ORGANIZATION OF A COORDINATED HOME CARE PROGRAM IN ERIE COUNTY, NEW YORK

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IN the United States several types of home health care programs can be identified: single-service home care, home health agency, coordinated home care, and comprehensive coordinated home care.

Single-service home care is defined in this paper as individual services provided to patients in their homes, such as those provided by the physician, visiting nurse, and physical therapist. These services historically have been provided by visiting nurse associations and public health agencies as well as by private practitioners.

A home health agency is a home care organization which provides or arranges for skilled nursing and at least one other therapeutic service to patients in their homes (*1*). A coordinated home care program is "one that is centrally administered and that through coordinated planning, evaluation, and follow-up procedures provides for physician-directed medical, nursing, social, and related services to selected patients at home" (*2*). In order to accomplish their goals, most of these programs have used a multidisciplinary team approach.

A comprehensive coordinated home care program has the added element of an interdisciplinary team of all appropriate health professionals who individually and collectively evaluate the full range of patient needs. This team provides or arranges for a complete and open-ended service incorporating into the program any services available in the community.

Home health agencies, coordinated home care programs, and comprehensive coordinated home care programs all meet the basic multiservice requirement for participation in Medicare. The goals of all three multiservice programs include reducing the cost of illness by providing comprehensive, high-quality, noninstitutional patient care to avoid hospitalizing the patient or confining him in a nursing home or in another type of long-term care facility. All are financed under the provisions of titles XVIII and XIX of Public Law 89–97.

The Erie County Coordinated Home Care Program is financed by a New York State Department of Health grant of approximately $100,000 per annum for 4 years and a single grant of $20,000 from Blue Cross-Blue Shield of Western New York, Inc. Although the program was funded in January 1964, it was not staffed until the end of 1965.

In 1966 the cost per patient-day was $6.82 based on 15,785 patient-days; in 1965 the cost per patient-day was $11.50 based on 8,075 patient-days. These costs include salaries of the interdisciplinary evaluative team; administrative expenses; fees for direct service to patients (visiting nurses, home health aides, and physical, speech, or occupational therapists); trans-

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portation of patients; equipment; and dental examinations, laboratory tests, and other diagnostic services.

The Interdisciplinary Team

Contemporary definitions of personal health stress emotional, social, and economic as well as physical well-being (*3*). Therefore, health professionals are beginning to meet patients' psychosocial and economic needs as well as their physiological demands in comprehensive health care programs. Such supportive services have been adopted in long-term care facilities, rehabilitation centers, public health agencies, and coordinated home care programs. As specialization in the rapidly developing complex of technical services has increased, the team approach in medicine and its allied professions has become increasingly necessary.

Multidisciplinary staffing, however, does not in itself guarantee interdisciplinary collaboration and effective achievement of organizational goals. The effectiveness of each team depends on its philosophy, purpose, and organizational structure—including staff functions and procedures—which minimize communication problems and status jealousies among the disciplines. Despite obvious and subtle pitfalls inherent in the interdisciplinary approach, the experiences of the Erie County Coordinated Home Care Program demonstrate that, if properly conceived, organized, and administered, an interdisciplinary unit can effectively meet the patient's needs.

Staff Roles and Functions

The Erie County Coordinated Home Care Program is an interdisciplinary, administrative, and evaluative public health team composed of a health care administrator, public health nurse, medical social worker, physical therapist, occupational therapist, nutritionist, and a home economist, who supervises the seven home health aides. The team also includes three physicians, one from the staff of each participating hospital.

The health care administrator, who is accountable to a deputy commissioner of health, is director of the entire program. Despite his training in a specific health discipline, the administrator, unlike a physician-administrator or nurse-administrator who functions in a dual capacity, does not provide or arrange for services for an individual patient; nor is he only a business manager, responsible for administrative details such as personnel, purchasing, and budget, having little or no responsibility for other aspects of the program.

The role of administrator in Erie County includes responsibility for these administrative details and also responsibility for encouraging and enabling each member of the team to participate with maximum effectiveness within his own sphere of competence in a "collaborative, dynamic, and pragmatic approach to meeting patient needs" (*4*). As Rosenberger has stated, "The administrator must be able to relate the efforts of other specialists to the achievement of the objectives of the enterprise . . . [by] facilitating the efforts of specialized personnel to render their service with a high degree of autonomy . . . [He] must not only recognize and respect autonomy derived from specialized competence, but must actively undertake to protect it" (*5*). The administrator's unique responsibility for implementation of the total treatment plan in the Erie County program places him in a position objectively to enable team members to fulfill their individual roles. The unusual organizational features discussed form a framework within which an effective interdisciplinary team process can evolve.

Although the team includes three physicians, the patient's personal physician continues to prescribe all services and retains ultimate responsibility for the total care of his patient. A team physician, one selected by each hospital from its staff as liaison between the personal physician and the team, but paid by the county, functions and clarifies the individual responsibilities of everyone in the treatment plan, including the patient and his family. A team physician explains to the team what concerns the personal physician has for his patient and tells the patient's physician about the problems confronting the team in meeting the patient's needs. Use of the speaker-phone, through which personal physicians can participate in team evaluations, facilitates the work of the team physicians.

Either the nurse or social worker or both visit the patient's home to meet the family and discuss intrafamily relationships, physical characteristics of the home, and the ability of the

family and patient to participate in patient care by making appropriate use of treatment personnel and special equipment. This information assists all team members in their individual and collective evaluations of the patient's needs and the team's ability to meet these needs.

Formerly, these visits were always made by the nurse and social worker, independent of each other. As their relationship matured, they began to share their impressions and space their individual visits so as to support each other's efforts to mobilize family resources. After further maturation of the relationship, the nurse and social worker, on separate visits, each gathered information useful to the other, thus obviating numerous additional visits. However, cooperation of the nurse and social worker did not obviate evaluations by members of other appropriate disciplines. As the relationship matures even further, other timesaving methods may evolve resulting in more effective use of their time. This evolutionary process continues uninterrupted until a change in personnel occurs at which time a new process begins.

Procedures

Each participating hospital has a home care referral coordinator, who, because of her knowledge of the program, can assist the personal physician in evaluating the suitability of coordinated home care for his patient. When the physician has determined a need for this type of program, he and members of the hospital staff complete the referral forms, which are available from the coordinator. Concurrently, a responsible member of the patient's family completes an application form. The coordinator sends the forms, including preliminary orders and recommendations of the personal physician, to the health department's home care office.

Processing the application and forms, which takes approximately 1 week, is begun after the home care office receives all the forms. Immediately, visits to the patient's home by home care team representatives are made as previously described. After these visits, a preadmission team conference is held. Using all available information every member of the team evaluates and determines his discipline's respective responsibility in meeting the applicant's needs. Thereafter at regularly scheduled case conferences the entire team reevaluates the function of every discipline in the total treatment plan as it applies to the patient's changing needs.

Unless his participation is precluded medically, socially, or by intensity of service required, a patient is accepted if he needs two or more services requiring coordination. Each member of the team has the opportunity to recommend the services of his discipline whether or not it has been initially prescribed. If a service not already prescribed seems indicated, the team physician discusses this service with the personal physician.

When the team and the personal physician have agreed on all of the services to be provided, the team arranges for these services with appropriate community resources. All team members consult with direct-service personnel throughout the treatment period. Both medical social workers and home health aides are provided directly by the program. The social worker, working directly with the patient and family, helps them to resolve problems connected with feelings about illness and its limitations, changing roles of family members resulting from illness, and vocational plans. The home health aide assists the patient with personal care, such as bathing, toileting, physical therapy exercises, occupational therapy, and light housekeeping.

If the program cannot meet the patient's needs appropriately, a more suitable plan of care is developed with the patient, his family, and his personal physician. Should the personal physician desire assistance in planning an alternate treatment program, the team will suggest other useful resources.

Effectiveness of the Program

The concept of the team as a collective therapist arranging for high-quality patient care forms the keystone of the program in Erie County. A measure of the effectiveness of the organizational structure in supporting this concept is the achievement of professional collaboration.

Team members, enabled to act and interact freely during case conferences, recognize and accept the special competence of their colleagues, learn to question and answer each other with increasing understanding, and develop

better comprehension of each other's functions. This acquired awareness enables each team member to subordinate his professional identity and allegiance and to focus on patient needs.

The representative of each discipline in the program is given equal opportunity to participate in the total treatment plan, by virtue of his equal representation on the team. Equal participation of all team members is organizationally guaranteed, and equal status is protected by the administrator. Team members need not expend their energies in protecting their role and status; they can concentrate all of their energies on collaboration in the interest of patients.

By sharing information, team members expand their knowledge of the patient and broaden their perspectives. Thus, the involvement of each member in the total treatment plan is dynamic. It changes as each member's perspective is broadened.

Unhampered by communication difficulties, the need to protect role and status, and limited perspectives, team members can, as a "collective therapist," function objectively and approach their goal of high-quality patient care. All team members can recognize that, during any given period, the primary need of the patient may be met by one discipline more than the others. As the needs of the patient or family or both change, so does the focal discipline. At any time, the team member trained in the focal discipline can consult with other professionals.

Case Examples

1. Mr. R was 22 years old, married, and had multiple fractures. The nurse made the preadmission home visit and discussed her impressions with the social worker. Using the information provided by the nurse, the social worker concluded that family relations in Mr. R's household were so conflict ridden that patient care could not be given effectively. When this evaluation was presented at the team conference, the team physician explained the situation to the personal physician, who agreed that the patient's admission to the program was ill advised. Through the team physician, the staff indicated to the personal physician that the patient's return to his home from the hospital, at that time, would not be in the patient's best interest and recommended nursing home placement as an alternative.

2. Mrs. P was 74 years old and in the hospital after her first cerebrovascular accident, which left her with hemiparesis on the left side. Because she was helpless and quite obese, her husband could not provide the necessary personal care. Her five children agreed that, by dividing the responsibility, they could provide the necessary care.

During the first month of care, the social worker was totally uninvolved since the family seemed able to meet its responsibilities. Later, family members renounced their responsibility, and total care devolved upon the youngest daughter who moved in with her parents. Consequently, the nurse asked the social worker to help remobilize the family. At this point social work became the "focal discipline" providing direct service to remobilize the family, and the social worker served as consultant to the team members already involved.

3. A brain-damaged infant, unable to suck and swallow, weighed approximately 7½ pounds after 10 months of postnatal hospitalization during which he had repeated infections of the upper respiratory tract. His pediatrician applied to the program for nursing care, social services for the parents, and special equipment. The pediatrician indicated that physical therapy was unnecessary and prognosis for the child was poor.

During the preadmission evaluation conference, the physical therapist suggested using recently developed techniques to stimulate the sucking and swallowing reflex and to foster general development of the child. The pediatrician accepted the suggestion. This treatment, which contributed substantially to the patient's improvement, was unknown to the pediatrician and team members until it was suggested by the physical therapist.

Conclusion

The experience of the Erie County Coordinated Home Care Program, with 217 patients, has been that an organized multidisciplinary team leads to interdisciplinary collaboration which results in high-quality patient care. The degree of collaboration depends on the extent

to which team members relate to each other unhampered by communication difficulties, limited perspectives, and fear of role and status threats. An interdisciplinary team can be organized to minimize these difficulties so that team members can fulfill their evaluative and therapeutic responsibilities.

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Education Notes

Care of Premature Infants. The Institutes for Physicians and Nurses in the Care of Premature Infants, New York Hospital-Cornell Medical Center, sponsored by the New York State Department of Health and the U.S. Children's Bureau, will begin their 19th year in the fall of 1967. The institutes are designed to meet the needs of physicians and nurses in charge of hospital nurseries for high-risk and premature infants and special centers for infant care and of medical and nursing directors and consultants in State and local programs for the care of such infants.

Five institutes are scheduled between September 1967 and May 1968. The sessions are 2 weeks in length for physicians and 4 weeks for nurses.

Physicians	*Nurses*
September 18–29	September 5–29
November 6–17	October 23–November 17
January 15–26	January 2–26
March 18–29	March 4–29
May 13–24	April 29–May 24

Attendance at each institute is limited to six physician-nurse teams. Participants pay no tuition, and stipends are provided to cover other expenses.

Early application for the institutes is essential because plans are contingent on the number of applications received. For additional information write to Box 143, Institutes in the Care of Premature and Other High-Risk Infants, New York Hospital, 525 East 68th Street, New York, N.Y. 10021.

Sports Medicine for Physicians. The University of Wisconsin Medical School will offer the first full-time course in sports medicine to U.S. physicians from September 1, 1967, to May 1, 1968. Open to eight physicians, this nondegree course will lead to a certificate of proficiency in sports medicine.

Faculty members will be drawn from the medical school's department of surgery and the university's departments of physical education and athletics. Facilities of the student health service will be used for clinical work, but all patients will be athletes.

The entire course is expected to exceed 960 hours. A total of 480 hours will be devoted to class and laboratory work, with concentration in the anatomy and physiology of sports trauma, physiology of exercise, rehabilitation after trauma, and nutrition of the athlete. At least 3 hours daily except Sundays will be devoted to clinical practice, and physician-students will travel with some teams.

Applicants unable to study full time may opt for a half-time program, which will devote about 320 hours to class and laboratory work. Full-time students will be encouraged to engage in research.

Tuition will be $1,000 for the year, and fees, including books, about $250. Stipends for working in the university health service part time are to be arranged with the director.

Additional information is available from Dr. Allan J. Ryan, University of Wisconsin, Madison 53706.

PUBLICATION ANNOUNCEMENTS

Address inquiries to publishers or sponsoring agency.

Continuing Education Courses for Physicians. Compiled by the Council on Medical Education of the American Medical Association. Reprinted from the Journal of the American Medical Asssociation. 1966; 198 pages. American Medical Association, 1 Farragut Square South, Washington, D.C. 20006.

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Adoption of Children. Second edition. 1967; 78 pages; $1.50. American Academy of Pediatrics, P.O. Box 1034, Evanston, Ill. 60204.

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Water Research. By Allen V. Kneese and Stephen C. Smith. 1967; 526 pages; $12.50. The Johns Hopkins Press, Baltimore, Md. 21218.

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Sewers for Growing America. How to plan, design, finance and build modern sewer systems. By Morris M. Cohn, Sc.D. 1966; 214 pages; $10. Certain-teed, Pipe Division, Ambler, Pa.

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Informal Group Process in Social Work. An account of a series of discussions on parent education. By Esther Kovenock. 1967; 116 pages. Division of Child Behavior and Development. Wisconsin State Board of Health, 1 West Wilson Street, Madison, Wis. 53701.

World Health Organization

WHO publications may be obtained from the Columbia University Press, International Documents Service, 2960 Broadway, New York N.Y. 10027.

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Measurement of the Public Health Importance of Bilharziasis. Report of a WHO Scientific Group. WHO Technical Report Series No. 349. 1967; 93 pages; $1.25; Geneva.

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