Progressive Patient Care

—*a challenge to hospitals and health agencies*—

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THERE has been a ground swell of interest in public health circles during the last several years in reexamining the entire concept and structure of community health services.

The last two annual meetings of the National Advisory Committee on Local Health Departments of the National Health Council have addressed themselves to such subjects. The American Public Health Association is also studying current patterns of organization of local health departments in relation to the kind of health services most needed today. There has been a rebirth of interest in the research approach to current problems of public health practice—community-oriented research aimed at developing new and better methods of public health services.

Health departments are not alone in recognizing a need to reevaluate their services. Hospitals are also facing this dilemma. On the one hand the medical profession and the American public expect and demand increased and better hospital services; on the other hand much concern is being expressed regarding the ever-rising costs of hospital care. Related to these problems is the need for more trained personnel than are available.

The public has become increasingly aware of the advantages of hospitals and nursing homes for the treatment of illness. Physicians require the hospital's resources to apply modern techniques of effective diagnosis and therapy. Each year a larger percentage of our population is over 65 years of age, and persons in this age group require twice as much hospital care as younger persons. Some illnesses and injuries, former killers, now are effectively treated, but at the expense of many days in the hospital. Further, we may expect that better methods of financing will increase hospital use by people who do not use them now because of economic barriers.

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Hospital Costs

Some of the very factors which increase hospital use also increase costs per hospital day. The advances in scientific medicine increase comfort and save lives, but more people, space, and equipment are required to do the job. In 1946 each hospital admission required an average of 4 laboratory procedures; today the average is 14. Although illness occurs on a 7-day week, hospital employees are gradually achieving the 5-day workweek. The short workweek, inflation, and the need for greater skills, plus competition for scarce personnel, has forced salaries up. An increase since 1946 of general hospital personnel from 1.5 to 2.0 employees per patient, coupled with salary increases, makes higher per diem costs inevitable.

Thus, hospitals are faced with having to provide more hospital days at higher costs per day.

Some comfort can be taken from factors which tend to offset these trends. Some medical discoveries—and hopefully more in the future—eliminate the need for hospitalization for some illnesses. Others have helped shorten the

average hospital stay. Improvement in managerial efficiency is a third factor.

Since it is clear that hospital costs and needs for scarce personnel cannot be reduced by arbitrarily cutting back services, hospital people feel it essential to review hospital operations critically; to isolate areas where increases in efficiency can be instituted without sacrificing quality of care. They feel that an important method of coping with their present dilemma lies in the systematic study of such areas and in the application of the results of research to the development of:

- More effective organizational patterns for the provision of medical services to the people.
- Better community planning for hospital facilities and better coordination of facilities within a community.
- Better techniques of administration.
- Improvement in the design of the physical plant.

This at the very same time that public health workers are asking how the health department can reorient its programs to meet more adequately the major health problems of today.

Hospital and public health personnel are both dedicated to the same goals. In the past, however, they have directed their primary efforts to opposite ends of the spectrum of the need for services. The hospital administrator has concerned himself largely with service to the acutely ill patient; the public health official has devoted his efforts principally to preventing disease; and the voluntary health agency has concentrated on gaps in health services. But there is beginning to appear unmistakable evidence of the willingness of these three groups to work together in planning complete community health programs.

Increasingly in the future, I believe, official and voluntary health agencies will sit down jointly with hospital planners to assess the need for community health facilities and services.

New Patient Care Concept

From the hospital side, there is already evolving a new concept of organization of services which shows promise, the concept of progressive patient care. This development has arisen from the attempt to better administrative devices for providing the health services most needed by the people.

Many hospitals are now incorporating one or more of the progressive patient care elements in their procedures. It, therefore, behooves both hospital and public health worker to examine this concept and identify their own possible roles.

The central theme of the progressive patient care concept is the organization of facilities, services, and staff around the medical and nursing needs of the patient. Its objective is that of tailoring services to the needs of the individual patient, whether in the hospital or the home. Patients are grouped according to their illness and their need for care. The staff serving each group of patients is selected and trained to provide the kind of services needed by that group.

The progressive patient care concept envisions the general hospital of the future as the focus of both outpatient and inpatient care; as much concerned with care of the long-term patient as with the treatment of the short-term patient; as readily available for assisting the physician with care of his patient in the home as for assisting him with care of the patient in the hospital.

Five elements are usually associated with the concept of progressive patient care in the general hospital: intensive care, intermediate care, self-care, long-term care, and the extension of hospital services through organized home care programs.

In the intensive care unit, critically ill patients are concentrated in one area regardless of diagnosis. These patients are under constant audiovisual observation of the nurse, with lifesaving techniques and equipment immediately available, and with nursing staff selected and trained to care for this type of patient.

In the intermediate care unit are concentrated patients requiring a moderate amount of nursing care, not of an emergency nature, many of whom are ambulatory for short periods and who are beginning to participate in the planning of their own care.

The self-care unit gathers patients who are physically self-sufficient and require only diagnostic or convalescent care which can be provided in hotel-type accommodations.

In the long-term care unit are patients requiring prolonged care.

Home care, the fifth element of progressive patient care, extends hospital services into the home to assist the physician in the care of his patients.

By concentrating patients with similar nursing needs into separate units in this manner, the staff can be selected, trained, and adjusted in number to render maximum service. Physical facilities can be planned accordingly.

There are many unanswered questions regarding progressive patient care. Much additional research is needed. For example, we can, at this time, only speculate on its possible effects on hospital costs. Also, there are other administrative devices for improving services which should be tested.

The basic concept of progressive patient care is far broader than its relationship to the general hospital. A similar trend has been developing in the mental health field. There is growing emphasis upon the provision of community facilities and services for patients with mental disorders, in contradistinction to continued enlargement of State institutions for the care of the mentally ill. Again, the objective is to look at the patient in accordance with his particular needs. Here, application of the progressive patient care concept leads to consideration of the need for a psychiatric unit in the general hospital, diagnostic and treatment facilities on an outpatient basis at the community level, including separate clinics, a halfway house involving sheltered care and group therapy, the so-called day hospital or night hospital, sheltered workshops, and home care programs.

In modern treatment of tuberculosis, too, treatment begun in a hospital can now be continued safely and effectively in the home at a relatively early stage.

Clearly, effective patient care, directed to the total needs of the patient requires better community planning than now exists in most places. Certainly public health workers should actively participate in this planning. In many places, the health officer can be the initiator of certain aspects of the program, assuming responsibility for the organization rather than the provision of services. Public health workers are well equipped to contribute to the long-term care and home care aspects of progressive patient care. By virtue of the multidisciplinary character of the health department staff and the focus of their training, they are accustomed to working as a team. They are also accustomed to teaching the patient and the family how to do for themselves rather than doing for them.

Before this potential contribution can become reality, however, public health people must demonstrate a willingness to supply the necessary skills. They must also fully accept, as a public health responsibility, the role of assisting the physician in the care of his patient through the provision of such services as home care programs. Actually, in places where public health workers are engaged in followup of patients discharged from tuberculosis and mental hospitals, they are already involved in some facets of progressive patient care. Extension of this responsibility to other types of long-term care, especially that associated with chronic illness and other long-term disabilities, should not be too difficult a hurdle to take. And yet, some brave new thinking is required.

It is relatively easy to determine for the community as a whole the magnitude of facilities and services needed for intensive, intermediate, and self-care, since these are measured in terms of hospitalized patients. Within the hospital, there can be a daily evaluation of the number of patients requiring each kind of care. With respect to long-term care, however, the situation is more complex. Here we are concerned with a dual problem: On the one hand are the many patients in general hospitals who could be transferred to a long-term care facility; on the other hand, many disabled persons are scattered throughout the community who would benefit by such care if it were available. The health officer and his staff are in a strategic position to assess the scope of the need for this latter type of care.

The home care segment of the program presents quite a different dilemma. For other elements, the organizational framework within which the service is provided is quite clearly that of the hospital or long-term care facility. For home care, some services are supplied by the hospital and some by other community

agencies. This is the stage of the full sequence of care in which the health department might be expected to have a major role. A wide range of services is desirable if maximum assistance is to be given the physician in the care of his patients. Physical therapy, occupational therapy, home nursing care, social services, X-ray, laboratory services, nutritional aid, and homemaker services, to name a few. The health department has an important role in giving guidance and leadership in developing resources to provide the services needed. Some of these can be supplied by the health department. Some can more appropriately be obtained from other sources. Not always will the same agency be the provider of service. The health department must be willing to fill in the void and equally willing to promote the use of and to lend its support to services already available under other auspices.

Hospital-based services are, perhaps, more apt to give continuity of care than those based elsewhere. It is easier for one organization to assist the physician in management of the patient's full regimen of treatment, even when some of the services used are provided from other sources. A home care program must be medically supervised, and adequate medical records must be maintained. Although an underpinning of financial support for the program will be needed if services to the medically indigent are to be provided, provision should be made for patients to pay for services whenever possible. The business office of a hospital can incorporate such payment in its regular system of patient billing without difficulty.

In some communities, particularly those with several hospitals, more complete coverage may be obtained through a home care program with services emanating primarily from the health department. A great deal more study and research is needed in this area to establish principles for the most effective organization of home care programs.

Nursing service may be provided equally well from the hospital, the health department, or the visiting nurse association. In weighing the ability and responsibility to provide this, or any other part of the total services needed, hospital and public health workers will have to think in terms of services the people need, the services they want, and the methods by which they can be furnished.

Joining Forces

Misunderstandings concerning who is responsible for what may be avoided by formal documentation of the relationship of various services. Likewise, the methodology of getting patients transferred from one service to another must be carefully worked out and understood by all participating agencies. A few communities have made a good start in this direction.

It is not uncommon for a health department to use hospital outpatient facilities for its heart, tuberculosis, or prenatal clinics. On the other hand, except for obstetrics and occasionally pediatrics, many public health workers still do not instinctively think of cooperative enterprises in which the health department and hospital jointly participate. As a local health officer some years ago, I certainly did not.

During the past few years, State health departments have been drawn closer to hospital and nursing home operations and their problems through their licensing and inspectional programs. As a rule, however, and perhaps of necessity, this has been a highly centralized function of a relatively small staff in the State health agency. The rank and file of public health workers have not participated to any considerable extent.

Health leaders are engaged in a never-ending search for ways and means to provide the kind of services the people need in ways that are most acceptable to them. In these days, when the chronic diseases and other long-term disabilities are the dominant clinical burden, neither the hospital nor the health department can escape its share of responsibility for providing the services such illnesses require.

By joining forces in a well-organized program of providing services tailored to meet patient needs, progressive patient care in its broadest concept, the resources of both the health department and the hospital can be used to far greater advantage to serve the total health needs of the community. At the same time, a vast new area of interest and of service will be opened to hospital and public health workers alike.