few who can report having been monitored in the interview and physical examination of more than one or two patients. A surprising number appear to have been awarded their M.D. degree without ever having been properly supervised in the complete clinical data-collecting process of even one patient!"

Mack Lipkin, M.D., Ghost medicine? The Pharos, Summer 1979

The personal physician in many teaching hospitals is not allowed to write orders - only the intern or resident may do so and they "are compelled to learn partly by making the mistakes the experienced have learned to avoid."

"In many hospitals, the patient needs an advocate-protector, a function best served by the personal physician."

Robert J. Master, et al, A Continuum of Care for the Inner City, New England Journal of Medicine , June 26, 1980

"Such independence [of the residents in training] is more readily fostered with patients who are medically disenfranchised. As a consequence, in Boston, and other urban centers some teaching hospitals do not allow community-based primary-care physicians to control the care of their patients within the hospital. Such exclusionary policies not only inhibit the development of stable physician practices in inner-city communities but also perpetuate the inequities of care long suffered by urban residents of low income."

Harold M. Schoolman, M.D., The Role of the Physician as a Patient Advocate, New England Journal of Medicine, Jan. 15, 1977

"The physician's indispensability in the care of the patient exists, moreover, only as a decision maker."

"In this role of patient advocate, the physician's cause is his patient's welfare as perceived by the patient and not the promotion of a particular intervention."

"Assessment is the critical activity required to make decisions in the presence of uncertainty. So, above all, the education of the physician should be directed to the acquisition of the knowledge and skills required for assessment and for the role of patient advocate. The formal education of the potential physician is not now geared to yield such a product."

"No medical school has established as primary educational objectives the learning of research, scientific inquiry and the assessment of data.....One result is that few graduates are competent to assess data. But an even more deleterious result is that medical students become accustomed to the acceptance of interpretation of data as a matter of dogma."

"Clinical decision making witnessed in teaching hospitals evolves through a series of subspecialists who provide an environment in which the diffusion of responsibility for decision making is tolerated, if not promoted. This environment permits the physician to deal with his discomfort [caused by uncertainty] by an acceptable procedure of allowing decisions to be made by others. When this procedure assumes multiple dimensions, the result is that no one is responsible for the patient. Decisions are now made not by a patient advocate, but rather by a therapeutic advocate.....This charge is a condemnation neither of specialization nor of teaching through specialty teams; it is a condemnation of our primary educational goals. Responsibility for assessment of data and for decision making as a patient advocate should be taught in just such an environment."

Ludwig W. Eichna, M.D., Medical-School Education, 1975-1979, New England Journal of Medicine, Sept. 25, 1980

"Learning is a thinking, problem-solving process that requires time. Medical-school education today involves too little thinking and problem solving.....Cramming does not stimulate students to question.....The clinical years perpetuate non-thinking.

Peter E. Dans, M.D., The great zebra hunt, The Pharos, July 1978

"What are the effects of our 'zebra hunting?' ....We do all the tests that we....can think of.....In effect we do tests where the predictive value approaches zero.

"Our approach makes it appear that common problems are not only uninteresting but also easily handled, when in fact the reverse is true."

Anne R. Somers, PhD, "Containment of Health Care Costs: A Diagnostic Approach" The Forum on Medicine, February 1979

"The 'technological imperative'. The well-known triumphs of modern scientific medicine and its corollary, medical technology, have resulted in the 'technological imperative,' i.e., a situation in which technology, and virtuosity in the use of such technology, tend to become ends in themselves....'Quality' is also frequently defined in terms of technological or process input rather than outcome in the form of improved health.

"This factor.....is probably the major single cause of rising costs today."

"Reorientation of medical education. I do not believe it will be possible to accomplish cost containment at the administrative or policy level unless it is built into the decision-making process of individual physicians.....This calls for a basic reorientation in the philosophy, organization, curricula, and financing of medical education."

Thomas Moloney and David E. Rogers, M.D., A Different View in the Contentious Debate over Costs, New England Journal of Medicine, Dec. 27, 1979

"Just how generalist physicians are trained - a seemingly minor nuance of interest only to medical educators - may be a major determinant of the size of medical bills in the decades ahead."

"To create a cadre of physicians who genuinely internalize the value of a low-technology style of practice, medical faculty will have to lead the way. Skeptics will note that this is a tall order. It requires a major change in outlook...."

Arnold S. Relman, M.D., 'Assessment of Medical Practices', NEJM, July 17, 1980

"One can only guess at the amount spent on useless technology; $10 or $15 billion does not seem excessive to me".

In looking to institutions of learning for the evaluation of technology, their response has been slow. Relman gives several reasons among them the idea that these kinds of studies are "not glamorous; there is little personal glory and they have a distinctly second-class status in academic circles. Bright young clinical investigators avoid such studies because the papers that result are relatively few in number.....and rarely taken seriously by tenure and promotions committees."

Leighton E. Cluff, M.D. Changing emphases in medical education, Pharos, Winter 1981

"Those faculty who generate large sums from patient care are becoming more influential in medical schools, and the incentives to increase this source of funds can diminish the incentives for improving or even sustaining the education and training programs essential to preparing good doctors."

"As the revenue from patient care becomes more and more important, teaching understandably may have to yield."

Author

H.F 248 Dean Johnson, Fred Norton,
Dr. Robt Reif, Randy Kelly, Janet Clark

S.F. 234, Gene Merriam, Dave Rued,
Robt Tennessen, Don Frank, Howard Knutson

A bill for an act

relating to health; providing for the establishment of a joint legislative study commission to study the educational programs in patient care at the University of Minnesota Medical School; appropriating money.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [STUDY OF PATIENT CARE EDUCATION.]

Subdivision 1. [COMMISSION.] There is established a joint legislative study commission to examine the educational programs for primary patient care of the University of Minnesota Medical School and the cost and funding sources for residency programs at teaching hospitals. Five members shall be members of the house of representatives appointed pursuant to the rules of the house and five shall be members of the senate appointed pursuant to the rules of the senate.

Subd. 2. [OFFICERS; MEETINGS; STAFF.] The commission shall elect a chairman and other officers as may be required from among its membership. Staff assistance shall be provided upon request of the commission by existing departments and agencies in the legislative and executive branches. Meetings shall be held at times and locations determined by the chairman. Members shall receive compensation in the same manner and amounts as provided for legislative committee service.

Subd. 3. [DUTIES.] The commission shall determine the effectiveness of the educational programs in teaching the

concepts and skills which are necessary to provide optimal and cost-effective patient care.

Subd. 4. [REPORT.] The commission shall, prior to January 7, 1983, submit to the legislature a report containing the commission's findings and recommendations including the following:

(a) Overall educational planning for the teaching of primary care physicians in the departments of medicine (general internists), family practice (family practitioners), and pediatrics (general pediatricians);

(b) The balance in each of the primary care departments between the requirements of the education of teachers and researchers and the requirements of the education of practitioners for the community;

(c) The balance between the role of the academic center (tertiary care, university centered hospitals), and the role of the community hospitals as providers of educational resources for the education of teachers and researchers and the education of practitioners;

(d) The body of knowledge being taught primary physicians by each of the above departments to enable them to fulfill their responsibilities effectively;

(e) The body of knowledge being taught the academically oriented or subspecialty oriented physician by each of the primary care departments to enable them to fulfill their responsibilities effectively;

(f) The educational and experiential backgrounds required for faculty appointment and promotion of teachers in each of the above departments;

(g) Appropriateness of the balance between primary care educational facilities and other educational facilities in the overall teaching programs of each of the primary care departments;

(h) The sources of money (legislative appropriations, grants, private practice income), and the allocation of such moneys within the department;

(i) The use of the resident's time in the various programs

(the teaching hospitals, including an analysis of the need for increased state funding of residency programs);

(j) The use of the resident's time in the various programs (the balance between education, research, and service); and

(k) The per capita cost of educating the residents in the various programs.

Sec. 2. [APPROPRIATION.]

The sum of $20,000 is appropriated from the general fund to the commission established by section 1 for the payment of expenses incurred in the operation of the commission. The funds are available until March 1, 1983.

Sec. 3. [EFFECTIVE DATE.]

Sections 1 and 2 are effective the day after final enactment.

Sec. 4. [REPEALER.]

Sections 1 and 2 are repealed effective March 1, 1983.

C. Fuller
2641 S. Shore
W. B. L. MN 55110

U of M Med School study legislation

Ann Tuohiese
5016 18th Ave. So.
Minneapolis, Mn. 55417

[1980?]

HEALTH

PROPOSED HEALTH CARE STUDY

An evaluation of the health care system in the United States with emphasis on the public/private sector role in planning, regulation, and financing.

by League of Women Voters of Massachusetts

Health is the principal public policy arena the League has not entered. Looking at our positions on the national, state, and local levels, we have the agenda for not only the '80's, but the 21st century except for the large hole - HEALTH.

The health care system in the United States is fragmented, duplicative, confusing, and costly. The issue itself is much in the public media and the scholarly journals. Health care cries out for the special painstaking, objective methods that the League brings to public policy decision making. Because the issue is in the public eye, it is a natural for attracting new members. Because the issue is complex and touches many interest groups, there are funding sources available for this study that would not be available for other League work.

The focus could be as follows:

National: Develop background material and/or education programs on planning, regulation, and financing. Provide guidelines for local facilities and services survey and for comparing local health statistics to national health statistics.

State Leagues: Develop background material and/or education programs on planning, regulation, and financing.

Local Leagues in Groups: Using data available, do a survey of facilities and services and using available data, compare local health statistics with national health statistics.

The whole United States has been divided into 206 health service areas and data are available based upon these areas. Health service could be a natural grouping for local and state Leagues. Local Leagues would be able, using the survey tools developed by national, to compile a directory of the health facilities and services available in their areas and also to compare the health of their area's population against the health statistics in the nation.

Next Step: After completing the first year's work - develop a set of criteria to be used in judging governmental action in the areas of planning, regulation, and financing.

We need this study because:

1. Health Care is the third largest industry in the United States.
2. Americans will spend over $200 billion this year on health care.
3. Community-based planning for health is funded by a federal agency (H & HR) everywhere in the United States.
4. Some states lack established health care priorities, yet must maintain a statewide health planning and development agency.
5. There are frequent governmental initiatives in health care planning, regulation, and financing.
6. For every dollar spent on health care, 40¢ is spent by some level of government.

As League members and as a nation we are pitifully uninformed about health care and unable to respond.

[1980]

HUMAN RESOURCES

Part I

Edith Bingham, Co-chair
341 Third Street
Wisconsin Rapids 54494
715-423-9405

The League of Women Voters has no position on HEALTH CARE; that is why we chose to undertake this study. Therefore, we cannot take any action to support or oppose legislation that will change our health care system. We can, and should, monitor what that system provides and how it affects our local communities. We will need this information when the time comes to take member agreement and form a position. Two major changes that I want you to be aware of and to monitor will be proposed in the next budget and legislative session:

1. Because of the cutback in federal funds for providing public health services and budget constraints in state funding, the Wisconsin Division of Health has reduced the intensity of a variety of public programs that it has traditionally provided to localities. Some of the programs that were cut back in 1979 include: public health education, nutrition, maternal and child health consultants, hotel and restaurant inspections, general sanitation services, public health nursing consultation, and occupational health. Further reductions are proposed by July 1, 1981, by the elimination of all state inspection of camps, mobile home parks, recreational-educational camps, and swimming pools, as well as consultation and/or investigation services for vector (animal disease carriers) and public nuisance control services. Restaurant inspections will be reduced from once every 12 months to once in 18 months. Inspections of taverns with restaurant licenses will continue to be the responsibility of the local town "health officer." The few counties in the state that have county-operated health departments will continue to receive these services from their own inspections and functions.

2. The other change for us to monitor is the proposed moratorium on the construction of any new hospital or nursing home beds in the state. The objective is to hold down the rate of increased cost of Medicaid. We should watch this to see if the hoped for result of better use of home health care and other alternatives to institutionalization is achieved or if patients are kept in hospitals longer, resulting in higher costs.

We will be forming a statewide committee to guide and lead the Health Study. Would you like to serve on that committee, or would someone in your League like to? Please send names to me, Edith Bingham, at the above address.

HUMAN RESOURCES - Part II

Phyllis Willett, Co-chair
254 E. Allman, Box 315
Medford 54451
715-748-4794

Happy New Year ... hang on tight! The Human Resource umbrella is enough to blow one over or under; and this year we not only have the health study, but we also are to have a human resource update. I can hear you saying that isn't possible. But wait -- it has to be possible. Many of our human resource positions will be quaking at their roots because of the very conservative stand of the country right now. We must keep those roots deep and firm until the pendulum swings more toward center. It is very important for us not to have shallow roots, and you, as the human resource chair of your League, must see that those roots are deep. So, if your League has no time for unit meetings on update this spring, I hope you will convince your membership and board to have meetings in the fall.

An everymember publication on the full range of HR issues will be mailed from national sometime this month. Discussion questions will be sent only to the president of your League. Please make a point to pick up these questions this month.

How to handle such a gigantic task as an update? First, together with the Board determine a focus. Maybe an across-the-board update isn't manageable -- or necessary. Perhaps most of your members know the latest positions or issues. In other words:

1. What issues would members benefit from taking on?
2. Where is there interest in updating? (Perhaps a short quiz would help.)
3. Are there any hot -- or even lukewarm -- local issues that could tie in with one of the national issues? (For example, a recent state report reveals that the greatest need for child care is in northeastern Wisconsin. What is the employment situation for youth in your locality? Etc.)

Second is getting started. 1) Review positions. 2) Consult your files. 3) Talk to public officials. 4) Touch base with other groups who have similar interests or positions. (For example, attend a Community Action Program meeting or a welfare rights meeting if there is one in your area.) 5) Do a project if you have time before fall. (For an example, see "CETA Monitoring," national pamphlet, May, 1979.)

These are times when human resources work needs to be alive and well. I'd like some feedback from you for your ideas -- just jot me a note. I can call you on televisit. It would be good to know what various resource chairs are doing. Maybe we could start a round robin.

March 1980

Russ Hereford

Controlling Health Care Costs: Strategies from the States

With Congress divided over how—and whether—to address the rising cost of health care, states have taken the lead in fashioning solutions.

The defeat of President Carter's hospital cost containment legislation in the House of Representatives underscores the difficult task facing those who seek to curb the high rate of inflation in health care. It also reemphasizes the key role which states must continue to play in the nation's health cost crisis. The role is not a new one for the states; in fact, they have taken the lead in developing solutions to the problem.

Although the health care cost problem has not disap-

Partially Scanned Material

Version 3
March 18, 2019

A General Summary of the
Minnesota Community Health Services Act of 1976
(Minnesota Statutes Section 145.911-145.922)

Section

145.911: Identifies the purpose of the bill as development and maintenance of an integrated system of community health services under local administration with a system of state guidelines and standards.

145.912: Definitions that develop a conceptual framework and define the scope of services that may be provided under this bill. Community health services that could be provided include:

- Community nursing services
- Home health services
- Disease prevention and control services
- Family planning services
- Nutritional services
- Dental public health services
- Emergency medical services
- Health education
- Environmental health services

145.913: Relates to the organization of the local board of health. The options include the assignment of responsibilities to a human services board, the county board or city council, or the establishment of an administrative board composed of elected officials, providers of health services and lay persons from the community. A Community Health Services Advisory committee to the local board of health is also mandated.

145.914: Describes local board of health authority for developing and maintaining community health services. The impact on existing boards and committees includes:

- Merger of existing township and municipal boards of health into a county system in those areas choosing to implement.
- Absorption of functions of county public health nursing committee.
- Encouragement of joint planning with health related agencies and boards such as social services, mental health, education, etc.
- Development of contracts for services
- Developing strategies to deal with manpower shortages

145.915: Defines duties of the county board to include plan review and approval and the development of regulations and minimum standards.

145.916: Prescribes budget process for the local board of health

145.917: Specifies the conditions for eligibility for the community health services subsidy. Participation is optional. The bill is designed to assist local areas develop services. The eligibility requirements for counties include:

- Minimum population of 30,000 or more; waiver for tri-county groups.
- Organizing local board of health
- Provision for local matching funds.
- Compliance with state rules
- A plan approved by county board and the State Commissioner of Health

Special subdivisions enable municipalities in Hennepin and Ramsey County and the city of St. Cloud to organize municipal boards of health

145.918: Prescribes the general duties of the State Commissioner of Health. The emphasis is on consultation, technical training, development of appropriate rules, for community health services plan review, and provides authority for the Department of Health to enter into agreements with local governments for provision of services

145.919: Establishes a State community health services advisory committee to advise the Commissioner of Health.

145.920: Describes the requirements for the community health services plan and emphasizes a process that encourages full community participation, coordinates the delivery of community health services with the public and private sector health and human services providers in the community, and emphasizes joint planning and purchase of services to reduce duplication and assure greater accountability for health services locally.

145.921: Describes the allocation formula, which has three factors: per capita income, per capita taxable value and per capita local expenditures for community health services. The formula also provides a minimum subsidy of $1.75 per capita and a maximum of $2.75 per capita; incentive payments for areas with 50,000 or more persons and for counties in multi-county groups; and local match required to raise local expenditurs to a minimal level of $4.50 per capita.

145.922: Provides for special grants to communities for provision of services for migrant agricultural workers and for American Indians.

Minnesota Department of Health
Office of Community Health Services
June 1979

NATIONAL HEALTH GOALS FOR THE 80'S

Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention — 1979

This report should be on the "must read" list of all public health professionals in Minnesota. Its bold purpose is to encourage a second public health revolution in the history of the United States.

The report represents an emerging consensus among scientists and the health community that prevention of disease demands a dramatic new emphasis in order to be successful.

The first revolution — the struggle against infectious disease — has been in large measure a resounding success. It has meant, however, that the pattern of killing and disabling diseases has shifted from infectious diseases to chronic diseases. Today, cardiovascular disease accounts for 50% of all deaths and cancer accounts for another 20%; accidents now cause a major share of death and disability, particularly among young people.

The second revolution in public health must minimize these modern killers. And we are our chief enemy:

- **We are killing ourselves by our own careless habits**
- **We are killing ourselves by carelessly polluting the environment**
- **We are killing ourselves by permitting harmful social conditions to persist, which destroy health.**

The report is optimistic, and defines our options for setting clear, measurable goals for public health action. The five major public health goals to be achieved by 1990 include:

- **A 35 percent reduction in infant mortality to fewer than nine deaths per 1,000 live births**
- **A 20 percent reduction in deaths of children aged one to 14, to fewer than 34 per 100,000**
- **A 20 percent reduction of deaths among adolescents and young adults to age 24, to fewer than 93 per 100,000**
- **A 25 percent reduction in deaths among the 25 to 64 age group**
- **A major improvement in health, mobility, and independence for older people, to be achieved largely by reducing by 20 percent the average number of days of illness among this age group.**

While this report is optimistic, it is clearly cautious about our individual and national commitment to achieve these goals. The wealth of information and program suggestions make this highly readable report a valuable addition to any public health professional's reading list.

The publication is available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402
(Stock Number 017-001-00416-2)

Minnesota Department of Health
Bureau of Administration
717 Delaware Street S.E.
Minneapolis, Minnesota 55440

COMMUNITY HEALTH SERVICES

COMMENTARY

MINNESOTA DEPARTMENT OF HEALTH
BUREAU OF ADMINISTRATION

Volume 1, No. 1

April, 1980

LOCAL HEALTH ADMINISTRATION FIRMLY ESTABLISHED IN MINNESOTA

The major objective in developing and implementing the Community Health Service Act of 1976 has been to encourage local communities to plan and implement locally administered community health services aided by State grants and subsidies. This legislation has been well received by public officials, health providers and consumers who quickly took advantage of the opportunity to become involved in local planning and provision of community health services. An important factor aiding in reception of the Act has been the local participation process. This process encourages local citizens to be involved in needs assessment, priority setting and program planning for their own local communities.

Figures 1-4 in this issue of the **Commentary** provide graphic evidence of the local support received and the progress made since February 1976 in developing the statewide community health services system.

Figure 1 indicates that prior to the Act there were three county and five city comprehensive health departments. The remainder of the State was served by Public Health Nursing Services, except for the counties of Roseau, Lake of the Woods, and Traverse.

Figure 2 indicates that by August of 1976 the Minnesota Department of Health had received twenty-six applications for community health services planning grant funds. These applications represented 48 counties and over 70% of the State's population involved in local community health planning within six months of passage of the Act.

Figure 3 indicates that by March 1977, Minnesota had twelve local CHS projects funded with community health services subsidy dollars, involving 26 counties and over 50% of the State's population.

Figure 4 indicates the current status of community health services in Minnesota. Forty-three local projects, involving eighty-three counties have been funded; four counties are to date not participating.

The majority of counties in the State have now assumed responsibility for community health services in their local communities. Local participation in needs assessment, priority setting and program development has greatly increased the quality, variety, and provision of community health programs in the State.

Over 95% of the State's population is now benefiting from the Community Health Services Act of 1976, with its emphasis upon prevention of illness and disability, and promotion of health and healthy lifestyles.

WE NEED YOUR HELP!

Your contributions are welcome! Commentary will report on CHS projects with new or unique approaches to CHS administration and program delivery. Contact your District Representative for further information. Share your ideas, your success with others through the Commentary.

JANUARY 1976

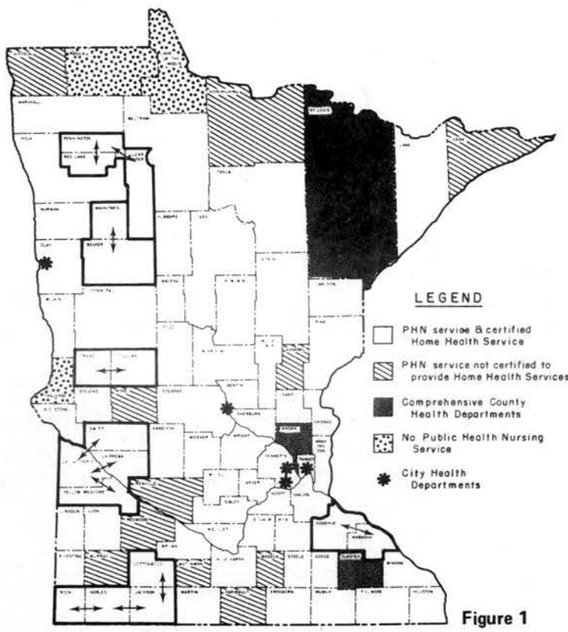

Figure 1

AUGUST 1976

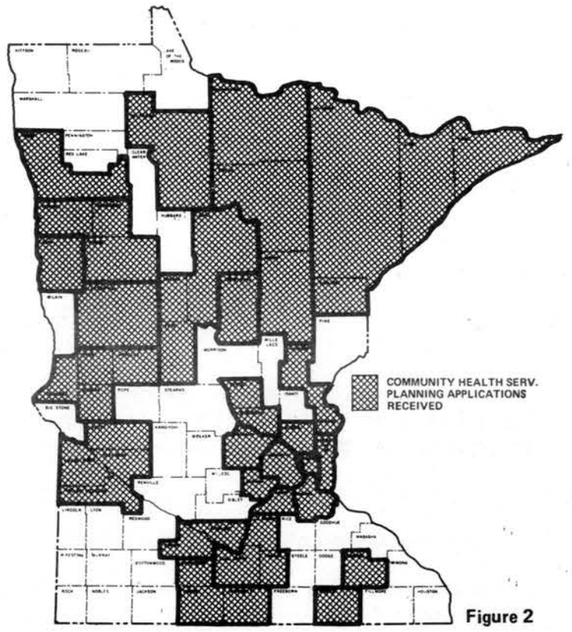

Figure 2

MARCH 1977

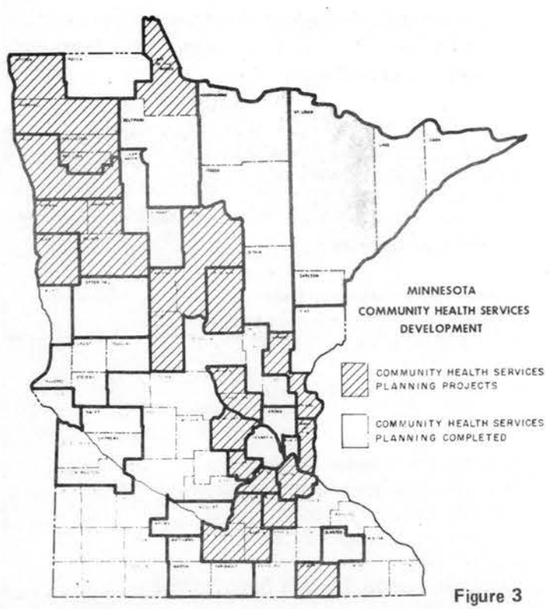

Figure 3

MARCH 1980

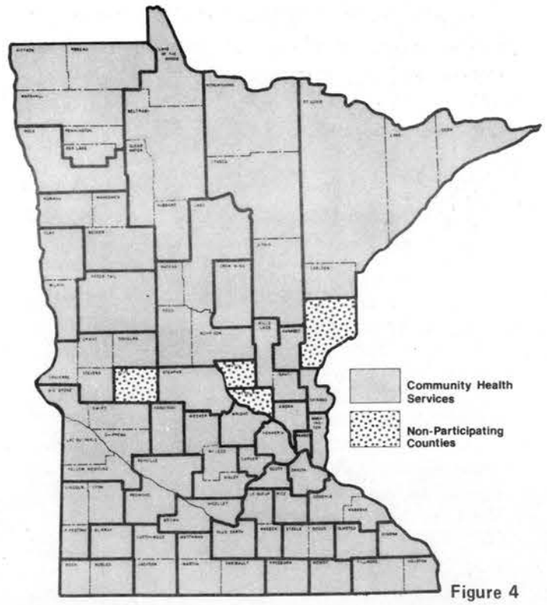

Figure 4

Policies Relating to Community Health Services

The Minnesota Department of Health has issued several policies relating to community health services. Following is a list of those policies and their subject matter:

Policy Subject	Policy #	Date Issued
Distribution of vaccines within Counties served by Local Boards of Health organized under the Community Services Act.	CHS – 1	1/24/78
Payment for vaccines used by Local Boards of Health or their designees	CHS – 2	10/24/79 (Rev.)
Federal Funds available for implementation of the National Immunization Initiative	CHS – 3	1/24/78
Revision of approved Community Health Services Plans	CHS – 4	5/1/78
Termination of Testing Program for private water supplies	CHS – 5	6/12/78
Regulation of Food, Beverage & Lodging Facilities	CHS – 6	6/12/78
Carry-over of Community Health Services Funding	CHS – 7	10/25/79 (Rev.)
Integration of Federal and State Funds for Emergency Medical vehicles and equipment	CHS – 8	12/4/78
Review Process for Applications for Community Health Services (CHS) Planning Grants, Subsidies, Native American and Migrant Special Grants Under the CHS Act.	PA – 6.0	10/2/79 (Rev.)

For further information on the above policies please contact the District Office in your area:

Northwestern District Office
1705 US Hwy. # 2 West
Bemidji, Minnesota 56601
218/755-3820
William Heisenfelt, District Rep.

Northeastern District Office
1730 London Road
Duluth, Minnesota 55812
218/723-4642
Jack First, Acting District Rep.

West Central District
Box 675, Fergus Falls State Hospital Grounds Building 4-C
Fergus Falls, Minnesota 56537
218/736-6922
Robert Poyzer, District Rep.

South Central District Office
Box 3047, 75 Navaho Avenue
Mankato, Minnesota 56001
507/389-6025
Rod Church, District Rep.

Central District Office
1848 N. 3rd St.
St. Cloud, Minnesota 56301
612/255-4216
Jack First, District Rep.

Southwestern District Office
Box 1065, Social Sciences Bldg., 1st Floor
Southwest State University
Marshall, Minnesota 56258
507/537-7151
John Blohm, District Rep.

Southeastern District Office
1220 Fourth Avenue Southwest
Rochester, Minnesota 55901
507/285-7289
Eric Anderson, District Rep.

Metropolitan District Service Area
c/o Minnesota Department of Health
717 S. E. Delaware Street
Minneapolis, Minnesota 55440
612/296-5471
Wayne Arrowood, District Services Rep.

League of Women Voters of Connecticut
60 Connolly Parkway, Hamden, CT 06514

July/August 1980
State Board Report

HEALTH CARE - WHAT WE CAN DO

1. Examine Medicare/Medicaid, Health Planning Resources & Development Act, and how your state and region implement them.

2. Who serves on your federally mandated planning committee?

3. How has Certificate of Need influenced your hospital in the past 5 years?

4. What health facilities are available in your area? Where are your primary, secondary and tertiary care hospitals?

5. Does your community have alternatives to hospital care? If so, how are they financed?

6. What special medical facilities attract people to your area?

7. What body governs your local hospital(s) and who serves on that body? Is the hospital private, proprietory, public?

8. What is the doctor/patient ratio in your community? Compared to the national average?

9. What kind of specialized equipment does your hospital have?

10. What is the average length of stay at your hospital(s) compared to the national average?

11 What hospital(s) on your area do which people in y our community use?

12 How are uninsured patients handled at your hospital(s)?

13 How dependent is your hospital on Blue Cross, Medicaid, Medicare?

14. What percentage of senior citizens use your hospital? Is their length of stay in line with the national average?

15. What is the difference between the "health maintenance organization" concept and private insurance? What are the differences in the various HMO's?

16. Who owns the insurance companies, the HMO's, and the drug companies?

17. Does your hospital have professional people assessing the quality of care? Who are they?

18. What agencies in your area promote health?

19. What agencies in your area provide follow-up or convalescent care?

TO LOCAL LEAGUES: A SUGGESTED START FOR A STUDY OF HEALTH CARE.

Examples of services available on an appointment basis include:

- Weight Control counseling
- Nutrition Counseling
- Cholesterol testing
- Adult Health Screening
- Early and Period Screening (EPS)
- WIC (Women, Infants and Children Supplemental Food Program)
- Family Planning Services

For patient and community education purposes, each Center has numerous pamphlets, printed materials and film strips on health and healthy lifestyles. Community groups utilize the Centers for regular meetings, including Al-Anon and weight control groups.

The Health Centers have proved to be very popular with residents of Ramsey County. Statistics demonstrate increasing use of the services offered through the Centers; 1980 projections indicate at least 17,000 client contacts.

The addresses of the Health Centers are:

White Bear Lake

3575 White Bear Avenue
612/777-1211

New Brighton

701 Eighth Avenue Northwest
612/633-0310

For information on the Ramsey County Health Screening and Education Centers, contact:

Ramsey County Public Health Department
150 East Kellogg, 9th Floor
St. Paul, MN 55101
612/298-5971

Ray Cink, Director

COMMISSIONER PETTERSEN ATTENDS CHS ANNUAL BOARD MEETING

Commissioner of Health George Pettersen was invited to the Cass-Todd-Wadena-Morrison CHS Annual Board Meeting August 15, 1980 to discuss such issues as the role of the Board of Health within that structure, future funding of CHS, and roles and relationships of local Boards of Health. Business items on the agenda included discussions about the Administrative Task Force Report, 1981 Budget/Plan Revisions, consideration of a Bi-County Environmental Health Proposal, and consideration of a by-law amendment.

The Commissioner stressed the importance of prevention as a means to reduce health care costs. He was supportive of the multi-county agency's efforts to develop a locally-controlled environmental health program, and offered Department assistance in their efforts to achieve this goal. Dr. Petterson stated he was pleased to have this opportunity to speak to this group and share his ideas with them, and to learn from them about their concerns and progress in developing a multi-county community health service delivery system.

Minnesota Department of Health
Bureau of Administration
717 Delaware Street S.E.
Minneapolis, Minnesota 55440

COMMUNITY HEALTH SERVICES

COMMENTARY

MINNESOTA DEPARTMENT OF HEALTH
BUREAU OF ADMINISTRATION

Volume 1, No. 3 **September, 1980**

DEVELOPMENT AND MANAGEMENT OF A MULTI-COUNTY CHS AGENCY

The initial planning for possible implementation of the Community Health Services (CHS) Act in Northeastern Minnesota was initiated in 1976. The only counties in the Northeastern District that met the necessary population requirements specified by the CHS Act were Itasca and St. Louis Counties. As a result of this, various county configurations were studied in an attempt to ensure that all counties would have an opportunity to qualify for CHS funding. Three CHS planning grants were awarded by the Minnesota Department of Health. Two grants were awarded to the Arrowhead Regional Development Commission (ARDC) to study multi-county configurations, and one to the St. Louis County Health Department to develop a plan for St. Louis County.

Based upon input from county task forces and recommendations from multi-county advisory committees, two separate CHS Boards were formed for the Northeastern District. This was accomplished within the local four county area by meshing the St. Louis County CHS Plan into the Carlton-Cook-Lake CHS Plan to form the Carlton-Cook-Lake-St. Louis Community Health Services Board on January 27, 1977. Since that time, the Carlton-Cook-Lake-St. Louis CHS Board has had its three subsequent CHS Plans approved and has also been funded for health services to Native Americans ('77-'81), Women, Infants and Children projects ('79-'80) and Family Planning projects ('79-'80).

The CHS Act encourages consideration of a variety of administrative structures to encourage local communities to develop community health services. The structure selected by the Northeastern District enabled the four counties to participate in and simultaneously provide for each county's local decision-making in developing a community health service delivery system. The structure adopted prescribes a multi-county Community Health Services Board and provides for the existence of local county boards of health to address specific county needs. The administrative structure consists of the four county boards of commissioners, a nine member Community Health Services Board, a nine member Community Health Services Advisory Committee and four county boards of health.

This structure, approved by the county boards of commissioners and the Minnesota Department of Health promotes local decision-making and service delivery by local county boards of health. The CHS Board is empowered, by law, to have authority and responsibility for the development and maintenance of an integrated system of Community Health Services for the area. Specifically, the CHS Board has the responsibility and authority for policy-making, coordination and integration of services and CHS planning and funding. Its responsibilities include:

- **The preparation of CHS Plans and budgets for the multi-county area**
- **Receiving and monitoring the expenditure of CHS subsidy funds awarded as a result of approved CHS Plans**
- **Monitoring local public health expenditures as approved within CHS Plans**
- **The identification of public health service needs and development of mechanisms for multi-county program development, evaluation, coordination, and integration**
- **Obtaining additional sources of public health funds for the area**
- **Informing local boards of health and boards of commissioners concerning the current status of community health services in the four county area**
- **Serving as a liaison between the four counties and the MDH.**

The specific county duties, staffing responsibilities and authorities vary due to variances in the structures of local boards of health. However, all local boards of health are responsible for provision of direct public health services designed to meet the needs

of its residents.

There are inherent obstacles to operating an administrative structure in a four county area comprising 10,362 square miles, containing one of the largest population centers in the State (i.e., Duluth, near 100,000) and sparsely populated rural areas (for example, Cook County, 217 persons per square mile). The major obstacles are different budgeting and reporting formats operating in the four county area that are undoubtedly experienced by other multi-county agencies. This particular obstacle has been dealt with locally by individual and group meetings with county auditors and other CHS fiscal contact persons for the purpose of implementing the Minnesota Department of Health's CHS Fiscal Management System.

The development of CHS Plans has provided valuable, comprehensive documents and usable work-plans for the provision of public health services within the counties. Public participation in resource allocation decisions has provided a forum for increased community awareness and has also led to increased coordination of planning and service delivery.

In addition to plan development activities, two approaches to evaluation have been implemented by the multi-county agency. The CHS Advisory Committee, with approval from the CHS Board, has taken an active role in evaluation. One approach has been geared to plan monitoring, and the second approach has been on a project basis. Examples of this second approach are an overview of the Special Native American Grant and a Level of Effort Evaluation that was presented in the CHS Board's 1978 Annual Report. The Level of Effort Evaluation was based on per capita expenditures for the six Community Health Services program areas. This evaluation was performed to give Board members comparison information regarding their funding priorities.

An additional project was the development of a CHS Historical Overview for the counties of Carlton, Cook, Lake and St. Louis. This document was initiated to identify resultant changes in county CHS program areas since the inception of Community Health Services in 1977. The report was designed to meet reporting requirements of the CHS Act, and was utilized in discussions at a meeting with CHS Board members and with CHS Advisory Committee members and area legislators at a meeting in St. Paul. The CHS Board has, for the past two years, met with area legislators to update them on the current status of Community Health Services, and present resolutions and/or a any items of concern for the coming session. The CHS Historical Overview was also designed to be utilized as a brief update to both officials and health providers at the state and local level.

The most recent example of multi-county sharing arrangements occurred with the development of the CHS Lake County WIC Nutrition Application. This recently approved special grant will provide WIC services to the residents of Lake County by means of contractual arrangements in the following manner:

- **The CHS Board administers the program and handles the financial reporting.**
- **Cook County personnel provide WIC clinic services to Silver Bay and the surrounding area.**
- **St. Louis County personnel provide WIC clinic services to Two Harbors and the surrounding area on a monthly basis.**

Another multi-county sharing agreement occurred in perhaps the most difficult CHS program area to deal with; emergency medical services. Funding changes, along with organizational and logistical factors have contributed to difficulties within this CHS program area. During the development of the 1979 CHS Plan, the Carlton-Cook-Lake-St. Louis CHS Board and the Aitkin-Itasca-Koochiching CHS Board provided supporting funding for a successful EMS grant application for Federal funds. The grant was developed by the Arrowhead Regional Development Commission utilizing, in part, CHS subsidy funds. Funds received, as a result of the grant, was approximately $550,000. Each participating county has appointed a representative to serve on an area-wide EMS Advisory Committee that will oversee disbursal of funds and implementation of a regional EMS system.

Other programs implemented on a multi-county basis have been:

- **Water well testing forms and related service provision arrangements.**
- **Uniform evaluation formats and voucher notification forms that assist county auditors in complying with CHS financial reporting requirements.**

During the coming year, the CHS Board plans to conduct program evaluations on disease prevention and control and environmental health services.

Time and distance factors remain obstacles in administering a multi-county Community Health Service system. At their last meetings, the CHS Advisory Committee and the CHS Board passed resolutions requesting that each county board of health appoint a CHS contact person. These persons shall represent a potential resource to the CHS Board and its staff in making applications for various special grant funds available for local Community Health Services. The need for a local mechanism became evident during the summer of 1980 when several special project grants became available under severe time constraints. These contact persons, working closely with CHS Board staff, will enable the CHS Board to operate as efficiently and quickly as possible in representing its counties.

In Northeastern Minnesota the CHS Act and its local application has enhanced the spirit of cooperation, while maintaining each county's local decision-making authority and identity with regard to public health programs. The CHS Board's emphasis is on joint planning, purchase of services and resource sharing to reduce duplication and cost of services. This also assures greater accountability for public health services. Improved local decision-making combined with flexibility of administrative structures has led to a successful and efficient method of determining and providing necessary community health services to local residents.

For those interested in receiving more information regarding CHS activities in Northeastern Minnesota, the CHS Board publishes a quarterly newsletter. Anyone interested in being placed on the mailing list may contact the CHS offices.

For information on this program, contact:

Bruce T. Rowe
Administrator
Carlton-Cook-Lake-St. Louis Board of Health
325 Lake Avenue South, Suite 604
Duluth, MN 55802

HEALTH SCREENING AND EDUCATION CENTERS IN RAMSEY COUNTY

The Ramsey County Public Health Department has expanded the availability of services in suburban areas of Ramsey County. Two Health Screening and Education Centers are now open and functioning, supported in part by local governmental resources and state subsidy funds available through the Community Health Services Act of 1976.

The Health Centers are located in White Bear Lake (Northeast Ramsey County) and in New Brighton (Northwest Ramsey County). The White Bear Center is located in a small shopping center, and the New Brighton Center is part of the New Brighton Community Resources Center. The New Brighton Community Resource Center, once an elementary school, includes a variety of services. In addition to the Health Center, there is a Mental Health Branch Office, a Community Corrections Branch Office, a Seniors Program, including Congregate Dining, and local school district community education programs.

The goal of the Health Centers is to offer preventive health services and to promote healthy lifestyles. The methods include health screening services, educational opportunities and resources, and referrals to health care providers when necessary and appropriate.

Each Health Center occupies approximately 2,400 square feet, about the area of a large two-story home. Within this space there is a reception and waiting area, three comprehensive examination rooms, a laboratory area, office and clerical area, and a multi-purpose open area.

Staff support for each area includes a licensed practical nurse and clerical support staff. Public health nurses are available for back up support. For the many scheduled clinical and screening programs at the Centers, a specialized health team is assigned to provide services. The 1980 budget for the two Centers is currently $110,000.

Examples of services available in the Health Centers on a walk-in basis include:

- Blood pressure checks
- Blood and Urine Tests
- Immunizations
- Mantoux testing for TB
- Throat Cultures
- Veneral Disease testing
- Vision and Hearing Screening

Ramsey County Health Center (New Brighton) — Interior View

New Brighton (Ramsey County) Community Resource Center

L/Tews
Nisjinbathaus
Lake

OCT 27 1980

353 E. Bernard St.,
W. St Paul, Minn.
Oct. 24, 1980

League of Women Voters of Minn.
555 Wabasha St.
St Paul, Minn.

To whom it may Concern

I would like to bring to your attention what I and many others in my situation consider a serious discrimination policy.

On behalf of disabled housewives (or any persons) who are unable to get any medical assistance such as Medicare or Medicaid under present Social Security laws, I ask your assistance in passing legislation or initiating programs that may help us meet the staggering expenses of medical care for disabled. As laws and regulations now read, a large number of us have not worked and paid into Social Security the number of quarters to be eligible for medical benefits.

Trying to buy medical coverage in an insurance plan is an enormous premium for disabled people to pay. Widows are covered and many others, but disabled or anyone unable to work must live to be 65 to get medical care.

Please bring this to the attention of those who can change this situation; this is discrimination against disabled housewives and people who also need medical care before age 65. And please hurry in your endeavors so we can live to that magical age.

I am a disabled asthmatic with allergy and lung conditions and a spinal neck injury. I am not a widow, but my husband had to retire at 63. I am 62. No health insurance, medicaid, or medicare is available to me until I turn 65.

Widows, blind, people who need kidney dialysis, etc. are allowed these benefits, as well they should be, but indeed one must breathe to even exist. This is discrimination against those disabled, not able to receive Welfare medical assistance and who do not have money enough to buy medical policies. There are millions of us in all degrees of disabilities. We are the forgotten former workers who paid social security from the beginning, but raised our families and became too disabled through the years to get all our needed quarters paid into Social Security to be eligible to receive medicaid, medicare or any medical insurance.

I appreciate your listening to this plea and urge you to act in some way to end this injustice.

Sincerely yours,

Ellen S. King

ELLEN S. KING
Social Security #477-03-3613
612-457-4011

Joyce - Will any of these concerns be addressed by the healthcare study? Joan

League of Women Voters of Connecticut
60 Connolly Parkway, Hamden, CT 06514

October 1980
State Board Report

TO: Health Care Chairs
FROM: Betsy Hedden
RE: Health Care Study

LEAGUE OF WOMEN VOTERS OF MASSACHUSETTS
HEALTH CARE STUDY BIBLIOGRAPHY

Items starred ** are first priority for unit study, those starred * are also high priority. If your public library does not have some of these items, request they be ordered.

I. BOOKS

Anderson, Odin W. Blue Cross Since 1929: Accountability and the Public Trust. Ballinger, 1975. ISBN 0-88410-122-3 $15.00

Recommended by BC/BS. Gives rundown on development of BC and promotes philosophy of the private sector as delivery agent for federal health funds.

Ballistella, Roger and Thomas G. Randall, Eds. Health Care Policy in a Changing Environment. McCurcheon. ISBN 0-8211-0-0131-5 $19.50

Discusses our deep-level health care problems, failure to find goals beyond cost containment, and effects of medical technology on society.

**Bogue, Ted and Sidney M. Wolfe, M.D. Trimming the Fat off Health Costs: A Consumer's Guide to Taking over Health Planning. Health Research Group (A Public Citizen Pamphlet). n.b. Probably free

**Commonwealth of Massachusetts, Department of Public Health. State Health Plan, 1980. LWVM Health Committee will arrange distribution to locals.

Contains current plans, back-up data, grants, etc. in all categories in which the HSA is working.

*Davis, Karen and Kathy Schoen. Health and the War on Poverty: A Ten Year Appraisal. Brookings Institute, 1978. ISBN 0-8157-1757-1 $11.95 (pb. ed. less)

Criticizes Medicare/aid for not initiating reform in administration at the time legislated. Sees a future in it via HMO's,

Enrenreich, Barbara and John Ehrenreich. The American Health Empire: Power, Profits, and Politics. Vintage (a Health-Pac pb.) 1976 ISBN 0-394-71453-9 $2.95

Resume of investigations by the Health Policy Advisory Group into private hospitals, mainly in New York.

Feder, Judith Medicare: Thd Politics of Federal Hospital Insurance. Lexington Books, 1977. ISBN 0685-9988-3, 24900 $16.95

(more)

Recommended by authorities in health planning.

**Fuchs, Victor R. (Stanford Medical School). Who Shall Live? Health, Economics, and Social Choice. Basic Books, 1974. ISBN 0-456-09185-7 $8.95 Surveys health care in re income, education, lifestyle, and our value system.

Ginsberg, Eli. The Limits of Health Reform. Basic Books, ISBN 0-07-023278-4. $8.50
Considers attainment of Health care goals through legislative action doubtful. A different view.

*Judd, Leda R. and Robert J. McEwan, S. J. A Handbook for Consumer Participation in Health Care Planning. and Update No. 1. Blue Cross Association, 1977. $1.50(?) and $1.00

Simplified data on health regulatory legislation, duties of HSA's, Development Agencies, and Coordinating Councils.

Kotelchuck, David and Rhonda Kotelchuck. Prognosis Negative: Crisis in the Health Care System, Vintage (a Health Pac pb.) ISBN 0-394-71757-0 $2.95

A follow-up study to Ehrenreich's.

Law, Sylvia (Health Law Project, U. Penn.) Blue Cross: What Went Wrong? Yale University Press, (2nd ed.) 1976. ISBN 0-300-01989-0 pb. $4.95

Thesis: Health insurance corporations are essentially public utilities and suffer from lack of regulation and consumer input. See periodical entry by Shurtleff below.

Reeves, Philip, et al. Introduction to Health Planning, 2nd ed. Information Resources Press, 1979. ISBN 0-87815-612-9. No price.

This edition suggested by Massachusetts Hospital Association was not examined, but if like the earlier edition is a "how to" compendium, not a critique.

*Sidel, Victor W. and Ruth Sidel. A Healthy State: An International Perspective on the Crisis in United States Medical Care. Pantheon Books, 1977. ISBN 0394-40760-1 $10.95

Compares U.S. and European health Planning; defends the goal of equity; readable; excellent bibliography.

**Massachusetts Public Health Association (MPHA). Major Health Problems in Massachusetts, 1980. Available through MPHA headquarters.

II. U. S. Department of Health and Welfare (DHEW) PUBLICATIONS

Ordering these is difficult. Some are available through U.S. Government Printing Office, and one must write first for price others from various DHEW offices in Maryland. - As much information is given here as possible. They may be available at college libraries and HSA offices. (The state League Committee

(more)

is attempting to obtain some of these in bulk and they will be distributed to local Leagues if available.)

Foley, Henry A. Current Developments in the National Health Planning Program. DHEW (HRA) 79-14004. Probably free on request.

Outlines organization of HSA's, SHPDA's add SHCC's, legislation, and goals for planning.

*Ginzberg, Eli (Ed.). Regionalization and Health Policy. DHEW (HRA) 77-623.

Pros and cons of regionalization to achieve equity and contain costs.

Government Controls on the Health Care System; The Canadian Experience. DHEW (HRA) 77-646 Rockville. Probably free.

Summarizes the Lewin study on the Canadian system done for U.S. Department of Commerce.

Health in America, 1776-1976. DHEW (HRA) 76-616. Hiattsville.

Gives a valuable historical perspective to our study.

*Healthy People: Surgeon General's Report on Health Promotion and Disease Prevention, 1979. DHEW (PHS) 79-55071 Rockville.

Outlines for infants, children, adolescents, adults, and the elderly.

Improving Health in America: U.S. Public Health Service Highlights of 1977-80. Obtainable free from Office of Assistant Secretary of Health, Washington, D.C. 20201.

Gives a quick total picture of government in health care, goals and machinery, such as HSA's.

Navarro, Vincente, M.D. National and Regional Health Planning in Sweden. DHEW (NIH) 74-240. Rockville.

Applies his findings in the Swedish system to our situation.

Promoting Community Health. DHEW (HSA) 75-5016. Bureau of Community Health Services, Rockville, Single copy free.

Data on government funded health centers.

Schweitzer, Stuart O. (ed.) Policies for the Containment of Health Care Costs and Expenditures (Proceedings of a conference sponsored by the John E. Fogerty Center, Bethesda, MD) 1976. DHEW (NIH) 78-184 $5.25 (Available through U.S. GPO. Stock No. 017-053-00070-1.

Interesting papers on the conference and lively discussions following each paper.

9more)

III. PERIODICAL ARTICLES

*Ginzberg, Eli. "How Much Will U.S. Medicine Change in the Decade Ahead? Annals of INternal Medicine, vo. 89, no. 4, Oct. 1978 pp. 89-557+

Makes predictions in four areas of medicine: Service to patients, modes of practice, governmental controls, public attitudes toward services. Excellent.

Hiatt, Howard,H.M.D. "Protecting the Medical Commons: Who is Responsible," New England Journal of Medicine, vol. 293, no. 5 (July, '75), 235-241.

Applies to present health care dilemma the adage, "Freedom in a commons brings ruin to all.

Marmor, Theodore R. and James A. Morone. "Representing Consumer Interests: Imbalances Markets, Health Planning, and the HSA's Milbank Memorial Fund Quarterly, vol. 58, No. 1 (Winter, 1980), pp. 125-165.

Applies political theory to the problem of representing disorganized consumers on a par with well-organized providers and planners. Cynical.

NOTE: The Milbank Quarterly is entirely devoted to public health and health planning. Every issue has information for us.

Shurtleff, John L. "Blue Cross: What Went Wrong? - A Review" Hofstra Law Review, Vol. 3, No. 1 (Winter 1975)

In reviewing first ed., severely censures Law's scholarship, particularly in re New York BC/BS efforts io contain costs, although he agrees with her basic thesis.

Tannen, Louis. "Health Planning as a Regulatory Strategy: A Discussion of its History and Current Uses," International Journal of Health Services, Vol 10, No. 1, pp. 115-131. Gives a rundown on health planning USA, planning will expose the real issues in health care, if not answer them!

*Weiner, Stephen (B.U. School of Law). "Health Care Policy and Politics: Does the Past Tell Us Anything About the Future?" American Journal of Law and Medicine, Vol. 5, No. 4 (Winter, 1980). pp. 331-341.

Advocates a long national analytical debate on health care! and proposes a format.

Wildavsky, Aaron. "Doing Better and Feeling Worce: The Political Pathology of Health Policy," Daedalus (Winter, 1977).

Recommended by health planners and public health thinkers.

Prepared by Helen Millet, Brockton LWV

Publisher's address list attached

ADDRESSES OF PUBLISHERS

American Enterprise Institute
for Public Policy Research
1150 17th Street, NW!
Washington, D.C.

Aspen Systems Corp.
20010 Century Blvd.
Germantown, MD 20767

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Harvard Square
Cambridge, MA 02138

(Publishes many books on health subjects)

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Cambridge, MA 02142

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Berkeley, CA 94704

McGraw-Hill Book Co.
1221 AVe. of the Americas
New York, N.Y.

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New York, N.Y.

Yale University Press
(for ordering)
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New Haven, Conn. 06520

GOVERNMENT SOURCES

Alpha Center for Health Plannin
(similar to ERIC in education)
4729 Montgomery La.-Suite 1102
Behtesda, Maryland

DHEW

Health Resources Administration
(HEA) and
Health Service Administration
(HSA)
3700 East-West Highway
Hyattsville, MD 20782

Public Health Service (PHS)
and Bureau of Community Health
Services (BCHS)
and National Health Institutes
(NHI)
5600 Fishers Lane
Rockville, MD 20857

U.S. Government Printing Office
(GPO) Washington, D.C. 20402

LWV Philadelphia
Chestnut Real Bldg
841 Chestnut St, 12th flor
19107

215-922-4499

Nov '80

Ann This may be of interest to you.
Margt

HEALTH CARE IN THE U.S. -- THE LEAGUE CONNECTION -- AN INTRODUCTION

(Note: While our local Health Care Committee has been concentrating its efforts on our local study, other Leagues have been preparing themselves for the national health care study adopted at the most recent LWV National Convention. The following article was written by June Wilson, a member of the LWV of Southern Chester County, for her League. It provides excellent background on national health care planning. Joyce Solo, Health Care Chair)

The League of Women Voters adopted the following item at its national convention last spring:

Health Care:

Evaluate the Health Care Systems in the United States with emphasis on the public and private sector roles in the delivery of services.

The formal study is not scheduled to begin until sometime in 1981. Given the complexity of the subject it will be wise to begin to acquire -- without re-inventing the wheel -- some background information and to stimulate discussion of the issues. What follows is a simplified overview of some of the areas which can be explored in depth later on.

Pivotal to this study is an understanding of the National Health Planning and Resources Development Act of 1974 (PL 93-641) and recent amendments (PL 96-79). The Act is the current version of a succession of Federal health planning and regulatory mandates since World War II. Initially, incentives like the Hill-Burton Act were aimed at catching up with expansion of needed medical care facilities while assuring care for the indigent. These actions and other factors contributed to the exorbitant costs we are experiencing today.

The combined public and private health care costs in the U. S. are over $200 billion annually with no end in sight, notwithstanding voluntary and legislative efforts to curb the spiral. Unprecedented advances have been made in medical technology; hospitals and nursing homes have proliferated; improvement in management practices and professional standards, and training of more health personnel proceed apace. Still we have underserved populations; morbidity and mortality statistics do not show very much improvement in health status; reimbursement policies of third-party payors (Medicare, Medicaid, Blue Cross/Blue Shield and private insurors) still encourage institutional rather than outpatient service and preventive care. Real or alleged malpratice continues to erode confidence in the medical profession.

In this context volunteer boards and staff of over 200 federally designated Health Systems Agencies (HSAs) along with Statewide Health Coordinating Councils (SHCCs) are charged with carrying out the purpose of the Law. The Pennsylvania Department of Health is designated the State Health Planning and Development Agency (SHPDA) which staffs our SHCC. There are nine HSAs in Pennsylvania. The Health Systems Agency of Southeastern Pennsylvania (HSA/SP) performs the regional health planning functions

HEALTH CARE continued

for the five-county area around Philadelphia. There are also five subarea councils, one for each county. Philadelphia in addition, has five district advisory councils to ensure local imput. The Boards and Councils must be broadly representative of their communities in both provider and consumer categories, with the majority (51% up to 60%) being consumers.

These agencies must develop five-year comprehensive health plans for their service areas. The State Health Plan is a composite of regional plans and also covers statewide concerns. The plans must address the characteristics of availability, accessibility, acceptability, continuity, workplace and institutional settings. Goals and standards set forth in the Plans are implemented as follows.

Project Review

First the HSA, and then the State, reviews applications for approval or disapproval of capital expenditures for health care facilities, following criteria of the State Certificate of Need Law (CON). Other projects, e.g., a substance abuse education program, may be reviewed selectively under Proposed Use of Federal Funds (PUFF) regulations. "Appropriateness Review" procedures and other cooperative planning and review activities are in various stages of development.

Resources Development

Although Congress never appropriated funds for this part of the Act, the agencies' Annual Implementation Plans outline short-term objectives and recommendations for improving the health status of the population. Action priorities are selected by HSA committees who serve as catalysts and monitors to encourage the filling of unmet needs. Material and technical assistance from HSAs and community educational campaigns working with community groups may help to achieve the desired results.

So far this has been the least emphasized and least known part of health planning but it is considered by many to be the most promising.

Both the carrot and the stick approach have been applied to Plan Implementation activities and there is much controversy over whether we need more or less regulation, more or less positive incentives for improving and streamlining the health care system.

SUMMARY

Health planning efforts are often thwarted by the lack of data for defining needs and evaluating services. If projections appear too stereotyped, both providers and consumers tend to cast planners in an adversary role. Yet, for the first time in history we have the framework, in writing, for planning future improvements.

HEALTH CARE continued

SUMMARY continued

Maintaining the proper balance of consumers and providers and equipping and assisting volunteers to function effectively is an ongoing problem, especially for consumers who seldom have organized backing. Consumer interests are ripe for responsible advocacy or irresponsible exploitation.

Heavy demands are made on decision-makers in health planning agencies and they may lack the time and knowledge to cope with the hard choices and trade-offs required. With millions of dollars riding on their decisions, not to mention distribution of services, they may be susceptible to the "hard sell" of vested interests. Planning units do not always deal effectively with political and legislative issues.

Providers claim they are victims of a system which has become increasingly punitive making it difficult for them to deliver quality care. Supporters of health planning claim "tiny triumphs" which must be nurtured by removing obstacles, and just "giving it time." Some put their hopes in Health Promotion (education, prevention, etc.)

Whether or not we continue to have regional planning, the national dilemma may lead us to compare proposals for National Health Insurance and a National Health Service. Methods of financing and reimbursement determine to a large extent who gets what care. Should we have private, catastrophic insurance with everyone paying something so that everyone is cost conscious? Should we de-regulate and rely on free-market competition to control cost and quality? Should we have cradle-to-grave health insurance for everyone regardless of ability to pay? Should we have socialized medicine? What is the future of Health Maintenance Organizations? (HMOs are prepaid comprehensive care organizations operating on a membership basis.)

There are many League connections: Human Resources (equal access and acceptability), Voters Service and Legislative Action (citizen involvement in the process), Environmental Quality, etc. After study and consensus members will be in a position to influence public policy in this important field. It was the Victorian statesman, Benjamin Disraeli, who said, "The health of the people is the State's greatest asset!"

VOTERS SERVICE REPORT
November, 1980

What a busy month we've had! Everyone has been so helpful and we've accomplished so much. It's so rewarding when we can fulfill the many requests we receive from the community and have fun at the same time.

On September 25th we had a registration table at Temple University. Elayne Lemanow made the arrangements with Temple and a table was set up in the Student Faculty Center. Marguerite Miles and Louise Page were there to register students and distribute election information.

Also on September 25th I made my radio and television debut! In the morning Sarah Grannis and I were interviewed on "Delaware Valley Voices" on WFIL. We talked about voter registration, the Arco Car Care Clinics, and League Activities in general. Later that day I joined other community members on Channel 6's "People to People". We appeared with the congressional candidates from the 1st and 3rd Districts to discuss election issues. Both activities were so exciting and my nerves got a real test.

Marcia Wilcox and Annette Sussman Friel went to the SmithKline Corp. on September 30th to register company employees and answer their election questions. Over 50 employees were registered during the lunch period.

On October 9th Fern Schulte spoke at the Park Drive Manor to a group of about 50 people. She talked about the history of the League and the activities the League is involved in. Hopefully a few people will be new members soon!

Also on October 9th Joyce Solo spoke to the Friendship Club of the Main Line about the upcoming election. Approximately 150 people were in attendance and Joyce said they were a very enthusiastic group.

That's it for this month. Be sure and vote on November 4th and if anyone has ideas for post-election voters service activities please give me a call.

Cyndi Mueller-Rohde
Voters Service Director

NEW MEMBERS IN OCTOBER

Barbara Polinsky
401C High Road, Andalusia, Pa. 19020

Meg Harkins
421 W. Johnson St. 19144

Joanne M. Townsend
4307 Vista Street 19136

Sophie S. Wice
135 South 19th St., #1510, 19103

Margaret S. Edwards
3027 North 25th St. 19132

A NEW CHARTER?

City Council has introduced a bill to establish a Commission "to frame a new Charter for the city." Ann Schoonmaker testified briefly at the hearing held by the Committee on Law and Government on October 14. If this commission is established, it will have the authority to present its recommendations to the voters without the approval of City Council.

LWV-Phila.'s overall position is in favor of changes that strengthen and modernize the Charter. If the Commission is established, Carol Baer will need committee members to do research and develop a course of study and recommendations. Call her at 667-6429.

The schools are provided up-to-date information on matters concerned with sexual behavior and education/informational materials. Olmsted County Health Department staff serve as advisors to the schools on revision or development of curricula. The School Nurse and Public Health Nurse coordinate their activities to assure they are fully informed on problems of school age children concerning sexual behavior.

The Olmsted County Health Department has utilized some of its budget to maintain a media program on family planning. Excellent use is made of free public media service time to inform the general public about the family planning program. The effectiveness of these information/education efforts via the public media cannot be easily measured. However it is an excellent way to inform people of options, problems, services and programs affecting their general health and well-being.

The Olmsted County CHS Agency approach to developing and implementing a family planning program by enlisting community support assures that all segments of the community concerned with or affected will be involved in its development and implementation. This method also assures that wise use of community resources will be made to provide an effective, coordinated family planning program.

For more information on this program, contact:

Charles E. Sandberg, Health Educator
Olmsted County Health Department
415 Fourth Street S.E.
Rochester, MN 55901

MINNESOTA DEPARTMENT OF HEALTH MEDICAL LABORATORIES HANDLING FEE

The Division of Medical Laboratories of the Department of Health has received and responded to many inquiries the past few months about the $1.50 laboratory handling fee. Following is a clarification regarding how an agency qualifies for an exemption from the handling fee:

- **An exempt agency is one that receives direct or indirect financial assistance (state or federal funds) through the Minnesota Department of Health.**
- **The exemption does not include private physicians, hospitals, or other medical facilities, except when a specific reason exists for an agency to make a specific request of a physician or medical facility to provide a service to that agency.**

The personnel in the Division of Medical Laboratories are informed of the agencies approved to date for exemption of laboratory fees.

For further information regarding the laboratory handling fee, please contact the Division of Medical Laboratories at 612/296-5210.

Minnesota Department of Health
Bureau of Administration
717 Delaware Street S.E.
Minneapolis, Minnesota 55440

COMMUNITY HEALTH SERVICES

COMMENTARY

MINNESOTA DEPARTMENT OF HEALTH
BUREAU OF ADMINISTRATION

Volume 1, No. 4 November, 1980

COORDINATION OF LOCAL RESOURCES TO SURVEY COMMUNITY HEALTH NEEDS

Prior to the Spring of 1980 the Beltrami County CHS Advisory Committee discussed the possibility of developing a health education component for its portion of the North Country (Beltrami, Clearwater, Hubbard, Lake of the Woods) 1980/81 CHS Plan. This component was not completed before the Plan submission primarily due to lack of adequate information on existing health education services available in the community.

Dr. Robert Montebello, Chairman of the Bemidji State University Division of Health, Education and Recreation, and member of the Beltrami CHS Advisory Committee suggested a way to resolve this problem. He proposed to involve students from his Health Education Class in a project that would obtain this valuable information and at the same time enable them to become informed on available local public health services or areas of service need.

In the Spring of 1980 four students volunteered to work on this project in cooperation with the Beltrami Nursing Service. A comprehensive survey form was designed to identify existing health education services and solicit information on what additional health education needs the community considered essential.

The Beltrami Nursing Service provided the postage and duplicating funds to mail two hundred and fifty-four survey forms to health, education, governmental, manpower, religious, social welfare and corrections agencies. There was a 47% response to the survey with seventy agencies reporting they provided some form of health education services. The students obtained the assistance of the Bemidji State University Computer Department to provide the data analysis for the project. The following basic information was provided by the Computer Department:

- **Nearly all the agencies providing health education services distribute printed material to their clients in addition to referring clients to other agencies for services. 45 agencies provide individual and/or group counseling to their clients.**
- **Although several respondents saw a need for more education on alcohol and drug abuse, 26 agencies were already providing these services.**
- **43 agencies provide services to the general public with all age groups receiving some form of service, with the low and middle socio-economic levels receiving most of the services (similar to the percentage within the general population).**
- **Health education is provided in over 20 different areas that includes alcoholism and drug abuse, safety and accident prevention, nutrition, mental and emotional health, human growth/development and physical fitness, smoking, weight control, heart disease, cancer, sex education and family living, environmental quality, first aid and CPR among others.**

Based on the final tabulated data the following primary conclusions were made:

- **The number of health education services provided in Beltrami County was more extensive than originally thought.**
- **A health education coordinator and more public information and awareness of existing services was needed before developing any additional education programs.**

The information obtained from this survey will be valuable to the Beltrami CHS Agency in determining the type of health education component to include in future CHS Plans. It will also be useful in determining the type of health education services to provide for the county and how to coordinate development of these services by the various agencies now providing some form of health education.

This cooperative project is an excellent example of coordinating community resources to identify local health needs. With minimum cost and staff time valuable assistance can be provided to CHS Advisory Committee members and staff to identify local health needs, set priorities and design service programs to meet the health needs of its residents. It is also an excellent way to involve all segments

of the community in the design, development and implementation of its community health service program.

For more information, contact:

Ruth Edevold, Administrative Assistant
North Country CHS Agency
Beltrami County Courthouse
Box 422
Bemidji, Minnesota 56601

CARE CENTER FOR THE ELDERLY
ALTERNATIVE TO EARLY INSTITUTIONAL CARE

The Carver County Community Health Service and the Carver County Community Social Services Agency have cooperatively developed and implemented a plan to provide an interim step to institutional care of the elderly. The result of this joint planning effort was establishment of the **Carver County Care Center** in October 1977. The Center is operated by the Carver County Community Social Services Agency and is supported by Federal Older American grant funds through the Metropolitan Council and local tax revenues. The Carver County Community Health Services Agency participated in all phases of development of the Center in the areas of needs assessment, program design, staffing and implementation.

The main objective of the Center is to delay or avoid institutional care of the elderly who are experiencing adverse physical or psychological effects generally associated with the aging process. The Center programs, activities and services are designed to improve or maintain the level of independent functioning, social skills and mental alertness of the elderly. Other services include referral and access to other community services, medical monitoring of physical conditions and respite for family caretakers.

The use of the Center by the elderly has steadily increased since its initial opening in October 1977. At present 39 persons are enrolled at the Center, participating in programs from one to five days a week. The Center is approaching a daily census figure of 20 participants with twenty to twenty-five persons identified as full service capacity (depending on the number of those identified as having severe handicaps).

The clientele includes persons with disabilities that range from **heart disease, stroke, diabetes, arthritis and amputation to mental illness.** The Center is also used by persons with less severe handicaps and those socially isolated in the community.

The supervisory and staff support for the Center is provided by a contract negotiated between the Carver County CHS Agency and the Carver County Community Social Services Agency. Medically-oriented services such as nursing and health program aide services, and occupational and physical therapy consultation are provided to the Center. The majority of referrals to the Center are made by the public health and roster nurses employed by the Community Health Service Agency.

The cost for services provided by the Center are estimated at approximately fifteen dollars per day at full capacity. Services include noon meals, snacks, craft materials, and transportation to and from the Center and other scheduled activities.

The Carver County Care Center is an economical and efficient way to use tax dollars to provide care for the elderly to avoid or reduce early, costly institutional care. More importantly, it provides a means whereby the community can assure that its elderly citizens will have every possible opportunity to live a productive and happy life with maximum independence and self-respect.

This cooperative venture between the Carver County CHS Agency and the Carver County Community Social Services Agency demonstrates how community agencies with similar clientele can work together to develop innovative and alternative approaches to providing health services. The result is a wiser use of community resources to provide public health services, while assuring that the dignity, independence and well-being of the citizen is assured in delivery of these services.

For information on the Carver County Care Center contact:

Vic Benetti, Supervisor
Carver County Care Center
c/o Carver County CHS Agency
609 West First Street
Waconia, MN 55387

COMMUNITY APPROACH
TO PROVIDING
FAMILY PLANNING SERVICES

The subcommittee on Health Education and Disease Prevention of the Olmsted County Community Health Services Advisory Committee concluded in a study report that even in a medical community like Rochester, Minnesota, there is a need to develop a community approach to providing family planning service for its residents. Based on information obtained from family planning programs operating in the community and others concerned with this issue, it was determined that the residents generally lacked adequate information upon which to base decisions concerning sexual behavior. The scope of the problem was identified as greater than one community agency could deal with effectively, and development of any family planning program would require coordinated community action and support.

The Olmsted County CHS Advisory Committee concluded from its study that the major factors considered important to maintaining an effective family planning program for Olmsted County were adequate clinical services and an education/information program. The county had adequate clinical services but lacked an adequate information/education network, to enable residents to make intelligent decisions on family planning methods, prevention of sexually transmitted diseases, and responsible sexual behavior. The Advisory Committee recommended that Olmsted County was the logical governmental unit to develop a coordinated community approach to develop an education/information program to complement family planning programs.

In 1979 the Olmsted CHS Agency was awarded a State Family Planning Special Projects Grant to develop a health education program. A Family Planning Special Projects Board was appointed and a Family Planning Health Educator was employed to begin implementation of this program. The Board membership included professionals from community agencies, clergy, physicians and other key persons who could provide advice and assistance. The Board was responsible for overall direction of the program.

In addition, a Family Planning Services Network Committee was formed to provide a vehicle of idea-sharing and interagency communication along with in-service education opportunities for family planning professionals. The Network is a communication and networking vehicle for all family planning activities in Olmsted County.

Under this Family Planning Special Projects Funds grant, a Task Force on Human Sexuality Curriculum was implemented to increase community awareness in the area of education for human sexuality among community groups, parents, professionals, and to gain an acceptance for a developmental approach to teaching parents and various professional disciplines. This Task Force has been working for one year. During that time it has studied the literature on research and methodology in sex education.

This winter the Task Force will begin writing an outline for preschool through 12th grade on the developmental sexuality component along with a parent complementary program. Its objectives are to:

- **Implement continued programs for parents,**
- **Train educators,**
- **Offer an introductory workshop,**
- **Publish a written guide for the parent complementary program,**
- **Write a developmental instructional component outline in human sexuality.**

Churches, civic groups and other community agencies have been invited to offer input and develop programs on human sexuality.

The primary purpose of these various group activities sponsored by the Olmsted County Family Planning Program was to obtain community involvement and coordinate a direction in family planning programs developed in Olmsted County. The impact on human sexuality program development implementation is a coordinated effort and depends on total community commitment and consensus.

The Olmsted County Family Planning Program contains an educational component to deal with community problems on sexual behavior. These services are provided by the Olmsted County Health Department to such programs as W.I.C. (Women, Infants and Children Program), sexually transmitted disease clinic, and the well baby clinic. The staff works on a one-to-one basis with the clientele to review behavior patterns, discuss problems and issues and recommend options to alter behavior.

Residents are informed of services through an informative brochure on available services. There is a VD/Family Planning Information line to answer specific questions of the public. Arrangements can also be made via telephone to link the caller with a physician, educator, public health nurse or other appropriate professional to obtain answers to questions or advice on problems.

[1987]

THE MINNESOTA COMMUNITY WELLNESS INVENTORY

Minnesota Council on Health
Minneapolis, Minnesota

One of the basic tools of wellness programs is the personal wellness inventory, a compilation of data about the wellness level of an individual. Such inventories usually consist of questionnaires designed to obtain information about personal medical history, exercise levels, feelings about one's self and others, nutritional habits, and so on. Available at differing levels of sophistication and complexity, these inventories provide personal profiles that are useful to wellness practitioners for determining how a person can modify parts of his or her lifestyle to attain better levels of wellness.

Because this approach is useful on the individual level, it is reasonable to extend the principles of measuring degrees of wellness to the community level. With this in mind, the Minnesota Council on Health has developed the Minnesota Community Wellness Inventory. It attempts to provide a picture of a community's wellness level, its needs in the area of health, and its responses to those needs. The inventory permits comparisons with other Minnesota communities and with the state as a whole on a number of wellness dimensions. It also provides a base for the community to observe its progress across time.

The development and use of social and health indicators has grown in the past decade as policymakers for government and private institutions have sought improved guideposts for decision-making. Indicators are population statistics that are relatively easy to obtain, and which illuminate social or health conditions that are difficult or impossible to measure. The conditions may be artificial constructs -- such as wellness -- that defy direct quantification. An example of an indicator might be the sale of non-fiction books as a reflection of community intellectual activity levels. Another might be attendance at symphony concerts as a measure of "high" culture.

Often, indicators that bear on the same condition are collected statistically into indexes. The well-known Consumer Price Index is an example.

The development and application of indicators and indexes can be a highly rigorous procedure, involving sophisticated statistical methods, or it can be a relatively crude procedure, providing only rough indications of the condition being examined. Both approaches are employed in the health field.* They are essential to the proper development of health improvement strategies. They can be useful for planning, evaluating existing programs, monitoring community change, diagnosing problem areas, and similar tasks.

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*For a thorough and contemporary discussion of health indicators, see G.E. Alan Dever, Community Health Analysis (Germantown, Maryland: Aspen Systems Corporation, 1980), particularly Ch. 7.

The data alone do not determine goals, however. Objectives must come from professional and community sources, guided by the data. Much of the work by health planners has followed an epidemiological model, in which population characteristics and the incidence of disease and specific individual health statistics are employed.

The Minnesota Community Wellness Inventory goes beyond those measures to embrace a more holistic perspective on health. It includes social conditions and community resources that have an effect on health. In this way, it provides a tool for the community to look both at the physical health of its residents and at the environment that relates to that level of health -- and may account for it. The inventory thus may become a vehicle for community action to address specific health problem areas, pointing out specific needs and remedies.

Three Indexes of Wellness

The inventory is comprised of three parts, each focused on a different dimension of community wellness. The Health Status Index utilizes fundamental measures of births, deaths and illness to describe existing health levels. The Social Status Index measures nonmedical conditions that influence wellness. The Wellness Resource Index puts a yardstick to some of the facilities-related areas in which communities can take steps to remedy and prevent wellness problems.

The indicators in the Minnesota Wellness Inventory were selected for their relationship to aspects of lifestyle that affect wellness, because those are most susceptible to intervention and change through community awareness programs and similar

collective action. Although the associations between a given indicator and a certain lifestyle attribute may not have a direct, one-to-one relationship, they are the best measures presently available.

It must be emphasized that the Minnesota Wellness Inventory is a tool to be used with discretion. It provides a crude but useful measure of the several aspects of wellness that are important to communities and their residents. It is not presented as a precise appraisal, but rather as an indication of direction, much as a weather vane. The invididual indicators may be revealing in themselves. Collected into the individual indexes, they suggest the degree of concern a community might have for the health of its citizens and the conditions that account for that health. The three indexes combined may provide a useful, quantitative signal for the community and its leaders: We're doing okay --- or, We've got some problems.

But it must be remembered that the indicators and the indexes that they provide were chosen arbitrarily. The weighting of each indicator is also arbitrary, and one condition may be much more significant than another. The indicators selected are those that are readily available, and the inventory can be collected and computed by laymen, without technical training in statistics. For this reason, there was no attempt to adjust the indicators for factors that public health specialists usually take into account. For example, the indicators in the Health Status Index are not adjusted for age or sex, two factors that vary among communities, and bear on the incidence of specific diseases. The error that these omissions introduce into the

indexes are likely to be slight, and won't interfere with the principal objective of the inventory: To give communities of Minnesota a simple, understandable and reasonably accurate method with which to appraise their levels of wellness.

Health Status Index

Each of the six indicators in this part of the inventory pertains to a medical condition linked to lifestyle. They are perinatal death rate, ischemic heart disease, hemmorhagic stroke deaths, lung cancer deaths, accidental deaths, and automobile crashes.

Perinatal Death Rate: This is a measure of how many fetuses die after the 20th week of pregnancy, plus the number of babies who die during the first four weeks of life. It is expressed as a ratio of deaths to 1,000 live births. This indicator is generally considered to reflect basic health conditions, because it incorporates emergency care, infectious diseases, and high risk births. It differs from the infant mortality rate, which is the proportion of babies that die within the first year, and was chosen because it yields a broader range of values for the sake of community-to-community comparison.

Ischemic Heart Disease: One of the leading causes of death, this indicator is associated with dietary habits. A high incidence suggests a consistent consumption of high-fat foods. It is believed to be sensitive to improved diet and exercise, to some degree. The major weakness of this indicator, and the two following, is that it is more a measure of lifestyle practices

begun 30 or 40 years ago, when the older people dying today were young, than a measure of current nutritional effects. Nevertheless, there may be a hereditary predilection for this disease that would affect the community's younger age groups as much as the old.

Hemmorhagic Stroke Deaths: This indicates levels of hypertension in a community on the assumption that high blood pressure can lead to fatal cerebral blood vessel ruptures. Since there are many drugs and relaxation techniques that lower blood pressure, it is readily subject to intervention. But it is an "old" measure, as mentioned above.

Lung Cancer Deaths: There is little question that lung cancer deaths are directly associated with the levels of smoking in a community. Again, this is a measure of people who began smoking years ago, but it is likely that attitudes toward smoking are passed on in families.

Accidental Deaths: Although at first glance it seems that accidental deaths are not controllable, it is reasonable to assume that this is a measure of community carelessness -- a condition that can be improved through awareness. It is also a measure of current status.

Automobile Crashes: This differs from accidental deaths in that it includes nonfatal as well as fatal crashes. The premise is that a high percentage of crashes are related to alcohol use, so this is essentially a rough measure of community drinking. A more precise indicator would be limited to those crashés occurring after midnight, but those data are not available.

Social Status Index

These indicators shed light on problem areas in a community other than the purely medical. They are teenage pregnancy, poverty level, crime rate, school dropout rate, youth dependency ration, aged dependency ratio;

Teenage Pregnancy: Technically, this measure refers to live births to women under age 18. It was chosen in lieu of the general birth rate because of disagreement over desireable levels of births. The teenage pregnancy rate reflects community sex education activities, family planning, moral values and related aspects.

Poverty Level: This is the percentage of people with incomes below established poverty guidelines. It provides a rough picture of a community's economic base, which is related to wellness in the sense that a wealthy community can afford adequate medical care. Whether the wealthy community enjoys a high level of wellness is another question, however, since medical care does not assure wellness. Still, economic wellness is related to general wellness.

Crime Rate: This is a measure of the total number of "index crimes" -- murder, forcible rape, robbery, aggravated assault, burglary, larceny, and motor vehicle theft -- that are reported. It extends the measures of wellness further into general social conditions in a community, and is susceptible to intervention. It is an imperfect indicator, however, because many crimes are not reported to authorities, and crime reporting rates vary from community to community.

School Dropout Rate: Another indicator of social conditions, this also reflects community values about education.

Youth Dependency Ratio: Age distribution affects community wellness levels, so this and the following indicator are useful in assessing community resource needs. The Youth Dependency Ratio is the proportion of persons under 15 to those between 15 and 64. The higher the ratio, the more need for youth services such as counselling centers, pediatricians, and drug and sex education resources.

Aged Dependency Ratio: This is the other end of the age spectrum, the ratio of those over 64 to those between 15 and 64. An older population has different wellness needs than a younger one, including senior citizen centers, transportation services, and community involvement programs.

Wellness Resource Index

The last segment of the wellness inventory consists of ten indicators that measure community response to wellness needs and problems. They are population-to-primary-care physician ratio, emergency services, chemical dependency counselling, multipurpose senior centers, smoking cessation programs, weight loss programs, hypertension clinics, tennis courts, public parks, and church membership.

Population-to-Primary-Care Physician Ratio: Although the presence of many doctors in a community is not a reliable indicator of wellness, it is nonetheless a useful measure of comparison. This is done at the county level by the Bureau of Health Manpower in the federal government. There are federal guidelines for desireable levels of primary care physicians,

but for the wellness inventory, physician levels are compared with the Minnesota state average. Since the inventory is intended for use in nonmetropolitan areas, the ratio has been determined by subtracting the respective ratios for the seven-county Minneapolis-St. Paul region, Duluth and Rochester. Primary care physicians are defined as doctors of medicine and doctors of osteopathy providing direct patient care who practice principally in general or family medicine, general internal medicine, general pediatrics, or obstetrics and gynecology. The limitation of other specialists is somewhat misleading because many specialists in medicine also perform primary care services. This, too, is a rough indicator of the availability of trained medical personnel in a community.

Emergency Services: To gauge community preparedness for medical emergencies, there are two stages to consider: basic life support and advanced life support. The former involves noninterventive life support services such as stabilization and protecting victims from further harm. Advanced life support includes interventive services such as defibrillation, intravenous therapy (including drug administration), and intubation (establishing clear airways). Advanced life support personnel have had speciallized training and are usually equipped with two-way communication between them and a physician. Most communities do not have advanced support services, and there is no data to indicate that it provides measurable benefits in a public health sense, beyond basic life support in emergencies. However, it reflects community resources and awareness. Distance is a factor in emergency service; consequently, the federal guideline value of 30 miles is used. A community with advanced life support

services within 30 miles is better off than one without them.

Chemical Dependency Counselling: According to staff members of the Johnson Institute, a good indicator of a community's awareness of and committment to handling problems of alcohol abuse and chemical dependency is whether the school district employs a trained chemical dependency counselor. Such a person would have taken special training and would be available during school hours for appointments or walk-in service.

Multipurpose Senior Centers: State and federal agencies provide many services for senior citizens, but the best thing a community can have is a multipurpose senior center. Such a facility, whether fixed or mobile, offers access to services such as transportation; in-home services such as Meals-on-Wheels and home visits; community services such as congregate dining and social activities, and services in care-providing facilities (e.g., nursing homes). If a community has a senior center with several programs, it is an indicator of wellness among older persons.

Smoking Cessation Programs: These come in many forms, from full-time programs to occasional clinics at health care facilities. They are designed to help smokers who want to quit, and to educate nonsmokers about the dangers of cigarettes. If a community has such a program, it is a sign of a commitment to the problem. For the purpose of the inventory, any such program earns points.

Weight Loss Programs: Like the smoking clinics, this type of resource can vary widely. A weight reductions center/program/organization (Weight Watchers, TOPS) would indicate that something

is being done in the community to address ongoing problems associated with overeating and obesity.

Hypertension Clinics: This indicator attempts to determine if a community has the resources to combat and prevent hypertension -- a regular or part time program that monitors people's blood pressure. It must do more than just provide clients with their blood pressure readings; it must refer persons with elevated blood pressure to a medical resource, because it's at the referral stage that something gets done about the problem in terms of drug therapy or stress management.

Tennis Courts: One of the many possible indicators of community involvement in physical fitness, this is useful because the United States Tennis Association has established a guideline ratio of tennis courts to population. The growth of tennis in the past decade has removed it from the category of sport for the wealthy, and a community with a high proportion of tennis courts is probably also meeting other fitness facility demands.

Public Parks: This is considered an indicator of community recreation facilities on the assumption that a high proportion of park space provides opportunity for outdoor activities, whether or not they are used. It is important to both physical and mental health.

Using the Wellness Inventory

The inventory was designed for use by people without special training in statistics. The information needed to complete it is available from a number of standard sources available in libraries and state agencies. A chief source of information is the Center for Health Statistics of the Minnesota Department of Health, 717 Delaware St. S.E., Minneapolis, MN 55440, phone 296-5353. The center will provide breakout data at the city level on special request; the center's published statistics for most indicators are provided only at the county level. Population data is available from a number of sources, and will soon be revised to account for the 1980 census. The sources and publications listed on the following pages were taken from material available at the time of preparation of this report. More recent material is available periodically.

Some inventory measures are not available for communities in statistical repositories. These must be gathered independently through interviews in the community. They, too, are indicated in the following pages.

The Minnesota Council on Health is a non-profit educational association. It is active in the promotion of the concept of wellness -- the movement toward physical, emotional, spiritual and mental health -- through self-responsibility of the individual. Its activities have included the promotion of the prevention of illness through community meetings, published materials, awards and direct contact with organizations, government and employers.

PART 1: HEALTH STATUS INDEX

CITY _____

COUNTY _____

LINE A INDICATORS	Perinatal Death Rate	Ischemic Heart Disease Deaths	Hemmorhagic Stroke Deaths	Lung Cancer Deaths	Accidental Deaths	Crashes
LINE B LOCAL RATES						
	STATE AVERAGES/RATES (SA)					
LINE C	15.7/ 1,000 live births	337/ 1,000 deaths	109/ 1,000 deaths	40/ 1,000 deaths	56/ 1,000 deaths	29/ 1,000 population
	THRESHOLD RANGE FORMULA (TR)					
LINE D	≤10.7=30 btwn=20 ≥20.7=10	≤308=30 btwn=20 ≥366=10	≤85=30 btwn=20 ≥128=10	≤31=30 btwn=20 ≥51=10	≤38=30 btwn=20 ≥74=10	≤25=30 btwn=20 ≥33=10
	SCORING					
LINE E						

SUMMARY INDEX

PART 2: SOCIAL STATUS INDEX

CITY _____

COUNTY _____

LINE A INDICATORS	Teenage Pregnancy	Poverty Level	Crime Rate	School Dropout Rate	Youth Dependency Ratio	Aged Dependency Ratio
LINE B LOCAL RATES						
	STATE AVERAGES/RATES (SA)					
LINE C	3.9/ 100 live births	15.9% below poverty level	4,156/ 100,00 populatn	34/1,00 secondary school students	36/ 100	18/ 100
	THRESHOLD RANGE FORMULA (TR)					
LINE D	2.1=30 btwn=20 5.7=10	12.1=30 btwn=20 19.6=10	2301=30 btwn=20 5917=10	26=30 btwn=20 42=10	31=30 btwn=20 41=10	12=30 btwn=20 24=10
	SCORING					
LINE E						

SUMMARY INDEX

PART 3: WELLNESS RESOURCES INDEX

CITY _____

COUNTY _____

	Popultn-to-Primry Care Phy Ratio	Emergency Services	Chemical Dependency Counselors	Multi-purpose Senior Centers	Smoking Cessation Clinics	Weight Loss Programs	Hyper-tension Clinics	Tennis Courts	Public Parks
LINE A INDICATORS									
LINE B LOCAL RATES									
	STATE AVERAGES /GUIDELINES/CRITERIA (SA)								
LINE C	2,300 pop/ 1 PC Phys	ALS BLS NA	FT PT NA	FT PT NA	FT PT NA	FT PT NA	FT PT NA	see table on worksheet	1.5 acres per 1,000 popultn
	THRESHOLD RANGE FORMULA (TR)								
LINE D	≤1377=30 btwn=20 ≥3283=10	ALS=30 BLS=20 NA =10	FT=30 PT=20 NA=10	FT=30 PT=20 NA=10	FT=30 PT=20 NA=10	FT=30 PT=20 NA=10	FT=30 PT=20 NA=10	calculate for each city	≥2.0 =30 btwn =20 ≤1.0 =10
	SCORING								
LINE E									

SUMMARY INDEX

[19817]

COMMUNITY WELLNESS INVENTORY

Data Recording Sheet

Date _____

Community name _____

	Indicator	Value
1)	school dropout rate	_____ # of students/1,000 secondary students who dropout (may include those who return during the school year)

Narrative description/comments:

_____

_____

_____

_____

2) emergency services

check one:

_____ advanced life support

_____ basic life support

_____ no emergency services available

Narrative description/comments:

_____

_____

_____

_____

3) chemical dependency counselors

check one:

_____ full time

_____ part time

_____ none available

Narrative description/comments:

_____

_____

_____

_____

4) multi-purpose senior center

check one:
_____ full-time
_____ part-time
_____ none available

Narrative description/comments:

_____

_____

_____

_____

5) smoking cessation clinics

check one:
_____ full-time
_____ part-time
_____ none available

Narrative description/comments:

_____

_____

_____

_____

6) weight loss programs

check one:
_____ full-time
_____ part-time
_____ none available

Narrative description/comments:

_____

_____

_____

_____

7) hypertension clinics

check one:
_____ full-time
_____ part-time
_____ none available

Narrative description/comments:

_____

_____

_____

_____

8) tennis courts _____# of public courts available (indoors & outdoors)

Narrative description/comments:

_____

_____

_____

_____

9) public parks _____approximate number of acres of parks and/or open space available in or around community

Narrative description/comments:

_____

_____

_____

_____

GENERAL COMMEMTS:

_____

_____

_____

_____

_____

_____

_____

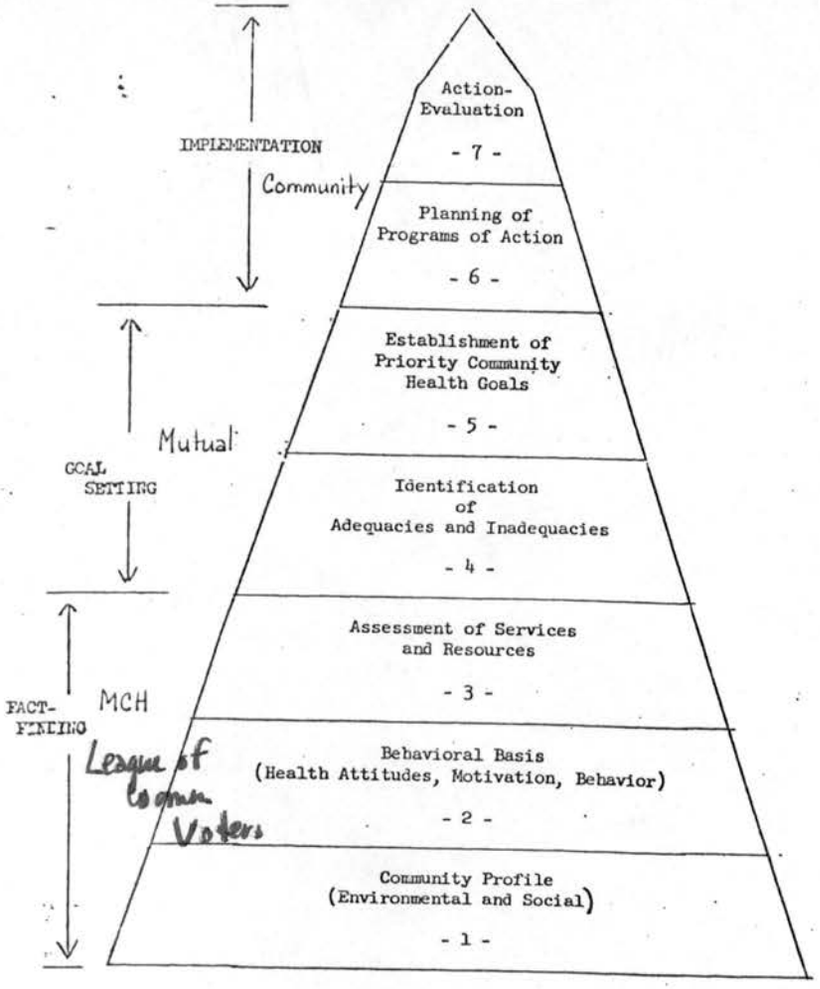
_____

_____

_____

_____

TO ASSIST AND IMPROVE COMMUNITY HEALTH SERVICES*



*From Planning Guide for the Assessment and Improvement of Community Health Services (Draft 3) NCCHS, September 1, 1963.

MCH COMMUNITY WELLNESS INVENTORY

CONTACT SHEET

DATE _____

COMMUNITY _____

LWV CONTACT PERSON:

NAME _____

ADDRESS _____

PHONE _____

Is your League interested in compiling an Inventory for your community at this time?

yes _____

no _____

We would like more information _____

If "yes", please indicate an approximate deadline that would be most feasible for you.

November 30, 1981 _____

December 31, 1981 _____

January 31, 1982 _____

February 28, 1982 _____

Other _____

MINNESOTA COMMUNITY WELLNESS INVENTORY
Data-Gathering Instructions

General Information:

The Inventory is composed of three indices -- Health Status, Social Status, and Wellness Resources. The three together include 21 indicators or 21 separate pieces of information which need to be obtained. MCH and your League will be sharing the responsibility for gathering this data. The indicators which we would like you to investigate are the following:

Indicator

1) school dropout rate
2) emergency services
3) chemical dependency counselors
4) multi-purpose senior centers
5) smoking cessation clinics
6) weight loss programs
7) hypertension clinics
8) tennis courts
9) public parks

Data Sources

Attached you will find a list of sources for the above indicators. These are suggested places to start when compiling the indicator data. You will most likely want to supplement these suggestions with other agencies, individuals, or organizations. For example, public health

agencies, community clinics and social service organizations may be good places to assist you in your search for Inventory information.

Recording of Data

Attached is a listing of indicators which is to be used for recording Inventory data. Please note that a brief narrative description of the indicator value is requested. This is important because we have found that the indicator data often do not fit neatly into categories. For example, you may find that smoking cessation clinics are available once a month, but not every single month, and at differing locations around the community. Therefore they could be considered either "full time" or "part time" when being scored. Write as detailed a description as you wish regarding each indicator. This will enable us to compile a more thorough and precise Inventory for each community. (Refer to the Inventory narrative description for an explanation of the individual indicators).

Additional Indicators

In the course of gathering data, you may encounter suggestions for indicators which are not included in our Inventory (e.g. day care services, transportation services for the elderly). Please feel free to record your ideas and suggestions on the Data Recording Sheet. We want the Inventory to reflect the unique needs and characteristics of your community.

1st vote Pugliese
defeated 626 yes = 28 votes
654 no

PROPOSED HEALTH CARE STUDY

reconsider - yes by 39 vote
From LWVUS convention - 1980 carried 638 yes, 624 no = 14 vote

A study of the health care system in the United States with emphasis on the private and public sector roles in the delivery of services.

SCOPE

Examine the health care system as it exists today

Assess the programs that mold it

- Planning/resource allocation—
- Statutes/governance—
- Funding/financing—

Evaluate its outcomes: the services that are delivered and their effects on people

Identify problem areas, if any

Describe the changes, if any, that could be made

Develop criteria to judge any program that impacts on the health care system to implement change

Transportation will be listed as a separate item on national program = editorial change - not substance

Social Security lost consideration by very little 648 yes 601
national security, arms control, + military spending lost adoption

Household membership - PIMP to allow 2nd person = 1/2

League of Women Voters Education Fund 1730 M Street, N.W., Washington, D.C. 20036 Tel. (202) 659-2685

memorandum

February 1981

This is not going on DPM

TO: State, Local and ILO Presidents
FROM: Nancy Neuman, Human Resources
RE: Health Care Proposal - An Update

As reported in our November 7, 1980 memo, we have developed a funding proposal for a two-year project on the health care dilemma in the United States. (For a description of convention action on the health care item, see Impact on Issues.) In response to inquiries from several Leagues, we are sending you a brief memo to share with you the scope and content of the funding proposal.

Based on extensive input and careful scrutiny by the board, staff and League members with health care program experience, the proposal encompasses a strong program of research, resource material development and citizen education outreach.

The two major goals of the proposal are: 1) to conduct an in-depth, citizen-consumer oriented analysis of the health care system and options for change, and 2) develop educational tools that the 1,400 state and local Leagues can utilize to reach the larger citizenry.

In order to achieve these goals, the following methodology will be implemented if we are successful in funding the entire proposal.

Extensive research of the health care system will be undertaken. Among the more immediate and difficult issues this project will address are: A) financing and reimbursment of health care services (including the effects of regulation and deregulation, manpower shifts, the role of third-party payers and state cost-containment programs); B) future demands on the system such as the growing elderly population and continuous technological innovations; C) the role of the citizen-consumer in the health care delivery system as utilizer and decision-maker; and D) the impact of preventive services, in terms of cost, access, availability and quality.

A variety of materials will be developed to assist state and local Leagues with their individual outreach efforts. A substantive facts and issues publication will discuss the health care needs of various segments of the population, trends that will affect the demand and cost of health care in coming decades, and major public and private programs that provide and pay for health care. This publication will also enumerate major policy options that citizen-consumers will need to consider in the debate over the future of the American health care system.

A slide show will be developed to reinforce and illustrate more dynamically the facts and issues publication. In addition, a leader's guide will be designed to provide a step-by-step "how-to" handbook that will enable Leagues to present information-packed workshops, conferences, seminars and TV or radio shows.

A major feature of the project will be a two-day national training conference that will enable participants (including at least one representative from each state) to examine and evaluate the existing system and participate in workshops geared to sharpen techniques for establishing productive dialogs among citizen-consumer and health care experts.

(over, please)

Community outreach is a critical component of the project. The LWVEF Health Committe and staff will provide technical assistance to state and local Leagues through correspondence, telephone and field service. In addition, funds will be used to make pass-through grants available to selected state Leagues for intensive citizen education campaigns. Funds may be used for special outreach efforts, including adapting the LWVEF slide show to reflect local concerns, holding special workshops and conferences, producing a pamphlet or brochure, or developing a TV or radio talk show.

Rita Wasmuth, Development Director and Karen Bluestone, part-time consultant to the LWVEF on this project, are presently working on procuring funds through several foundations. If you would like more detailed information on the proposal, please contact Karen Bluestone. You may call on the LWVEF WATS line: 800-424-5483, 9:00 a.m. - 1:00 p.m., EST.

6

BACKGROUND MATERIAL FOR HEALTH CARE UNITS, March 1981

STUDY OF THE EFFECTIVENESS OF CITY HEALTH CARE PROGRAMS: PRIMARY CARE AND LONG TERM CHRONIC CARE

What is primary care?

Primary care includes the spectrum of basic health services that people need on a continuing basis to maintain their physical well-being and to restore them to health when they are sick. (Secondary care refers to specialized services such as those found in a community hospital. Tertiary care is the most highly specialized, as would be found in a teaching hospital or medical center.)

Primary care is seen as the key to success in improving the health of the population and in solving many of our major health care problems through, for example, control of hypertension, early detection and treatment of cancer, provision of maternal and infant care, reduction of the number of unwanted teenage pregnancies, and improved nutrition for the population.

Where in Philadelphia is there a shortage of primary care services?

The federal government designates an area as medically underserved (MUA) when its Index of Underservice indicates problems in the following areas:

--The percentage of the population under the poverty level
--The percentage of the population 65 years of age and over
--The infant mortality rate of 5 consecutive years
--The ratio of primary care physicians to population.

Philadelphia has many MUAs by census tract, mainly clustered in the northcentral, west, and south sections of the city, as well as parts of Germantown, and Strawberry Mansion.

In addition, the Department of Health and Human Services designates certain areas as Health Manpower Shortage Areas (HMSAs).

Philadelphia has three primary care HMSAs: one in the Covenant House area (Germantown), one in Northcentral, and one in South Philadelphia.

What is the city's role in the provision of primary care?

Since the closing of Philadelphia General Hospital in 1978, the city has established seven Family Medical Centers (FMCs), which offer comprehensive, family-oriented health care to any resident of the city who enrolls. Three additional FMCs are in the planning stages. The FMCs operate on sound health care principles: Generally patients are seen by the same health care team at each visit and the programs stress disease prevention and health maintenance. Patients are also eligible for specialized outpatient services at certain "back-up" hospitals under contract to the city and even inpatient services, as needed, upon referral to the health care team. No individual or family is ever charged out-of-pocket for any of the FMCs services, although the FMCs do collect from third party payors (Medicare, Medicaid, Blue Cross/Blue Shield, etc.) when the individual is covered.

The FMCs are part of a primary care system (or non-system) that includes services in other settings: private physician offices, private dentist offices, group practices, hospital outpatient departments, public health centers, community comprehensive health centers, children and youth programs. In many areas, the various providers of care compete for the same patients. Many patients use more than one provider of care. Some primary care centers receive partial funding from the Bureau of Community Health Services, Department of Health and Human Services, Region III. Others receive partial funding from the Commonwealth of Pennsylvania. The FMCs receive both state and federal funds, mostly in categorical grants for particular programs such as maternal and infant care, venereal disease control, immunizations, and communicable disease control, etc., as well as payments from Medicare and Medicaid. There seems to be little effort to coordinate the delivery of services, even among the publicly funded centers.

How do the Family Medical Centers differ from the federally funded community health centers?

Aside from the differences in services which may be offered, there are two significant differences between the FMCs and the federally funded community health centers:

1) The community health centers must, by law, have a community board, which is consumer dominated. FMCs have no such board, although the new Strawberry Mansion FMC, if funded through the Urban Health Initiative, will be an exception. (The city has a commitment to fund the Strawberry Mansion FMC if Urban Health Initiative funding does not come through.)

2) The community health centers must, by law, charge users whose incomes are above the poverty line on a sliding-scale fee basis. The FMCs do not charge users out-of-pocket at all for their services, although they do collect from third-party payors whenever possible.

Who do the FMCs serve? Who should they serve?

The FMCs, according to the Department of Public Health Annual Report for 1979-80, served about 60,000 individuals, with a total of close to 200,000 patient visits. According to Dr. Soricelli, Deputy Health Commissioner, the need is for "population groups who have no way to pay."

Because of the complexity of the health care system, no one knows for sure how many people who are in need of health care services are not receiving them. The group of especially great concern to health care planners is made up of people with low incomes who are ineligible for Medicaid, who have no other health insurance, or have inadequate insurance coverage. For most of these people, food and shelter are their first consideration. Preventive services and primary care are inaccessible unless they are provided with public funds. The HSA/SP's Health Systems Plan for 1980 estimates that there are 190,000 to 300,000 people in the Southeastern Pennsylvania region with inadequate or no insurance coverage. The largest proportion of this population is in the city of Philadelphia. Is this the population the FMCs should be serving? If so, they clearly are not reaching all or even most of the population in need. Are the FMCs, together with the other publicly funded community health centers, meeting the needs? No one seems to know.

Should the city expand the F.C's?

According to Dr. Soricelli, Deputy Health Commissioner, the seven F.Cs currently in operation are working at capacity. The city is planning for, and has a commitment to fund, three new F.Cs---in Health Districts #7 and #8 and in Strawberry Mansion. Another F.C, in the Mantua area, has been under consideration and appears in the city's capital budget for 1983, but there is no definite commitment to fund its operation.

While there could possibly be opposition to further expansion of the F.Cs in the community or from other providers of care, the main barrier to expansion is funding. Even though the city receives state and federal funds to support its health care programs, expansion of the F.Cs as they are currently financed would have to come largely from city funds. Obviously there is a point at which expansion of the F.Cs will not be consistent with political pressures in the city to keep costs and taxes down.

The existing F.C's have no active outreach program. Obviously, if the centers are operating at capacity, a successful outreach program would overburden their facilities and lessen the quality of care. Edward V. Sparer, et al., in a Health Law Project Report (Health Law Project Library Bulletin Sept./Oct. 1976) put it this way, "the present F.C 'free care to all' program will be true to its promise only so long as 'all' do not try to enroll and use the F.C." The same report recommended a number of innovative methods the city could use to increase funding for F.Cs from federal sources: 1) H.D affiliation, with potentially greater payments from Medicaid clients, 2) designation as Community Health Centers (with community boards and sliding scale fees), 3) premium and fee subsidies through the Grey Area Premium Supplements (GAPS) program, and 4) use of National Health Service Corps personnel. With current and impending cutbacks in federal funds for human services, the chance of success in obtaining large increases in funds is probably slim. Nevertheless, the city could investigate these options.

LONG TERM CHRONIC CARE

What is long term chronic care (LTCC)?

Long term chronic care, defined as care provided for 30 days or more, includes all services designed to maintain or improve the condition of functionally disabled persons. These services include nursing home care, home health care, sheltered living arrangements, residential day care, and other services designed to give supportive help to persons in need. Approximately 90% of people in need of LTCC are over 65 years of age; 10% are younger.

Where in Philadelphia is there a shortage of long term care services?

In-home services

In spite of its many advantages, in-home care has been underdeveloped and underutilized in the city, as elsewhere, largely because of federal and state government and other third-party reimbursement biases which favor care in institutional settings. No area is completely without services, but the number of services is small compared with the need that would be evidenced if more liberal reimbursement were available.

Nursing homes

The Health Systems Agency has just completed a locational analysis of nursing home bed needs in the Philadelphia region. The region has been divided into 22 "clusters" --areas in which populations regularly seek services. The clusters cross county lines, but 12 of the 22 clusters are either totally or partially located in the city. In these 12 clusters there is a documented need for 1,961 nursing home beds. Almost every section of the city is affected by this severe shortage. The most acute need is for beds for patients whose only source of payment is Medicaid.

What is the city's role in the provision of long term care?

In-home services

Before June 30, 1979, the city provided directly some in-home health care services through the District Health Offices and Family Medical Centers. In fiscal year 1979, the total number of visits made by professional personnel was approximately 12,000. Since June 30, 1979, the city has been purchasing in-home care under contract from a newly created agency, Community Home Health Services of Philadelphia, a voluntary corporate agency. The city pays $250,000 to CHHS, which buys 6,250 home visits at $32, the price the city pays. It would seem that the city has cut back severely on the home care it provides, but Dr. Soricelli, Deputy Health Commissioner, says that the figures are not comparable because current staff still fill some home care functions in particular programs (VD, immunizations, tuberculosis).

Nursing homes

The city currently maintains two skilled nursing facilities: the Philadelphia Nursing Home (PNH), formerly Landis Hospital, with 500 nursing care beds, which is located at Girard and Corinthian Avenues, and the PNH Northeast Unit (Riverview), with 130 beds, located in Northeast Philadelphia at 7979 State Road. Plans to move the patients from the Northeast Unit to Landis have been delayed. Adjacent to the Northeast Unit is Riverview Home for the Aged, a residential facility with approximately 250 beds, also run by the city. Admission to the PNH is through the Family Medical Centers.

It is very expensive to maintain patients in PNH. The cost per patient is around $70 per day as compared with a general range of $35 to $50 per day in other facilities. Persons who have worked at PNH say that this is because PNH takes the sickest, most difficult to care for patients, who are almost always turned away from other nursing homes. The staffing ratios must be high because of the intense level of care that must be given.

The residential section of Riverview is not operating at capacity--an anomaly in a situation where there is a shortage of housing for the elderly. Various explanations have been given--lack of referrals, staffing problems, stringent conditions for accepting residents.

Other services

Many LTCC services in Philadelphia are provided through the Philadelphia Corporation for the Aging, a private non-profit corporation which serves as the city's Area Agency on Aging (AAA).

The city runs six senior centers (4 by the Health Department and one each by the Philadelphia Housing Authority and the Philadelphia Allied Action Commission) which are funded through PAC. The city has three additional centers which are not funded through PAC. PAC has a contract with the city to provide domiciliary care centers in cooperation with the Mental Health/Mental Retardation centers. It also has a contract with the Department of Public Welfare to provide adult foster care.

PAC provides a wide range of services both in-home and in the community. It also has an active community planning process. PAC estimates that they serve about 3,000 senior citizens out of about 49,000 who need their services.

Who does the city serve in its LTCC programs? Who should it serve?

The answer to the first question seems to be that the city serves a very small proportion of the population in need. The LWV will want to consider: 1) whether the city has a responsibility to the unserved citizens in need and, if it has, 2) whether the responsibility should be filled by an expansion of city services or 3) whether the city should encourage the development of services by others to meet the needs.

What can the city do to promote the development of LTCC services?

The LWV's booklet, "You and Your City", lists the Mayor's Commission on Services to the Aging with the following description: "coordinates all municipal programs relating to services for the aging, and aids in the development of new programs in cooperation with federal, state and private agencies. Its members are appointed by the Mayor."

While this commission is still operating as a service agency, there is no evidence that it is performing an important planning function. Certainly planning for the orderly development of needed services is one of the most important steps the city can take. Perhaps the Department of Public Health should have an Office of Planning and Evaluation that will assess health care needs on a continuing basis, examine city programs, and facilitate the coordination of existing services in the community and the development of new services to meet demonstrated needs.

Nursing home development in the city has been slow for several reasons.

Entrepreneurs say that it is hard to build in the city because of high land costs, the wage tax, and union construction costs. Moreover, state Medicaid reimbursement has been low and potential developers hesitate to build to serve a primarily Medicaid population. Perhaps the city can try to attract nursing home developers by finding suitable sites (City Planning Commission) and providing low cost loans (Philadelphia Industrial Development Corporation).

CONSENSUS QUESTIONS FOR HEALTH CARE STUDY

Is access to health care a right or a privilege?

PRIMARY CARE

What factors should the city consider in determining priorities for its primary care program in terms of

Populations served?

Location of centers?

Should the city take additional steps in planning for and coordination of primary care services? What steps?

What should be the future of the Family Medical Centers? Consider

Expansion. If so, where will the money come from?

Outreach programs.

Community boards.

Free care vs. sliding scale fees.

LONG TERM CHRONIC CARE

What factors should the city consider in determining priorities for its long term chronic care program in terms of

Populations served?

Services provided?

Should the city take additional steps in planning for and coordination of long term chronic care services? What steps?

Does the city have a responsibility to citizens in need of long term care services? If so, should this need be met by

expansion of city services, or

incentives to insure the development of services by others? Which services? How?

What should be the future of the Philadelphia Nursing Home?

Expand to meet community needs?

Continue as is?

Phase out when and if alternative nursing home services are available?

No decision, pending further study?

League of Women Voters Education Fund 1730 M Street, NW, Washington, DC 20036 (202) 659-2685

March 19, 1981

Ann Pugliese
Council of Metropolitan Leagues
5016 18th Avenue
Minneapolis, Minnesota 55417

Dear Ms. Pugliese:

I am presently working with the League of Women Voters Education Fund in raising funds for the two-year citizen education health care study. It is impossible at this time to predict when the project will begin as any work on the national level is dependent on outside funding. Although no funds have been secured as yet, we are making headway in that direction.

The major goal of the citizen-education project is to provide information, skills and outreach tools for state and local Leagues to use in improving and strengthening the health care system.

In order to achieve that goal, the citizen-education project methodology includes: 1) an extensive research component, 2) development and wide dissemination of resource materials, 3) a two-day national training conference and 4) an intensive community outreach effort.

The research component will tackle a number of pressing and difficult issues. Primarily, it will examine the financing and reimbursement of health care services, including the effects of regulation and deregulation, the role of third-party payers and state cost containment programs. The cost effectiveness of manpower shifts, preventive services and technological innovation will also be researched as well as the role of the citizen-consumer in the health care delivery system as utilizer and decision maker.

Three major publications and one slide show will be used to present this information into clear, understandable and useable materials. These resource materials will be developed and disseminated throughout the two-year program. Please note that a memo from Nancy Neuman to all state, local and ILO presidents discussing the proposal in greater detail is in the mail.

Because of the broad scope of the research component of the project, there are any number of issues that would complement the LWVUS effort. I have enclosed, for an example, a listing of research questions prepared by the LWV of Toledo-Lucas County that may help you identify a specific topic of concern to your local area.

I hope this is helpful to you.

Sincerely,
Karen Bluestone

Karen Bluestone
Consultant
Health Care

Enclosure

HR asst.

Mar '81

59 Temple Place, Room 700
Boston 02111
426-2857

Ann P.

MEMO TO BOSTON LEAGUE MEMBERS

FROM: THE HEALTH COMMITTEE

This memo is designed to reacquaint old members and orient new members to the issues of health planning and the State League Health Study. The April article will focus on school health in Boston. PLEASE BRING BOTH WITH YOU TO THE APRIL UNITS.

WHAT IS THE STATE STUDY? It is a one year study about health planning in Massachusetts -- it is a manageable way to look at all aspects of health care.

WHAT IS HEALTH PLANNING? Health Planning has a federal legisltative history which dates back to the 1960's with the so-called "Partnership for Health Act" which called for consumers and health care professionals to work together to plan for health services in their community in a manner which was acceptable, accessible and hopefully cost effective. Like so much of the 60's legisltation, the intent was good but the law had no teeth.

The current health planning legislation came about in 1974 and is known as the National Health Planning & Resources Development Act. Under the act, health planning takes place in three district forms - local health planning agencies on Health Systems Agencies. (In Massachusetts these are all private, non-profit corporations). The Boston "HSA" is called The Health Planning Council for Greater Boston and it covers 65 cities and towns in the Commonwealth; State Health Planning Agencies called State Planning and Development Agencies (SHPDA), in Mass. the State Department of Public Health is Designated as the SHPDA; and finally there is a state-wide Health Coordinating Council on SHCC which is comprised of represen-tatives from the HSA's and other citizens.

These organizations produce a number of documents but the 3 most important are: The State Health Plan (SHP) the Health System Plan (HSP) and the Annual Implementation Plan (AIP). The HSP and AIP are written by the HSA while the SHP is product of the SHPDA and SHCC. All 3 documents must follow federal guidelines as outlined in the law and in federal regulations. Please note the initials, health planning is full of them - but don't be intimidated -- ask what they mean!

WHY DO WE HAVE ALL THIS STRUCTURE? It is all too easy to blame it on money, so I will -- Health Planning came into being just as everyone began to realize that health care costs were going through the ceiling and there seemed to no end in sight. This increase in cost combined with a system whose technology was not keeping pace with its management (a little like running McDonald's with the same tools used at the local sub shop) created what most people felt was a non-system. All of this was going on, while we as a consuming nation, were demanding that more health care be available to more people and that Uncle Sam pick up the tab in the form of national health insurance. That's a rather simple way of saying that a lot of people thought the health care system was out of control and health planning and regulation was a way to control it.

RENT CONTROL AND HOW IT GREW...

In August 1968 Mayor White created the Boston Rent Review Board by proclamation. Consisting of 15 unpaid members representing tenants, landlords and public interest groups, its purpose was to negotiate settlements between landlords and tenants over rents and housing conditions. In 1969 the City Council adopted a law (Ch.10) which established a Board of Rent Appeals whose function was the same as the Review Board's had been except that Board members were now paid and the staff support expanded from 2 to 14 people. Two years later a new local ordinance was passed (Ch.11). Its expanded powers were: (1) to take action on tenant grievances; (2) to monitor evictions; and (3) to initiate action to reduce rents.

The basics of the current rent control law were enacted by the City Council in 1973 under the state enabling legislation of Chapter 842. That law simply established the right of the City to control rents and evictions during a time which was considered to be a "housing crisis". As Councilor Langone stated, "We created the law, not all the bureaucracy and rules that followed."

After the law came the establishment of the Rent Control Administration, the Rent Control Board, and the miriad of regulations which any tenant or landlord must decifer in order to apply for a rent adjustment or eviction. Today, rent control covers all rental units in the City of Boston except: (1) government owned housing; (2) structures with 2 units, or 3 units one of which is occupied by the owner; (3) units which have become voluntarily vacant since January 1, 1976 (the enactment of vacancy decontrol (Ch.15); and (4) certain other structures with special circumstances.

In order to receive a rent increase on a rent controlled unit, the landlord must file financial statements on the property for the previous year with the Rent Control Administration. A hearing officer listens to the case of both parties, tabulates the data in accordance with the Rent Control formula, makes a recommendation to the Board which then makes a final decision. Although there is an appeal process the Board rarely changes its decision. The process takes an average of 4 months, though certain cases have been known to drag on longer than a year. An eviction case follows the same process except that regardless of the decision, unless the tenant chooses to leave voluntarily, the landlord must also go through Housing Court.

At the March units we will look more closely at the rent adjustment formula, how the process really works, and the composition of the Board. These will be consensus units so it will be a chance not only to learn, but also to make your voice in the League count.

-- L. A. Rosenfeld --

RENT CONTROL CONSENSUS QUESTIONS

1. What should be the goals of a rent control system?
2. How is the present rent control system in Boston meeting those goals?
   a. should the rent control formula for adjustments be changed?
   b. should there be required annual general adjustments?
   c. should the composition of the Rent Control Board be changed?
   d. should vacancy decontrol be eliminated?
   e. what are some other ways the system could be improved?
3. What alternatives to rent control presented are acceptable?
4. Should there be rent control in Boston?
   a. if not, how can it be reasonable eliminated?
   b. if yes, why?

ALL I WANT IS A ROOM SOMEWHERE

Congress established in 1949 and reaffirmed in 1968 a national housing goal of "a decent home and a suitable living environment for every American family." What happened? In 1979 HUD estimates that more than 10.1 million rental households lived in substandard housing or were paying more than 25% of their income for housing. The existing rental housing supply is decreasing every year and vacancy rates are declining throughout the country.

Regionally, the Northeast has been the worst. With a national vacancy rate estimated at 4.8%, the Northeast has a vacancy rate of 4%. In Boston this problem is even more severe. Here the vacancy rate is estimated at between 2 and 3%. What's the problem? The lack of new construction, abandonment, arson and condominium conversion all diminish the supply of rental housing available.

It is estimated that Boston currently has 125,000 unsubsidized rental units, about 45,000 of which are rent controlled. In addition we have 12,500 federally subsidized units and 38,000 BHA owned units. At least 5,000 of the BHA units are currently uninhabitable. Boston also has 800-1000 vacant (single and multi-family) houses, about 200 of which are beyond repair.

Every year this stock has continued to erode. 2000 residential properties a year go to land court for non-payment of taxes--a good number of which end up in the City's hands. Many remain vacant for years or succumb to the wrecker's ball. An average of 600 vacant houses are demolished every year at a cost of $1.8 million to the taxpayers.

What is the future of rental housing in Boston? Many landlords feel it is nearing an end. How has rent control affected Boston's housing stock? It was originally implemented in 1973 as the result of an "urgent housing crisis". The vacancy rate was 5% then and is 2% now. For some answers, some questions, alternatives and what will no doubt be a very lively discussion -- COME TO THE MARCH UNITS!!!

--L.A. Rosenfeld--

ANSWERS TO QUOTABLES: 1. f.; 2. e.; 3. a.; 4. b; 5. c.; 6. i; 7. d.; 8. j.; 9. g.; 10. h.; 11. l.; 12. k.

PUBLIC HEARING

There will be a public hearing regarding the MBTA service cutbacks on Thursday, February 26 at 6:00 P.M. in the hearing room, 21st floor of the McCormack State Office Building, 1 Ashburton Place in Boston. This is a chance to testify on the cutbacks that affect you...Is there a subway stop closing in your neighborhood? THIS IS YOUR CHANCE TO MAKE YOUR VOICE COUNT.

THE HOUSING COMMITTEE WOULD LIKE TO THANK THE FOLLOWING PEOPLE FOR THEIR TIME AND SUPPORT OF OUR RENT CONTROL STUDY:

George Slye
Noel O'Leary
Councilor Ianella
All City Housing Organization
Councilor John Sears
Michael Rotenberg
Rep. John Bussinger
Councilor DiCara
Rolf Goetze
Bernard Shawdawry
Emily Actinberg
Ellen Gordon
Councilor Langone

GREAT DECISIONS '81

The World Affairs Council of Boston is sponsoring Great Decisions '81, a nation-wide study-discussion program, developed by the Foreign Policy Assoc. to bring people together for the purpose of discussing foreign policy issues. It will enable each participating individual the opportunity to take part in the decision-making process in Washington through the completion of opinion ballots following a major topic discussion. These ballots will be sent to the State Dept., where local opinion is interpreted at a national level. For more information on joining a Great Decisions group, or forming on in your community, please contact Debbie Belcher at the World Affairs Council, 22 Batterymarch St., Boston, MA or call 482-1740.

MILLER's COURT

The Channel 5 program is looking for League audience participation. Upcoming program tapings are: Housing/Land Control - March 3; Living Together - March 10; Animal Rights - March 17; Terrorism - March 24; and Credit - March 31. For further information on how you can participate, please call the League Office.

THERE OUGHT TO BE A LAW!

The Mass. LWV has a new publication which describes in clear, concise terms how to go about getting that law that you want. Learn how a bill progresses thru the Mass. legislature, how to find out where it is along the way and where the citizen lobbyist can effectively influence it. For more information, call the Mass. League office at 357-8380.

IF YOU'VE ALWAYS WANTED TO COME TO A UNIT MEETING BUT DON'T KNOW ANYONE -- CALL THE OFFICE -- A HOUSING COMMITTEE MEMBER WOULD BE MORE THAN HAPPY TO GO WITH YOU.

Ann P.

APR 28 1981

METROPOLITAN
MEDICAL
CENTER
900 South Eighth Street
Minneapolis, Minnesota 55404
Telephone 612/347-4444

Hello!

My name is Ann Christy. As a Health Educator at Metropolitan Medical Center, I facilitate health education and promotion programs in APPLE - A Positive Plan for Lifestyle Enrichment. APPLE presents programs to business and industry, hospitals, churches and community groups from one hour to 16 hours in length.

In order for your members to be effective within your organization and society, it seems helpful for them not only to be aware but put into practice healthy lifestyles. This includes basic skills in nutrition, exercise and stress management.

If you are interested in exposing your membership to healthy lifestyle practices, I am ready to help you with a program presentation at your next future membership meeting.

For further information on what's involved, give me a call. I am looking forward to the possibility of working with you and your group members.

Respectfully,

Ann Christy

Ann Christy
Health Education Specialist
347-4654

AC:nb

LEAGUE OF WOMEN VOTERS OF ILLINOIS
67 East Madison St., Chicago 60603

APR 16 1981

April, 1981

TO: Local League and ILO Presidents
Health Care Chairs

FROM: Jean Peterson, Human Resources Chair

RE: National Health Care Study

As you are all aware, a not-recommended item on Health Care was passed by the delegates to the 1980 LWVUS Convention. Funds were not available for this program item, but LWVUS agreed to undertake an extensive search for funding of the LWVUS study.

Local League presidents recently received a memo from Nancy Neuman, LWVUS HR chair, dealing with the funding proposals which have been developed. The major goals are to conduct an in-depth, citizen-consumer oriented analysis of the health care system and options for change, and to develop educational tools that the state and local Leagues can utilize to reach the citizenry. I encourage you to read this memorandum.

I have had conversations with Karen Bluestone, who has been hired by the Ed Fund as a part-time consultant to work on procuring funding and this is where they are at the moment:

The proposal has been sent to several foundations and at the moment they are working seriously with the Robert Wood Johnson Foundation of Princeton, New Jersey, the Kellogg Foundation of Battle Creek, Michigan, and the Kaiser Family Foundation in California. All of these are extremely interested in consumer oriented projects and the health industry. LWVUS expects to receive some definitive information within the next few weeks. While they do not expect any one foundation to pick up the costs for the entire proposal, they are hoping to receive funding in certain areas from each of them, and possibly from certain other foundations.

The proposal was originally written before the Administration's proposed budget cuts were announced and it may be necessary to change or adjust the focus of the study to take this into account. Some of their contacts have indicated that they may be interested in delving more into the role of the states in health care, given the emphasis on block grants that President Reagan is pushing for. The elimination of HSAs will, of course, have a major effect on the regulation of health care within the various states.

I asked Karen what they will do if the funding is not forthcoming and if they have plans to ask National Council to drop the proposal. She indicated that they have no plans to do so at this time, they do expect to receive funding, even though possibly not on the scale which we would all like. I asked for some sort of time line, which she was unable to give me, but did indicate that they should certainly have some more concrete information by the time the Leagues begin their planning process for 1981-82.

With the drying up of government money, private foundations are being inundated with requests for grants. The League's reputation is serving us well in this search for funds and they are cautiously optimistic. I'll keep you posted!

the wellness Gazette

for Council Members and Opinion Leaders in Minnesota

April 1981 | The Minnesota Council on Health | Vol. 4 No. 4

First Field Test Completed
MCH "Report Card" Ready For Statewide Use

With the first field tests completed, the Minnesota Council of Health "report card" project is ready for statewide use.

Funding will be sought from foundations and the federal government to conduct a two-year program in 20 Minnesota communities.

Field tests of the health report card, a technique to measure overall levels of wellness in communities, were conducted in four Carver County communities.

The report card, which took two years to develop, is a set of three indexes that evaluate the status of physical health, social conditions and health resources in a community. It is the first comprehensive measurement tool devised to look at all dimensions of community health at the same time.

Formally known as the Community Wellness Inventory, the report card gives communities a statistical guide on which to base public health planning policy. It enables a city to compare its wellness levels with:

- state or professional norms and standards
- wellness status of similar communities
- its own status over time, indicating improvement or decline

Although designed for Minnesota communities, the report card can be adapted easily for other states, according to MCH President, Wheelock Whitney.

"The Community Wellness Inventory will give public officials a guide for informed decision-making," Whitney said. "We hope that as the inventory is polished and improved it becomes a useful tool in Minnesota and elsewhere."

The Council's report card uses 21 indicators to assess community disease and accident rates, social deviance, economic conditions that affect health, and health and recreation facilities and services. That broad examination of diverse factors coincides with a "holistic" view of health, one that embraces mental and spiritual factors as well as physical conditions.

(Cont. on page 4)

Chaska Scores High in Field Test

(for story see "Quarterly Briefing")

MCH and Learnex
Help Business Promote Wellness

Because the Minnesota Council on Health is aware of the high cost of "unwellness" to business, MCH and the Learnex Corporation of St. Cloud are working together to help companies develop durable and successful health promotion strategies and programs.

Learnex Corporation is a consulting and training organization with expertise in organization development, team-building, supervisory and management training and human resource development.

Now Kensey Phelps and D. Edward Jones of Learnex also offer some guidelines to companies that are thinking about health promotion.

They realize that health promotion is not for everyone. It's success, they believe, will depend upon an infinite number of variables.

First of all, each company should assess its need by asking some basic questions about the well-being of their employees and the well-being of the company.

For example, how much is sickness and unhappiness costing our company annually?

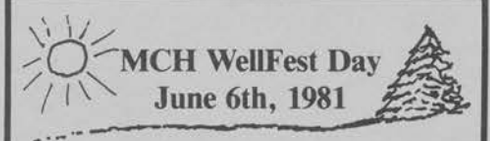
And, in what ways are we already promoting employee health?

A lot of mistakes and false starts can be avoided Jones said by careful assessment and diagnosis before anyone is committed to a course of action.

If a decision to go ahead is made, the two men agreed it should be a long term commitment. Selling wellness means changing attitudes about health, lifestyle and survival. That takes time.

Another suggestion is to establish performance criteria. Decide specifically what you want to accomplish and then continuously evaluate your progress.

(Cont. on page 4)



Bring your family and come to the first annual Minnesota Council on Health **WellFest** Day on June 6, 1981.

The day's program will focus on our internal and external environment and their impact on our physical, mental and spiritual wellness.

We will learn how to set wellness goals for ourself and our family that can be implemented practically and enjoyably.

Tim Kneeland, associated with the American Lung Association and Director of Training for Wildernet, Inc., is going to coordinate and plan events aimed at improving the quality of everyday living.

Refreshments and a nutritious lunch are included.

Children's activities are planned.

Turn page for registration and more details. Register as soon as you can!

Scan

WHAT MAKES ME FEEL THIS WAY?
Growing Up With Human Emotions
Eda LeShan

LeShan writes this one particularly for youngsters but her enjoyable style would interest readers of any age.

She explains the importance of knowing and listening to all the feelings of mind and body—shared ones, confusing ones, ones to control and why.

Grown up feelings are explored as well. Macmillan Publishing Co., Inc. 128 pages $1.95

A Word to the Wise

We are aware of the existence of a self, of a core in our personality which is unchangeable and which persists throughout our life in spite of varying circumstances, and regardless of certain changes in opinions and feelings. It is this core which is the reality behind the word "I" and on which our conviction of our own identity is based.
Erich Fromm

Whatever else educating ourselves may be, it cannot be easy. It cannot be painless. It cannot be spoon-fed. But it can be a delight, as any difficult challenge can be a delight.
Sydney Harris

Nutrition

Carrots Parmesan With Tofu

1 cup mashed tofu
¼ cup milk
1 egg
½ cup parmesan cheese
pepper to taste
dash nutmeg
1 tablespoon tamari soy sauce
5 large carrots, sliced & cooked til tender
1 small onion (if desired) thinly sliced
½ cup cashew nuts or sunflower nuts
½ cup grated cheese (any kind)

Blend first 7 ingredients in blender. Arrange carrots & onions in greased 1½ quart casserole. Pour tofu mixture over carrots. Top with cashews and cheese. Bake at 350 degrees about 25 minutes.
(Any green vegetable, slightly cooked, such as broccoli, zuccini, peppers, etc. is good in with the carrots.)

MCH Board Member & Nutritionist
Mary S. Adams.

•

Did you know that one large stalk of broccoli gives as much vitamin A as 1 dozen large eggs, more calcium than 1 cup of cottage cheese, more potassium than two 7 inch bananas, and as much vitamin C as 4 large oranges? And by the way, that large stalk of broccoli has only 73 calories. (From March issue of "Prevention" magazine)

Strong Bodies Build Strong Minds. . .

Vlasie Solon

Meet the Board

Vlasie Solon is Vice-President and Resident Manager of the Duluth Branch of Dain Bosworth, a member of the New York Stock Exchange.

His name is evidence of a heritage rich in the values his mother and father brought with them when they came to the United States from Greece.

Born in Duluth, Vlasie's memories of growing up revolve around his closely knit family. They prayed together daily and learned Greek history and theology from their father. For six years he and his sister and brothers attended Greek school four afternoons a week.

Today Vlasie is President of the church in which he was raised and continues to sing in the choir there with his sister and brothers.

He and his brothers grew up believing that you should work at building a strong mind in a healthy body and Vlasie said they began keeping physically fit by lifting weights, chopping wood and sawing logs for heating their home. When Vlasie was 14 he started boxing. He took time to play high school football but kept boxing until he reached the amateur final matches and won the region 8 championships. He became a finalist in the Upper Midwest Golden Gloves tournament in Minneapolis, and turned professional at the age of 18. In his spare time Vlasie coached the Duluth Boxing Team.

During the two years he spent in the Army's Special Services, he coached the 8th Army Boxing Team and the All-Korea Boxing Team.

Home again, he finished his degree in Political Science, Psychology and History at the University of Minnesota-Duluth. Vlasie was president of the UMD-Y Club and the International Club on campus and received the Bulldog award, second highest award for leadership at the University of Minnesota-Duluth.

Vlasie is on the board of the Duluth YMCA and the Duluth Junior Achievement Club, the Greek Orthodox Church and active in several other civic organizations.

He is proud of the growing opportunities there are in his city to keep physically fit. His 16-year-old son, Jerry, who is on the high school swimming team, skiis with his dad at Spirit Mountain and swims in the lakes around the area. They both jog on Duluth's beautiful trails and in the YMCA when the weather demands.

Vlasie said he still follows boxing but he keeps himself fit by exercising four or five times a week, primarily with tennis. He was runner-up in the Duluth Championship tennis tournament last year and semi-finalist in racquet ball a few years ago.

Vlasie Solon has been an active, supporting member of the MCH Board of Directors since the organization began. He represents the Minnesota Council on Health throughout his part of Minnesota by speaking and presenting awards to others, like himself, who work in their communities to promote wellness, physically, spiritually and emotionally.

wellness Gazette

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Where Does MCH Get Its Funding?

Wheelock Whitney, MCH President

Memo from Wheelock

One of the important lessons I've learned after years of work in both the chemical dependency and health promotion fields is that people are usually willing to join in a good cause. Minnesotans are ready, in fact eager to volunteer their time and talent for something they believe in.

This has been the case during the past three years since we founded the Minnesota Council on Health. Our Council is based largely on volunteerism, and many of our 10,000 members have come through when they were called upon. That's the reason we've been able to carry out so many public education programs such as our newsletter, community HealthFests, the State Fair booth, the Wellness Handbook and hosts of other activities.

This volunteer spirit has helped the Council to operate on a relatively small budget and still make it possible to accomplish many of our goals. Some of our goals, however, can't be achieved solely through the efforts of volunteers. Funds are needed for printing, mailing, transportation, supplies and personnel.

I am often asked, "Where does MCH get its funding—would it be all right for me to make a contribution to MCH—is a contribution tax-deductible?" When asked I do encourage people to support our work, but it may be true that there are a number of members who have wanted to give but haven't known how to do so.

That's why the Board of Directors at its last meeting suggested that I remind our members through the pages of *The Wellness Gazette* that donations are one way they can help advance the cause of good health. Donations from a few individuals have helped the Council to carry out its mission so far. But frankly, more is needed if we are to expand our work.

Part of our funding needs come from some ambitious new programs now on the drawing board. Our just-completed Wellness Inventory is designed to bring the message of prevention to communities throughout Minnesota. It will enable community leaders to find weak spots in the wellness environment in their neighborhoods, and we plan to help those communities organize efforts to overcome those weaknesses.

Another project in the design stage is a series of one-day Health Fairs in the workplace. They will bring holistic health information inside the factory and office walls. We also hope to produce and distribute posters and other printed materials for distribution to the thousands of employers in Minnesota.

These programs will come about only if we can raise the necessary funds. Council staff members right now are preparing grant applications to foundations in an effort to raise some of the needed dollars. But we will surely need more. That's why when people ask me today, "What can I do to help the Council?" I often suggest a donation.

As a non-profit organization, the Council has been able to function so far without membership dues. Voluntary donations (which, of course, are tax-deductible) can help to keep it that way. If you're able to contribute, send your check, large or small, to the Minnesota Council on Health at 1645 Hennepin Ave., Suite 201, Minneapolis 55403.

Certificates of Achievement

1) St. Therese Elementary School–Deephaven, MN
For: Wellness in-service program for all staff members throughout 1980-81 school year.

2) Greater Mankato Wellness Committee–Mankato, MN
For: Wellness efforts throughout the Mankato area, especially the recent symposium "Living Well... Learning How", as part of a community-wide January, 1981 Week of Wellness.

3) Minnesota Personnel and Guidance Association
For: Promotion of all aspects of both personal and professional wellness for its members and the general public through such efforts as their mid-winter 1981 conference "Promoting Healthy Living".

Congratulations!

Carver County's Chaska Scores High

Suzanne G. Mayer, Administrator

MCH Quarterly Briefing

Some welcome springtime news! The Council has completed one of its major projects—a field test of our Community Wellness Inventory. As we noted in an earlier issue of the Gazette, Carver County was chosen as the site for this demonstration project. The Inventory (or community report card) was compiled for 4 Carver County communities—Chaska, Watertown, Waconia and Norwood. Chaska was the first of these four to receive the report card. The verdict for Chaska? A "grade" of B overall. That's not bad if you consider a grade of C as average. But it still shows room for improvement of course, as do the grades of the other three communities. The report card was an evaluation of lifestyle-related community health conditions. But no one is taking the grade too seriously yet, since the test scores are still too new to interpret with great confidence. The Wellness Inventory is designed to measure overall lifestyle-related health levels in a community from the perspectives of physical health of its residents, social conditions bearing on health and community facilities related to health. The inventory field test was conducted with the help of Leslie Winter, health educator with Carver County Community Health Services and Susan Hoffert, Information and Referral coordinator for Carver County.

Out of a possible 630 points on the inventory, Chaska received 510—an 81 percent score that would convert to a B in the normal school grading sense. We warn against placing too much emphasis on the overall score as a precise measure of community health, however.

The scoring systems applies equal weight to 21 statistical indicators divided into three separate indexes. Scores were assigned by comparing Chaska figures to state norms or professional standards for the various health conditions. It will take more testing to develop baseline data before the scores will have full meaning. Even though the scoring is arbitrary in some areas, Chaska's test provides an opportunity to examine the new Community Wellness Inventory. The 21 indicators allow possible scores of 20 for matching the state average on that indicator, 30 for improving on the state average or professional norm, or 10 points for falling below the average or norm.

(Cont. on page 4)

MCH "Report Card" (Cont. from page 1)

The inventory is composed of three indexes: health status, social status, and wellness resources. Each of the indicators can be examined by itself, as can each index. The three indexes can also be combined for a grand total community score.

Whitney cautioned that the indexes are not to be considered precise mathematical measures of health, but rather as rough estimates of conditions. "They can point to problem areas that require more detailed evaluation," he said.

Indicators in the health status index include the rates of perinatal death, ischemic heart disease deaths, hemmorhagic stroke deaths, lung cancer deaths, accidental deaths and automobile crashes.

The social status index includes rates of teenage pregnancy, poverty, crime and school dropouts, and the community's youth and aged dependency ratios.

The wellness resources index includes physician availability, emergency services, availability of tennis courts and public parks, and the presence of chemical dependency counselling, multi-purpose senior centers, smoking cessation clinics, weight loss programs, and hypertension clinics.

The indicators were selected in consultation with medical authorities, public health officials, and specialists in other fields. Whitney emphasized that some of the norms or standards were arbitrarily determined, while others were chosen from statistical averages.

"The indicators must be interpreted with good judgment, and not accepted blindly as unchallenged truth," he said. "For example, the health status indicators are not adjusted for age and sex differences."

To evaluate a community's variation from state norms on those indicators, differences in age and sex distribution from the state averages should be considered.

The report card is designed for use by non-professionals after a training session. A field test of the system was completed last month in Chaska (see accompanying story), and two other Carver County communities are now being evaluated.

Results of the field trials will be used to fine-tune the inventory for statewide use. The Council on Health plans to seek funding from foundations to carry out a two-year program in 20 Minnesota communities.

That program would include use of the Wellness Inventory and a still-to-be-developed survey of community residents to see if their perceptions of wellness agree with the report card findings. It would also offer professional guidance by the Council for community leaders in developing action programs suggested by the inventory findings.

Further information about the inventory can be obtained by contacting MCH.

Chaska Scores High (Cont. from Quarterly Briefing)

On that basis, here's how Chaska did:

Health Status Index—Better than the state average on perinatal death rate, lung cancer deaths, and automobile crashes. Worse than the state average on heart disease deaths and accidental deaths. Near the state average for hemmorhagic stroke deaths. Score: 130 of a possible 180 points.

Social Status Index—Better than the state average on teen pregnancy, poverty level and school dropouts. At the state norms for crime, dependent youths, and dependent elderly. Score: 150 of a possible 180 points.

Wellness Resource Index—Better than the state average or professional norms in availability of chemical dependency counselling, weight loss clinics, smoking cessation services, emergency services and public parks. At the norms in ratio of physicians to population, multi-purpose senior centers, hypertension clinics, and tennis courts. Score: 230 points out of a possible 270.

When more communities in Minnesota are scored on the same inventory, it will be easier to appraise Chaska's standing on community wellness. The Council is seeking funding to bring the inventory and associated services to 20 Minnesota communities in the next two years. That program would include use of the Wellness Inventory and a still-to-be-developed survey of community residents to see if their perceptions of wellness agree with the report card findings. It would also offer professional guidance by the Council for community leaders in developing action programs suggested by the inventory findings.

MCH & Learnex (Cont. from page 1)

They believe it is also important that health promotion should focus on the entire organization. This can be a struggle, but it can be accomplished without tradeoffs that might create resistance.

And finally, Phelps and Jones said, build in participation. Participation by the employee means that he or she not only accepts the program—it means the employee "buys" the program because the resulting experience proved its need.

If you or your company would like more details send the name and address to Minnesota Council on Health, 201 Fawkes Building, 1645 Hennepin Avenue, Minneapolis, MN 55403 or call (612) 332-0389 and we will send a free copy of "Guidelines for Successful Organizational Health Promotion."

•

A fundamental principle with most mental health professionals is the importance of the ability to play and have fun. Your work is important to your life, of course, but play may be even more important. How you play isn't particularly important—sports, music, travel—but taking the time to get away from more pressing concerns is important.

MCH "Wellness Handbook"

You Are Invited to the First Annual

MCH·WellFest·Day

Saturday–June 6, 1981

At Camp Owendigo On Carver's Lake

Bring your Family and come to the first annual Minnesota Council on Health **WellFest** Day on June 6, 1981 at Camp Owendigo on Carver's Lake.

In the morning we will explore the ways that the environment effects us internally. In the afternoon we will concentrate on the natural external environment and the various aspects of wellness.

Rain or Shine—

8:30 am	Check-in & socialize (tea & muffins will be served)
9:00	Welcome from MCH President Wheelock Whitney
9:10	Environmental overview from **WellFest** Coordinator Tim Kneeland
10 to noon	Internal environment —mental —physical —spiritual
12 to 1:30	Lunch (included in day's registration cost)
1:30 to 3:30	External environment — home —work —natural
3:30 to 4 pm	Summary & integration by Wheelock & Tim

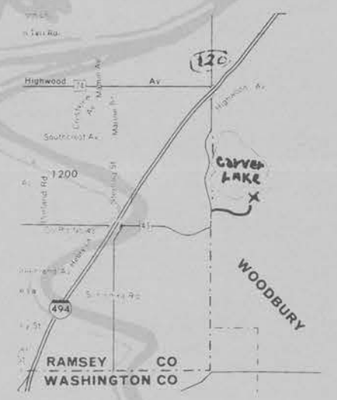
Activities planned for youngsters of ALL ages to free parents who wish to attend environment programs. Register soon.

Registration for the First Annual MCH **WellFest**
Single $15____ Couple $25____ Family $30____ Ages of children?_____

Send to: Minnesota Council on Health
201 Fawkes Building
1645 Hennepin Ave
Minneapolis, MN 55403
(612) 332-0389

Name: _____
Address: _____
City: _____
State & Zip: _____
Phone: _____

Want to make this a camping weekend? Check box and we will send you a list of camp grounds near Camp Owendigo. ☐



Directions to Camp Owendigo
Go east on 94 to Century Ave—Highway 120-exit. Turn right (south) exactly 3.1 miles to camp entrance. Located on Carver's Lake the camp is no more than one-half hour away from most places in the Twin Cities.

Some Thoughts About Sexual Wellness. . .

In the Winter issue of "The Minnesota Wellness Journal" an Excelsior, MN counselor, Jeanine Hall discusses our culture's historic confusion about sex.

The confusion and mythology which surrounds sex seems to stem from our own personal reluctance to talk to each other about it and our culture's reluctance to research or study the subject of sex until very recently.

Hall said that some people think that our country is now in the midst of a sexual revolution but others believe that it is more accurate to call it a convalesence period that is allowing us to "integrate our beliefs and values with our physical behavior and our emotions."

Perhaps there is hope that someday soon we really will do as we say we do, comfortably.

Like the other aspects of our wellness, the sexual one evolves and constantly changes along with our life settings, situations and events.

But—Hall said we could ease the process of integrating greatly. To form values we need facts. She suggests that we separate the facts about sex from the myths. To do that we need a way to receive information about sex and at the same time be able to exchange views and concerns with others.

Unless we open up and talk about sex honestly to each other the results of study and research will lead us right back to more myth.

"Finally, and most importantly," Hall adds, "we need the permission to *value* our sexuality from churches, education systems, families and the health care systems. . .(because) people are less likely to abuse something they value."

We know that our wellness is enhanced by acknowledging our own individual needs and respecting our own particular value system.

Each of us is a whole made up of many parts. Our wellness depends upon how comfortably we are able to fit the parts together.

If we stay physically fit doing exercise that we enjoy and eat well balanced meals that answer our body's needs, our appearance improves and we feel good physically.

If we have a good relationship with those around us and take some time occasionally to enjoy our own company as well, we are more apt to experience emotional and mental well-being.

If we want to be sexually well, our actions follow in line with our carefully thought out beliefs and values.

The result? A richer, fuller life—physically, emotionally and spiritually.

Shoe by Jeff MacNelly

Used by Permission Jefferson Communications

The Minnesota Council on Health
201 Fawkes Building
1645 Hennepin Avenue
Minneapolis, Minnesota 55403
Phone (612) 332-0389

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Ann Pugliese
5016 18th Ave. S.
Mpls, MN 55417

HEALTHY INDIVIDUALS • HEALTHY FAMILIES • HEALTHY COMMUNITIES

May 19, 1981

To: Geri Nelson
From: Ann Pugliese
Subject: call for assistance from local League

Received a call today from Shirley Workman (Cannon Falls unit of Red Wing LWV) concerning their local Health study - their community hospital. They wanted more information about the contractual relationship between their hospital and ~~Hutton~~ Health Resources, Inc. of Maplewood - also their relationship with St John's Hosp. of St Paul, Mn. None of the three firms has been able or willing to satisfy the questions of the study committee. They (LWV) fear their reputation will suffer in the community because of their vigorous questioning of hospital authorities concerning new construction needs.

I referred her to the director of the State Health Planning and Development Agency and I proceeded to contact the asst. director of the Metro. Health Bd., Paul Riddle. He believes that Health Resources Inc. is a profit making subsidiary of St John's and they probably have a management contract with the Cannon Falls Hosp. to provide services not readily available to a small hospital. He said these contracts can range from very limited service to full operation & ownership. He explained the implications for both partner hospitals. He also suggested she contact the chief executive officer of St Johns and the director of the Rochester Health Systems Agency.

I returned the call of Ms. Workman, telling all the points of Mr. Riddle. She said next week they will seek unit consensus and may not reach it because of the strong feelings about the the League image in the community if they oppose the construction & contract. She will notify me of the results.

Department
of Public
Welfare
State of
Minnesota

Mary C. Bremer
Public Information Officer

Telephone:
612/296-4416

May 12, 1981

Ann,

I hope the enclosed information gives you a place to start. I'm sorry I didn't have something more handy to give you.

Please feel free to call on me if I can be of further assistance.

MB

state of minn.

League of Women Voters of Minnesota

Convention Workshops
48th State Convention
June 12, 1981
St. Cloud State University

HEALTH CARE RESOURCES

LWVMN	Ann Pugliese	5016 18th Avenue South Minneapolis, MN 55417	(612) 729-3029
State Health Planning and Development Agency		101 Capitol Square Building 550 Cedar Street St. Paul, MN 55101	(612) 296-2407
Metropolitan Health Board (planning and review)		300 Metro Square Building 7th and Robert St. Paul, MN 55101	(612) 291-6351
Minnesota Department of Health (Community Health Services Maternal, Child and Family Laboratories Disease Control Environmental Health Vital Records Statistics Certificate of Need Health Education HMO Hospital Rate Review Facility Complaints)		717 Deleware Street S.E. Minneapolis, MN 55440	(612) 296-5221
Minnesota Department of Public Welfare (Medical Assistance Medicaid Mental Health State Hospitals Deaf and Blind Services)		Centennial Office Building St. Paul, MN 55155	(612) 296-6117
Foundation for Health Care Evaluation (Physicians Standards Review Hospital Utilization)		2221 University Avenue S.E. #300 Minneapolis, MN 55414	(612) 379-4443
Minnesota Coalition on Health Care Costs		2221 University Avenue S.E. #440 Minneapolis, MN 55414	(612) 623-3384
Minnesota Council on Health (Wellness Inventory)		1645 Hennepin Avenue Minneapolis, MN 55403	(612) 332-0389

METROPOLITAN
HEALTH
BOARD

300 Metro Square Building, 7th Street and Robert Street, Saint Paul, Minnesota 55101 Area 612, 291-6359

JUN 24 1981

June 23, 1981

Harriette Burkhalter, President
League of Women Voters of Minnesota
555 Wabasha, Room 212
St. Paul, MN 55102

consumer/prov.

Dear Ms. Burkhalter:

The Metropolitan Council Health Board is seeking nominations for persons to fill vacancies on the board's Developmental Disabilities Task Force.

The 25-member group is comprised of persons who are substantially handicapped by severe, chronic mental or physical disabilities which started in their developmental years (before age 22), parents and providers of services for the developmentally disabled. Both consumers and providers are needed to fill the vacancies. Representation from Metropolitan Council Districts 5 and 9, as well as from minority groups and urban and rural poverty areas are particularly welcome. Council District 5 covers most of north Minneapolis. District 9 includes Richfield and Bloomington in Hennepin County.

The Task Force advises the Health Board and the Metropolitan Council on needs of developmentally disabled people and helps coordinate planning to meet those needs. The Task Force meets from 1 to 4 p.m. on the second Tuesday of every other month.

Persons in your organization who may be interested in applying for appointment to the Task Force should send a resume (academic, professional and/or voluntary experience) to me at the Health Board staff, 300 Metro Square Building, Saint Paul, MN 55101, by July 22. I can also be contacted by calling 291-6364. Thank you for your attention to this request.

Sincerely,

Toni Lippert

Toni Lippert, Program Manager
Developmental Disabilities Program
Metropolitan Health Board/Metropolitan Council

TL:ms

JUL 1 1981

METROPOLITAN
HEALTH
BOARD

300 Metro Square Building, 7th Street and Robert Street, Saint Paul, Minnesota 55101 Area 612, 291-6359

June 30, 1981

Henriette Burkhalter, President
League of Women Voters of Minnesota
555 Wabasha, Room 212
St. Paul, MN 55102

Dear Ms. Burkhalter:

all appt.

Recently you were sent a letter dated June 23, 1981, notifying you that the Metropolitan Health Board of the Metropolitan Council was seeking nominations to its Developmental Disabilities Task Force. The information regarding the type of nominees being sought was incomplete. In addition to consumers and providers of developmental disabilities services, the Health Board particularly welcomes representation from the general public. This is one of the principal reasons your nominations were solicited.

Call Ann Pugliese?

We hope you will note this oversight and assist the Health Board in its efforts to have the most equitable representation and citizen participation possible in this activity. If you have any questions, please call me at 291-6364.

Sincerely,

Toni Lippert

Toni Lippert, Program Manager
Developmental Disabilities Program
Metropolitan Health Board/Metropolitan Council

TL:ms

JUN 22 1981

Cannon Falls, MN
June 18, 1981

Ms. Ann Pugliese
League of Women Voters of Minnesota
555 Wabasha
St. Paul, MN 55102

Dear Ann:

I am sending you some of the materials from the health care study our local league did this past year. Our committee will continue to be active this next year as we will be closely watching the outcome of the current Cannon Falls Community Hospital proposal. Our hospital is a public facility owned by a hospial district, and the situation is rather unique. The committee is also interested in the Wellness Inventory and we have become quite interested in the wellness theory. We plan to do the inventory and attend the workshop.

I wanted to have a chance to talk with you after the meeting, and I tried to find you on Saturday. If one, or two, of our committee could be useful to your study, we will be happy to join the steering committee. As you can tell we have become deeply interested in the subject of health and health care.

Enclosed is information about the National Chamber of Commerce Health/Action packet----which was prepared by Interstudy. It presents business points of view and is an important facet. We also secured a study packet "The Nation's Health"--Courses by Newspaper, University Extension, University of California, San Diego. This is a newspaper study course but is really good background material because of the variety of contributors.

I'm getting ready to go to a family re-union in North Dakota and wanted to get this letter to you before I leave, but I see that the typing is rather frenzied as I'm under pressure to get going. Please let me know what I can do to help.

Sincerely yours,

Fern Peterson

Fern Peterson
R.R. 1, Box 3
Cannon Falls, MN 55009

P.S. Could you send a copy of the Wellness Inventory to Carol Sweasy, 827 Erdy 3rd St, Red Wing, MN 55066 as the LWVRW wants to be involved in the inventory.

1267 Foursome

Minnesota Council on Health

201 Fawkes Building, 1645 Hennepin Avenue, Minneapolis, Minnesota 55403 612-332-0389

June 12, 1981

LEAGUE OF WOMEN VOTERS OF MINNESOTA

and

THE MINNESOTA COMMUNITY WELLNESS INVENTORY

During 1980-81 the Minnesota Council on Health has developed and field tested the Minnesota Community Wellness Inventory. As of June, 1981 the Inventory is ready for wide-spread use throughout Minnesota. The Council is currently seeking funding for a demonstration project to support this statewide implementation in approximately 10 communities of between 5,000 and 15,000 population. One important facet of the proposed project involves gathering community data for the indicators which comprise the inventory. This data-gathering primarily involves talking with individuals and officials in agencies and organizations (e.g.hospital, school, law enforcement, public health). Health data from the Minnesota Department of Health will supplement the locally obtained data to complete the inventory. For those local Leagues which are interested, an in-depth training session of the data-gathering process will be provided at the September, 1981 regional meetings of the Leagues.

Further information can be obtained and questions concerning the Inventory can be answered by calling (collect, if necessary) Suzanne Mayer at the Council office, (612) 332-0389.

Minnesota Council on Health
1645 Hennepin Ave., Suite 201
Minneapolis, MN 55403

The Minnesota Council on Health (MCH) is a non-profit, statewide, educational organization working in the areas of disease prevention and health promotion. Founded in May, 1977, the Council's overall goal is twofold -- to promote the concept of wellness (physical, emotional & spiritual well-being), and to encourage Minnesotans to seek lifestyles conducive to preventing illness and thereby reducing health care costs. The Council focuses its efforts on two target areas - the workplace and the community. Emphasis is placed on providing resources to non-metropolitan areas of Minnesota, areas traditionally not as richly endowed as their urban counterparts with health care services, providers and health promotion resources. Past and current major activities of the Council include the following:

1) HealthFests (i.e. town meetings on health and wellness) in five rural Minnesota communities;

2) "Summit" meetings (forums for community leaders to discuss disease prevention and health promotion issues/needs) in six Minnesota Communities;

3) Wellness Gazette (quarterly newsletter of wellness and healthy living information) mailed to 11,000 MCH members throughout Minnesota, approximately one-quarter of whom live in out-state areas;

4) Health columns (topics include physical fitness, nutrition, spiritual wellness, stress management) distributed to all weekly newspapter in Minnesota and used by more than 110 out-state papers;

5) Recognition awards to individuals and organizations throughout Minnesota who are actively contributing to an increased level of health and wellness for Minnesotans;

6) Workplace health promotion. Council efforts include a) an employee health promotion program, b) a health promotion survey of non-metropolitan worksites to increase employers' awareness of workplace health/wellness needs, c) co-sponsorship of a conference to inform businesses of the economic/financial issues related to worksite health/wellness;

7) Health fairs -- participation in and support of health fairs sponsored by hospitals, schools, businesses, colleges and community groups throughout Minnesota;

8) Resource sharing with organizations throughout the state -- provision of films, wellness handbooks, planning assistance, speakers and other tools necessary for implementation of wellness programs;

9) Support of and assistance with wellness efforts of other voluntary agencies on a variety of disease prevention topics (e.g. women and smoking; the elderly and drug use; adolescent smoking);

10) Community wellness inventory.

Funding for these projects, as well as all on-going expenses necessary for daily operation of the Council, are provided by voluntary contributions from members. In addition to the 14-member board of directors, there are approximately 11,000 Council members throughout Minnesota. Members are involved to varying degrees, on a volunteer basis, in the Council's activities. Council staff includes a full-time administrator and a part-time administrative assistant. Major projects (in whole or in part) are generally undertaken on a contractual basis by short-term consultants.

THE MINNESOTA COMMUNITY WELLNESS INVENTORY

Minnesota Council on Health
Minneapolis, Minnesota

One of the basic tools of wellness programs is the personal wellness inventory, a compilation of data about the wellness level of an individual. Such inventories usually consist of questionnaires designed to obtain information about personal medical history, exercise levels, feelings about one's self and others, nutritional habits, and so on. Available at differing levels of sophistication and complexity, these inventories provide personal profiles that are useful to wellness practitioners for determining how a person can modify parts of his or her lifestyle to attain better levels of wellness.

Because this approach is useful on the individual level, it is reasonable to extend the principles of measuring degrees of wellness to the community level. With this in mind, the Minnesota Council on Health has developed the Minnesota Community Wellness Inventory. It attempts to provide a picture of a community's wellness level, its needs in the area of health, and its responses to those needs. The inventory permits comparisons with other Minnesota communities and with the state as a whole on a number of wellness dimensions. It also provides a base for the community to observe its progress across time.

The development and use of social and health indicators has grown in the past decade as policymakers for government and private institutions have sought improved guideposts for decision-making. Indicators are population statistics that are relatively easy to obtain, and which illuminate social or health conditions that are difficult or impossible to measure. The conditions may be artificial constructs -- such as wellness -- that defy direct quantification. An example of an indicator might be the sale of non-fiction books as a reflection of community intellectual activity levels. Another might be attendance at symphony concerts as a measure of "high" culture.

Often, indicators that bear on the same condition are collected statistically into indexes. The well-known Consumer Price Index is an example.

The development and application of indicators and indexes can be a highly rigorous procedure, involving sophisticated statistical methods, or it can be a relatively crude procedure, providing only rough indications of the condition being examined. Both approaches are employed in the health field.* They are essential to the proper development of health improvement strategies. They can be useful for planning, evaluating existing programs, monitoring community change, diagnosing problem areas, and similar tasks.

---

*For a thorough and contemporary discussion of health indicators, see G.E. Alan Dever, Community Health Analysis (Germantown, Maryland: Aspen Systems Corporation, 1980), particularly Ch. 7.

The data alone do not determine goals, however. Objectives must come from professional and community sources, guided by the data. Much of the work by health planners has followed an epidemiological model, in which population characteristics and the incidence of disease and specific individual health statistics are employed.

The Minnesota Community Wellness Inventory goes beyond those measures to embrace a more holistic perspective on health. It includes social conditions and community resources that have an effect on health. In this way, it provides a tool for the community to look both at the physical health of its residents and at the environment that relates to that level of health -- and may account for it. The inventory thus may become a vehicle for community action to address specific health problem areas, pointing out specific needs and remedies.

Three Indexes of Wellness

The inventory is comprised of three parts, each focused on a different dimension of community wellness. The Health Status Index utilizes fundamental measures of births, deaths and illness to describe existing health levels. The Social Status Index measures nonmedical conditions that influence wellness. The Wellness Resource Index puts a yardstick to some of the facilities-related areas in which communities can take steps to remedy and prevent wellness problems.

The indicators in the Minnesota Wellness Inventory were selected for their relationship to aspects of lifestyle that affect wellness, because those are most susceptible to intervention and change through community awareness programs and similar

collective action. Although the associations between a given indicator and a certain lifestyle attribute may not have a direct, one-to-one relationship, they are the best measures presently available.

It must be emphasized that the Minnesota Wellness Inventory is a tool to be used with discretion. It provides a crude but useful measure of the several aspects of wellness that are important to communities and their residents. It is not presented as a precise appraisal, but rather as an indication of direction, much as a weather vane. The invididual indicators may be revealing in themselves. Collected into the individual indexes, they suggest the degree of concern a community might have for the health of its citizens and the conditions that account for that health. The three indexes combined may provide a useful, quantitative signal for the community and its leaders: We're doing okay --- or, We've got some problems.

But it must be remembered that the indicators and the indexes that they provide were chosen arbitrarily. The weighting of each indicator is also arbitrary, and one condition may be much more significant than another. The indicators selected are those that are readily available, and the inventory can be collected and computed by laymen, without technical training in statistics. For this reason, there was no attempt to adjust the indicators for factors that public health specialists usually take into account. For example, the indicators in the Health Status Index are not adjusted for age or sex, two factors that vary among communities, and bear on the incidence of specific diseases. The error that these omissions introduce into the

indexes are likely to be slight, and won't interfere with the principal objective of the inventory: To give communities of Minnesota a simple, understandable and reasonably accurate method with which to appraise their levels of wellness.

Health Status Index

Each of the six indicators in this part of the inventory pertains to a medical condition linked to lifestyle. They are perinatal death rate, ischemic heart disease, hemmorhagic stroke deaths, lung cancer deaths, accidental deaths, and automobile crashes.

Perinatal Death Rate: This is a measure of how many fetuses die after the 20th week of pregnancy, plus the number of babies who die during the first four weeks of life. It is expressed as a ratio of deaths to 1,000 live births. This indicator is generally considered to reflect basic health conditions, because it incorporates emergency care, infectious diseases, and high risk births. It differs from the infant mortality rate, which is the proportion of babies that die within the first year, and was chosen because it yields a broader range of values for the sake of community-to-community comparison.

Ischemic Heart Disease: One of the leading causes of death, this indicator is associated with dietary habits. A high incidence suggests a consistent consumption of high-fat foods. It is believed to be sensitive to improved diet and exercise, to some degree. The major weakness of this indicator, and the two following, is that it is more a measure of lifestyle practices

begun 30 or 40 years ago, when the older people dying today were young, than a measure of current nutritional effects. Nevertheless, there may be a hereditary predilection for this disease that would affect the community's younger age groups as much as the old.

Hemmorhagic Stroke Deaths: This indicates levels of hypertension in a community on the assumption that high blood pressure can lead to fatal cerebral blood vessel ruptures. Since there are many drugs and relaxation techniques that lower blood pressure, it is readily subject to intervention. But it is an "old" measure, as mentioned above.

Lung Cancer Deaths: There is little question that lung cancer deaths are directly associated with the levels of smoking in a community. Again, this is a measure of people who began smoking years ago, but it is likely that attitudes toward smoking are passed on in families.

Accidental Deaths: Although at first glance it seems that accidental deaths are not controllable, it is reasonable to assume that this is a measure of community carelessness -- a condition that can be improved through awareness. It is also a measure of current status.

Automobile Crashes: This differs from accidental deaths in that it includes nonfatal as well as fatal crashes. The premise is that a high percentage of crashes are related to alcohol use, so this is essentially a rough measure of community drinking. A more precise indicator would be limited to those crashes occurring after midnight, but those data are not available.

Social Status Index

These indicators shed light on problem areas in a community other than the purely medical. They are teenage pregnancy, poverty level, crime rate, school dropout rate, youth dependency ration, aged dependency ratio.

Teenage Pregnancy: Technically, this measure refers to live births to women under age 18. It was chosen in lieu of the general birth rate because of disagreement over desireable levels of births. The teenage pregnancy rate reflects community sex education activities, family planning, moral values and related aspects.

Poverty Level: This is the percentage of people with incomes below established poverty guidelines. It provides a rough picture of a community's economic base, which is related to wellness in the sense that a wealthy community can afford adequate medical care. Whether the wealthy community enjoys a high level of wellness is another question, however, since medical care does not assure wellness. Still, economic wellness is related to general wellness.

Crime Rate: This is a measure of the total number of "index crimes" -- murder, forcible rape, robbery, aggravated assault, burglary, larceny, and motor vehicle theft -- that are reported. It extends the measures of wellness further into general social conditions in a community, and is susceptible to intervention. It is an imperfect indicator, however, because many crimes are not reported to authorities, and crime reporting rates vary from community to community.

School Dropout Rate: Another indicator of social conditions, this also reflects community values about education.

Youth Dependency Ratio: Age distribution affects community wellness levels, so this and the following indicator are useful in assessing community resource needs. The Youth Dependency Ratio is the proportion of persons under 15 to those between 15 and 64. The higher the ratio, the more need for youth services such as counselling centers, pediatricians, and drug and sex education resources.

Aged Dependency Ratio: This is the other end of the age spectrum, the ratio of those over 64 to those between 15 and 64. An older population has different wellness needs than a younger one, including senior citizen centers, transportation services, and community involvement programs.

Wellness Resource Index

The last segment of the wellness inventory consists of ten indicators that measure community response to wellness needs and problems. They are population-to-primary-care physician ratio, emergency services, chemical dependency counselling, multipurpose senior centers, smoking cessation programs, weight loss programs, hypertension clinics, tennis courts, public parks, and church membership.

Population-to-Primary-Care Physician Ratio: Although the presence of many doctors in a community is not a reliable indicator of wellness, it is nonetheless a useful measure of comparison. This is done at the county level by the Bureau of Health Manpower in the federal government. There are federal guidelines for desireable levels of primary care physicians,

but for the wellness inventory, physician levels are compared with the Minnesota state average. Since the inventory is intended for use in nonmetropolitan areas, the ratio has been determined by subtracting the respective ratios for the seven-county Minneapolis-St. Paul region, Duluth and Rochester. Primary care physicians are defined as doctors of medicine and doctors of osteopathy providing direct patient care who practice principally in general or family medicine, general internal medicine, general pediatrics, or obstetrics and gynecology. The limitation of other specialists is somewhat misleading because many specialists in medicine also perform primary care services. This, too, is a rough indicator of the availability of trained medical personnel in a community.

Emergency Services: To gauge community preparedness for medical emergencies, there are two stages to consider: basic life support and advanced life support. The former involves noninterventive life support services such as stabilization and protecting victims from further harm. Advanced life support includes interventive services such as defibrillation, intravenous therapy (including drug administration), and intubation (establishing clear airways). Advanced life support personnel have had speciallized training and are usually equipped with two-way communication between them and a physician. Most communities do not have advanced support services, and there is no data to indicate that it provides measurable benefits in a public health sense, beyond basic life support in emergencies. However, it reflects community resources and awareness. Distance is a factor in emergency service; consequently, the federal guideline value of 30 miles is used. A community with advanced life support

services within 30 miles is better off than one without them.

Chemical Dependency Counselling: According to staff members of the Johnson Institute, a good indicator of a community's awareness of and committment to handling problems of alcohol abuse and chemical dependency is whether the school district employs a trained chemical dependency counselor. Such a person would have taken special training and would be available during school hours for appointments or walk-in service.

Multipurpose Senior Centers: State and federal agencies provide many services for senior citizens, but the best thing a community can have is a multipurpose senior center. Such a facility, whether fixed or mobile, offers access to services such as transportation; in-home services such as Meals-on-Wheels and home visits; community services such as congregate dining and social activities, and services in care-providing facilities (e.g., nursing homes). If a community has a senior center with several programs, it is an indicator of wellness among older persons.

Smoking Cessation Programs: These come in many forms, from full-time programs to occasional clinics at health care facilities. They are designed to help smokers who want to quit, and to educate nonsmokers about the dangers of cigarettes. If a community has such a program, it is a sign of a commitment to the problem. For the purpose of the inventory, any such program earns points.

Weight Loss Programs: Like the smoking clinics, this type of resource can vary widely. A weight reductions center/program/organization (Weight Watchers, TOPS) would indicate that something

is being done in the community to address ongoing problems associated with overeating and obesity.

Hypertension Clinics: This indicator attempts to determine if a community has the resources to combat and prevent hypertension -- a regular or part time program that monitors people's blood pressure. It must do more than just provide clients with their blood pressure readings; it must refer persons with elevated blood pressure to a medical resource, because it's at the referral stage that something gets done about the problem in terms of drug therapy or stress management.

Tennis Courts: One of the many possible indicators of community involvement in physical fitness, this is useful because the United States Tennis Association has established a guideline ratio of tennis courts to population. The growth of tennis in the past decade has removed it from the category of sport for the wealthy, and a community with a high proportion of tennis courts is probably also meeting other fitness facility demands.

Public Parks: This is considered an indicator of community recreation facilities on the assumption that a high proportion of park space provides opportunity for outdoor activities, whether or not they are used. It is important to both physical and mental health.

Using the Wellness Inventory

The inventory was designed for use by people without special training in statistics. The information needed to complete it is available from a number of standard sources available in libraries and state agencies. A chief source of information is the Center for Health Statistics of the Minnesota Department of Health, 717 Delaware St. S.E., Minneapolis, MN 55440, phone 296-5353. The center will provide breakout data at the city level on special request; the center's published statistics for most indicators are provided only at the county level. Population data is available from a number of sources, and will soon be revised to account for the 1980 census. The sources and publications listed on the following pages were taken from material available at the time of preparation of this report. More recent material is available periodically.

Some inventory measures are not available for communities in statistical repositories. These must be gathered independently through interviews in the community. They, too, are indicated in the following pages.

The Minnesota Council on Health is a non-profit educational association. It is active in the promotion of the concept of wellness -- the movement toward physical, emotional, spiritual and mental health -- through self-responsibility of the individual. Its activities have included the promotion of the prevention of illness through community meetings, published materials, awards and direct contact with organizations, government and employers.

PART 2: SOCIAL STATUS INDEX

CITY _____

COUNTY _____

LINE A INDICATORS	Teenage Pregnancy	Poverty Level	Crime Rate	School Dropout Rate	Youth Dependency Ratio	Aged Dependency Ratio
LINE B LOCAL RATES						
	STATE AVERAGES/RATES (SA)					
LINE C	3.9/ 100 live births	15.9% below poverty level	4,156/ 100,00 populatn	34/1,00 secondary school students	36/ 100	18/ 100
	THRESHOLD RANGE FORMULA (TR)					
LINE D	2.1=30 btwn=20 5.7=10	12.1=30 btwn=20 19.6=10	2301=30 btwn=20 5917=10	26=30 btwn=20 42=10	31=30 btwn=20 41=10	12=30 btwn=20 24=10
	SCORING					
LINE E						

SUMMARY INDEX

PART 3: WELLNESS RESOURCES INDEX

CITY_____

COUNTY_____

LINE A INDICATORS	Popultn-to-Primry Care Phy Ratio	Emergency Services	Chemical Dependency Counselors	Multi-purpose Senior Centers	Smoking Cessation Clinics	Weight Loss Programs	Hyper-tension Clinics	Tennis Courts	Public Parks
LINE B LOCAL RATES									
	STATE AVERAGES /GUIDELINES/CRITERIA (SA)								
LINE C	2,300 pop/ 1 PC Phys	ALS BLS NA	FT PT NA	FT PT NA	FT PT NA	FT PT NA	FT PT NA	see table on worksheet	1.5 acres per 1,000 popultn
	THRESHOLD RANGE FORMULA (TR)								
LINE D	≤1377=30 btwn=20 ≥3283=10	ALS=30 BLS=20 NA =10	FT=30 PT=20 NA=10	FT=30 PT=20 NA=10	FT=30 PT=20 NA=10	FT=30 PT=20 NA=10	FT=30 PT=20 NA=10	calculate for each city	≥2.0 =30 btwn =20 ≤1.0 =10
	SCORING								
LINE E									

SUMMARY INDEX

WELLNESS INVENTORY DATA SOURCES

Health Status Index

Indicator	Source
Perinatal Death Rate (City level)*	Minnesota Health Statistics, 1978 Available from Minnesota Department of Health, Center for Health Statistics
Ischemic Heart Disease Deaths (City level)	Minnesota Health Statistics, 1978
Hemmorhagic Stroke Deaths (City level)	Minnesota Health Statistics, 1978
Lung Cancer Deaths (City level)	Minnesota Health Statistics, 1978
Accidental Deaths (City level)	Minnesota Health Statistics, 1978
Automobile Crashes (City level for cities over 5,000 population)	Motor Vehicle Crash Facts, 1979 Table 1.1 "Crashes by City Groups", pp.16-18. Available from the Minnesota Department of Public Safety, Office of Traffic Safety (612)296-6652. Data for cities of less than 5,000 population (or those of 5,000+ but not included in the listing) available from Dept. of Traffic Safety, (612) 296-9507.

*The Center publication, Minnesota Health Statistics, is issued annually and contains data at the county level. For city-level data, special arrangements must be made with the Center (612)296-5353.

WELLNESS INVENTORY DATA SOURCES, CONTINUED

Social Status Index

Indicator	Source
Teenage Pregnancy (City level)	Minnesota Health Statistics, 1978 "Mother's Age, Percent, Under 18"
Poverty Level (County level)	Information available from Minnesota Analysis and Planning System (MAPS) U of MN (612) 376-7003. Statistics are based on 1970 census data; (more current information is now being prepared, based on 1980 census data).
Crime Rate (City level)	Minnesota Crime Information, 1979 Table 10 "Minnesota Summary Information Rate per 100,000 Inhabitants, 1978" pp. 45-49. Available from the Minnesota Department of Public Safety, Bureau of Criminal Apprehension, Criminal Justice Information Section, (612)296-2252.
School Dropout Rate	Local school district
Youth Dependency Ratio	Minnesota Health Statistics, 1978
Aged Dependency Ratio (County level)	Minnesota Health Statistics, 1978

WELLNESS INVENTORY DATA SOURCES, CONTINUED

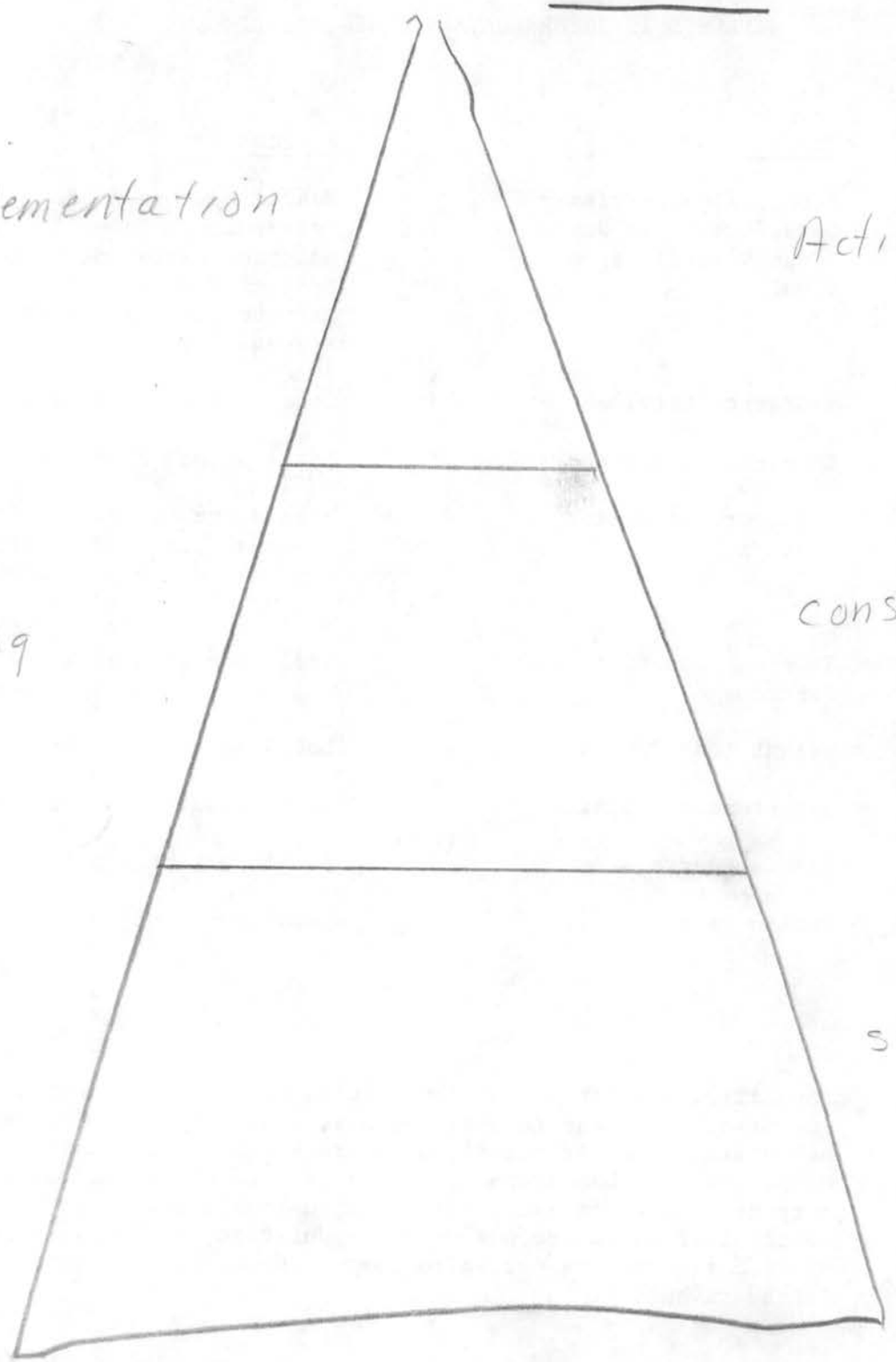
Wellness Resource Index

Indicator	Source
Population-to-Primary Care Physicaian Ratio (County subdivision level)	Health Systems Agency, e.g. Metropolitan Council & Metropolitan Health Board "Health Systems Plan for the Twin Cities Metropolitan Area - 1979-1980 Midyear Revision"
Emergency Services	Local police, hospital officials
Chemical Dependency	Local school district officials
Multipurpose Senior Centers	Area Agency on Aging. List of regional directors available from the Minnesota Commission on Ageing (612)296-2770
Smoking Cessation Programs	Local hospital officials
Weight Loss Programs	Local hospital officials
Hypertension Clinics	Local hospital officials
Tennis Courts	Local park officials
Public Parks	Local or county park officials

Population statistics for communities is available from a number of state and federal sources. The 1980 U.S. Census will be available in early 1981, with breakdowns by community. The Minnesota Stae Demographer, located in St. Paul, maintains current population estimates.. Various publications in the source list above include recent population estimates. Population figures are needed to compute several of the statistics in the inventory.

MC H

LWV



after data gathering, continuation is at the option of each party

League of Women Voters of Minnesota

Ann Pugliese, Health Care Chair, (612) 729-3029

Convention Workshops
48th State Convention
June 11, 1981
St. Cloud State University

MINNESOTA COMMUNITY WELLNESS INVENTORY

The LWVMN is offering to local Leagues beyond Minneapolis-St. Paul and their suburbs the opportunity to take part in a joint project with the Minnesota Council on Health. They have developed a "report card" of local health status--Leagues can investigate conditions in their community or county and "grade" the results.

The 21 indicators should not be difficult to determine, and it could be a short-term project for one person. As shown on the enclosed pyramid chart, this is the fact-finding stage that can lead to further study and Action, possibly with the Minnesota Council on Health. LWVUS has encouraged us to look into our local conditions as an introduction to their proposed study on "the private and public sector roles in the delivery of services."

ROLES--MCH

orientation, reimburse expenses, provide materials, direct the project

LWVMN

coordinator between MCH and local Leagues

provide fall workshops for orientation

September 22 - Minneapolis
September 24 - Austin
September 29 - Grand Rapids
October 1 - Willmar

LOCAL LEAGUES

read materials

discuss with own Board

recruit volunteers

attend fall workshop if possible (bring materials)

carry out project

report to MCH and LWVMN

advance to further study and Action as desired

This is an indication of interest, not a workshop reservation.

The LWV of _____ is interested in using the MCH Wellness Inventory.

Name_____ ___will attend workshop in _____

Address_____ ___cannot attend

_____

Please respond by August 31 to: LWVMN, 555 Wabasha, St. Paul, MN 55102.