Problems of Organized Home Care For the Long-Term Patient

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WHEN WE CONSIDER the pressing problems facing public health today, we are immediately confronted with the magnitude of chronic disease and the ever-mounting costs associated with it. The chronically ill or disabled patient has been with us for some time. His numbers increase as the proportion of older persons in our population increases.

One important aspect of this growing problem is the vast and complicated task of providing services to the chronically ill. In this task, health departments today have new opportunities and responsibilities associated with the care of certain long-term patients.

What Is a Long-Term Patient?

According to the National Conference on Care of the Long-Term Patient, the definition "includes only those persons suffering from chronic disease or impairments who require a prolonged period of care, that is, are likely to need or who have received care for a continuous period of at least 30 days in a general hospital or care for a continuous period of more than 3 months in another institution or at home, such care to include medical supervision, and/or assistance in achieving a higher level of self-care and independence" (*1a*).

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How Many of These People Are There?

The data collected for persons disabled for more than 3 months show that in the United States in 1950 the number was 5.3 million—3.5 percent of the total population.

Who Are These People?

2.1 million are persons 65 years of age and older—17 percent of this age group.

1.8 million are persons from 45 to 64 years of age—6 percent of the age group.

1.4 million are persons under 45—1 percent of the age group.

For the civilian noninstitutional population, illness of more than 3 months prior to disability is considerably more common in the male population. From age 55 to age 64, the ratio of male to female is of the order of 2 to 1.

Where Are These People?

4.2 million—79 percent—are at home or in general hospitals; 14 percent are in long-term hospitals, nursing homes, or homes for the aged; 7 percent are in homes or schools for the mentally deficient.

What Illness and Disability Have They?

The 12 leading causes of chronic disease or disability (*1b*) are:

1. Cardiovascular-renal disease.
2. Nervous or mental diseases.
3. Rheumatism and allied diseases.
4. Permanent results of accidents.
5. Senility.
6. Tuberculosis.
7. Blindness and diseases of the eye.
8. Chronic diseases of the digestive system.
9. Diabetes mellitus.
10. Chronic results of communicable diseases.
11. Asthma.
12. Cancer.

What Are the Needs of These People?

The chronically ill or disabled need comprehensive medical care which is concerned with diagnosis, treatment, and prevention of illness and disability, as well as the attainment of maximum rehabilitation of the individual within his physical and emotional limits.

How May These Services Be Provided?

Services to the long-term patient can be provided in a host of ways—among them through general hospitals, chronic disease hospitals, nursing homes, outpatient clinics, and the home.

Organized home care is "that phase of comprehensive medical care which through coordinated efforts is designed to meet the individual medical and related social, economic, and vocational needs of those patients who may be treated at home" (*2*).

Differentiating organized home care programs now in effect in a few communities from the more familiar and customary ways or providing care at home are:

1. In an organized program, administrative responsibility for total care is centered in one agency or institution.

2. There is a plan for the coordination of services and community resources through regularly scheduled formal conferences of all personnel concerned with patient care.

It should be reemphasized that home care services must be coordinated into a total program that will, ideally, include hospitalization, institutionalization, and continued care on an ambulatory basis.

Why Home Care?

Certain basic factors underlie the desirability of a home care program. One of the major considerations in such a program is the shortage of institutional beds. While the time may come when such a shortage is not a problem, it is not now foreseeable. Although many patients require some kind of service, it is not necessarily the 24-hour service offered by an institution. Many services can be given in the home as well as, or better than, in the hospital, and they will frequently be of equal or better quality. When such services are given in the home, they permit a proper utilization of institutional beds.

Moreover, home care permits the use of such family resources as housekeeping, housing, utilities, and food.

Final considerations weighing heavily in favor of organized home care are the great psychological and emotional advantages apparent in allowing certain patients to remain with their families.

Are There Limitations on Such a Program?

Certain limitations will necessarily be imposed by deficiencies in home environment, the extent and complexity of medical needs, individual problems of adjustment and stress, and available resources within the community (*3*).

Is Home Care a New Idea?

The first committee of the Boston Dispensary, which was established in 1796, stated, in its initial report:

"It having been found by experience, both in Europe and in several of the capital towns of America, that dispensaries for the medical relief of the poor are the most useful among benevolent institutions, a number of gentlemen propose to establish a public dispensary in the town of Boston, for the relief of the sick poor;

which they presume will embrace the following advantages:

"1. The sick, without being pained by a separation from their families, may be attended and relieved in their own homes.

"2. The sick can, in this way, be assisted at a less expense to the public than in a hospital.

"3. Those who have seen better days may be comforted without being humiliated; and all the poor receive the benefits of a charity, the more refined as it is the more secret."

What Is the Practicing Physician's Role?

Organized home care is not considered to be a medical care program designed to replace or supplant the services of the private physician or the family doctor. At the present time, the development of home care is directed primarily toward the health problems of nonambulatory indigent and medically indigent patients. It would, however, appear that the development and provision of adequate supportive services in the community could be of inestimable value to the practicing physician and his patients.

Home care programs offer the possibility of a higher grade of medical practice than is presently possible. This becomes apparent when we consider the chronically ill private patient who is financially able to pay for all or part of his care, and who, while requiring some supportive services, does not need the 24-hour services of a hospital or institution. Today, even though his physician could adequately provide medical care services in the home, the patient has difficulty in receiving supportive services at a reasonable cost if, indeed, he can receive them at all. As a result, many patients are obliged to enter hospitals or other costly institutions which, in many instances, are physically and psychologically less pleasant than the home.

We should anticipate considerable future readjustments designed to encourage a broader application of home care principles, not only with regard to the medically indigent but also in relation to those patients who are able to pay for all or part of their care. We should also anticipate general modification of voluntary health insurance plans and benefits based on the obvious advantages of home care for many subscribers and their physicians.

What Structure and Organization Is Entailed?

In order to provide acceptably complete and adequate service, a home care program should have at its disposal the services and resources of a general hospital.

It should be able to make coordinated use of such community resources as health, welfare, and social agencies.

There must be integrated cooperation among professional personnel engaged in the program.

The program should have specific geographic limitations.

The program must have adequate financial support.

There must also be centralized administrative responsibility for the program. Such responsibility may be localized in a variety of agencies. For instance, in Philadelphia, the Visiting Nurse Society has served as the voluntary health agency through which an organized home care program has been developed. In Richmond, Va., the health department has developed a citywide program in cooperation with the Medical College of Virginia. Hospital-centered, the program financially is supported principally by the health department, with the medical school financing that part considered to be educational. In Chicago, the department of public welfare arranged home care services for its clients. Montefiore Hospital (New York City) provides care to selected long-term patients who may be transferred to the hospital when necessary. The Massachusetts Memorial Hospital and the Boston Dispensary provide medical care for both short- and long-term patients. Medical services have been coordinated through social agencies as in the Jewish Community Services of Queens, New York City.

Auspices which contribute to the development of home care programs vary from community to community. Health departments, departments of public welfare, medical societies, voluntary health organizations—a virtually limitless number of combinations can spark the provision of a program.

Does the Health Department Have a Stake?

The position of the local health department in the field of chronic disease control was de-

fined in 1950 by the American Public Health Association (*4*):

"As new programs of public medical care are developed, their administration can logically be entrusted to the local health department. The well-organized and adequately staffed local health department is fitted for this task because of its strong combination of medical and organizational skills, its accustomed responsibility for a public trust, its emphasis on promotion of health and prevention of disease, and its understanding of the organizational elements required to achieve a high quality of care."

In many existing programs, preventive and curative services have been combined to a considerable extent. Prevention of the progress of a disease—the basic reason for early case finding—has resulted in the merging of public health and clinical laboratories. Public health and bedside nursing programs have been combined. Public health nurses are being utilized for the followup of discharged hospital patients. This combination of preventive and curative services is essential in present and future approaches to disease control.

The combination of services may, in many areas, represent a break in health department tradition. In communicable disease control, the health department was not generally concerned directly with the provision of medical services to sick people. From this point on the health department must be concerned if it is to keep its place as a functioning part of the American community. By its very nature, chronic disease is allied with the need for medical and nursing care. More and more frequently, that medical and nursing care will be arranged for, or supplied by, the local health department.

What Kind of Patient Is To Be Taken Care of?

Home care programs should provide services of a general nature and should not be limited to a particular disease category or type of disease. The kind of patient acceptable for home care depends upon criteria established by the community, both for acceptance requirements and for the kinds and amounts of service that will be offered. All kinds of patients are being cared for at home: the acutely and chronically ill of all ages and all diagnostic categories.

What Are the Minimum Services Necessary?

The chronically ill home care patient needs the care and guidance of a personal physician. The physician functions as the leader of the medical care team, outlines the plan of treatment, and gives specific orders for the patient's care which can only be carried out under his guidance and direction. For special needs, specialist consultation should be available. In this area, a hospital or medical school program can draw upon especially assigned consultants or upon staff or faculty members. Where this is not practicable, the health department can make arrangements for specialist consultation on the advice of the physician in charge.

As chronic disease programs develop, public health agencies will need to revise their policies and provide a sufficient number of public health nurses to include nursing care of the sick at home. It is the public health nurse who will determine the nursing needs of the patient with a chronic illness. She will give and supervise indicated care. She will teach the patient and his family how to deal with the specific chronic disease problem in the home. When necessary, she will make arrangements with a responsible person (usually a family member) for round-the-clock care. She will direct the treatment prescribed by the physician and encourage the continuance of medical supervision as long as necessary. She will give special treatments such as enemas, irrigations, catheterizations and inhalations, and she will be available for special services during pregnancy. She will also help the patient live within his limitations to his full capacity through the use of proper rehabilitation techniques.

Moreover, because of her visits to the home, the nurse will be in the best position to note the family's needs and to make referrals for medical and social services. She will also be able to observe conditions affecting family and community health and to bring them to the attention of the proper authorities.

The social worker is also essential to a home care program. Her knowledge of the social needs of the patients—housing, financial, emo-

tional—makes it possible for her to refer them to the various community agencies that can help them. By pointing out special social needs of the patient, the social worker makes it possible for social agency programs to meet those needs. An example is the recommendation for increased food allowances to prevent further illness or disability.

She will also, of course, give direct casework service when necessary. One of the benefits of this service will be the help given to patients and families in adjusting to individual situations created by the presence of a sick person in the home. Through her knowledge of community resources, she will help to integrate these services with other services being provided to patients so that patients may receive more adequate and more understanding care.

Provision of medications and appliances is necessary to any effective home care program. These should be made available on the order of the physician. They may then be obtained by the patient, or they may be provided by the health department or through public and private agencies.

The services just discussed are necessary for the establishment of any home care program. Expanded programs—which will come as experience is gained and as personnel become available—may include the following services:

Housekeeper service is usually supplied by a family agency or by a religious order. The housekeeper must be a person competent to manage a home and children under the active supervision of the caseworker. Her duties might include marketing, cooking, cleaning, mending, and such services to the patient as changing bed linen, giving bed baths, and serving food. To perform these duties efficiently, the housekeeper should have special training in home management, budget, nutrition, and child care. She should also have an understanding of behavior and attitudes.

The nutritionist can make an invaluable contribution in a number of home care cases by proper dietary planning.

Physical medicine and occupational therapy depend upon early inception for success. There is a personnel shortage in this field, so the nurse will probably be responsible for carrying out therapy prescribed by a physiatrist. Emphasis should be placed on self-care procedures, and the family should be trained in giving treatment to the patient.

Dental care is important in the preventive and rehabilitative aspects of certain illnesses. Emergency dental care should, therefore, be incorporated into the home care framework.

It is apparent, then, that adequate home care requires the combined efforts of welfare, medical, vocational, and guidance services. These services should be available to all who need them. A careful review of those organizations that provide home care in some degree will make apparent home care services available in the community.

What Are the Costs?

Discussion of costs in relation to home care is, of necessity, highly theoretical. Differences in methods, variations in services, and differing techniques make it impossible to offer a definitive statement. Costs can be figured on cost per patient, cost per patient visit, and cost per patient-day. Results, of necessity, vary according to the method used. In some places, home care is less expensive than hospital care. In others, it is more expensive. This, however, is not the important factor.

The quality of home care should at least equal hospital care. It can be superior to hospital care. It is an error to insist on thinking of home care only as a moneysaving device. The importance of home care lies in the fact that in many instances the patient will be better taken care of. Properly used, with the proper motivating philosophy, home care is better for many patients—medically, financially, socially, and emotionally—than hospitalization. And the patient is the subject of primary concern in any program of health.

How Is a Home Care Program Organized?

Many factors must be considered in setting up a new, or in expanding an established, home care program. The first step is to identify the needs which the program is to meet in the community. When the needs have been assessed—when the resources have been examined—the

necessary services to be furthered will be apparent, as will the gaps in community resources that must be filled.

In estimating the need for home care, every effort should be made to explore all of the sources from which patients may be drawn: at home; outpatient clinics; general hospitals; special hospitals; mental institutions; tuberculosis sanatoriums; nursing homes; convalescent homes; homes for the aged. When the needs are known, the program can be adjusted to the available funds, facilities, and personnel.

It is recognized that many health departments face the problem of knowing that they do invaluable work, but that that work is frequently intangible. It has become so much a part of the community background that it is taken for granted. People never think, for instance, of the fact that their water is pure until it becomes polluted. In this context, it is probable that once a home care program is launched—that once the community again becomes aware that its health department is making better health a tangible, easily seen reality in relation to the families that form the community—it will have overwhelming support. When that support is gained, expansion will be no problem. It will be demanded.

At this particular time, however, when practicality is a necessity, home care programs offer many advantages:

They meet the medical care needs of the homebound patient.

They decrease the length of hospital stay.

They diminish expenditures for the construction of additional hospital beds.

They provide continuity of service.

They create an opportunity to apply preventive measures effectively.

They function as a case-finding tool.

Basically, it does not matter whether the operating agency for a home care program is the community's general hospital, the local health department, or some other responsible community agency. The program will succeed if it meets a need and if community resources are effectively utilized. Those resources will be effectively utilized as the community recognizes that home care is a service that will benefit the community in every aspect of its health and welfare.

REFERENCES

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Emergency Medical Force Sent to East Pakistan

An emergency medical force composed of 6 Public Health Service scientists and 80 Army medical corpsmen was sent to East Pakistan in mid-August to assist the country in meeting the threat of postflood epidemics. Head of the force is Dr. Alexander D. Langmuir, chief epidemiologist of the Public Health Service's Communicable Disease Center, Atlanta, Ga.

Reports from Pakistan to the Foreign Operations Administration indicate that 7 million persons have been left homeless or seriously affected by the unprecedented floods occurring this year. The primary concern of the Pakistan Government is the threat of major epidemics of typhoid fever, dysentery, cholera, and malaria, all of which thrive in postflood conditions.