Local Health Department Services for Long-Term Patients

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CONTROL of chronic diseases is demanding increasing attention from both public health practitioners and clinicians because, briefly, (*a*) the number and proportion of people having chronic illness or disability attendant with old age are markedly increasing; (*b*) since control of communicable diseases is requiring less attention, other health problems are becoming relatively more prominent; (*c*) now that more can be done in preventing, treating, or limiting chronic diseases, the attitudes of medical personnel toward such conditions are changing; and (*d*) the increasing effectiveness of medical and health care has resulted in a growing complexity and cost of such services, so that fewer and fewer persons can afford to use the available facilities without the assistance of organized services and programs.

One approach to the problem of satisfying medical needs has been the purchase of insurance against the costs of medical catastrophes through organized prepayment plans. Although 75 percent of persons are covered by insurance, it has been found that only 25 percent of their medical costs are met thereby (*1*). Among the aged, who are generally more prone to chronic disabilities, have fewer resources, and are in lower income groups (*2*), both of these percentages are lower. It should be noted, too, that thus far insurance has provided aid mainly for institutional medical care (*3*).

Another approach to meeting the medical and financial needs of the chronically ill is to promote better use of health and social services in the community outside the institution. A wide range of information and referral services (*4*) and "organized" or "coordinated" home care programs (*5*) have been developed in recent years. Generally in larger communities, special information or referral services have been established, usually by voluntary social agencies. Their objectives are the improvement of care and the conservation of professional manpower and money through more efficient use of community resources. These services direct inquirers to agencies that will best meet the needs of the client, but they do not assume any continuing responsibility for the applicant. The home care plans have most frequently been based on existing hospitals (*6*); a number have been established by medical schools to provide educational opportunities for their students and staffs; and others have been developed by visiting nurse services and a variety of other community agencies. In most instances, programs have been developed for the benefit only of indigent or medically indigent persons.

The programs of selected large and active local health departments providing chronic disease services were surveyed by Muller and Kovar in 1955 (*7*). The American Public Health Association's Program Area Committee on Chronic Disease and Rehabilitation, which sponsored the survey, considered that the results of the survey indicated only meager official assumption of responsibility for control

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of chronic disease and disability (*8*). Since the time of this survey, further chronic disease services have probably been developed in a number of individual local health departments.

This paper describes the early experiences of the chronic disease program established in the Health Department of Newton, Mass.

One of more than 40 municipalities comprising the Boston metropolitan area, Newton has a population of 92,000. Situated about 7 miles west of downtown Boston, it includes 13 villages and covers an area of 18 square miles. Newton is predominantly a middle-class residential suburb, although it has a number of industries within its boundaries.

The Newton Health Department has been directed by a public health trained physician since 1935. Some of the other community agencies are a well-staffed and well-equipped hospital, which serves several of the western suburbs of Boston, a visiting nurse association, a tuberculosis and health association, a chapter of the American National Red Cross, a community council, and a community chest.

In developing the program, proposed policies were discussed and established with the aid of three advisory groups: (*a*) a medical committee of 6 physicians, representing the local medical societies, the hospital staff, and the board of health; (*b*) a technical committee of 12 persons, mainly professional workers from major health and social agencies; and (*c*) about 30 citizens recruited from boards of health and social service agencies and from religious and business groups. Professional members of the program staff also met with the various agency representatives to exchange information and ideas and for consultation.

Later in the development of the program, the staff met with professional workers who were closely associated with a particular client to evaluate the client's social and medical status before formulating his program of care. From these discussions grew an increasing awareness of the needs, medical and otherwise, of both the community as a whole and of individual long-term patients and their families. Particularly in the formative stages of the program, formal acceptance of the idea and willingness to cooperate were encouraged by these conferences.

The Program

The Newton home care and geriatric program, established in March 1960 by the Newton Health Department in collaboration with the Newton Community Council, was one of three demonstration projects in Massachusetts subsidized by the Massachusetts Department of Public Health. The objective of the Newton project was to develop a demonstration coordinated home care program and also to make available information, referral, and counseling services in connection with the care of elderly and long-term patients.

A "coordinated home care program" was defined as an organized plan to assist the physician, the patient, and the family during that phase of prolonged illness or disability when the patient's needs can best be met in the familiar surroundings of his home. The plan has a centrally coordinated program bringing to the patient and his family the benefits of planned, comprehensive, and continuing care through the organized use of medical, nursing, social, rehabilitative, and other community resources required by the homebound patient. Such a plan extends into the community the kind of multiprofessional operation that functions in a hospital. The home care program, however, is not meant to be a substitute for hospital or nursing home when these facilities are necessary for medical or nursing reasons; nor is it recommended when unfavorable conditions in a particular situation make it impossible for the patient to be adequately cared for at home.

The information, referral, and counseling services were to be provided by the coordinator of the program for those patients who did not qualify for or require coordinated home care. Such services were offered to the many patients who did not need physician care on a continuing basis, or who were obviously in need of personal services only, or who needed institutional placement.

A full-time medical social worker was appointed to the program. Her professional services were made available through the home care program, in which she acted as the coordinator, assuming continuing responsibility for coordinating services for eligible patients, and the information, referral, and counseling services mentioned above. In addition, the di-

rector and the nursing supervisor of the health department served as physician and as public health nurse to form with the coordinator a professional and coordinating team.

Any Newton resident with prolonged disability was eligible for the services of the program regardless of his diagnosis, age, or financial status. He was accepted if he met the following criteria: (*a*) he was in need of regular medical care and his personal physician considered that home care was, for any reason, preferable to institutional care; (*b*) physical or social circumstances of the patient's home were feasible, or could be readily made so, for home care; and (*c*) the complexity of the situation warranted coordinated services.

From March 1960, when the program was initiated, to June 30, 1961, 137 persons were referred to the program, 42 men and 95 women. Their age distribution was 21 under 60 years, 25 aged 60–70, 40 aged 70–80, 40 aged 80–90, and 11 more than 90 years old. Twelve persons were on public assistance; the remainder depended on personal or family resources.

Services. Frequently a patient or his family asked for more than one kind of service, so that the total number of services requested exceeds the number of referrals:

Type of services requested	*Number*
Personal care and housekeeping	73
Evaluation for home care	24
Social service counseling	21
Placement	21
Homemaker services	16
Nursing care	9
Financial assistance	8
Rehabilitation	7

Patients who asked for evaluation for home care services were discussed by the coordinator with the physician and the public health nurse. However, the coordinator used her own discretion and judgment in deciding which patients should be referred to the other members of the team before determining what assistance should be offered, as shown below:

Type of services given	*Number*
Recommendations for care	79
Counseling	29
Evaluation for home care	19
Referrals to other agencies	17
Information only	16
Consultation	13

"Recommendations for care" were made when, in the opinion of the medical social worker, the nursing home or the available helper was able to fulfill the requirements of the individual under consideration. Otherwise "Information only" was given, for example, when the names of nursing homes in a particular area or the sources of homemaker or other services were requested. "Counseling" in this program was limited to problems of care. Persons with other types of problems were referred to appropriate sources. "Evaluation for home care" occurred when clients were considered in conference by the full staff. "Consultation" indicates situations in which other professional workers sought the help of the coordinator in dealing with problems for which they were responsible. In such cases, the coordinator had no direct contact with the patient or client. Many persons received more than one kind of service.

Of the 19 patients evaluated for home care, only 7 were accepted for home care service. The disparity between these figures is a reflection of the difference in concept of what constitutes home care in the minds of the referring agency and of the program. Five of the 19 patients were desperately ill at the time of referral, and they died before plans could be made for their care at home. Several other patients did not need continuing medical care.

Referral sources. How the public learned about the program is of some interest in showing the importance of making contacts with the community's professional workers, and the relatively poor response to impersonal forms of communication. Information about the program which stimulated the first 137 referrals was communicated through the sources shown below:

Information source	*Number of applicants*	*Percent*
Physicians	33	24
Hospitals	17	12
Health department	15	11
Family service bureau	15	11
Visiting nurse association	10	7
Church groups	9	7
Other agencies	14	10
Newspapers and other literature	24	18
	137	100

Although medical or other advisers, in several instances, had not referred applicants to the program directly, these advisers were recorded as the original informants since the applicants had learned of the program from them. The sources of direct referral were:

Source	*Number*
Self or family	82
Physician (directly or indirectly)	31
Hospital	10
Other agencies	14

Discussion

A number of authoritative groups have been recommending a further development of coordinated home care programs and other community extensions of health services into the home (*5,6,8*). A wide range of sponsoring agencies have established various programs for this purpose. Opinions vary regarding where these services are best located (*9*). Hospitals, health departments, or any other community agencies each have both advantages and disadvantages as sponsors for home care programs or any other projects designed to improve the use in the home of available health resources. It should be emphasized, however, that coordinated home care programs can provide for only a few homebound patients selected from the many with prolonged disability. Many can be cared for adequately only in institutions; others may require only additional nonmedical assistance in their homes to meet their needs.

Although local health departments have long provided some chronic disease services, very few have had chronic disease programs which could be recognized as such. Medical care for chronic illness has been regarded as the concern of the private practitioner and the hospital, except for tuberculosis and other communicable diseases and mental illness.

We have for a long time been dazzled by the spectacular successes achieved in our hospitals with the wonders of modern medicine. It is difficult, therefore, for the public and the professions now to accept the idea that for selected patients good care can also be maintained outside the hospital setting through thoughtful planning.

Before launching any new health services within a community, we need to consider how much can be done merely by the better use of existing services. A first step is to encourage agencies and institutions with available services for special segments of comprehensive patient care to look more carefully at the problems of maintaining continuity of care and of interagency communication and consultation. Too frequently it is assumed that all the patient's needs are being adequately met, when even brief consideration of the total situation at a case conference uncovers glaring but remediable deficiencies.

The preliminary study committee set up by the Newton Community Council, which preceded the establishment of the Newton program, revealed a lack of continuity and of comprehensiveness in meeting the needs of many individuals and families, partly because of a deficiency in communication and consultation among those providing services. Sometimes a lack of knowledge about resources or misunderstanding as to their functions prevented those in need from seeking help. Even among those who could well afford a full range of services, there appeared at times to be need for someone who could concentrate on the patient, rather than on his various diseases.

By virtue of its position in the community, the local health department has a number of strategic advantages in promoting a community program for the care of the long-term patient, which may include a home care program, information and referral services, or other facilities. Among these advantages are:

1. The local health department has a legal and professional responsibility for protecting and promoting the health of the community and for extending the use of available scientific resources.

2. It is in a position to cooperate (as it does in other health matters) with private practitioners and voluntary health and social agencies concerned with such a program, and it can collaborate with others without displacing those agencies already giving direct service.

3. It has a traditional emphasis on preventive services so that its staff can readily apply a preventive approach to chronic disease control in the same way that it did with communicable disease or maternal and child health programs

in the past. Home services can thus be planned to deal with problems before admission has become necessary as well as after treatment in an institution has occurred. As knowledge of prevention or means of early diagnosis and casefinding advances, techniques for extending these services can be integrated into the health department's program.

4. It has an epidemiologic outlook which can be used to study the problems of chronic illness in the population concerned, measuring the needs of those to be served and relating these needs to the community's resources.

5. The local health department is always relatively near the patient's home. Its staff has access to families through many other locally provided health services, and can help maintain continuity of care in collaboration with hospitals and clinics which may be chosen by the patient although located some distance away from the patient's home.

Summary

A demonstration project was established by the Newton (Mass.) Health Department and the Newton Community Council to develop a coordinated home care program and to provide information, referral, or counseling services to persons with long-term illness or disability attendant with old age. Advisory committees, comprising physicians, professional workers in health and social agencies, and citizens, assisted in proposing and establishing program policies. An appointed medical social worker and the director and nursing supervisor of the health department served as the coordinating team.

From March 1960, when the program was initiated, to June 30, 1961, 137 persons were referred, most of whom had learned of the project from physicians or personnel in hospitals or health and social agencies in the community. Recommendation for care was indicated for 79 clients because, in the opinion of the medical social worker, the nursing home or the available helper was able to fulfill the requirements of these clients. Counseling, limited to problems of care, was provided for 29 persons. Decision as to those in need of evaluation for home care was made at staff conferences, and 19 persons received this service. Seventeen clients were referred to other agencies, and 16 were given information only. Consultation was indicated for 13 persons for whom other professional workers enlisted the coordinator's aid. Many persons received more than one type of service.

The advantages a local health department enjoys in promoting a community program for care of the long-term patient were demonstrated by the early experiences of the project.

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