Assessment, Planning, and Action for Community Health Services

WANDA VAN GOOR

IN THE YEARS of planning that led to the creation of the National Commission on Community Health Services, several national health agencies recognized the need to remove organizational and administrative bottlenecks to progress in community health. They needed a way to study, develop, and test different methods of assessing, planning, and organizing health services within a community and for setting national goals for community health services.

The final proposal for such a commission was developed by a committee under the chairmanship of Dr. Ernest L. Stebbins, dean of the School of Hygiene and Public Health, Johns Hopkins University. That committee included members drawn from the American Public Health Association, National Health Council, American Hospital Association, American Medical Association, Public Health Service, and other groups. The commission, set up as an independent, nonprofit corporation, was formally organized in New York City on September 10, 1962, with Marion B. Folsom as chairman and Dr. Dean W. Roberts as executive director.

The commission's official sponsors are the American Public Health Association and the National Health Council. Financial support has come from the Kellogg Foundation, the Public Health Service, the McGregor Fund, the Vocational Rehabilitation Administration, Smith, Kline and French Foundation, the Prince Georges' County (Md.) Board of Commissioners, and the Commonwealth Fund.

Mrs. Van Goor is director of publications, National Commission on Community Health Services, Bethesda, Md.

The Commission's Charge

The commission received a general charge in May 1962 when Abraham Ribicoff, then Secretary of the Department of Health, Education, and Welfare, sent a telegram to Folsom which said: "Your study . . . is the largest single award to be approved under the Community Health Services and Facilities Act of last year and we look to the results of your study to move the entire field of public health forward. . . ."

Specifically, the commission has seen its task as requiring two types of studies: one, self-studies in selected communities to determine how communities get action for needed health services; the other, studies oriented to goal setting for communities throughout the nation and carried out by task forces.

Guidelines. Before the commission outlined programs for carrying out its charge, it developed the guidelines which it felt should be basic to such an operation.

1. That the commission be concerned with developing principles which can be used by communities in assessing their specific health problems in long-range perspective and in planning effective organizational approaches to them.

2. That the commission concern itself primarily with agency relationships rather than with specific agencies.

3. That it study the interplay among private and public health agencies in the delivery of community health services.

4. That study recommendations be tested continuously in program activities even while the commission proceeds with its investigations.

5. That it make an effort to include communities without known, ready leadership.

6. That, in developing its reports, the commission utilize the results of recent studies done under competent direction, rather than attempt to re-plow the entire field of community health service research.

7. That ultimately the studies and their recommendations must rely for implementation on the extent to which they inspire communities to act on their own.

After 2 years of working within these guidelines, the commission members, staff, and committee personnel are convinced that they are sound and basic to its work.

Program and Progress

The commission set up three projects to fulfill its charge: The community action studies project, the national task forces project and the communications project.

Community action studies project. The basic purpose of this project is to explore the dynamics of community health behavior. The project began with the selection of 22 communities which were to undertake intensive studies of their health needs and services. The communities provide the basic finances and leadership necessary to conduct the studies; the commission provides self-study consultants and survey instruments. The consultants serve each community 10 days, advising on any aspect of the study local leaders request.

The principal survey instrument is a comprehensive planning guide for the assessment and improvement of community health services. Prepared by the community action studies project staff, the guide details the steps necessary for a complete survey and evaluation of community health services and provides necessary checklists, charts, and tables. Specialized instruments for data collection or indepth studies are being appendixed to the guide as they are developed. The first is concerned with the study of hospitals and related facilities.

As the project progresses, two limitations of the self-studies have become evident: (*a*) They have conveyed nothing about other methods that communities use to achieve health action and (*b*) they have allowed too brief a period of time for the commission to assess their long-run effectiveness.

To meet these limitations, a second activity was added to the project, the retrospective analysis of previous community health studies. The commission has learned that more than 3,000 community health studies have been undertaken since 1945. In the project 500 will be analyzed to identify the methods and motives involved in the studies. Then a random sample of 50 will be followed up in the communities to see if action was taken as the result of the studies and what factors were responsible for their outcome. The commission has developed the coding forms and manuals to be used in analyzing the 500 studies. Because of limited resources, however, the commission is seeking outside financing to complete the work.

The communities that were not ready to undertake self-study or, seemingly, any other approach toward improving their health services, compose a group of special interest to the project. A community readiness study has been set up including some exploratory work to clarify the basic concepts involved and to try to determine what makes a community ready for health action. The Public Health Service has made a grant to support this study.

Preliminary results indicate that community success is directly related to the operation of an effective planning mechanism in the community. If this is true, it may be that the greatest contribution the commission could make to the improvement of the nation's community health services would be the development of guidelines which would enable communities to organize and maintain effective planning mechanisms.

Basic to all four activities of the community action studies project is the concept of process analysis. Several social scientists, identified by the commission as process analysts, have been enlisted as consultants to develop, refine, and implement study approaches. They have organized sociologists, psychologists, and political scientists from faculties of Harvard University and the Universities of North Carolina, Michigan, and Oregon into multidisciplinary

teams. These professional people are studying the project communities while the communities are studying themselves. Through questionnaires and interviews, the teams are collecting information on attitudes and activities that influence community action for health.

The process analysts are concerned neither with the community itself nor with the health study but with the process of community health study. They will analyze also the retrospective analysis and community readiness studies for this processing data. The work of the process analysts represents the first efforts by a national agency to conduct community action-oriented research in the health field. Their findings will considerably increase current knowledge of community organization processes.

National task forces project. The second project, oriented to goal setting for the nation as a whole, is being carried out by seven task forces. Each has a chairman and 12 to 15 members with a wide range of knowledge and experience in voluntary and official programs in related interests. Their fields of knowledge include medicine, nursing, dentistry, social work, public health, behavioral and social sciences, education, hospital and nursing home administration, physical planning, and leadership from national voluntary agencies, both lay and professional. In addition to their professional qualifications, task force members also represent a wide range of viewpoints on the subjects under consideration.

The advisory committee to the national task forces project is chaired by Stebbins. Its members are the chairmen of the seven task forces, Dr. Gaylord W. Anderson, Ray E. Brown, Richard W. Case, Dr. Lenor S. Goerke, Dr. George James, Dr. Leonard W. Mayo, and Dr. Isidor S. Ravdin. The committee guides intramural communication and coordinates the project program.

The task forces deal with seven subjects: comprehensive health, environmental health, health services facilities, health services manpower, organization of community health services, financing community health services and facilities, and community assessment, planning, and action.

To date the task forces have produced more than 50 "community position" papers ranging in subject matter from disaster planning to group practice of medicine.

Communications project. Communications are viewed by the commission as the dialogues an organization engages in with selected groups or with individuals to help accomplish its purposes and arrive at its goals. Communications are designed to provide a continuous interchange of information and knowledge among commission leadership, production units, and the various "publics," professional and lay, that are engaged with the commission in the dialogue on community health services. Communications in the commission are seen as having four distinct functions:

1. To make available to commission leadership (sponsors, commissioners, advisory committees) the information and knowledge they require for directing the commission's work.

2. To provide a continuous flow of information among the production units of the commission in order to coordinate their efforts.

3. To maintain an exchange of information among communities conducting studies with commission assistance and among communities conducting similar studies without commission assistance.

4. To inform and be informed by the commission's various publics. There are basically three groups the commission must reach: the professionals involved primarily with health and related disciplines; the elected and appointed officials, businessmen, industrialists, labor leaders, and others of the power structure—leadership that is essentially nonprofessional insofar as the health-related fields are concerned; and those people who make up the wide base of informed public opinion but represent different points of view, individually and through organized groups. Consumer interests are, of course, represented in the commission's relationship with all groups.

In addition to the meetings, reports, seminars, conferences, newsletters, speakers' bureaus and usual media activities used to foster understanding and communications, the commission will conduct a national conference on community health services in September 1965 in San Francisco, Chicago, Philadelphia, and Atlanta.

The conference will be a series of regional forums at which invited participants will study and react to findings of the community action studies project and recommendations of the seven task forces. Data gleaned from the forums will be used by the commission in preparing its final report to the nation in 1966.

Implementation of Recommendations

The commission is unique among research projects in that it has, as an integral part of its program, a period of time set apart specifically for beginning the implementation of its recommendations. Following its report to the nation in the spring of 1966, the full effort of the commission will be directed toward acceptance of its recommendations and putting them into operation.

The resources for implementing the commission's recommendations are already being garnered. The same concern for the country's health services that motivated the formation of the commission and the same devotion and skills that have brought it thus far on the way are the basic resources for implementation. As more and more people become involved in the commission's activities, they become a part of the future implementation program.

At midpoint (September 1964) the commission can see tangible results of its work. Two of the project communities have completed their studies, set up permanent planning groups for their community health needs, and started action to meet the goals set by the studies. Other communities, not a part of the commission project, have applied to the commission for advice and guidance in similar projects. National meetings of community study chairmen and coordinators have developed an awareness of the wide extent of concern about America's community health services.

Task forces are preparing drafts of their reports and developing recommendations, and the communications project is well into the work of the national conference and planning for the communications aspect of implementation.

Continuing Responsibility

Future implementation of the commission's recommendations will be a responsibility of the sponsors. Through their committees, seminars, and conferences, they will have opportunities to utilize the information and recommendations developed by the commission in the promotion of community health services. Health and welfare agencies can use the various reports of the commission in developing programs and recommending legislation. Official health and planning agencies at all levels will be able to find a guideline in commission reports to implement their programs. Health and allied groups and a wide range of leadership will find commission recommendations useful. Recommendations will be pertinent to the work of leaders responsible for municipal planning and administration; business interests and labor; political groups; schools, colleges, educators, and affiliated associations. In general, all community leaders and consumers will find the material useful.

Education Note

Oral Science Training Program. A broad program for dentists of graduate training in nutrition and oral science leading to a Ph.D. is offered by the Department of Nutrition and Food Science of the Massachusetts Institute of Technology. The program is intended to help broaden the scientific base of the nation's dental school facilities and curriculums by serving as a training center for leaders in dental education and research.

A $530,000 grant from the National Institute of Dental Health, Public Health Service, is being used to support students and their research. For further development of the project, the W. K. Kellogg Foundation of Battle Creek, Mich., has made a $440,000 grant which will be used mostly to provide and equip specialized laboratories and to support unique education programs.

Candidates for September 1965 admission should write for further information to Prof. Robert S. Harris, director of training program in oral science, Department of Nutrition and Food Science, Massachusetts Institute of Technology, Cambridge 39, Mass.