Small-Grants Projects in Massachusetts for the Chronically Ill and Aged

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A NETWORK of community services for the chronically ill and the aged is evolving from a small-grants program of the division of adult health, Massachusetts Department of Public Health. The program has had a significant impact on public health practice not only in the communities but also in the division.

The Community Health Services and Facilities Act of 1961 provided matching 5-year formula grants to States for extending out-of-hospital health services for the chronically ill and the aged. The Massachusetts Department of Public Health chose to use a portion of these funds to aid local communities by giving subgrants for various projects.

Lack of experience in preparing grant applications has inhibited the use of the project grant funds by community service agencies (*1*). Therefore, a consultation service has been provided by the division to assist potential applicants in formulating a project design. Subsequently, 35 applications for grants were submitted to the division that were accepted for funding.

Over and above the responsibility of fulfilling the directives of the Community Health Services and Facilities Act, the State health department had the following reasons for deciding to establish the small-grants project program: (*a*) project grants could serve to awaken interest, to encourage experimentation, and to stimulate the development of new or improved services, (*b*) the availability of project funds could attract qualified personnel to community health agencies, (*c*) the administration and experience gained from development of a project plan might provide educational experience for existing personnel at the community level, (*d*) experimentation facilitated by such a program might provide the basis for more realistic future statewide programing, and (*e*) regionalization of services might be achieved.

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Policies and Priorities

The division of adult health formulated the following policies for administration of the chronic disease project grants.

In accordance with the intent of the act, any public or nonprofit private agency or institution in a State or community is eligible for a grant. The purpose of this policy is to develop, to strengthen, and to extend the services that will meet the out-of-hospital needs of the chronically ill or aged person.

The maximum grant for the first year is limited to approximately $10,000, thus making it possible to extend the total funds as far as possible. If substantially larger amounts are needed, the applicant is encouraged to apply directly to the Public Health Service. The applying agency or institution must contribute to the cost of the project in increasing amounts during succeeding years. This financial support

may be derived directly from the resources of the sponsoring agency or from other official or voluntary community funds.

Documented evidence of the participation of other community agencies in the planning and development of a project must be provided to insure optimal collaborative relationships while the project is being conducted and to increase the potential for its survival after State support is ended.

The services provided must be extended to as wide a geographic area as possible and cut across municipal boundary lines—if it is advantageous and economical to do so.

Project objectives must be clearly defined, attainable, and amenable to measurement or evaluation.

The grant application must include a comprehensive and realistic plan of procedure, in sufficient detail to indicate that the applicant could move immediately and smoothly into the operational stages of the project.

The division of adult health has been concerned about the feasibility or acceptance of policies relating to local financial support or regionalization. In some situations they may not be achievable. For example, in economically depressed areas of the State, it may be unrealistic to expect a community to support fully a much needed service that has been successfully demonstrated through project funds. Long-range subsidy may be needed. Although an extension of the project service area may have been attempted initially, the test will come when abutting communities begin to contribute financial support to a shared service and have tested and survived the stress of joint administrative responsibility. Within the next 2 or 3 years, experience should provide valuable information on local financing and regional administration.

Procedures

Preparation of project plan. Procedures for administering project grants have gradually evolved. Soon after beginning the program, it became apparent to the division that the majority of community agencies hesitated to prepare an application even if they were interested enough to approach the division, because organizing and writing a project plan seemed like an insuperable hurdle. Therefore, if the potential applicant had a worthwhile idea for a project, was able to justify the need for the proposed service, and community support could be demonstrated, the division agreed to assist in formulating the project plan. A consultant team—a generalist in public health practice with experience in project design and a specialist with technical knowledge in the major area of project emphasis—was assigned this responsibility.

The team, fortified with background information about the agency, the community setting, and local resources, met periodically with the staff of the applying agency. They helped the agency group to formulate a statement of objectives (what do you want to do?), a documentation of need (why is the service needed?), a step-by-step plan of operations (how will you do it?), and a listing of staff requirements (who will do it?).

After the initial consultation, the applying agency assumed the responsibility for preparing a first draft of the project plan. Usually, final grant applications evolved from three or four preliminary drafts and required approximately 1 year for completion before they were ready for submittal to the division. The sponsoring agency was informed that the application must stand on its own merits—that the division and not the consultant team would be the final approving body.

Project review. An extradepartmental technical review committee was created to provide impartial, objective, and technically informed appraisal of all grant requests. The committee consisted of a social scientist from an academic setting, a local public health administrator, a public health nurse with research experience, a social worker functioning in the field of community organization, and an administrator of a State voluntary agency. The committee evaluated all applications on the basis of feasibility, completeness, and practicality of operational plan, adequacy of staff and other supporting resources, degree of community support, and extent to which the plan was expected to benefit both the community and the State. The committee recommended either acceptance for funding, rejection, or modification of the plan before final acceptance. Final legal approval rests with the State health commissioner.

Less than 10 percent of the applications were rejected, and approximately 20 percent were approved conditionally but later funded when the plan was revised and strengthened. The high rate of acceptance was related to careful screening in the early phases of project planning. Potential applicants were advised not to proceed further with a project that was poorly conceived, lacking in local support, or weak in basic design. In addition, the consultation service provided by the division helped most applicants with a workable idea to eventually produce a satisfactory project plan.

Continuing consultation. When a project was funded, the applicant was informed that a member of the division staff had been assigned as a liaison between the project and the division. Usually, this was the same person who had served as a technical consultant while the project was being drafted. The staff liaison conferred with project personnel three or four times during the first 6 months of the project, and less frequently after it was fully organized and proceeding satisfactorily. The project director was required to submit a semiannual and an annual report of project activities. Guidelines were provided for the preparation of these reports. Statistical service data were required. The division staff reviewed these reports carefully. Frequently, they identified problems or suggested areas needing technical consultation.

Periodically, a memorandum was sent to all project directors. The purpose was to foster communications between the division and the project personnel as well as to coordinate the projects. A number of advantages stemmed from the close-working ties, amounting to almost a partnership, between the division and a project staff. Problems were often prevented or corrected before they reached major proportions, and solutions were worked out together. The division staff tried to avoid dependency, unwelcome intervention, or overdirection of the community agency.

Description of Projects

Thirty-five applications for chronic disease project grants were approved from January 1, 1963, through December 31, 1965. Nine projects have been completed and the State subsidy has been terminated. Of the nine, four project activities are being continued by the sponsoring agency. One applicant has received a grant from the Public Health Service to continue the project on a more extensive basis.

Another project gave knowledge about volunteer services for the aging that has been a practical reference guide for other agencies. The findings from two projects, a demonstration and a survey, are currently being implemented. The impact of another project on the sponsoring agency has not yet been measured in terms of specific action, but it has served to create continuing interest in comprehensive medical care.

Briefly, the following services have been provided through the 35 projects:

Rehabilitation (4 projects). These services have been extended to smaller hospitals by means of a traveling rehabilitation team, then into the community through coordinated patient-care planning. Training courses in home management for handicapped homemakers have been offered. They involved not only the homemaker but also professional personnel who worked with the handicapped person in the home. An acute-stroke rehabilitation unit in a hospital has been operated; predischarge and postdischarge planning and followup were included. Two projects are sponsored by voluntary agencies and two by hospitals.

Nursing (3 projects). In one project, nursing supervision has been demonstrated in four small nursing agencies. Generalized family-centered nursing services in two semirural areas also have been provided. All the projects are sponsored by voluntary health agencies.

Homemaker services (7 projects). All the homemaker services were organized on a regional basis. Three projects are sponsored by voluntary health agencies, two by voluntary social agencies, and two by independent organizations.

Information and referral services (2 projects). These services were designed to provide information about available community health and social services and to promote closer working relationships between the agencies. One project is sponsored by an official health agency and one by a voluntary social agency.

Gerontology (3 projects). Trained volunteers have served as social work aides to a se-

lected group of "isolates." A medical social worker was assigned, on a demonstration basis, to work with members of a group of golden age clubs. The use of older age volunteers by community agencies has been explored. Two projects are sponsored by voluntary social agencies and one by a university.

Nutrition (3 projects.) A statewide study of nutrition practices has been conducted. Nutrition services in a semirural area have been demonstrated, and the extent and type of service required for the chronically ill and aging have been evaluated. One project is sponsored by an official health agency and two by professional associations.

Casefinding and followup (3 projects). Casefinding methods for chronic lung diseases have been demonstrated and tested, and persons with cases of rheumatic fever have been followed to promote continuity of penicillin therapy. One project is sponsored by an official health agency, one by a voluntary health agency, and one by a hospital.

Education (5 projects). Postgraduate medical education has been supported, with emphasis on evaluation and educational activities. Closed circuit television has been used for patient education in a hospital setting. The role of a cancer clinic in intensive physician education has been extended, and early examination for cancer, emphasized. Psychiatric services have been used for patients and medical and paramedical personnel in a cancer clinic. Four projects are sponsored by hospitals and one by a professional association.

Continuity of patient care (3 projects). The activities of three large general hospitals in out-of-hospital care of patients, particularly in the nursing home setting, have been explored. The projects are sponsored by the hospitals.

Social service (1 project). The sociomedical needs of patients with multiple sclerosis have been studied. This project is sponsored by a hospital.

Administration (1 project). A new records form system has been introduced into a nursing agency for the purpose of collecting more meaningful data on patients with chronic disease. The project was sponsored by a voluntary health agency.

The projects have varied widely in problems attacked and services offered; however, grants for certain types of desirable services have not been requested. For example, no one has requested assistance for the development and operation of coordinated home health services either under the auspices of a hospital or a community nursing service. Effort is currently being expended to encourage potential applicants to draft such a project plan. Otherwise, the diversity of current projects has helped to establish a network of services that are likely to provide the bases for an evolving master plan of organized home health services in the State.

Sixteen projects serve the Metropolitan Boston area, which has the largest density of population and contains approximately half of the State's population. The remaining projects are scattered throughout Massachusetts.

The variation in sponsoring agencies is of interest. With 3 exceptions, official agencies have not applied for project grants, while 10 voluntary agencies have sought them out as a means of extending and developing their services. Five projects also have been sponsored by voluntary social agencies, 11 by hospitals, 1 by a university, 2 by independent organizations, and 3 by professional associations.

Problem Areas

Each project has encountered problems, to a greater or lesser extent, in one or more of the following areas: (*a*) recruiting qualified personnel, (*b*) financial management, (*c*) preparation of records and reports, and (*d*) concern about local control.

The shortage of skilled personnel is statewide. The supply of trained professional personnel is larger in the Metropolitan Boston area, but the demand is greater. Hospital-based projects have been more successful than community agencies in obtaining a staff. It is difficult to recruit public health nurses, social workers, and physical and occupational therapists. However, the division has been successful in helping agencies to find qualified staff. Frequently, the projects were viewed by applicants as an opportunity to gain professional growth and recognition. Troubles in financial management sometimes have been related to a lack of experience in business management by the smaller

health and social agencies. The division has paid for consultation on the establishment of bookkeeping procedures. If records and reporting systems of the sponsoring agency have been of mediocre quality, assistance has been provided with the development of new or modified record forms.

Initially, the boards of several agencies expressed concern about the control that the State might have over a local project. The division emphasized that conducting the project was the responsibility of the sponsoring agency but that operational procedures must conform to the project plan, although modifications would be considered if permission were requested in writing. During the drafting stages of the project plan and the first year of the project, apprehension of community agencies about outside domination diminished markedly. A desire to succeed, a willingness to change and adopt new practices, and a feeling of mutual understanding have prevailed.

Impact of Projects

In addition to the development of community services for the chronically ill, the small-grants projects have made a recognizable contribution to public health practice at both State and local levels. There has been little change in the administration or conduct of public health programs in the State over an extended period. However, special project funds, intensive consultation, improved communications, and the policies relating to the acceptability of a grant application have contributed significantly to changes that represent progress in the attainment of the objectives of this small-grants program.

Regionalization of service area. The 351 towns and cities of Massachusetts are known for their rigid opposition to intercommunity activities or joint administration of services. This has been variously attributed to local pride, fear of losing control, suspicion of the extent of financial backing of a neighboring community, or apprehension about losing jobs. Applicants for grants were advised that projects designed to serve a broad population base would be viewed more favorably than those limiting services to a single community. The nature of some projects was such that this was not always a practical general requirement.

If regionalization were defined as an extension of the service area to adjoining communities, 13 of the 26 active projects could qualify. However, if it also were an implication of jurisdictional and administrative responsibilities, then only five projects would meet the more rigid criteria. Project sponsorship by community area councils has been the single most important factor contributing toward regionalization of services.

By broadening the geographic base of projects, community services for the chronically ill and aging have been made available to a population of approximately 2.4 million as compared with 1.9 million who might be served if the concept of regionalization had not been encouraged and projects had been limited to only the core community.

Interagency collaboration. Fragmentation of services has been another major hurdle to overcome in the development of comprehensive services. In the development of the project plan, applicants were encouraged to involve other agencies in the community and to build into the project design mechanisms for interagency working relationships. The results have been rewarding. Fourteen of the 26 active projects include working closely with one to more than a dozen other agencies in the community. Case conferences and referrals and joint planning and sharing of services are included. As a result, a giant step has been taken toward the increased comprehensiveness of services and continuity of patient care.

Multipurpose community service centers. Closer working relationships between health, social welfare, mental health, recreation, and other services have been suggested but are rarely realized, especially at the community level. So far, a singly administered center has not been achieved. However, one project, a combined nursing-homemaker service, shares office facilities and staff with other agencies concerned with mental health, alcoholism, youth development, and recreation. Joint planning and program development are organized on a communitywide basis; and a closely integrated service, particularly in casefinding, education, and followup results.

Generalized services. Most communities in Massachusetts have three independent, separately administered, public health nursing services. The official public health agency is primarily concerned with nursing service in the field of communicable disease control and maternal and child health. School health services are under the jurisdiction of the school department and bedside nursing care in the home is generally under the auspices of a voluntary nursing association.

The division established a policy that project applications dealing with the development or extension of nursing services must embody the concept of generalized services to be eligible for financial support. One such project in operation has provided a practical demonstration of this principle which is attracting the interest of other communities.

Demonstration of shared supervision. A one- or two-man agency is likely to suffer from lack of stimulation and guidance. Willingness to share resources with other small agencies under the administration of one combined agency has been limited. One project concerned with home nursing services provides for nursing supervision to be shared by four participating agencies. The eventual goal is to amalgamate the four agencies.

Stronger administrative practices. Numerous opportunities occur for strengthening administrative practices and operational procedures. Personnel functions are often poorly described; working contracts are loosely defined; and records and reports are inadequate, poorly maintained, and unamenable to statistical analysis. Since project applications require a tightening of these and other facets of agency operations, improvements have been noted within the sponsoring agencies.

Public education. Working with community groups in the development of a project application has, in a number of instances, involved meetings of the division staff with lay boards and other lay groups. This experience has been of practical value and has enhanced the public image of public health practice in the State.

Relations between State and community health services. Community health agencies frequently complain that the State health department has only cursory relationships with them. The development of project grant applications, the continuing consultation available to staff of funded projects, and the sense of partnership that has developed have tended to create closer working ties and better understanding.

Recognition of the evaluation concept. Many service agencies tend to ignore the responsibility for evaluation of services or, if they recognize the need, may fail to approach the evaluation systematically. Every application must include a clear statement as to how the value or outcome of the project will be evaluated. So far, the majority of projects have depended on service records to provide data on the utilization of services. Some records have been well designed and yield useful facts about the service provided as well as some identification of factors influencing utilization. However, this area needs further development and refinement of methodology, and the funding agency is responsible for continuing consultation and practical approaches to evaluation that are adaptable to service projects.

Increased emphasis on program planning and development. Agencies rarely become implicated in the organized planning and development of programs. The creation of new activities or the revamping of existing ones often occurs without formal design or intent. The result is a high mortality for new programs. As a result of the requirements of the grant application, project plans have been developed in considerable detail. The chance of failure from lack of specificity or clarity of procedures has been minimized. It is too soon to measure the impact of these practices on the future program-planning patterns of agencies.

Division benefits. The administration of this program has had beneficial effects on the staff and the internal operations of the division. The staff has developed closer working ties with community agencies through joint planning and reviewing of projects. Skills have been sharpened in consultation with community workers. The staff also has developed a greater awareness of community organization and of evaluative procedures, and more appreciation of the role of the social scientist in evaluating the projects. The quality of field trip reports has improved, and they have been submitted

with more regularity. The degree of community acceptance and the challenge of a new program have perhaps in part, been the prime motivating factors responsible for growth of the staff and better organization of a number of division operations.

Summary

A network of community services for the chronically ill and the aged is evolving from a small-grants program of the division of adult health, Massachusetts Department of Public Health. Emphasis has been placed on the provision of consultation service to assist potential applicants in formulating a project design.

A total of 35 applications for chronic disease project grants were approved by the division from January 1, 1963, to December 31, 1965. These projects have served to awaken interest, to encourage experimentation, and to stimulate the development of new or improved services. The administration and experience gained from the development of a project plan has provided educational experience for the personnel in community agencies. In addition, experimentation facilitated by this program has provided the basis for more realistic, future statewide programing.

REFERENCE

(*1*) Clark, W.H., and Dyar, R.: A review of local research projects in California. Public Health Rep 78: 381–386, May 1963.

National Institute of Mental Health Reorganization

The National Institute of Mental Health, Public Health Service, has reorganized to use more effectively and flexibly Federal funds to support the new national mental health program. Institute responsibility encompasses activities from basic research to community-based comprehensive mental health centers. The new plan of organization will give more emphasis to clinical research, prevention programs, evaluation of treatment methods, innovative and experimental training programs, and epidemiologic studies. It will also inaugurate extensive programs to eliminate specific widespread mental health problems.

Five associate directorships have been created to give the program components of the Institute administrative focus and identity. All the branches and offices will be administered by the associate directors for extramural research, manpower and training, mental health service programs, field investigations, and intramural research.

The new administrative structure establishes four specialized program operations as centers for the study of alcoholism, narcotics and drug abuse, suicide prevention, and metropolitan mental health problems. These centers will be responsible for all Institute activity in their assigned fields, including conduct and support of research, training, demonstrations, and consultation.

Four additional centers will coordinate all Institute activities for the study of schizophrenia; mental health and social problems such as automation, divorce, sex deviation, poverty, race relations, and leisure; mental health of children and youth; and crime and delinquency.

Two model community mental health centers will be set up; one is focused around a general hospital and the second is based on a large State mental hospital.

The Institute will sponsor experimental and special training programs for professional personnel. These will include training general medical practitioners in psychiatry and expanding programs for all professional mental health workers, including psychiatrists.

Two major advisory groups—the National Advisory Mental Health Council and the Board of Scientific Counselors—will continue to serve the Institute.