Community Health Services to the Aged and Chronically Ill

LESLIE W. KNOTT, M.D.

TODAY, for the first time, there is available both the money and the program with which to make a beginning toward providing the full spectrum of health services which all of us in public health have so long envisioned for the chronically ill and the aged in our population.

For the first time we have within our grasp a means to employ more fully the health knowledge we have gained through research to provide direct services to people.

I refer, of course, to the Community Health Services and Facilities Act of 1961 (Public Law 87-395), an act which Secretary Ribicoff has called "one of the most important advances in the history of Federal health legislation."

I think that no one in public health would disagree with the Secretary's estimate of this legislation. We know only too well the tremendous size of the chronic disease problem, especially among our older people. We know, in fact, that the most pressing challenge facing public health is to relieve the increasing burden imposed by chronic disease and disability upon millions of lives and upon the strength and security of our nation.

On February 9, 1961, President Kennedy, in his special health message to Congress, expressed a concern for this problem when he said: "The health of our nation is a key to its future—to its economic vitality, to the morale and efficiency of its citizens, to our success in achieving our own goals and demonstrating to others the benefits of a free society."

The President also said that the ability of an individual to afford adequate health care is to no avail if the necessary community facilities and services for providing such care are not available.

The Community Health Services and Facilities Act of 1961 resulted directly from the Administration's awareness that facilities and services are not available in most communities to provide good quality, comprehensive health care outside the hospital.

The President and the Congress have done their part—now it is up to all of us in public health and the people in every community to make use of this legislation.

Briefly, the act provides:

1. An expanded program of matching grants to assist States in building up health services for the chronically ill.

2. A new program of special project grants to conduct studies, experiments, and demonstrations for developing new or improved methods of providing out-of-hospital community health services, particularly for the chronically ill and the aged.

3. An appropriation authorization increase which would double the annual Hill-Burton grant funds available for construction of nonprofit nursing homes, allowing 5,500 nursing home beds to be built each year, compared with 2,980 beds under the previous ceiling.

4. A broadened grant program for research and demonstrations to improve the design and function of hospitals and related health and medical facilities.

The act also provides increased appropriation

Dr. Knott is chief, Division of Chronic Diseases, Public Health Service. *This article is based on an address before the annual meeting of the National Council on the Aging, New York City, October 9, 1961.*

authorization for grants-in-aid to schools of public health for professional training and consultation services, liberalized eligibility criteria for rehabilitation centers applying for Hill-Burton construction assistance funds, extension of authorization for hospital construction loans under the Hill-Burton program, and finally it makes certain modifications in the program for the construction of health research facilities.

In this paper I shall concentrate on the first two provisions of the act: the additional grants to States for building up services for the chronically ill and the project grants for demonstrations, studies, and experiments of new or improved methods of providing health services outside the hospital, particularly for the chronically ill and the aged.

State Grants

The first of these provisions, the State grants, provides for increasing the authorized amount of Federal funds allocated among State health departments. These are known as formula grants because they are distributed on the basis of a formula prescribed by the Surgeon General of the Public Health Service. The additional funds as appropriated by Congress may by law be earmarked for specific purposes. Furthermore, the grants are made available only if the State submits an acceptable plan for using such funds and is able to match the grant with its own monies in whole or in part, again as determined by the Surgeon General.

For the remainder of this fiscal year, for example, Congress has already appropriated $6 million as formula grants under this new law. This will be allocated to State health departments according to each State's own resources, total population, and proportion of the nation's aged who reside in the State. No State will receive less than $40,000, and in each case every $2 of the Federal grant must be matched by $1 of State monies.

State plans for using formula grants must be directed to increasing the availability, scope, and quality of out-of-hospital community health services for the chronically ill and the aged. As one may expect, these plans will vary from State to State. In some States the funds will be used primarily at the State level to provide training, consultation, technical assistance, and recruitment programs, assignment of professional personnel to local areas, strengthening of licensure procedures for nursing homes, the development of educational materials, and other activities designed to help local areas.

In other States funds may be used principally to give direct financial aid or grants to local communities which in turn will, on their own, develop and expand appropriate out-of-hospital services in accordance with local needs. Still other States will use a combination of these methods for putting Federal grants to use.

In speaking of out-of-hospital services, we visualize such programs as nursing care of the sick at home; homemaker services; coordinated home care which provides a wide range of services, including medical as well as nursing, special therapy, and social services, under a coordinated plan of operation; information and referral services to assist patients in getting to the right type of facility or service; diagnostic or screening activities for the early detection of disease at a time when treatment can be the most effective in preventing complications and disability; and education and training programs for professional and lay health personnel who are concerned with services for the long-term ill or aged. Out-of-hospital care also encompasses consultation, training, and technical services aimed at the improvement of patient care in nursing homes.

I wish to place special emphasis upon home health services. I firmly believe that many chronically ill persons can be adequately cared for in their own homes provided community services are available. This is much preferred by many patients and may significantly reduce the cost of service to the individual or to the agencies or communities supporting them. Nursing home care, however, is the only answer for other patients, and efforts must be directed to assist nursing homes as well as to require good standards of care from them.

All of these services mentioned exist to some degree in scattered areas throughout the country. The number of patients served, however, is exceedingly small compared with the need. Existing coordinated home care programs, for example, serve about 5,000 persons; only about 3,000 families have the benefit of homemaker

services; about half the 1 million completely homebound patients receive nursing service. Rural areas are the most deficient, but nearly 200 cities with populations of 25,000 or more lack home nursing service. It is unnecessary at this time to go into detail regarding the many problems and needs relating to nursing home care.

Although use of the new State formula grants provided by the act is not limited to these specific areas of interest, the general purpose is to assist States and communities to initiate, expand, and develop activities that will prevent disability, restore the disabled to maximum function, and keep them in their own communities and preferably in their own homes when that is feasible.

Project Grants

The second provision of the new law is of particular interest to the expansion of community health services—the special project grant. The basic objective of the formula grant as described above is to extend or improve the availability, scope, and quality of health services primarily for the aged and the chronically ill. In contrast, the objective of project grants is to study, conduct experiments, and demonstrate new or improved methods of providing such services. Although the basic objectives differ, the two kinds of grants-in-aid may to some extent overlap. However, out of the emphasis on study and experimentation in the project grant we believe there will emerge more effective and more economical ways of organizing and delivering preventive as well as care services. As in the formula grant, the emphasis is placed on services outside the hospital.

Examples of the types of projects that could be considered for special project grants are listed in the leaflet, "Project Grants to Develop and Demonstrate Better Methods of Providing Community Health Services for the Chronically Ill and Aged" (PHS Publication No. 881), which is available to all interested communities and agencies from the Public Inquiries Branch, Public Health Service, Washington 25, D.C. The following are a few examples of the kinds of projects that would be suitable for grant aid:

- Demonstration of how nursing programs can prevent or reduce disability.
- Comparative study of the quality of a service given by personnel who have had a particular kind of training as compared with the quality of service given by those without such training.
- Investigation of costs and effectiveness of health services as provided under differing circumstances.
- Testing of new ways of organizing or combining various types of services in terms of effectiveness in improving patient status.
- Demonstration of ways of preventing or reducing the need for institutionalizing the ill or disabled or ways of returning the institutionalized patient to his community without jeopardizing his health.

The project grant authority presents the opportunity to use imagination, to test ideas, and to venture in new paths in order to improve the lot of the disabled and those at risk of being disabled.

Project grants can be made available to any State or local public agency or any nonprofit private organization. Eligible agencies include health departments, welfare groups, social agencies, voluntary health associations, hospitals, and educational institutions. All applications should be forwarded directly to the Public Health Service for consideration and processing. When an application is received which may be of interest to the health department or other official agency of the State, comments will be solicited from such agencies and will be considered in the reviewing of the application.

Implications for the Community

Since project grants are designed largely to assist individual groups and local communities in setting up services that may be new to an area or to test new ideas, how can the community best prepare to take advantage of this opportunity? What are the implications?

Organization. First and foremost, some organized community group must take the leadership in becoming familiar with grant requirements and in developing suitable projects for consideration. As already indicated this may be a local governmental health or welfare department or some established nonprofit

agency. Persons experienced in developing communitywide services, however, are keenly aware of the need to consider relationships with other organized community groups that have an interest in the subject of any health undertaking. Nor can we exclude the general citizenry and the people who are to be served.

As a general rule, therefore, I believe that a project applicant should, in the planning stage, seek the advice, assistance, and preferably, participation of other groups that have like or related interests or who may be affected once the project is established. Certainly this would include the health professions, official and voluntary health and welfare agencies, governmental groups (particularly elected officials), industrial and labor leaders, civic and fraternal organizations, professional membership organizations, the clergy, Blue Cross and other private health insurance groups, and education representatives.

Early consultation of interested or affected parties can do much to enhance the eventual understanding, acceptance, and future financial support so essential to the sound establishment of a new service. Representatives of the press, radio, and television may be consulted in order to further public understanding and support of a project. Appropriate State agencies can be the source of good advice, and, as explained in the section on formula grants, the State health department may provide a system of financial aid to give initial support for developing or expanding local services. Seeking counsel, of course, does not mean that the applicant should divest itself of responsibility for project sponsorship. Counseling with others is suggested as the means of assuring success by avoiding misunderstanding, conflict, and lack of coordination among services.

Determination of need and resources. Another essential early step is to determine the need and resources existing in the community. Need may be determined through direct application of findings from a number of excellent sources. Among them are the extensive findings of the McNamara Subcommittee on Aging of the United States Senate, the excellent reports submitted by the States preliminary to the White House Conference on Aging, the final recommendations of the White House Conference itself, and the information provided by the National Health Survey.

By means of such information we can calculate that for X population there will be X amount of need. Caution must be exercised, however, to be reasonably sure that national data are applicable to the community in question. Communities vary in population characteristics such as age composition, incomes, and major occupations. It is possible to go to the extreme of conducting a door-to-door survey within the community, but this is costly, time-consuming, and not always necessary. Most communities need only follow the in-between approach used in Guilford County, N.C. There the yardstick for planning was fashioned by an assessment of need among individuals known to various agencies or professional groups.

To begin with, all the physicians in Guilford County were asked to report all long-term illness cases that they saw during 1 month. The physicians submitted reports on what they felt were the unmet needs of these individuals as far as health services were concerned. During the same month, a canvass was made of patients in local nursing homes and hospitals. The Visiting Nurse Association was asked to report on the long-term patients on its roster. The resulting collection of data provided the community with a good, general idea of the extent of its problem. The second step was an evaluation of existing resources. The third step was a comparison of the total demonstrated need and the extent to which this need was being met by available resources. The difference, of course, constituted the extent of the community problem.

Among other things, the community learned that many hospital patients did not need the intensive services of a hospital. The community also learned that many patients in nursing homes or in their own homes were not getting the kinds and amounts of services they needed.

On the basis of this brief but thorough study, Guilford County determined that it should give highest priority to providing care services in the home.

An important point to remember is that each community must determine its own needs and resources. Each community must answer for itself such questions as these: What are the

population characteristics in this community? What is the pattern of illness? What are the unmet needs? What health problems are most urgent in this community? What is the existing pattern of medical care? Is there a tendency to hospitalize immediately? Is there an existing program to provide services in the home? If so, are these services adequate? What services are available through the social agencies in the community?

With the determination of need, resources, and gaps in service, the community should then proceed with the development of projects that are feasible. Perhaps a "row-boat" rather than a "cabin-cruiser" service may be all that is required or can be afforded in the beginning. The important thing is whether the program provides a basic service most needed by the aged and the chronically ill in the community.

Availability of services. It is equally essential to all successful community programs that the patient receive the available services he needs regardless of where he lives, who he is, or what his ability to pay. Also, it is better for a community to plan limited services upon a broad base than to have intensive services for a small section of the individuals in need of services. Making services available to all, including those with the ability to pay, is a reversal of the usual public health policy. In most public health programs, those who can pay are not included; in the case of services for the chronically ill or disabled, it is vital that they be included. Chronic disease and disability are no respecters of personal status. Most communities should therefore establish a fee for service based on ability to pay at the very start of their program. If a demonstration program offers free services for 3 years, don't expect the community to be willing to start paying for something that they previously got without charge. Gradually increasing financial support can be derived also from agencies within the community which see the demonstrated values of such a program.

Counseling and referral services. In the "tooling up" phase of the community program, it is important to remember that care and treatment services for the older person, while basically no different from services required by all age groups, is often very different in extent of services required. We know that the average older person needs a larger volume of services, for example, and that some services he requires are more complex, more comprehensive, and needed over a longer period of time.

In any program of community health services for the chronically ill and the aged we must therefore strive to provide appropriate, adequate, comprehensive, and continuous care to the individual according to his changing needs. In other words, as Dr. Edwin L. Crosby of the American Hospital Association has so aptly said, "Our goal should be getting the right patient in the right place at the right time."

If the community is to meet this goal, it is necessary to contact, evaluate, and coordinate available services and facilities for each patient. This suggests some centralized system of information, counseling, and referral service.

With the growing concern about the health and health-related needs of the chronically ill and aged, there have been considerable modifications in the patterns of existing information and referral services. Some of the most important modifications include: assistance to the patient, his family, and his physician in working out the best treatment plan, better use of existing community resources through more appropriate referrals, and documentation, on a continuing basis, of inadequate service so that appropriate groups in the community can be made aware of the needs and can take steps to provide additional services and facilities.

Finally, the potential of the individual community program for influence beyond its own borders must be considered. One of the basic purposes of the Community Health Services and Facilities Act is to encourage and support more than the "garden variety" of local programs. Hopefully, each community program will be designed to meet the challenge of providing example and precept for the benefit and guidance of other communities and the nation as a whole.

Conclusion

Secretary Ribicoff in a recent speech before the National Foundation in New York said: "A research discovery in the laboratory, until it is

applied, saves mice, not men! Breakthroughs in research should not be followed by breakdowns in delivery."

But all too often there have been breakdowns in delivery—in the transfer of research benefits from mice to men.

The Community Health Services and Facilities Act of 1961 holds out to us the promise of an end to such breakdowns. It offers the tool by which we may build a closer partnership within our State and communities—a partnership which is carefully organized and operated to deliver services to people.

I believe that it is toward this goal of providing services to people that the leaders in our health and welfare movements in America can make a significant contribution. The Community Health Services and Facilities Act of 1961 will be only as effective as the leadership in our States and communities.

We must not fail to make full use of this unique opportunity to narrow the gap between the acquisition of knowledge through research and the application of knowledge through direct services to the increasing millions of aged and chronically ill among us. Only in this way will our older people in their declining years find new opportunities for usefulness, self-esteem, and a higher level of physical and mental health.

Division of Community Health Services

A new Division of Community Health Services was established in the Public Health Service on November 28, 1961, merging the public health administration programs of the former Division of Community Health Practices and the medical care administration activities of the former Division of Public Health Methods.

Dr. William H. Stewart, former chief of the Division of Public Health Methods, heads the new division.

"The new division reflects the fact that community services and medical administration are inseparable entities and must be closely coordinated," Dr. Luther L. Terry, Surgeon General of the Public Health Service, said.

"There is no longer a clear dividing line between curative and preventive medicine," Dr. Terry explained. "In treating the chronically ill and aged, particularly, we need visiting nurses, physical therapists, homemaker aides, and many others who are employed by health departments and other community organizations."

The division will conduct studies and support research, training, and demonstrations. Subjects to be studied include medical manpower, systems of financing, methods of payment, cost analysis, and other aspects of health economics.

Another major function of the division will be to stimulate and support the planning and coordination of health services in the community.