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SHOULD BAYLOR UNIVERSITY MEDICAL CENTER, DALLAS, TEXAS, DEVELOP A HOME CARE PROGRAM?

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CHAPTER I

INTRODUCTION

General Information Concerning the Problem

In the past, hospitals in general have tended to have little concern for the patient once he left the hospital. If further care and guidance were needed, the patient was expected to return to the hospital's outpatient clinic or go to his physician's office. If he was unable to do so because of physical or mental disability and family or economic problems, then his medical progress often suffered. Deepening concern for the discharged patient and an awakening responsibility to the needs of the community, however, have caused many professional personnel to recognize the need for extension of the hospital's services into the homes of selected patients to insure the patients' continued welfare.

Medical care of patients in their own homes has long been an important aspect of the practice of medicine in this country. The attitude of physicians, nurses, and the family toward avoiding hospitalization and separation from the family has radically changed since World War II, however. This change has been due to many factors: the trend toward suburbanization, smaller families, smaller homes, fewer bedrooms, vanishing domestic help, female members of the family working, changing trends in medical practice, and the unique attitudes towards the hospital as the center of community health.[1] The avoidance of a prolonged

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[1]David Littauer, I. Jerome Flance, and Albert F. Wessen, Hospital Monograph Series No. 9: Home Care (Chicago: American Hospital Association, 1961), p. 2.

hospitalization when such care is not in the best interests of the patient and his family, however, remains the objective of any comprehensive health care plan; and home care for selected patients has been aimed toward this objective.[2]

The Hospital Setting and History of the Hospital

Baylor University Medical Center is a nonprofit, voluntary, church-affiliated, short-term, general hospital located in the eastern section of Dallas, Texas. It is composed of Veal Teaching and Research Hospital, 108 beds; Truett Medical and Surgical Hospital, 436 beds; and Women and Children's Hospital, 250 beds, for a total of 794 beds plus 150 bassinets. The Dental College, Wadley Research Institute and Blood Bank, School of Nursing and Nurses' Home, and Medical Library are all a part of the same complex (Appendix A).

During the fiscal year 1 July 1965 to 30 June 1966, there were 34,068 admissions to the hospital and 6,084 births for a total of 40,152 admissions and births. The number of patient days excluding infants was 249,261 with an average length of stay of 7.32 days and an average cost per patient day of $50.62 (Appendix B). During the first three months of that fiscal year 14.2 per cent of the admissions were age 65 or over; these patients accounted for 21.5 per cent of the patient days, and their average length of stay was 10.9 days as compared to 7.2 days for those admissions under age 65 during the same three months.[3] After

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[2]American Hospital Association, Hospitals and Coordinated Home Care Programs (Chicago: American Hospital Association, 1966), p. i.

[3]Personal interview with Admitting Officer, Baylor University Medical Center, Dallas, Texas, 12 May 1967.

Public Law 89-97 (Medicare) became effective on 1 July 1966, the percentage of admissions of patients age 65 and over rose to 16.7 per cent, their percentage of patient days rose to 25.3 per cent, and their average length of stay increased to 11.9 days as compared to 7.9 days for patients under age 65 for the same three months' period, July through September, 1966.

During the 1965-1966 fiscal year, 9 per cent of the patients admitted to the hospital were clinic patients who received care at rates commensurate with their economic capabilities (Appendix B). Approximately 20 per cent of these clinic patients were age 65 or over.[4] Table 1 reveals that the average length of stay of clinic patients has also gradually increased, particularly since 1 July 1966.

Baylor University Medical Center ranks ninth in the nation among all general and other special hospitals for admissions, eighth among the general and maternity hospitals for births, and twenty-third among the voluntary, general hospitals for number of beds.[5]

The organization of the medical center is depicted in Figure 2 (Appendix C).

Baylor University Medical Center was first chartered by the State of Texas on 16 October 1903 as the Texas Baptist Memorial Sanatorium. Within six years a new sanatorium was constructed and ready to receive patients, and by 1914 the hospital had a bed capacity of 250. A Nurses' Home and Training School was completed and occupied in March, 1918. Thereafter, growth of the hospital was steady and continuous.

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[4]Personal interview with Administrative Director, Outpatient Clinic, Baylor University Medical Center, Dallas, Texas, 12 May 1967.

[5]Ranking of Baylor (Dallas: Baylor University Medical Center, 1966), p. 1. (Mimeographed.)

TABLE 1

SUMMARY OF CLINIC PATIENTS ADMITTED TO BAYLOR UNIVERSITY MEDICAL CENTER[a]

Date	Total No. of Clinic Patients Admitted	Total No. of Patient Days	Average Length of Stay (Days)
July thru Dec 65	764	5,066	6.63
Jan thru Jun 66	725	5,102	7.03
July thru Dec 66	745	5,245	7.04
Jan thru Apr 67	522	3,962	7.59

[a]Source: Personal interview with Administrative Director, Outpatient Clinic, Baylor University Medical Center, 12 May 1967.

By 1950, the Children's Building, the Maternity Hospital, and the Truett Memorial Hospital had been added. Over 600,000 patients were admitted during the hospital's first fifty years.[6] On 16 April 1959 the hospital's name became "Baylor University Medical Center." In the same year, the new Women and Children's Hospital was dedicated. Throughout this period new equipment and services were added, and improvements were constantly being planned in order to bring the best of sophisticated care to the patient and to advance medical research and teaching. The history of the Center has proven the progressive nature of its policies.

Today Baylor University Medical Center conducts twenty-seven approved training programs. It has one of the nation's most complete pathology departments; equally active are the departments of physical medicine, virology, radiology, and irradiation therapy and nuclear medicine; and over 1,800 personnel are actively engaged in patient care (Appendixes B and D).

In 1966, the Center began a planned $8 million expansion program that is scheduled for completion in 1969.[7] To be added are 200 beds, 35 of which are for short-term psychiatric patients; enlarged emergency treatment facilities; expanded physical medicine, radiology, and pathology laboratories; four intensive care units; a 20-bed day hospital division for surgical patients; and expanded food and ancillary services. Of the elements of progressive patient care, intensive care, intermediate care, and outpatient care will be exemplified.

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[6]Baylor University Medical Center, Sixty Years . . . Baylor University Medical Center, 1903-1963 (Dallas: Baylor University Medical Center, 1966), p. 4.

[7]Baylor University Medical Center, Growing with Greater Dallas (Dallas: Baylor University Medical Center, 1966), p. 1.

Conditions Which Prompted the Study

Greater Dallas ranked as the twentieth most populated Standard Metropolitan Statistical Area in the nation in 1965.[8] Its population in 1960 was ascertained to be 1,289,000. It has been estimated that the population increases 30,000 to 40,000 annually.[9] During this study, then, there were approximately 1,534,000 people in the Greater Dallas area. This population was served by twenty-four hospitals that were members of the American Hospital Association and two small nonmember hospitals, all of which provided a listed total of 4,422 beds.[10] The shortage of hospital beds in the area has been a recurring problem; each year Dallas would need to provide 100-150 additional beds to accommodate the population increase alone. Since the United States Public Health Service considers 4.5 beds per 1,000 population as the general average needed to adequately support a community, Greater Dallas could utilize a total of 6,900 hospital beds at the time of this study.[11] There have been times at Baylor University Medical Center when only those patients whose life or health would be seriously endangered by delayed hospitalization could be admitted. Also, many physicians' applications for appointment to the Medical Staff have been postponed because of this bed shortage.

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[8]Luman H. Long (ed.), The World Almanac and Book of Facts, 1967 (New York: Newspaper Enterprise Association, Inc., 1966), p. 380.

[9]Baylor University Medical Center, Growing with Greater Dallas, loc. cit.

[10]American Hospital Association, "Registered Hospitals in the United States," Hospitals, XL (1 August 1966), 210.

[11]Malcolm T. MacEachern, Hospital Organization and Management (3d ed.; Berwin, Ill.: Physicians' Record Co., 1962), p. 47.

National health survey data have revealed that approximately 40 per cent of the noninstitutionalized homebound population of the United States receive constant personal care.[12] The sama data indicated that, at any one time, 500 of every 100,000 persons in the general population were homebound because of a chronic illness. Therefore, probably 200 people of every 100,000 are candidates for some form of home care services. It has been estimated that of these, 20 per cent (40 persons per 100,000) would require the services of a coordinated home care program. Hence, in the Greater Dallas area, approximately 600 persons would benefit from the assistance of a coordinated home care program.

St. Paul Hospital has the only home care program in the Dallas area.[13] During this study, the St. Paul Home Care Program was caring for twenty-five patients, and gradual expansion of the program was planned.[14] It would seem that a considerable need for more home care programs in the community exists.

Statement of the Problem

The problem was to determine the role that Baylor University Medical Center, Dallas, Texas, should play in home care for discharged patients.

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[12]U.S. Department of Health, Education, and Welfare, Public Health Service, Survey of Coordinated Home Care Programs (Washington, D.C.: U.S. Government Printing Office, 1963), p. 24.

[13]American Hospital Association, loc. cit.

[14]Personal interview with Nursing Supervisor, Outpatient Clinic, St. Paul Hospital, Dallas, Texas, 10 May 1967.

Factors Bearing on the Problem

The following facts were considered to be pertinent to the problem:

1. The Nursing Staff, Baylor University Medical Center, was not capable of assuming the increased workload that would be produced by a home care program, both from the standpoint of number of personnel and type of trained personnel that would be needed, without personnel augmentation.[15]

2. The Physical Medicine Service, including Occupational Therapy, was unable to provide services in the home in support of a home care program without augmentation of personnel.[16]

3. There was not a Social Work Service within the hospital's organization.

4. There was no Vocational Rehabilitation Service organized within the hospital.

5. Speech therapy service was limited to one individual who worked on an on-call basis.

6. The hospital did not have extra equipment; e.g., hospital beds, mattresses, wheel chairs, bed side-rails, trapeze bars, and intermittent positive pressure machines, stockpiled to support patients' needs in the home.[17]

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[15]Personal interview with Nursing Supervisor, Women and Children's Hospital, Baylor University Medical Center, Dallas, Texas, 23 January 1967.

[16]Personal interview with Chief, Physical Therapist, Baylor University Medical Center, Dallas, Texas, 24 January 1967.

[17]Personal interview with Director of Purchasing, Baylor University Medical Center, Dallas, Texas, 8 May 1967.

7. The hospital did not have a privately-owned vehicle for transporting personnel engaged in home care.

Assumptions

It has been assumed that:

1. The shortage of hospital beds in the Dallas community and at Baylor University Medical Center will be a continuing problem despite proposed expansions.

2. The trend toward increasing longevity of the American population will continue with its attendant prevalence of chronic debilitating diseases necessitating prolonged care of one type or another (Appendixes E, F, G, H, I, and J).

Definitions of Unusual Terms

Home care: The American Hospital Association has defined home care as "the provision of health care and/or supportive services to the sick or disabled person in his place of residence."[18] The American Medical Association has said that home care is "any arrangement for providing under medical supervision needed health care and supportive services to a sick or disabled person who is at home."[19]

Home care programs: Organized home care provided by (1) a single service agency, such as the Visiting Nurses Association; or (2) a multiple service agency, such as a public health department, that arranges

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[18]American Hospital Association, "Statement on the Role and Responsibilities of Hospitals in Home Care," Hospitals, XXXVIII (1 July 1964), 85.

[19]American Medical Association, "Development and Use of Home Care Services," Journal of the American Medical Association, CXCVII (11 July 1966), 130.

for two or more types of home service, such as nursing, physiotherapy, speech therapy, or homemaker's service; or (3) that provided by coordinated home care programs which offer a wide range of services around the patient's needs and which are based at a hospital, medical school, medical clinic, extended care facility, or rehabilitation facility or are coordinated by a public health, welfare, or nursing agency.[20]

Coordinated home care program: " . . . one that is centrally administered, and that through coordinated planning, evaluation, and followup procedures provides for physician directed medical, nursing, social, and related services to selected patients at home."[21]

Appendix K discusses the terminology as is applied by Public Law 89-97 (Medicare).

Objectives, Standards, and Limitations

Objectives

The objectives of the study were to:

1. Define the scope of home care programs in general and the patients to whom the service should be made available;
2. Determine an estimate of the number of patients in the Baylor University Medical Center by type that could be appropriately treated by a home care program;
3. Assess the degree to which Baylor University Medical Center could participate in a home care program;

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[20] Ibid.

[21] U.S. Department of Health, Education, and Welfare, Public Health Service, Survey of Coordinated Home Care Programs, op. cit., p. 24.

4. Determine the amount of support that could be provided to Baylor University Medical Center by various health and welfare agencies in the Dallas community; and

5. Establish standards for the operation of the most suitable home care program for Baylor University Medical Center.

Standards

The standards for a coordinated home care program should encompass the participating agency and its personnel, the administration of the program by that agency, the selection of patients to benefit by the program, and the care to be furnished those patients. Furthermore, the standards must equal or exceed those outlined by the U.S. Department of Health, Education, and Welfare, the American Hospital Association, and the American Medical Association. The following would be considered minimum requirements:

1. Standards of Home Care Agency and Its Personnel[22]

a. The agency should provide at least one therapeutic service; i.e., physical, speech, or occupational therapy, medical social services, or home health aide services, in addition to skilled nursing services to its patients.

b. The agency should be properly licensed by the state.

c. The agency must designate a physician, as medical coordinator, and/or a registered professional nurse, as nurse supervisor, to direct the agency's performance in providing home care as prescribed by the

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[22]U.S. Department of Health, Education, and Welfare, Social Security Administration, Health Insurance for the Aged: Conditions of Participation for Home Health Agencies (Washington, D.C.: U.S. Government Printing Office, 1966), pp. 7-14.

patient's physician. If a nurse is designated as the program supervisor, it is preferable that a public health nurse be appointed.

d. The agency's policies should be subject to the approval and regular review of an advisory group of personnel appointed because of their knowledge and interest in health affairs. Lay persons as well as professional representatives from the health care field are desirable.

e. The agency must be organized, staffed, and equipped to provide its stated services to homebound patients on a part-time or intermittent basis.

f. All personnel working with the agency should be fully qualified to perform their assigned tasks.

2. Standards of Administration of the Program[23]

a. The agency should provide for a thorough and systematic evaluation of its program at least every two years.

b. All policies governing plans, organization, operation, and control should be in writing.

c. The agency should have written policies concerning the qualifications, responsibilities, and conditions of employment for each type of personnel in its organization.

d. Statistical and financial records must be maintained so that the cost of the services provided can be accurately assessed.

e. Complete clinical records must be maintained on each and every patient concerning admission, clinical, and discharge data.

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[23] Ibid., pp. 7-21.

3. Standards of Patient Selection[24]

a. The patient should not require further hospitalization and should be incapable, for one reason or another, of making visits as frequently as is dictated by the illness to a physician's office or an outpatient clinic.

b. The patient should be in need of a complex of medical, nursing, social, and related services over an extended period of time.

c. Treatment of the patient must be within the capabilities of the program.

d. A suitable physical and psychological home environment must be available to the patient.

4. Standards of Patient Care[25]

a. Treatment of the patient will be as prescribed by the patient's attending physician.

b. The attending physician must coordinate the patient's management with the program's nurse supervisor or medical coordinator.

c. The attending physician should review the total management of the patient with the program director at least every two months.

d. Management of the patient is accomplished by and under the supervision of professional registered nurses and other professional personnel; e.g., physical, occupational, and speech therapists, and social workers, as indicated.

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[24]American Hospital Association, "Statement on the Role and Responsibilities of Hospitals in Home Care," loc. cit.; and American Medical Association, "Development and Use of Home Care Services," op. cit., p. 130.

[25]U.S. Department of Health, Education, and Welfare, Social Security Administration, loc. cit.

Limitations

During the surveys of the records of patients in Baylor University Medical Center, the following limitations in the system were encountered:

1. The validity of the data obtained from the recertification forms (Appendix L) could be questioned since the physicians, many times, had to make their determination of the type of post-hospital care planned long before actual discharge was contemplated and with the knowledge that no organized home care plan was in effect. Also, those patients age 65 and over who were hospitalized less than two weeks were not required to have the determination noted on their records of the post-hospital care planned. However, since such cases were more apt to be acute than chronic, and since the chronic cases are more suited for home care, this bias was not considered to affect the purpose of the study. Also, since the percentages of patients age 65 and over that were considered suitable for home care by the medical staff of the hospital (as noted on the recertification forms) and by the author (as determined by the survey of the inpatient records) were comparable, the recertification forms were considered to be, at least, a good indicator of the type of patients suitable for a home care program.

2. The validity of the data obtained from the personal survey of the inpatient's medical records could also be questioned since the validity had to be based on the judgment of the surveyor alone. Undoubtedly, the same surveyor would get differing data each time he made a resurvey on the same patients, if such were possible, and any number of other surveyors would get as many differing figures. But one surveyor using the same criteria and performing the survey in as short

a time as possible would be expected to be more constant in his determinations.

3. The judgment of the surveyor in selecting the inpatients suitable for home care was considered to be consistent and reliable; however, it was not possible for him to assess the suitability of the patient's physical and psychological home environment to which he would return. This determination would require the services of a social worker or the intimate knowledge of the attending physician. Lack of a social work service and limited survey time did not allow for this evaluation.

Parenthetically, it may be added that one Los Angeles hospital surveyed 7,136 admissions and determined that 14.8 per cent were qualified for home care but found that only 47.3 per cent of these had suitable homes to go to.[26]

Literature Review

The prototype of the modern concept of an organized home care program was established by Dr. E. M. Bluestone, the director of Montefiore Hospital, New York City, in 1947.[27] Since that time, home care has developed along two main avenues: one, the hospital extends its services into the home to provide supervised care; and two, a community agency, such as the Visiting Nurses' Association or local health department, expands its existing programs, often in cooperation with the local

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[26]Jack H. Engelmohr, "Home Care Program Can Succeed: One Hospital's First Year Report," Hospital Topics, XLIV (August, 1966), 56.

[27]U.S. Department of Health, Education, and Welfare, Public Health Service, Survey of Coordinated Home Care Programs, op. cit., p. 5.

hospitals, to provide a coordinated home care program.[28] There are many types of patients who can be appropriately cared for in the home: the individual convalescing from recent illness or surgery; the child with rheumatic heart disease or nephrosis; the adult with advanced multiple sclerosis, chronic heart disease, disabling stroke, fracture, arthritis, or emphysema; and the patient with a terminal illness, such as cancer, heart failure, or bronchopulmonary disease.

The basic services of a home care program are:

1. Medical care and supervision, including services of medical specialists as consultants to the attending physician.
2. Nursing care and/or nursing supervision.
3. Availability of hospital inpatient service.
4. Social service.
5. Nutritional guidance.
6. Laboratory and radiology service.[29]

The following services should be available to supplement the basic services as necessary:

1. Physical therapy.
2. Occupational therapy.
3. Speech therapy.
4. Appliance, equipment, and sterile supply service.
5. Home-delivered meal service.
6. Transportation service.
7. Homemaker-home health aid service.[30]

It has been generally held that hospital-based home care programs have been and will continue to be the most successful and satisfactory programs. Hospitals have available many more services than most other

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[28]American Hospital Association, Hospitals and Coordinated Home Care Programs, op. cit., pp. 2-4.

[29]Ibid.

[30]Ibid.

organizations can readily provide. Furthermore, it is much simpler for the hospital to transfer the patient and his records to the hospital's Home Care Department from one of its inpatient departments and vice versa than it is for a community agency to effect these exchanges with a less interested hospital.[31]

The primary objectives of a home care program have been to expedite the recovery of the patient by therapeutic and rehabilitative measures applied in the home environment, to prevent or postpone disability, to prevent or shorten institutionalization, to maintain the integrity of the family unit as much as possible during the illness of one of its members, and to keep the cost of care within the most reasonable limits.[32]

Any health agency engaged in home care may, by meeting certain standards, participate in the health insurance program for the aged, Public Law 89-97 (Medicare).[33] As of 28 April 1967, there were 1,780 participating home health agencies caring for 194,400 patients, all of which were provided visiting nurse care in the home; physical therapy was the second most frequently offered service.[34]

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[31]Harold Rubin, "Home Care Programs," Medical World News, VII (17 June 1966), 90-92.

[32]David Littauer, I. Jerome Flance, and Albert F. Wessen, "Home Care: Summary of a Comprehensive Study," Hospitals, XXXV (16 January 1961), 42.

[33]U.S. Department of Health, Education, and Welfare, Social Security Administration, op. cit., pp. 3-4.

[34]"Digest of the News: PHS Reports on Medicare Home Health Agencies," Hospitals, XLI (16 February 1967), 23; and U.S. Department of Health, Education, and Welfare, Social Security Administration, Medicare Newsletter, Number 26, 18 May 1967.

Most authors have estimated that approximately 10 per cent of medical, surgical, and pediatric patients in the hospital, at any one time, are suitable candidates for home care; however, in some areas as many as 33 per cent of the inpatients could be properly treated by home care and 10 to 27 per cent more become eligible within ten days after the survey is made.[35] It has been further estimated that with a home care program, hospitalization can be shortened by an average of 23.5 days per patient.[36] The average time patients are cared for by a home care plan has been reported to vary from 15.6 to 66.6 days.[37] The Associated Hospital Services of New York learned that for every twenty-two patients they had on home care, one hospital bed was made available at 80 per cent occupancy.[38]

The most applicable information on the cost of a home care program reported that during the first year of the program the average cost per day was $5.24 with a census rising to fifty patients during the third quarter of the program.[39] Another recent report listed $3.80 per day as the average cost per day, $7.51 as the average cost per home care patient day, and $149.18 as the average cost per patient during the previous four-year period.[40]

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[35]Engelmohr, op. cit., p. 55; Rubin, op. cit., p. 92; and Joseph B. Stiefel, "Changing Concepts--Home Care," Hospital Progress, XLV (November 1964), 82.

[36]Ibid.

[37]Ibid.; and Mary T. Ancker, "Hospital's Home Care Program Widened Service, Created New Hospital Beds," Hospitals, L (1 October 1966), 83.

[38]Stiefel, op. cit., p. 84.

[39]Engelmohr, op. cit., p. 58.

[40]Ancker, loc. cit.

Patient acceptance of home care has been exceptionally favorable. The Hospital Council of New York has reported that 93.2 per cent preferred home care, and the Associated Hospital Services of New York has reported 85 per cent acceptance based on a freer, more cheerful atmosphere, being with one's family, the saving of money, and enjoying the services rendered at home.[41]

Research Methodology

Professional and official publications were reviewed in order to define the scope of the most desirable home care program. Personnel with experience in public health and home care nursing were interviewed, and the director of one hospital-based home care program in Dallas, Texas, was interviewed. Numerous key personnel at Baylor University Medical Center were interviewed in order to assess that organization's ability to coordinate and support a hospital-based home care program.

In order to arrive at an estimate of the number of patients in Baylor University Medical Center that could appropriately be treated by a home care program, two approaches were used. First, recertification forms, that were prepared by attending physicians on their Medicare patients after two weeks' hospitalization, were reviewed after the patients were discharged from the hospital during March, 1967 (Appendix L). On this form, physicians must indicate their plans for post-hospital care; i.e., extended care facility, office care, home health care, or another plan. The number of patients for whom home health care

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[41]Hospital Council of Greater New York, Organized Home Medical Care in New York City (Cambridge, Mass.: Harvard University Press, 1956), p. 113; and Anthony Lenzer, "Home Care: The Patient's Point of View," Hospitals, L (1 November 1966), 70.

was planned, their major diagnosis, and the number of physicians who proposed home health care were tabulated. Second, a personal survey of all medical records of patients hospitalized on the wards during the period 3-4 and 8-9 in May, 1967, was made; a determination was made as to each patient's suitability for home care on that date while still in the hospital; and the major diagnoses of those suitable for home care were recorded.

The above accumulated data was then evaluated and compared with existing published data.

CHAPTER II

DISCUSSION

Results of Surveys

During the month of March, 1967, there were 3,390 patients discharged from Baylor University Medical Center, Dallas, Texas. Of these, 477 (14.07 per cent) were age 65 or over. As previously noted, patients age 65 and over comprised approximately 15 per cent of admissions to the hospital. Almost 35 per cent (165) of these senior citizens were hospitalized two weeks or longer, and of these, exactly 40 per cent (66) were earmarked for home health care by their attending physician on the recertification forms. These sixty-six patients who were felt to be suitable for home care by their own physicians upon discharge from the hospital represented 13.83 per cent of all patients age 65 and over who were discharged during the month and 1.94 per cent of all discharges. The determinations were made by forty-seven different physicians concerning patients with the major diagnoses as noted in Table 2.

During a six-year period (1 June 1953 through 31 May 1959), 385 patients were accepted for treatment by the Home Care Department, Jewish Hospital of St. Louis, Missouri, whose 500 beds served a

TABLE 2

MAJOR DIAGNOSTIC CATEGORIES OF PATIENTS EARMARKED FOR HOME CARE BY ATTENDING PHYSICIANS AT BAYLOR UNIVERSITY MEDICAL CENTER[a]

Diagnosis	No. of Patients	Percentage of Total
Arteriosclerotic Heart Disease	15	22.72
Malignancy (Postoperative and/or Postirradiation)	12	18.18
Cerebrovascular Disease	8	12.12
Blood Dyscrasia	5	7.57
Arterial Insufficiency, Lower Extremities	4	6.06
Chronic Bronchopulmonary Disease	3	4.54
Severe Degenerative Arthritis	3	4.54
Postoperative Cholecystectomy	3	4.54
Postoperative Diaphragmatic Hernia	2	3.03
Peptic Ulcer, Posthemorrhage	2	3.03
Thrombophlebitis Sequelae	2	3.03
Fractures (Lower Extremity--1, Ribs and Clavicle--1)	2	3.03
Convalescent Pneumonia, Chronic Renal Disease, FUO, Severe Back Strain, Postoperative Transurethral Resection (1 each)	5	7.57
Totals 17 Diagnoses	66	100.00

[a]Source: Personal survey of recertification forms, Baylor University Medical Center, Dallas, Texas, 2-5 May 1967.

population of almost 1.5 million people, also.[1] The major diagnostic categories of patients treated by their home care program is similar in many respects to the above listing (Appendix M). Other home care programs have reported like diagnoses.[2] Elderly patients usually have multiple diagnoses which complicate their management and need for professional care; so, the single diagnosis listed above does not give the accurate total picture of the patient's true medical condition.

On 3-4 and 8-9 May 1967, the medical records of all patients (excluding newborns) in Baylor University Medical Center were surveyed and a determination made in each case as to the suitability of that patient for home care at the time of the survey. The results of that survey are depicted in Table 3.

The author used the following criteria to determine a patient's suitability for home care while making the survey. Patients were selected for home care when:

1. The patient's condition was such that he did not require intensive nursing care, constant observation by professional personnel, or frequent and complicated treatments by professional personnel.

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[1]Littauer, Flance, and Wesson, Hospital Monograph Series No. 9: Home Care, op. cit., p. 10.

[2]Ancker, op. cit., p. 84; and Hospital Council of Greater New York, op. cit., p. 81.

TABLE 3

PATIENTS SUITABLE FOR HOME CARE AT BAYLOR UNIVERSITY MEDICAL CENTER[a]

Hospital	No. of Records Surveyed	No. of Patients Suitable For Home Care	No. of Patients Age 65 and Over	No. of Patients Age 65 and Over Suitable For Home Care	No. of Clinic Patients	No. of Clinic Patients Suitable For Home Care
Truett Medical and Surgical	415	34	142	24	1	0
Veal Teaching and Research	94	13	25	5	20	4
Women and Children's	172	3	11	0	2	0
Totals	681	60	178	29	23	4
Percentages		7.34		16.29		17.39

[a]Source: Personal survey of inpatient medical records, Baylor University Medical Center, Dallas, Texas, 3-4 and 8-9 in May, 1967.

2. The patient was not fully ambulatory in the sense that he could not visit an outpatient clinic or physician's office daily or even twice weekly without endangering his health or causing undue discomfort.

3. The patient would require nonprofessional observation and assistance at least at irregular intervals during the day, trained or professional nursing guidance and care one to three times weekly, a physician's followup every one to two weeks, and other professional guidance from the social and therapeutic fields at varying intervals of time.

4. The patient was not undergoing extensive and frequent diagnostic studies.

5. The patient listed a home address in the city or county of Dallas. A nursing home or other institution was not acceptable.

The above criteria were adopted from those outlined in the definition of selected patients in the U.S. Department of Health, Education, and Welfare, Public Health Service publication Survey of Coordinated Home Care Programs (Appendix K). If any doubt existed in the surveyor's mind about a patient meeting any certain criteria, professional nurses on the ward assisted in the evaluation.

As indicated in Table 3, 8.19 per cent of the patients in Truett Medical and Surgical Hospital were judged to be suitable for home care, 13.82 per cent of those in Veal Teaching and Research Hospital, and only 1.74 per cent of those in Women and Children's Hospital. Of all the patients in Baylor University Medical Center, 7.34 per cent were candidates for home care at the time of the survey. Of all patients age 65 and over, 16.29 per cent were felt to be suited for home care; this

compares favorably with the 13.83 per cent of patients age 65 and over earmarked for home care by their private physicians on the recertification forms. Of the twenty-three clinic patients in the hospital, 17.39 per cent were deemed as eligible for home care.

Among the fifty hospitalized patients that were judged to be candidates for home care, over three-fourths of them were suffering from the late effects of five illnesses: cerebrovascular disease, fractures of the lower extremities, malignancies, arteriosclerotic heart disease, or a herniated nucleus pulposus. The term "late effects" is used since the acute episode of the illness had subsided, indicated surgery and/or irradiation therapy had been performed, and convalescence or a terminal status were anticipated.

More specifically, eleven patients (22 per cent) were victims of one or another type of cerebrovascular deficiency; nine patients (18 per cent) were convalescing from fractures of the lower extremities; eight patients (16 per cent) had had therapy for some type of malignancy; seven patients (14 per cent) had arteriosclerotic heart disease and were postinfarction, recovering from cardiac failure, or had had arrhythmia; and three patients (6 per cent) were recovering from surgery for a herniated nucleus pulposus. Each of the remaining twelve patients (24 per cent) had one of the following major illnesses: arterial insufficiency of the legs, a blood dyscrasia, chronic pulmonary disease, chronic arthritis, postoperative cholecystectomy, diabetes mellitus, hepatitis, chronic low back strain, Parkinson's disease, multiple

sclerosis, brain injury, or spinal cord injury.[3]

Since the preponderance of these patients were elderly, many had other, often several, complicating conditions that increased their need for attention and nursing care; but the major diagnoses as listed were the precipitating causes for admission.

Most programs have reported a preponderance of patients age 65 and over. Likewise, invariably female patients have outnumbered male patients.

Baylor University Medical Center's Ability to Support a Home Care Program

Baylor University Medical Center could provide four of the six basic services needed for a home care program as recommended by the American Hospital Association.[4]

1. Medical care of clinic patients on a home care program could be accomplished by the hospital's intern and resident staff with appropriate supervision by appointed attending staff members. Private physicians would manage all other patients under their care as usual. Medications would continue to be dispensed by the pharmacy as if the home care patients were outpatients and would be delivered to the patient by the home care nurses or physicians, thereby creating no increased burden on the pharmacy.

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[3]A personal survey of inpatient medical records, Baylor University Medical Center, Dallas, Texas, 3-4, and 8-9 May 1967; Ibid., p. 56; Engelmohr, op. cit., pp. 52-58; and Ancker, op. cit., p. 83.

[4]American Hospital Association, Hospitals and Coordinated Home Care Programs, op. cit., pp. 2-4.

2. The hospital could ensure the availability of inpatient service to home care patients upon the recommendation of the attending physician and after coordination with the home care office in the hospital.

3. The Chief Dietitian of Baylor University Medical Center indicated an eagerness for her service to participate in a home care program.[5] She could see no difficulties in accomplishing their role as dietary consultants to the patient in the home if necessary.

4. The laboratory and radiology services of the hospital could also provide their support to the management of the home care patient since there would be no significant increase in their workloads. Patients would still be brought to the radiologist as always, and laboratory specimens for analysis could be collected and delivered to the laboratory by the home care physicians and/or nurses in most cases; therefore, the latter areas should have no difficulty in supporting a home care program.

The two basic services that could not be supported by the hospital were limited to nursing care and social services.

The seven supplemental services endorsed by the American Hospital Association--(1) physical therapy; (2) occupational therapy; (3) speech therapy; (4) appliance, equipment, and sterile supplies; (5) home-delivered meals; (6) transportation; and (7) homemaker-home

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[5]Personal interview with Chief, Dietary Service, Baylor University Medical Center, Dallas, Texas, 12 May 1967.

health aids--could not be made available to home care patients from the hospital's resources. Likewise, qualified personnel to serve as Medical Director and Nurse Coordinator for the program would be needed to supplement the hospital's staff.

Community Support for a Home Care Program

Within the Dallas area there are many agencies that could assist Baylor University Medical Center in developing a home care program. The agencies considered most capable of providing aid of one type or another to the hospital are discussed.

Visiting Nurse Association of Dallas

The Visiting Nurse Association of Dallas had seventeen staff nurses who accomplished 28,095 home visits for 3,034 patients during November, 1965, to November, 1966.[6] Twenty-eight of these patients were referrals from the Outpatient Medical Clinic and 191 were from the Maternity Clinic, Baylor University Medical Center. The Association's home nursing care was restricted to the city limits of Dallas; $5 per visit was charged to those that were able to pay. Each nurse averaged 8.62 visits per day during the year and at any one time had 35-48 patients to manage (Appendix N).

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[6]Personal interview with Director, Visiting Nurse Association, Dallas, Texas, 24 January 1967; and Visiting Nurse Association, Comparative Statistical Report, 1964 through 1966 (Dallas: Visiting Nurse Association, 1966), p. 1.

The Association also had eight home health aides who helped 2-4 patients per day totaling 246 families and 2,177 visits during the year. The charge to the patient was $3.25 the first hour, $1.75 for each additional hour, or $15.50 per day (Appendix O).

The Association has also provided for meals-on-wheels to those who have no means of preparing their food (Appendix P).

The Director, Visiting Nurse Association of Dallas, said that the Association could easily manage more patients since she anticipated no problem in obtaining more nurses to help with the home nursing care.

County Health Department

The Dallas County Health Department Public Health Nurses provide home nursing care to patients within the county of Dallas much as the Visiting Nurse Association does for the city of Dallas.[7] Seventeen staff nurses have averaged seeing five to six patients daily. Nursing care as prescribed by the attending physicians has been provided to Medicare patients and to only medically indigent under age 65. Progress reports have been submitted to the attending physicians at least every two months. Almost one-half of their referrals have been from private physicians. The Health Department did not have home health aides.

Both the County Health Department and the Visiting Nurse Association have had a position vacancy for one physiotherapist which they have been unable to fill.

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[7]Personal interview with Director of Nurses, Dallas County Health Department, Dallas, Texas, 10 May 1967.

County Welfare Department

The Dallas County Welfare Department did not provide any health services to welfare recipients but did provide for the rent, utilities, and food of proven needy persons.[8] They also have had twelve homemakers who have assisted needy families with light housework in the past, but the funding for this service by the Office of Economic Opportunity would be terminated on 30 June 1967 and so need not be considered further.

State Welfare Department

The Texas State Welfare Department has provided monetary assistance to needy persons through four programs: Old Age Assistance ($100 per month maximum), Aid to the Needy Blind ($90 per month), Aid to the Totally and Permanently Disabled ($74 per month), and Aid to Families of Dependent Children ($72 per month for one child, $96 for two, $114 for three, and $135 for four or more).[9] Their homemaker service was also expected to be discontinued on 30 June 1967.

County Chapter of the National Foundation

The Dallas County Chapter of the National Foundation has assumed the duty of assisting children up to age 19 with congenital defects.[10] Children, so afflicted, of the medically indigent have been aided by hospitalization, orthopedic appliances, medicines, and outpatient therapy

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[8]Personal interview with Coordinator, Homemaker Service, Dallas County Welfare Department, Dallas, Texas, 10 May 1967.

[9]Personal interview with Regional Director, State Department of Public Welfare, Dallas, Texas, 11 May 1967.

[10]Personal interview with Director, Dallas County Chapter, National Foundation, Dallas, Texas, 10 May 1967.

if they are not eligible for another source of aid. Physicians' fees have not been paid. Physicians refer patients to the Chapter, and they in turn refer the patient to the necessary hospital.

Education Agency, Office of Vocational Rehabilitation

The Texas Education Agency, Office of Vocational Rehabilitation, has been interested in helping those afflicted individuals who may become productive again.[11] Restorative surgical services have been limited to the needy; however, vocational training has not been limited to the indigent. Evaluation and counselling have been available for the mentally ill, the retarded, and for those with physical disabilities. Patients are then referred to the proper hospital, agency, or school for the needed assistance.

Caruth Memorial Rehabilitation Center

Some patients seen at the Texas Education Agency have been referred to the Caruth Memorial Rehabilitation Center where training in business machines, stenography, drafting, orthopedic brace making, cabinet making, spray painting, and upholstering were available; likewise, physiotherapy, occupational therapy, speech therapy, and nursing services have been available as outpatients or inpatients in the forty-bed hospital.[12]

American Cancer Society

The Dallas County Unit, American Cancer Society, has provided counselling, furnished dressings, loaned sick room equipment to the

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[11]Personal interview with Vocational Counsellor, Texas Education Agency, Office of Vocational Rehabilitation, Dallas, Texas, 10 May 1967.

[12]Personal interview with Director, Vocational Training, Caruth Memorial Rehabilitation Center, Dallas, Texas, 11 May 1967.

home, supplied transportation for ambulatory patients to and from treatment centers, and promoted postlaryngectomy speech lessons for needy victims of cancer.[13]

Summary

Within the city of Dallas, home nursing care, home health aides, and meals-on-wheels were available through the Visiting Nurses Association to assist Baylor University Medical Center with a Home Care Program; home nursing care could also be provided by the county of Dallas. A fifth and essential basic service, nursing care and supervision, and two supplemental services (home health aides and home-delivered meals) of a home care program were thereby accessible to Baylor University Medical Center.

Needy disabled patients who have a rehabilitation potential could be aided by the Texas Education Agency and its many referral agencies through counselling, vocational training, and, at times, restorative surgical measures. Needy children with congenital defects have been aided by the National Foundation and needy cancer patients by the American Cancer Society. The State and County Welfare Departments have assisted the needy monetarily. So there are several more of the supplemental services for a home care program available within the community--i.e., physical, occupational, and speech therapy, equipment, and supplies--for selected patients.

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[13]Personal interview with Administrative Director, op. cit., 24 January 1967.

Medicare Support to Home Care Programs

Hospitals and their patients who are age 65 and over can benefit from Public Law 89-97 (Medicare) through the assistance it provides a hospital or other health agency that participates in the health insurance program as a home health agency (Appendix K). If the agency provides skilled nursing services and at least one other therapeutic service--i.e., physical, speech, or occupational therapy, medical social services, or home health aide services--and meets other conditions of participation as detailed in the appendix, many of these home health services will be paid by the health insurance program.

The home health services that will be paid for include nursing service, physical therapy, occupational therapy, speech therapy, medical social services, home health aide services, services of interns and residents, outpatient services which cannot be provided in the home, and medical supplies and appliances.

Services that are not paid for include meals-on-wheels, homemaker service, ambulance and special transportation, drugs and biologicals, expenses incurred by immediate relatives or members of the household, and dental services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth unless related to the surgical or orthopedic treatment of conditions in this area.

During the ensuing year after at least three consecutive days of hospitalization, a Medicare patient is entitled to 100 visits in his home by home care personnel; visits to a medical facility as an outpatient is also authorized, but is to be counted as a part of the allowed 100 visits. The 100 visits also apply to each spell of illness

which begins on the first day of hospitalization and ends sixty days after he has been out of the hospital or extended care facility. These provisions are covered under Part A of the law. Under Part B of the law, the patient is entitled to 100 visits without prior hospitalization or the Part B 100 visits may supplement the Part A visits. The annual deductible of $50 and 20 per cent co-insurance apply to Part B, but the spell of illness concept does not.

Alternative Home Care Programs

Baylor University Medical Center could approach home care along any one of several plans, from the most austere to the most elaborate. The following four home care programs are representative of the gradations along this scale of refinement.

Limited Home Care Service

The Medical Center could provide nursing and home health aide services in the home to clinic patients from the city of Dallas by arranging for these services to be provided by another health agency. This, in fact, has been done for several years with the help of the Visiting Nurses Association of that city. As noted previously, 219 patients (approximately eighteen per month) from the Center were visited by the Nurses Association during November, 1965, to November, 1966. Assuming that 17 per cent of the clinic patients continue to be suitable for home care and that the number of clinic patients admitted to the hospital remains between 1,400 and 1,500 yearly, then about twenty patients per month would benefit from the program.

Such a limited program would entail no added expense, no increase in personnel, and little effort to coordinate and supervise; it would be

easy to evaluate and would be a good base from which to expand. The office of the Administrative Director, Outpatient Clinic, Baylor University Medical Center could serve as the hospital's control center for integrating the patient's needs with the services to be provided by the Visiting Nurses Association. This program, however, offers a very restricted service to the patient and would not appreciably shorten the patient's hospitalization since only nursing care could be provided. It also would not allow the hospital to participate as a home health agency without the proper guidance from an advisory committee and a physician or registered professional nurse.

Limited Home Care Department

As a second alternative, the hospital could organize a Home Care Department and restrict its limited services to clinic patients from the city of Dallas, again approximately twenty per month. An advisory committee of prominent professional and lay persons would be appointed to direct and guide the department's policies. A full-time public health nurse would need to be employed as the program's supervisor. She would work with the nursing, intern, and resident staff of the hospital in selecting the proper patients for the program and would coordinate the selected patient's care with the Visiting Nurses Association of Dallas for nursing and home health aide services. Interns and junior residents under the supervision of a senior resident could provide the necessary medical management in the home with visits every one or two weeks as indicated. Pharmacy and laboratory services also could be easily provided the patients at home during visits by the nurses, interns, and residents. This plan, then, would provide for more and better

professional care for the patient in the home--i.e., nursing, home health aid, medical, pharmacy, and laboratory services. The program would entail a minimum of expense to the hospital--approximately $1,500 monthly for the salary of the nurse and her secretary and for the transportation costs of the program personnel. The program would be relatively easy to supervise, coordinate, and evaluate; and it would allow the hospital to participate as a home health agency. Assistance to the patient, however, would not include any of the supplemental services (except home health aid service), social service, nutritional guidance, and X-ray service. It is doubtful, therefore, that hospitalization would be shortened appreciably so that any savings would be realized by the hospital in terms of bed occupancy, patient days, or cost per patient day.

Unlimited Home Care Department

A third plan would entail the organization of a Home Care Department with its advisory committee, a physician as supervisor, a public health nurse as coordinator, and a clerical staff. The committee would be necessary to establish and approve departmental policies. The medical supervisor with the help of the nurse coordinator would be responsible for selecting and approving the proper patients for home care, for supervising the interns and residents while engaged in home care, and for reviewing periodically (at least every two months) the management of other home care patients with their private physicians; he would also evaluate the over-all program, act as the liaison between the program and the advisory committee, and be administratively and professionally responsible for the program. The nurse coordinator would work with

the Visiting Nurses Association and the County Health Department to provide nursing service (to city and county patients) and home health aid service (to city patients only); she would also coordinate dietary, pharmacy, laboratory, and radiology services with appropriate hospital personnel. A medical social worker, occupational therapist, and physiotherapist would need to be employed to provide these services in the home. Further, a stockpile of medical equipment should be acquired for loan or rent (Appendix Q) and consumable sterile supplies, such as needles, syringes, and dressings would be needed. Coordination with the Texas Education Agency and the Caruth Memorial Rehabilitation Center could provide vocational rehabilitation for specific patients.

Initially, the program should be restricted to approximately fifty patients per month, selected from those age 65 and over and the clinic patients. As the department gained experience and was able to employ more personnel it could manage all the clinic patients (approximately twenty per month) and all those age 65 and over (approximately seventy per month) eligible for home care.

It has been estimated that one social worker can adequately counsel forty patients per month.[14] So initially, at least, one social worker would be able to manage the above patient load. Then, two, and perhaps even five, would eventually be needed, based on an expected 7 per cent of all patients being suited for home care (200 per month).

At least one-fourth of the elderly patients on home care, experience has shown, have required the services of a physiotherapist.[15] A

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[14]Hospital Council of Greater New York, op. cit., p. 189.

[15]Ibid., p. 300.

physiotherapist should not be expected to make more than five visits per day to patients in the home, should in most cases see a patient twice weekly, and, therefore, could assist on the average 12.5 patients per week. So, for every fifty patients on a home care program, it can be estimated that the services of one full-time physiotherapist would be needed.

Approximately 50 per cent of patients on home care can be expected to benefit from occupational therapy.[16] Only one visit to each patient every two weeks should suffice, however.[17] Again five home visits per day can be planned; so for every 100 patients on a home care program, the full-time services of an occupational therapist would be beneficial.

With such a coordinated home care program the patient would have available to him all the essential services that would be needed in the home; the period of hospitalization for such patients should be appreciably shortened; and the department would be recognized as an approved health agency. Such a large program would be difficult to administer and would be more expensive than the former programs. It also cannot be denied that home care is an inefficient way to utilize personnel, since they are unable to care for as many patients as when they are centralized in a clinic or hospital. This no doubt has accounted for the fact that too many programs have too few patients; however, the convenience and the monetary savings the patients realize as well as

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[16] Ibid., p. 200.

[17] Ibid., p. 300.

the fact that the hospital enhances greatly its role as a community health center have been immeasurable benefits. Furthermore, space and equipment requirements for the hospital are minimum; no electronic devices are needed; no expensive construction is involved; a large capital expenditure is not necessary; and vital hospital beds are saved for the acutely ill who need them most.

If initially the home care program was restricted to fifty patients per month, the following savings to the hospital would accrue once the program was well established. If an average of 23.5 days' hospitalization, as previously reported, could be saved at $50.62 per patient per day and if each patient averaged spending 66.6 days on home care, as recorded previously, at $5.24 a day, then approximately $14,000 per month would be saved by each group of fifty patients on home care. This savings would finance the cost of a program and allow for its gradual expansion, as it is estimated that the salaries of the medical supervisor, nurse, coordinator, physiotherapist, occupational therapist, social worker, and five secretaries, plus the cost of office equipment and supplies, equipment and sterile supplies for loan or rent to patients, and transportation for program personnel would be $8,500 per month. In 1961, the Lower Bucks County Hospital, Bristol, Pennsylvania, launched its home care program with only $5,000.[18]

Gradually Expanding Program

The fourth possibility is actually a blending of the previous three programs. This program begins modestly and economically; and as

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[18]Ancker, op. cit., p. 80.

experience and confidence in the program are gained, the role of the Medical Center would be gradually expanded to a multi-service, coordinated, hospital-based home care program for Greater Dallas.

To begin, a Home Care Service (under the aegis of the Outpatient Clinic) for the benefit of clinic patients who have been discharged from the hospital and who live within the city of Dallas would be organized. Planning on approximately twenty home care patients per month, the organization of the service would initially consist of:

1. An advisory committee.
2. A public health nurse as supervisor/coordinator of the program.
3. A clerical assistant for the nurse.
4. The house staff of interns and residents to select patients for home care (with the assistance of the nurse supervisor/coordinator) and to provide medical care in the home for the selected patients. Home visits by the physicians should be accomplished at least once monthly, preferably every two weeks.
5. Staff nurses as needed from the Visiting Nurses Association of Dallas to provide home nursing care as coordinated by the Nurse Supervisor/Coordinator of the hospital.
6. Home healthaides as needed from the Visiting Nurses Association of Dallas to provide care as prescribed by the attending physicians.

Meals-on-wheels could be arranged as needed for home care patients through the Visiting Nurses Association, also, although this service is not included in Medicare coverage. Nutritional guidance by the Dietary Department of the hospital could be accomplished prior to discharge of the patient from the hospital and at times could be indicated

in the home. The hospital would also provide laboratory, radiology, and pharmacy services as always and would insure the patient that rehospitalization could be accomplished any time it was indicated. The patient's medical records would be maintained within the Office of the Home Care Service. Approval of the service as a home health agency would be sought as the service is organized.

The immediate costs of this modest beginning would be limited to the salary of the Nurse Supervisor/Coordinator and her clerical help; the cost of office furniture, equipment, and supplies; and the transportation needs of the program personnel; approximately $2,500 per month.

As soon as feasible, the service would be reorganized as a separate Home Care Department and the following activities added:

1. A full-time medical social worker would be employed with a clerical assistant.

2. An equipment pool would be gradually accumulated so that needed nedical equipment and supplies can be loaned or rented to home care patients. A suggested listing for initial needs is outlined in Appendix Q.

The provision of clean bed linens, disposable needles and syringes, sterile dressings, intravenous fluids, irrigating solutions, and oxygen should also be planned. This additional cost would be approximately $1,700 per month for essentially the same patient load. All of the basic services would now be provided the patients, as well as the supplemental services, equipment and supplies, and home health aide services.

The next planned expansion would provide a medical supervisor for the department. He would, along with his other duties of supervision,

begin a widespread publicity campaign for physicians and patients alike to promote the advantages of the Home Care Program in preparation for extending the service to selected private patients eligible for Medicare benefits. This important addition to the Home Care Staff (with secretary) would cost approximately $2,000 per month.

The third expansion of the department would be directed toward obtaining the services of a full-time physiotherapist and occupational therapist. As the number of elderly patients on the program increases, the need for both therapists will become more acute. The speech therapist available to the hospital on-call will no doubt be needed more and more, also. All the while, those other services that are available within the community for selected patients can be utilized as well. With the addition of the two full-time therapists and their secretaries, costing about $2,500 per month, the program should be able to gradually manage all clinic patients (20 per month) and patients age 65 and over (70 per month) eligible for home care at a departmental cost of $8,700 per month. All of the basic and supplemental services are now available to the patients through the coordinated home care program except transportation services for the majority of patients.

Eventually, then, the program would be broadened so that any patient within the hospital could be referred to the Home Care Department for consideration as a home care patient. The patient load could be expected to approach 200 per month in time. Direct admission to the home care program without prior hospitalization would be the final goal of a program that the hospital and community would be proud to support.

The advantages of this progressive development of the Home Care Department are:

1. It makes possible early approval of the department as a home health agency thereby insuring payment to the hospital for its services by the government and easing the burden of payment by the patient.

2. It allows for a gradual outlay of funds to support and enlarge the program.

3. The most important services are provided as they are most apt to be needed.

4. Evaluation of the program is possible at various levels of development, thereby allowing for a more accurate assessment of the program's value before any possible premature expansion of the program is made.

5. Hospitalization for patients would be shortened, the hospital would be able to ease its bed shortage, and patients would be returned to their preferred home environment sooner.

Disadvantages of this program continue to be mainly the inefficient use of program personnel tending fewer patients in a decentralized fashion and the difficulties encountered in administering such a large and complicated undertaking.

Although apparently a costly undertaking at first glance, any properly managed program should more than support itself through the savings realized from decreasing the patients' days in the hospital.

The legal implications involved in home care have caused much concern in the minds of some members of the legal profession.[19] The

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[19]William A. Regan, "A Legal Look at Progressive Patient Care, Part 3: Minimum Care Units," Hospital Progress, XL (July, 1959), 90-91.

degree of professional responsibility for the patient undergoing treatment "off-the-hospital-premises" must be recognized by the hospital. It would appear axiomatic that the patient must understand that the hospital cannot accept responsibility for the personal well-being of a patient when no member of the hospital is directly supervising the patient. It has been suggested that a hospital supporting a home care program should use consent forms signed by the patient signifying the patient's full understanding and appreciation of his status in relation to the hospital.

Summary

At any one time approximately 7 per cent of all patients in Baylor University Medical Center could be suitably managed on a home care program as determined by the author's one-time survey of the inpatient medical records. This estimate was lower than the usual 10 per cent of patients that are said to be suitable candidates for home care. The lower percentage for the Center is undoubtedly due to the fact that it is truly a short-term hospital, in great measure, because of its energetic medical review and utilization review committees.

Of the patients age 65 and over in the hospital, 16 per cent were found to be candidates for home care by the same survey; and 17 per cent of the clinic patients in the hospital were so classified. Of all the patients eligible for home care, 58 per cent were age 65 and over, 8 per cent were clinic patients, and the remaining one-third were private patients under age 65.

Baylor University Medical Center had several limiting factors at the time of the study that would hinder its engagement in a multi-service coordinated home care program initially. These were essentially due to

the lack of a medical social service; insufficient nursing, occupational therapy, and physical therapy personnel; and the lack of excess medical equipment for home care use. It was also beginning an $8 million expansion program that would require the coordinated efforts of many, but when completed it would enhance the hospital's ability to support a home care program by its expanded physical therapy, occupational therapy, neuropsychiatric, laboratory, radiology, and outpatient facilities.

Community support for a home care program at Baylor University Medical Center was available in several areas. Home nursing service, home health aide service, and meals-on-wheels could be provided by the Visiting Nurses Association of Dallas for the city, and home nurses were available through the County Health Department for the county of Dallas. Monetary assistance for the needy could be obtained from the State and County Welfare Departments. The Dallas County Chapter of the National Foundation was available to help needy children under age 19 with congenital deformities. The Texas Education Agency, Office of Rehabilitation, could provide restorative services to needy handicapped patients and vocational training to any handicapped individuals who were potentially productive. The agency accomplished its rehabilitative efforts with the help of the Caruth Memorial Rehabilitation Center and other hospitals and training centers in the state. The American Cancer Society offered many home services to needy cancer victims as well as transportation, counselling, and postlaryngectomy speech lessons. No agency could be located that offered physiotherapy, occupational therapy, or speech therapy in the home.

Lastly, support to all patients age 65 and over was assured by Public Law 89-97 (Medicare) which became effective 1 July 1966. By

meeting certain standards for participation, hospitals (and other health agencies) could be recognized as home health agencies and would be reimbursed through Medicare at reasonable rates for the care of patients at home (Appendix K).

Four different home care programs, varying in services offered and based on the assumption that the survey statistics will remain valid, were discussed. The one program considered to be the most appropriate for Baylor University Medical Center will be proposed as the conclusion to this study in the next chapter.

CHAPTER III

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

As a result of this study, it has been concluded that the role Baylor University Medical Center, Dallas, Texas, should play in home care for discharged patients is one that begins modestly and economically. As experience and confidence in the program is gained, the role of the Medical Center should be gradually expanded to a multi-service, coordinated, hospital based home care program for Greater Dallas. All the community services available to support the program should be utilized to the fullest by the coordinated efforts of the Home Care Program. The fourth alternative program describing a gradually expanding program, therefore, is proposed as the Home Care Program for Baylor University Medical Center.

It is proposed that an advisory committee, first, be appointed consisting of a licensed physician, a professional public health nurse, a medical social worker, a physiatrist, and two prominent community citizens knowledgeable in health matters. It should then promulgate policies or bylaws similar to those outlined in Appendix R.

Secondly, a public health nurse should be employed to act as the supervisor/coordinator of the program. She would establish, equip, and staff a Home Care Service office as a part of the Outpatient Clinic and would develop home care nursing service policies using Appendixes S and T as guides after coordination with the Visiting Nurses Association of

Dallas and the County Health Department. She would then gain approval of these procedures by the advisory committee. Home health aide service policies would be similarly developed and approved using Appendix U as a guide. Coordination with other community agencies would also be effected by the nurse. Likewise, she would publicize the program's intent to the intern and resident staff and other departments in the hospital that will be needed to participate in the program. An explanatory brochure should be developed for the information of clinic patients (and later other patients) eligible for the program.

Once the service is operational and it has been determined to be of definite value, approval as a home health agency and participation in the health insurance program for the aged should be a recognized goal. A separate Home Care Department should then be organized and progressively developed as outlined in the fourth alternative. Such a program will offer the most services to the patient while economically advancing the status of Baylor University Medical Center as a progressive community health center.

Recommendations

The following recommendation for implementation is therefore presented:

1. That the proposed gradually expanding home care program be approved for adoption by Baylor University Medical Center, Dallas, Texas.

It is recommended that the following studies be implemented in the near future:

1. A study be devoted to determine the scope and format of the medical, statistical, administrative, and financial records that would

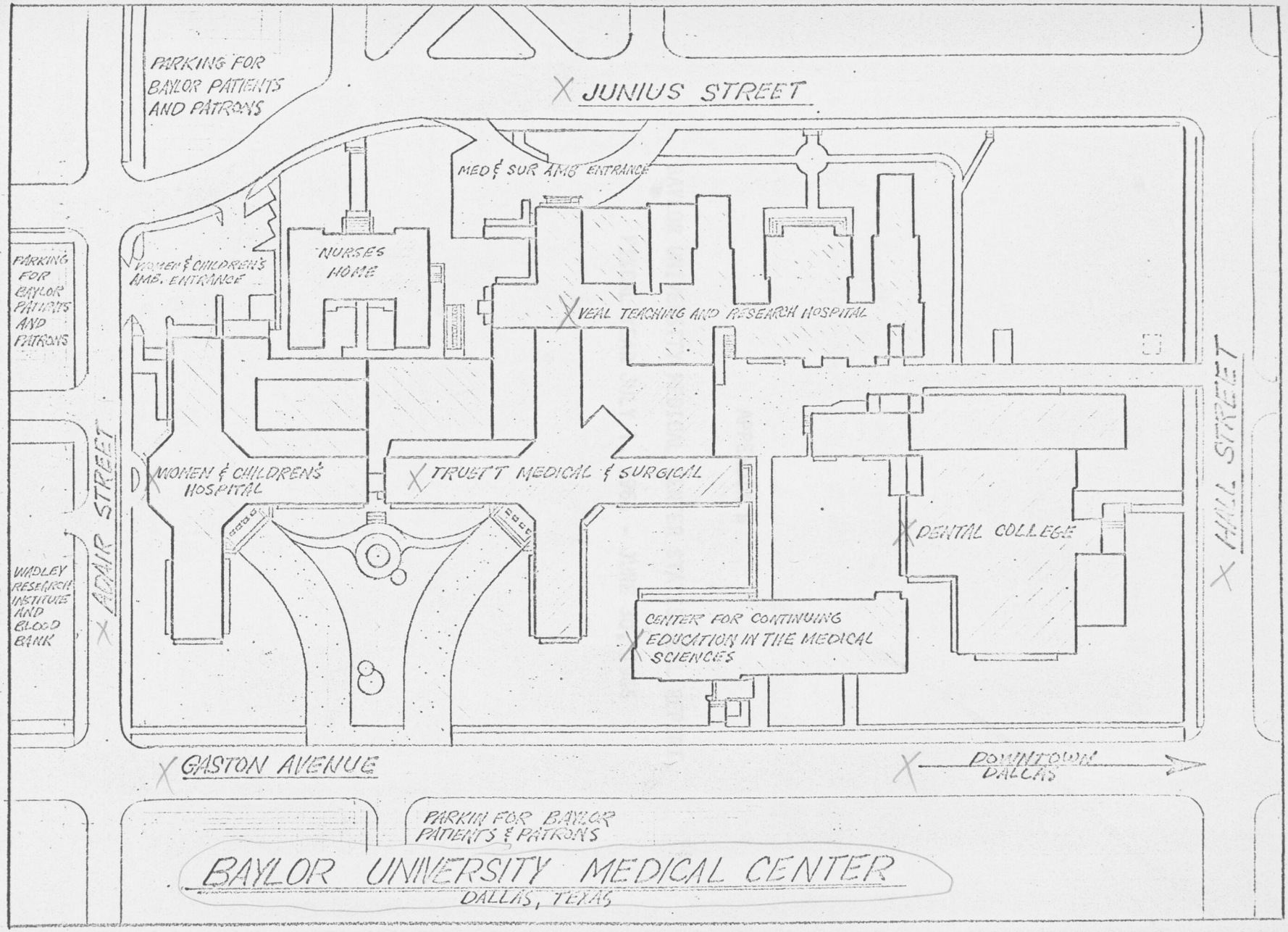
be appropriate for the program at Baylor University Medical Center, Dallas, Texas.

2. A study be devoted to the legal aspects of home care.

3. A seminar devoted to home care be conducted at Baylor University Medical Center, Dallas, Texas, to which notable persons in the field are invited to discuss with the hospital staff their opinions and experiences.

APPENDIX A

DIAGRAM OF BAYLOR UNIVERSITY MEDICAL CENTER, DALLAS, TEXAS


PARKING FOR BAYLOR PATIENTS AND PATRONS
JUNIUS STREET
MED & SUR AMB ENTRANCE
NURSES HOME
WOMEN & CHILDREN'S AMB. ENTRANCE
PARKING FOR BAYLOR PATIENTS AND PATRONS
VEAL TEACHING AND RESEARCH HOSPITAL
HALL STREET
ADAIR STREET
WOMEN & CHILDREN'S HOSPITAL
TRUETT MEDICAL & SURGICAL
DENTAL COLLEGE
WADLEY RESEARCH INSTITUTE AND BLOOD BANK
CENTER FOR CONTINUING EDUCATION IN THE MEDICAL SCIENCES
GASTON AVENUE
DOWNTOWN DALLAS
PARKIN FOR BAYLOR PATIENTS & PATRONS
BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

APPENDIX B

BAYLOR UNIVERSITY MEDICAL CENTER STATISTICAL REPORT, FISCAL YEAR JULY 1, 1965 - JUNE 30, 1966

BAYLOR UNIVERSITY MEDICAL CENTER

STATISTICAL REPORT

Fiscal Year July 1, 1965 - June 30, 1966

ADMISSIONS	Twelve Months 1964-1965	Twelve Months 1965-1966
Total	33,975	34,068
Births		
Male	3,353	3,146
Female	3,304	2,938
Total	6,677	6,084
Total Admissions & Births	40,652	40,152

Summary of Admissions	Including	Exc. Infants	Including	Exc. Infants
Number of Admissions	40,652	33,975	40,152	34,068
Number of Patient Days	275,161	247,703	275,131	249,261
Average Length of Stay	6.76	7.29	6.85	7.32
Average Cost per Patient Day	43.62	48.45	45.86	50.62

DAILY OCCUPANCY

Total Hospital Beds - Average	788	791
Percent of Occupancy	86%	86%
Average Length of Stay	7.29 days	7.32 days
Total Bassinetts - Average	150	108
Percent of Occupancy	50%	66%
Average Length of Stay	4.11 days	4.25 days

EMERGENCY UNIT

	Number	Percent	Number	Percent
Admitted	5,491	25.4%	5,765	24.0%
Treated and Discharged	16,154	74.6%	16,916	70.3%
Transferred	---	---	1,277	5.3%
Left	---	---	100	.4%
Total	21,645	100.0%	24,068	100.0%

OUTPATIENT CLINIC

Admitted	1,448	9.1%	1,489	9.0%
Treated and Discharged	14,403	90.9%	14,973	91.0%
Total	15,851	100.0%	16,462	100.0%

PATIENT DAYS	Twelve Months 1964-1965	Twelve Months 1965-1966
Summary by Service*		
General Medicine	54,781	61,567
Psychiatry	91	64
Neurology	5,261	6,006
General Surgery	34,390	37,904
Obstetrics Deliveries	25,540	23,093
Obstetrics Not Delivered	1,601	1,312
Obstetrics Aborted	1,306	1,124
New Born	27,479	26,004
Gynecology	19,808	20,246
Urology	19,973	18,538
Proctology	6,423	6,270
Orthopedics	26,610	26,674
Fracture	14,882	12,927
Neurosurgery	14,584	15,402
Thoracic Surgery	8,637	10,128
Oral Surgery	773	585
Plastic Surgery	2,521	1,896
Ophthalmology	1,604	1,670
Otolaryngology	4,092	3,488
Pediatrics	851	1,165
Total	274,207	276,063
Average Length of Stay	6.8 days	6.9 days

* Medical Records Statistics

BAYLOR UNIVERSITY MEDICAL CENTER

DEPARTMENTAL STATISTICAL REPORT

Fiscal Year July 1, 1965 - June 30, 1966

ANESTHESIOLOGY	Twelve Months 1964-1965 Number	Percent	Twelve Months 1965-1966 Number	Percent
	Surgery		Surgery	
Anesthetics given by:				
Anesthesiologist	14,230	75%	14,916	79%
Nurse Anesthetist	4,683	25%	3,985	21%
Total	18,913	100%	18,901	100%
	Delivery Room		Delivery Room	
Anesthetics given by:				
Anesthesiologist	379*	6%	385*	7%
Nurse Anesthetist	5,623	94%	5,243	93%
Total	6,002	100%	5,628	100%

* Does not include Locals and Saddle Blocks performed by Obstetricians

BUSINESS OFFICE				
Number of Patients with Blue Cross	9,079	27%	9,689	28%
Patients with Commercial Insurance	21,409	63%	21,725	64%
Total	30,488	90%	31,414	92%
Patients with no insurance	3,487	10%	2,654	8%
Total	33,975	100%	34,068	100%

CARDIAC LABORATORY				
Cardiac Catheterization	147		165	

DIETARY				
Patients' Meals Served	613,145		643,834	
Employees' Meals Served	449,704		338,461	
Total Meals Served	1,062,849		1,102,502	
Average Cost Per Meal	$ .926		$ .991	

	Twelve Months 1964-1965	Twelve Months 1965-1966
ECG-EEG-BMR		
Number of Procedures		
Basal Metabolism Rate	36	20
Electrocardiogram	14,397	16,400
Electroencephalograph	1,474	1,550
Total	15,907	17,970
ENGINEERING		
Tons of Air Conditioning Produced	396,479	389,895
Total Ton Hours of Air Conditioning	9,385,009	8,179,200
Kilowatt Hours of Electricity Used	14,844,800	15,248,000
Cubic Feets of Gas Used	334,318,808	324,836,119
Pounds of Steam Produced	286,293,396	277,769,378
Gallons of Water Used	140,014,000	149,869,000
FINANCE		
Number of Payroll Checks Written	55,602	56,781
HEALTH CLINIC		
Total Visits	5,037	5,463
Number of Pre-Employment Physicals	1,248	1,193
Number of Employees Seen in:		
Emergency Unit	394	422
INHALATION THERAPY		
Number of Patients Seen	56,432	64,288
Change from last period	13.0% inc.	13.9% inc.
Number of Treatments Given	129,797	141,211
Change from last period	12.4% inc.	8.8% inc.
LABORATORIES		
Total Number of Tests Performed	655,350	690,387
Change from last period	3.9% inc.	5.3% inc.
Autopsies	406	405
Bacteriology	135,929	149,666
Chemistry	135,914	153,972
Cytology	1,117	2,355
Hematology	165,581	171,437
Immunohematology	43,143	38,841
Serology	19,541	24,061
Surgical Tissues Examined	14,044	15,615
Urinalysis	49,590	49,621
Virology	9,615	10,685

	Twelve Months 1964-1965	Twelve Months 1965-1966
LAUNDRY		
Pounds of Flatwork	5,055,055	5,245,815
Pounds of Presswork Processed	264,247	260,545
Change from last period	3.7% inc.	-1.4% dec.
Total	5,319,302	5,506,360
Change from last period	1.8% inc.	3.5% inc.
MEDICAL RECORDS		
Number of Reports Transcribed*	48,669	45,447
Number of Minutes Dictated*	115,200	137,100
* Includes: Histories, Physicals, Discharge Summaries, Consultations, Operative Reports and Letters		
Number of Records Furnished to:		
Insurance Companies	1,904	1,420
Doctors (not on Baylor staff)	128	206
Other hospitals	288	204
Social Security & Veterans' Adm.	560	494
Attorneys	304	216
Other	---	76
Total	3,184	2,616
OPERATING ROOMS		
Major Operations	9,915	10,081
Minor Operations	10,411	10,179
Total	20,326	20,260
PERSONNEL		
Full-Time	1,724	1,696
Part-Time	336	345
Temporary	60	83
On Call	36	39
Students	172	173
Leave of Absence	20	29
Grants	---	34
Total	2,348	2,399
PHARMACY		
Number of Prescriptions Filled	364,654	402,741
Change from last period	2.9% inc.	10.4% inc.
Total Number of Prescriptions Filled from Sept. 1, 1930 to:	5,649,477 (8-10-65)	6,034,041 (7-21-66)

	Twelve Months 1964-1965	Twelve Months 1965-1966
PHOTOGRAPHY (Audio-Visual Services)		
Newborn Pictures:		
Complimentary	6,434	5,821
Re-orders	12,640	11,301
Total	19,074	17,122
Public Relations	1,542	1,497
Medical	2,711	3,746
Other	4,382	4,100
Total	27,709	26,465
16mm Cine Film (Motion Picture)	--	7,903 ft.
PHYSICAL MEDICINE		
Total Number of Treatments	144,441	149,966
Change from last period	5.6% inc.	3.8% inc.
Total Number of Patients Treated	54,211	55,429
Change from last period	6.0% inc.	2.2% inc.

PUBLIC RELATIONS	Number	Hours	Number	Hours
Volunteer Service Corps:				
Senior Volunteers	340	32,677	337	28,644
Junior Volunteers	106	7,954	99	8,504
Checkerettes	111	639	115	3,770
Total	557	41,270	551	40,918
Grand Total to Date From September, 1954 to:		350,701 (June 30, 1965)		391,619 (July 3, 1966)

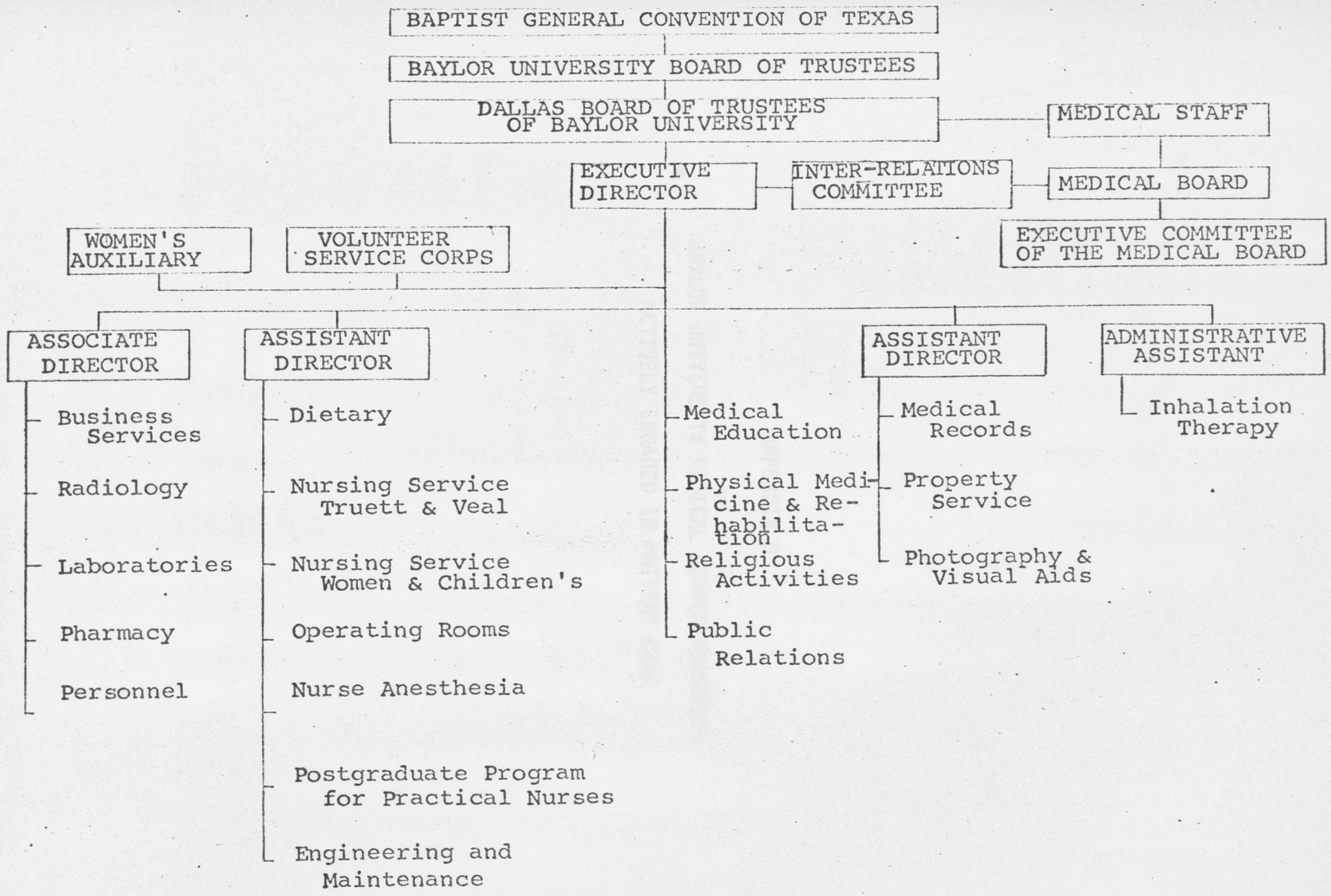
PURCHASING		
Number of Purchase Orders	8,894	9,383
Number of Invoices Processed	14,412	15,664
Number of Requisitions Filled:		
Stock	11,832	12,732
Special	14,700	15,726
Total	26,532	28,458
Print Shop	---	2,681

	Twelve Months 1964-1965	Twelve Months 1965-1966
RADIOLOGY		
Number of Patients Examined	48,214	50,724
Number of Examinations	63,970	67,997
Number of Therapy Treatments		
Radium or Cobalt	196	184
Superficial or Ortho-Voltage	1,589	1,495
Megavoltage	14,116	13,964
Number of Radioactive Isotopes		
Diagnostic Procedures	1,890	2,771
Therapeutic Procedures	81	106
Patients Treated	81	106
RELIGIOUS ACTIVITIES		
Professions of Faith	593	399
Rededications	1,589	1,345
Daily Religious Services	2,861	2,861
Bedside Visits	54,900	66,280

October, 1966

APPENDIX C

ADMINISTRATIVE ORGANIZATION, BAYLOR UNIVERSITY MEDICAL CENTER, DALLAS, TEXAS



ADMINISTRATIVE ORGANIZATION
Baylor University Medical Center
Dallas, Texas

January 1, 1967

APPENDIX D

BAYLOR UNIVERSITY MEDICAL CENTER PERSONNEL ACTIVELY ENGAGED IN PATIENT CARE

TABLE 4

BAYLOR UNIVERSITY MEDICAL CENTER PERSONNEL
ACTIVELY ENGAGED IN PATIENT CARE[a]

Medical Staff	591	
Residents and Fellows	71	
Internes	20	
Registered Nurses	379	
Dietitians	24	
Dietetic Internes	7	
Inhalation Therapists	24	
Occupational Therapists	1	
Physical Therapists	21	
Speech Therapist	1	(on call)
Pharmacists	14	
Medical Technologists	51	
ECG, EEG, BMR Technicians	18	
Laboratory Technicians	24	
Radiology Technicians	22	
Post Graduate Practical Nurses	120	
Licensed Vocational Nurses	127	
Nurses Aides	245	
Male Nurse Technicians	72	
	1832	

[a]Source: Personal interview with Director of Personnel, Baylor University Medical Center, Dallas, Texas, on 11 May 1967.

APPENDIX E

PROJECTIONS OF TOTAL POPULATION OF THE UNITED STATES BY AGE

TABLE 5

PROJECTIONS OF TOTAL POPULATION
OF THE UNITED STATES BY AGE[a]

Age	1965		1970		1975		1980	
	No. (000's)	%	No. (000's)	%	No. (000's)	%	No. (000's)	%
Total All Ages	195,129	100.00	211,430	100.00	230,415	100.00	252,056	100.00
Under 5	21,242	10.88	23,991	11.35	27,312	11.85	30,557	12.12
5-14	39,380	20.18	41,746	19.74	45,342	19.67	51,387	20.38
15-24	30,360	15.55	36,045	17.04	39,573	17.17	41,993	16.65
25-34	22,374	11.46	25,220	11.92	31,139	13.51	36,517	14.48
35-44	24,462	12.53	22,997	10.87	22,458	9.74	25,267	10.02
45-54	22,067	11.30	23,360	11.04	23,574	10.23	22,194	8.80
55-64	16,973	8.69	18,501	8.75	19,846	8.61	21,056	8.35
65 and Over	18,102	9.27	19,571	9.25	21,171	9.18	23,087	9.16

[a] Source: U.S. Department of Commerce, Bureau of the Census, Statistical Abstract of the United States, 1965 (Washington, D.C.: U.S. Government Printing Office, 1965), p. 6.

APPENDIX F

PREVALENCE OF CHRONIC ILLNESS: PERSONS WITH LIMITATION OF ACTIVITY DUE TO CHRONIC CONDITIONS BY AGE, UNITED STATES, JULY, 1959-JUNE, 1961

TABLE 6

PREVALENCE OF CHRONIC ILLNESS: PERSONS WITH LIMITATION OF ACTIVITY DUE TO CHRONIC CONDITIONS, BY AGE, UNITED STATES JULY 1959-JUNE 1961[a]

Age	Total Population	Persons with One or More Chronic Conditions					
		Total	No Activity Limitation	Having Some Activity Limitation			
				Total	Not in Major Activity[b]	In Amount or Kind of Major Activity[b]	Unable to Carry on Major Activity[b]
	NUMBER OF PERSONS (000'S)						
All Ages	176,302	73,849	54,577	19,273	5,056	10,243	3,973
Under 17	61,911	11,116	9,996	1,120	580	407	133
17-44	63,068	28,596	23,943	4,652	1,630	2,600	422
45-64	35,989	22,068	15,475	6,593	1,803	3,745	1,045
65 and Over	15,334	12,070	5,162	6,908	1,043	3,491	2,374
	PERCENT DISTRIBUTION OF PERSONS						
All Ages	100.0	41.9	31.0	10.9	2.9	5.8	2.3
Under 17	100.0	18.0	16.1	1.8	.9	.7	.2
17-44	100.0	45.3	38.0	7.4	2.6	4.1	.7
45-64	100.0	61.3	43.0	18.3	5.0	10.4	2.9
65 and Over	100.0	78.7	33.7	45.1	6.8	22.8	15.5

[a] Source: U.S. Department of Health, Education and Welfare, Public Health Service, National Health Survey, "Chronic Conditions Causing Limitation of Activities, United States, July, 1959-1961," Health Statistics, Series B - No. 36 (Washington, D.C.: Government Printing Office, October, 1962), p. 19.

[b] Major activity refers to ability to work, keep house, or go to school.

APPENDIX G

PREVALENCE OF CHRONIC ILLNESS: DISTRIBUTION OF PERSONS WITH CHRONIC ACTIVITY LIMITATION AFFECTING MAJOR ACTIVITY, BY DURATION OF LIMITATION AND BY AGE, UNITED STATES JULY, 1959-JUNE, 1960

TABLE 7

PREVALENCE OF CHRONIC ILLNESS: DISTRIBUTION OF PERSONS WITH CHRONIC ACTIVITY LIMITATION AFFECTING MAJOR ACTIVITY[a] BY DURATION OF LIMITATION AND BY AGE, UNITED STATES, JULY 1959-JUNE 1960[b]

Age	Persons with Major Activity Limitation	Duration of Major Activity Limitation			
		Under 1 Year	1-4 Years	5 Years or More	Unknown
	NUMBER OF PERSONS (000's)				
All Ages	13,573	2,115	5,039	5,680	739
Under 17	539	130	213	175	
17-44	2,887	622	924	1,193	147
45-64	4,598	779	1,703	1,936	180
65 and Over	5,549	583	2,199	2,376	391
	PERCENT DISTRIBUTION OF PERSONS				
All Ages	100.0	15.6	37.1	41.8	5.4
Under 17	100.0	24.1	39.5	32.5	
17-44	100.0	21.5	32.0	41.3	5.1
45-64	100.0	16.9	37.0	42.1	3.9
65 and Over	100.0	10.5	39.6	42.8	7.0

[a] Major activity refers to ability to work, keep house, or go to school.

[b] Source: U.S. Department of Health, Education, and Welfare, Public Health Service, National Health Survey, "Duration of Limitation of Activity Due to Chronic Conditions, United States, July 1959-June 1960, Health Statistics, Series B - No. 31 (Washington, D.C.: Government Printing Office, January, 1962), p. 12.

APPENDIX H

PREVALENCE OF PERSONS RECEIVING CARE AT HOME BY AGE AND SEX ACCORDING TO TYPE OF CARE, UNITED STATES, JULY, 1958-JUNE, 1959

TABLE 8

PREVALENCE OF PERSONS RECEIVING CARE AT HOME BY AGE AND SEX ACCORDING TO TYPE OF CARE, UNITED STATES, JULY 1958-JUNE 1959[a]

Age and Sex	Total Population (000's)	Type of Care					
		Total	Constant	Part-Time	Total	Constant	Part-Time
		Number of Persons (000's)			Rate Per 1,000 U.S. Population		
All Ages	171,300	1,128	650	478	6.6	3.8	2.8
Under 15	53,969	121	84	37	2.3	1.6	0.7
15-44	67,455	125	66	59	1.9	1.0	0.9
45-54	20,026	81	44	37	4.0	2.2	1.8
55-64	15,029	144	88	56	9.6	5.9	3.7
65-74	9,769	214	102	112	21.9	10.4	11.5
75 +	5,052	443	266	177	87.7	52.7	35.0
Males	83,360	491	255	236	5.9	3.1	2.8
Females	87,941	637	395	242	7.2	4.5	2.7

[a]Source: U.S. Department of Health, Education and Welfare, Public Health Service, National Health Survey, "Persons Receiving Care at Home, United States, July 1958-June 1959," Health Statistics, Series B - No. 28 (Washington, D.C.: U.S. Government Printing Office, October, 1961), p. 2.

APPENDIX I

PERSONS RECEIVING PERSONAL CARE AT HOME: DISTRIBUTION OF PERSONS BY AGE ACCORDING TO LENGTH OF TIME RECEIVING SUCH CARE, UNITED STATES, JULY, 1958-JUNE, 1959

TABLE 9

PERSONS RECEIVING PERSONAL CARE[a] AT HOME: DISTRIBUTION OF PERSONS BY AGE ACCORDING TO LENGTH OF TIME RECEIVING SUCH CARE, UNITED STATES, JULY 1958-JUNE 1959[b]

Length of Time Under Care	All Ages	Age		
		Under 45	45-64	65 and Over
	Number of Persons (000's)			
All Persons	1,128	245	225	658
Under 1 Year	306	57	75	174
1-4 Years	429	63	76	290
5 Years or More	344	124	68	152
Unknown	49	1	6	42
	Percent Distribution			
All Persons	100.0	100.0	100.0	100.0
Under 1 Year	27.1	23.3	33.3	26.4
1-4 Years	38.0	25.7	33.8	44.1
5 Years or More	30.5	50.6	30.2	23.1
Unknown	4.4	.4	2.7	6.4

[a] Personal care was defined as family help or nursing care provided part-time or full-time in the person's own home either by members of the household, other relatives, friends, or persons hired for the service, or by charitable or public agencies. Usual care required by infants not included as nursing care.

[b] Source: U.S. Department of Health, Education and Welfare, Public Health Service, National Health Survey, "Persons Receiving Care at Home, United States, July 1958-June 1959," Health Statistics, Series B-28 (Washington, D.C.: U.S. Government Printing Office, October, 1961), p. 4.

APPENDIX J

NUMBER OF PERSONS RECEIVING CARE AT HOME AND PER CENT DISTRIBUTION BY IMPAIRMENTS AND OTHER CONDITIONS RESPONSIBLE FOR THE CARE ACCORDING TO TYPE OF CARE, UNITED STATES, JULY, 1958-JUNE, 1959

TABLE 10

NUMBER OF PERSONS RECEIVING CARE AT HOME AND PERCENT DISTRIBUTION BY IMPAIRMENTS AND OTHER CONDITIONS RESPONSIBLE FOR THE CARE ACCORDING TO TYPE OF CARE, UNITED STATES, JULY 1958-JUNE 1959[a]

Impairments and Other Conditions	Type of Care					
	Total	Constant	Part-Time	Total	Constant	Part-Time
	Number of Persons (000's)			Percent Distribution		
All Persons	1,128	650	478	100.0	100.0	100.0
Impairments	444	260	184	39.4	40.0	38.5
Vision	63	26	38	5.6	4.0	7.9
Paralysis	266	154	72	20.0	23.7	15.1
Other	155	80	75	13.7	12.3	15.7
Other Conditions	684	390	294	60.6	60.0	61.5
Circulatory	176	117	59	15.6	18.0	12.3
Heart	108	67	42	9.6	10.3	8.8
Other	67	50	17	5.9	7.7	3.6
Arthritis and Rheumatism	117	49	69	10.4	7.5	14.4
Senility	90	40	51	8.0	6.2	10.7
Other	300	184	115	26.6	28.3	24.1

[a] Source: U.S. Department of Health, Education, and Welfare, Public Health Service, National Health Survey, "Persons Receiving Care at Home, United States, July 1958-June 1959," Health Statistics, Series B - No. 28 (Washington, D.C.: U.S. Government Printing Office, October, 1961), p. 11.

APPENDIX K

BAYLOR UNIVERSITY MEDICAL CENTER RECERTIFICATION FOR INPATIENT HOSPITAL SERVICES

BAYLOR UNIVERSITY MEDICAL CENTER

RECERTIFICATION FOR INPATIENT HOSPITAL SERVICES

(To be completed by_____, the 14th day after admission)

Patient's Name: _____ Case No._____ Room No._____

Physician's Name:_____ Date Admitted:_____

The Utilization Review Plan requires that long-stay patients be recertified at regular intervals. The following items are needed:

REASONS FOR CONTINUED HOSPITALIZATION:_____

_____

_____

_____

_____

_____

ESTIMATED PERIOD OF TIME PATIENT WILL REMAIN IN HOSPITAL:_____

PLANS FOR POST-HOSPITAL CARE: (Check One)

☐ Extended Care Facility ☐ Office Care ☐ Home Health Care

☐ Other (Specify:)

Date:_____ _____

Signature of Attending Physician

SECOND RECERTIFICATION (To be completed by_____, the 21st day after admission)

PLEASE INDICATE ANY CHANGES IN THE ABOVE INFORMATION:_____

_____

ESTIMATED PERIOD OF TIME PATIENT WILL REMAIN IN HOSPITAL:_____

Date:_____ _____

Signature of Attending Physician

THIRD RECERTIFICATION (To be completed by_____, the 45th day after admission)

PLEASE INDICATE ANY CHANGES IN THE ABOVE INFORMATION:_____

_____

ESTIMATED PERIOD OF TIME PATIENT WILL REMAIN IN HOSPITAL:_____

Date:_____ _____

Signature of Attending Physician

Fig. 3

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APPENDIX L

MAJOR DIAGNOSTIC CATEGORIES OF PATIENTS ON HOME CARE, JEWISH HOSPITAL, ST. LOUIS, MISSOURI

TABLE 11

MAJOR DIAGNOSTIC CATEGORIES
OF PATIENTS ON HOME CARE[a]

Arteriosclerotic heart disease	125	32.5%
Malignancy with metastases	62	16.1
Diabetes mellitus with complications	54	14.0
Tuberculosis	28	7.3
Postoperative care	17	4.4
Fractures	14	3.7
Rheumatic heart disease	12	3.1
Cerebral arteriosclerosis	9	2.4
Pneumonia	8	2.1
Rheumatic fever, acute	6	1.6
Infectious hepatitis	5	1.3
Hypertension	4	1.0
Pulmonary emphysema	4	1.0
Renal disease	3	0.8
Pemphigus	2	0.5
Spinal cord injury	2	0.5
Thrombophlebitis	2	0.5
Ulcerative colitis	2	0.5
Other	22	5.7
Total	385	100.0%

[a]Source: David Littauer, I. Jerome Flance, Albert F. Wessen, Hospital Monograph Series No. 9, Home Care (Chicago: American Hospital Association, 1961), p. 23.

APPENDIX M

VISITING NURSE ASSOCIATION COMPARATIVE STATISTICAL REPORT

1964 THROUGH 1966 (NOVEMBER TO NOVEMBER)

TABLE 12

VISITING NURSE ASSOCIATION - COMPARATIVE STATISTICAL REPORT 1964 through 1966 (Nov. to Nov.)

PATIENTS	1964	1965	1966	% + or - ('66 over '65)
Patients brought forward November 1st	368	339	386	+ 14%
New admissions	1,967	2,475	2,678	+ 8%
	2,335	2,814	3,064	+ 9%
VISITS	20,689	24,677	28,095	+ 14%
NEW FAMILIES	1,647	2,221	2,451	+ 10%

PAY STATUS
Information on income incomplete due to open accounts payable

SERVICE	1964	1965	1966	% + or -
Total Days Patient Service	2,748	2,796	3,310	+ 18%
Total Days Illness	73	73	100	+ 37%
Total Days Vacation	176	147	128	- 13%
Total Days Special Activities	38-1/2	24	23	- 4%
Average visits per nurse per day	7.78	8.81	8.62	8.72 visits

REFERRED BY	1964	1965	1966	% + or -
Agencies	91	140	169	+ 20%
Family and Friends	440	466	596	+ 28%
Physician	374	354	348	- 2%
Visiting Nurse	47	68	39	- 42%
Childrens Medical Center	21	12	6	- 50%
Baylor Clinic (Morbidity)	26	25	28	+ 12%
Baylor Maternity	224	157	191	+ 21%
Parkland Hospital System	233	940	1,109	+ 18%
St. Paul Clinic	--	--	--	--
Methodist Clinic (Morbidity)	17	38	40	+ 5%
Methodist Maternity	364	480	361	- 25%
	1,837	2,680	2,887	+ 8%

Comparative Statistical Report (Continued)

CLASSIFICATION by AGE GROUPS

	ADMISSIONS				VISITS			
	1964	1965	1966	% + or -	1964	1965	1966	% + or -
Newborn	491	379	375	- 1%	1,874	1,225	1,113	- 9%
28 days - 1 year	26	30	20	- 33%	258	153	189	+ 24%
1 - 4 years	43	64	52	- 19%	254	260	229	- 12%
5 - 19 years	192	238	310	+ 30%	774	878	1,245	+ 42%
20 - 44 years	538	568	611	+ 8%	3,387	3,476	3,035	- 13%
45 - 64 years	307	505	648	+ 7%	3,141	4,641	5,273	+ 14%
65 & over	738	1,030	1,158	+ 12%	10,094	12,620	15,130	+ 20%
Absent - Not Found					907	1,424	1,881	+ 32%
	2,335	2,814	3,064	+ 9%	20,689	24,677	28,095	+ 14%

Comparative Statistical Report (Continued)

DIAGNOSIS CLASSIFICATION

	PATIENTS				VISITS			
	1964	1965	1966	% + or -	1964	1965	1966	% + or -
Antepartum	174	227	252	+ 11%	363	355	508	+ 43%
Postpartum	359	246	258	+ 5%	2,010	1,344	1,237	- 8%
Health Promotion (all ages)	562	456	458	+ 4%	2,316	1,527	1,514	- 9%
Arthritis	44	50	78	+ 56%	610	817	1,168	+ 43%
Cancer	159	231	247	+ 7%	1,425	2,099	2,505	+ 19%
Cardio-Vascular	136	179	207	+ 16%	1,822	2,209	2,837	+ 28%
Cardio-Vascular-Accident	123	217	182	- 16%	1,364	2,064	1,898	- 8%
Diabetes	44	115	125	+ 9%	515	1,001	1,031	+ 3%
Orthopedic	107	140	156	+ 11%	1,139	1,498	1,606	+ 7%
Other Chronic Illness	172	322	277	- 14%	3,052	4,034	3,433	- 15%
Tuberculosis	2	3	6	+100%	52	127	210	+ 53%
Venereal Disease	4	19	18	- 5%	34	152	166	+ 9%
Other Communicable	94	134	91	- 32%	560	767	582	- 24%
Mental Health	20	13	20	+ 54%	132	86	105	+ 22%
Other Non-Communicable	335	462	689	+ 49%	4,388	5,173	7,414	+ 43%
Absent - Not found					907	1,424	1,881	+ 32%
	2,335	2,814	3,064	+ 9%	20,689	24,677	28,095	+ 14%

APPENDIX N

VISITING NURSE ASSOCIATION OF DALLAS HOME HEALTH AIDE SERVICE--COMPARATIVE REPORT NOVEMBER 1, 1964, THROUGH OCTOBER 31, 1966

TABLE 13

VISITING NURSE ASSOCIATION of DALLAS
HOME HEALTH AIDE SERVICE-COMPARATIVE REPORT
November 1 through October 31, 1964-1965-1966

	'64	'65	'66	1964	1965	1966
Total FAMILIES SERVED				169	181	246
Carried Over	28	34	38			
New Admissions	141	147	208			
Total ADULT FAMILIES SERVED				52	77	140
Total FAMILIES WITH CHILDREN				117	104	106
Total NUMBER OF CHILDREN				487	424	545
Total VISITS				1,419	1,777	2,177
Visits to FAMILIES WITH CHILDREN	898	968	665			
Visits to ADULTS ONLY	521	809	1,512			
AVERAGE NUMBER OF FAMILIES SERVED EACH MONTH				42	55	181
Total DAYS SERVICE				1,349	1,579	1,790-1/2
UNFILLED REQUESTS for SERVICE for ACTIVE CASES (No Homemaker Available)				258	242	222
NEW REFERRALS SERVED				141	147	203
VNA	60	72	132			
CHD	31	21	28			
Self-family-friend	26	26	12			
Health Agencies	15	11	28			
Social Agencies	9	17	3			
NEW REFFERALS NOT SERVED				225	224	248
VNA	3	3	2			
Health Agencies	18	17	20			
CHD	10	6	7			
Social Agencies	19	11	19			
Self-family-friend	175	187	200			
REASON FOR NO SERVICE						
No Homemaker Available	57	70	80			
24 Hour Service	34	26	46			
Irregular Hours	18	25	3			
Daily Service-Long Period	52	48	30			
Out of Area	31	40	39			
Communicable Disease	7	3	14			
Family Made Other Arrangements	26	12	28			
Total REFFERALS SERVED & NOT SERVED				366	371	451
FEES FOR SERVICE				$112	$276	$354
PERSONNEL...Total DAYS Sick Leave				43	63	71
Total DAYS Vacation				59	50	66
Total DAYS In-Service Training						26

Statistical year November to November

APPENDIX O

VISITING NURSE ASSOCIATION OF DALLAS

MEALS-ON-WHEELS 6/1/66 - 10/31/66

TABLE 14

VISITING NURSE ASSOCIATION of DALLAS

MEALS ON WHEELS 6/1/66 - 10/31/66

Total PATIENTS SERVED		334
Oak Cliff	161	
Dallas	173	
Forwarded previous month		286
Oak Cliff	141	
Dallas	145	
New Admissions		56
Oak Cliff	24	
Dallas	32	
Total DISMISSALS		63
Oak Cliff	18	
Dallas	45	
Total MEALS PROVIDED		5,850
Oak Cliff	2,995	
Dallas	2,855	
FEES COLLECTED		-$1,142
11/1/66 through 5/31/66	$420*	
6/1/66 through 10/31/66	721	

* Other half of collected fees to Womens Council

COST OF FOOD (4 months) -$2,869

APPENDIX P

SUGGESTED LIST OF EQUIPMENT FOR LOAN OR RENT TO HOME-CARE PATIENTS WITH COSTS

TABLE 15

SUGGESTED LIST OF EQUIPMENT FOR LOAN OR RENT TO HOME CARE PATIENTS, BY COST[a]

Equipment	No. of Items	Item Cost	Total Cost
Bed, hospital	5 ea	$228.00	$1140.00
Bed, mattress	5 ea	30.00	150.00
Bedpan (nylon)	5 ea	5.50	27.50
Cane	5 ea	3.50	17.50
Commode, bedside	5 ea	35.00	175.00
Crutches, adjustable	5 pr	4.00	20.00
Ice bag, disposable	5 ea	1.75	8.75
Intermittent positive pressure machine	2 ea	400.00	800.00
Rubber sheets	5 ea	2.00	10.00
Side rails, bed	5 pr	64.00	320.00
Trapeze bars	5 ea	35.00	175.00
Urinal, disposal	5 ea	.25	1.25
Walker	5 ea	71.00	365.00
Wheel chair	5 ea	75.00	375.00
			$3585.00

*Source: Personal interview with Director, Purchasing, Baylor University Medical Center, Dallas, Texas, on 8 May 1967.

APPENDIX Q

SUGGESTED BYLAWS AND POLICIES

OF XYZ HOME HEALTH AGENCY

TEXAS STATE DEPARTMENT OF HEALTH

BYLAWS OF XYZ HOME HEALTH AGENCY

I. Primary Function

1. The chief purpose of this agency is to provide skilled nursing services and other therapeutic services, whether provided directly or indirectly, on a visiting basis in a place of residence used as the individual's home.

2. Records will be maintained in such a way that activities and expenditures attributable to services provided under the Health Insurance Program are identifiable.

II. Agency Supervision

1. Either a physician or a registered professional nurse will be designated to supervise the agency's performance in providing home health services in accordance with the orders of the physician responsible for the care of the patient and under a plan of treatment established by such physician.

III. Professional Advisory Group

1. A professional advisory group will be established for the purpose of approving and providing regular review of policies covering skilled nursing and other therapeutic services, and of the professional health aspects of other policies.

2. The composition of this body, while changing in membership from time to time, will always include a licensed physician and a registered professional nurse. Whenever possible, the registered professional nurse will be a public health nurse. In addition, it is the objective of this agency to include lay persons knowledgeable in health affairs and a wide range of professional representatives from such disciplines as medical social work, nutrition, speech, physical, and occupational therapy. Regardless of the group's constituency, some member or members will not be persons employed by the agency.

IV. Program Evaluation

1. A systematic evaluation of the agency's program will be performed at least once every two years.

2. This evaluation, notwithstanding additional procedures to be defined and initiated in the future, will entail a review of patient records on a sample basis in order to determine that services are being used appropriately and the extent to which the needs of the patients the agency serves are being met both quantitatively and qualitatively.

3. The evaluation will also encompass a review of over-all management aspects of the service to assure economy and efficiency of operation.

4. The evaluation will be conducted by the agency staff or by the professional advisory group, or by a combination of the two bodies.

V. Acceptance of Patients

1. Decisions as to the desirability and practicality of accepting patients for care are based on medical, nursing, and social information provided by the physician responsible for the patient's care, institutional personnel, and staff of the home health agency.

2. Considerations relevant to the acceptance of patients include:

   a. Adequacy and suitability of agency personnel and resources to provide the services required by the patient.
   b. Attitudes of patient and his family toward his care at home.
   c. Comparative benefit to the patient's health of care at home as distinguished from care in a hospital or extended care facility.
   d. Reasonable expectation that patient's medical, nursing, and social needs can be met adequately in his residence, including a plan to meet medical emergencies.
   e. Adequate physical facilities in the patient's residence for his proper care.
   f. Availability of family or substitute family member able and willing to participate in patient's care.

VI. Establishment and Review of Plan of Treatment

1. Services and items to be provided will be specified under a plan of treatment established by the physician responsible for the care of the patient.

2. The total plan will be reviewed by the attending physician, in consultation with agency professional personnel, at such intervals as the severity of the patient's illness requires, but in any instance at least once every two months.

3. The original plan of treatment will be incorporated in the record maintained by the agency for the patient.

VII. Physician's Orders

1. All original orders of a physician are to be signed by the physician and incorporated in the patient record maintained by the agency.

2. All changes in orders for the administration of dangerous drugs and narcotics are to be signed by the physician and incorporated in the patient record maintained by the agency.

3. All other changes in orders are to be signed by either the physician or registered nurse.

VIII. Clinical Records

1. The agency will maintain for each patient a clinical record which covers the services the agency provides directly and those provided through arrangements with another agency.

IX. Development of Agency Staff Criteria

1. Qualifications, conditions of employment, duties, and training curricula for existing and future agency personnel will be developed and implemented in accordance with the best known practices in the rendering of home health services.

(Date and signature of authorized representative)

In order to fulfill the provisions of Bylaw IX above, the following outline of essential references is presented, keyed to the "Conditions of Participation for Home Health Agencies."

Personnel Policies - Condition VI

1. Qualifications required - Conditions IX through XIV and Condition SVI

2. Responsibilities (job descriptions) - see Duties, Conditions IX through XV, as applicable

3. Conditions of Employment - Condition VI, A, 1, 2, 3, and 4

Training of Home Health Aides - Condition XVII (if applicable)

1. Faculty - Condition XVII, A.

2. Basic training content - Condition XVII, B., C., and D.

Supervision of Home Health Aides - Condition XVIII

1. Assignment - Condition XVIII, A. These five considerations to be spelled out.

2. Supervision - Condition XVIII, B. Should be delineated according to this paragraph.

AGENCY SERVICE POLICIES

Service policies should be in writing and readily available to every member of the staff. A complete statement of these policies serves as a guide to the staff in general practice and provides the staff with administrative backing for limitations of service under certain circumstances. Written service policies give the health officer precise information to use in interpreting service to the practicing physicians and seeking their acceptance of operational procedure.

Agency service policies should include definitive statements concerning the following:

1. Type of service provided and what it includes
2. Availability of service; days, hours and area covered
3. Medical supervision required
4. Payment for services; services for which a charge is to be made and method of fee determination and collection
5. Physician-Nurse relationships
   a. The number of visits a nurse may make when a patient is in need of medical attention and no medical care has been secured
   b. A plan for assisting families who are not familiar with medical resources to obtain guidance in selecting a physician
   c. The extent of bedside care that may be given until physicians' orders are obtained
   d. The extent and kind of nursing care that may be given when the patient is under the care of a dentist, oesteopathic physician or physician in a distant city
   e. The necessary frequency of the physician's contact with the patient to continue nursing care for short or long term illness
   f. The accepted method of obtaining physician's orders
   g. The frequency of renewal of physician's orders
   h. Policies regarding drug therapy, such as:
      -Drugs that a practical nurse may give
      -Drugs with untoward effects that may be given only by professional nurses and under special circumstances
      -Drugs the nurse will not give
      -Telephone orders for hypodermic injections
      -Teaching a family member to give hypodermic injections
   i. Certain treatments and procedures which require special orders (a procedure not considered a nursing function or where unusual risk is involved)
      -Intravenous injections, blood transfusions or collecting blood specimens
      -Insertion of indwelling catheters
      -Tub bathing patients
   j. Emergency medical orders
      (Standing orders for nursing care to be given in an emergency, or on first visit when physician cannot be reached, or a physician has not yet been selected) such as: First aid, surgical dressings, pressure sores.

* * * * * *

From "Organizing Home Care Nursing Services" by Julia Brandeberry, Michigan Department of Health. Presented to Nursing Section at TPHA Annual meeting held in Corpus Christi, February 20-23, 1966.

APPENDIX R

SUGGESTED HOME CARE NURSING SERVICE POLICIES

TEXAS STATE DEPARTMENT OF HEALTH

SUGGESTED NURSING SERVICE POLICIES

BELOW ARE LISTED SAMPLES OF COMMONLY USED POLICIES APPROVED BY MEDICAL ADVISORY COMMITTEES AND ACCEPTED BY BOARDS OF DIRECTORS. THEY WERE COMPILED FROM WRITTEN POLICIES OF SEVERAL VOLUNTARY AGENCIES IN TEXAS.

1. Working hours of the nurses will be 8:30 AM to 5:00 PM, Monday through Friday. Saturday, Sunday, and holiday calls will be made by special arrangement.

2. Patients residing in nursing homes will (will not) be visited.

3. Nurses are not allowed to transport patients in their own or in Agency cars.

4. Nurses may not procure food, medicines, etc., for patients from stores, supply houses, clinics, etc.

5. If a nurse is present at a death, she should notify the physician or clinic.

6. Nurses may not remove sutures.

7. Blood withdrawal requests are not accepted.

8. When nursing care and treatment have to continue for extended periods, effort should be made to plan with the physician and patient and family for someone in the home to learn the procedure, thus making the limited supply of prepared staff available to the community.

9. Nurses do not carry emergency or other drugs in their nursing bags unless specifically ordered by their Medical Advisory Committee.

10. Telephone and oral orders must be confirmed in writing. A second visit without a written order may be made only with the consent of the nursing supervisor.

11. Medications not bearing the manufacturer's label of content must be verified by prescription number with the pharmacist. The container and the patient's record must indicate the verification.

12. Standing orders, approved by the Medical Advisory Committee, may be used in situations where a physician is not available. Every effort should be made to contact the attending physician.

13. Written progress notes and summary of the patient's condition will be sent to the physician or clinic when new orders are requested.

14. Written orders for intravenous infusion are accepted if:

    a. The solution is isotonic (physiological saline or 5% glucose).
    b. The patient has the necessary sterile equipment.
    c. There is someone reliable in the home to watch the flow.
    d. Nothing is added to the solution.
    e. If unable to start after two attempts, the nurse will notify the physician.

15. Hypodermoclyses may be given with hyaluronidase (such as Alidase or Wydase) added to the tubing above each needle.

16. Injections -

    a. The Agency retains the right to refuse to give injections which:

        (1) Have allergy promoting qualities such as antigens.
        (2) Cause an unusual reaction in a patient.
        (3) Require more supervision for administration and observation than is possible for the Agency, such as anticoagulants, gold, etc.

    b. Orders for immunizations will be referred to the City and County Health Departments.

    c. Orders for anti-allergic injections used in asthma or hay fever are not accepted.

    d. Insulin injection instructions will be given on 6 consecutive days. The number of instructions will be increased if indicated.

    e. Aqueous epinephrine (adrenalin) hydrochloride 1:1000 will be carried in the nursing bag. If a patient has an anaphylactic reaction to a drug, he should be given three-tenths (0.3) of one cc. of epinephrine hydrochloride subcutaneously. Notify the physician, if this is not too time-consuming, and obtain transportation to the nearest hospital emergency room. Meanwhile, treat the patient for shock and notify the supervisor.

    f. Injections of narcotics may be given by RN's as ordered by physicians. Families may be taught. Families must keep a record of dose and time. Patient's respiration and pulse must be checked. Narcotics would not be given if patient's respirations are under 14 per minute. Of course, no medication is given without a signed order.

    g. The nurse may give gamma globulin after the doctor has calculated the amount to be given.

    h. Parenteral vitamin therapy orders may be accepted for periods up to 90 days. Except for conditions, such as pernicious anemia, which requires continued vitamin therapy by intramuscular injection, the physician should be consulted about the other plans for treatment before the period is over.

17. Procedures not to be performed without special permission of the Medical Advisory Committee -

    a. Intravenous injections or venipunctures.
    b. Administration of medication which may cause anaphylactic shock, severe reaction or is still in the experimental stage.
    c. Male catheterizations--changing of male retention catheter.
    d. Inoculations, vaccinations and tests provided by the Health Departments.
    e. Clipping of toenails of a diabetic patient.

BELOW ARE SAMPLES OF STANDING ORDERS OR EMERGENCY MEDICAL ORDERS WHICH ARE TO BE USED IN INSTANCES WHERE THE PHYSICIAN'S ORDERS ARE NOT IMMEDIATELY AVAILABLE. THEY AUTHORIZE AND DEFINE WHAT NURSING CARE MAY BE GIVEN UNTIL MEDICAL CARE CAN BE OBTAINED. THESE SAMPLES WERE COMPILED FROM WRITTEN MATERIAL OF SEVERAL VOLUNTARY AGENCIES IN TEXAS.

MEDICALLY ILL PATIENTS WITHOUT AN ATTENDING PHYSICIAN

1. General care unless contraindicated may be given before a physician's order is obtained. Pulse and respiration should be taken and temperature taken unless contraindicated.

2. If private physician care is indicated the family should be advised to call the County Medical Society for names of doctors located in the vicinity.

3. To obtain an ambulance in extreme emergencies, regardless of economic status, call the Police Department.

BURNS AND SCALDS

1. If mild, apply paste made by baking soda and water on clean, freshly ironed cloth or sterile gauze.

2. If severe and widespread, wrap patient in clean sheet first, then blankets and obtain medical care.

3. For chemical burns, wash off the chemical with large amounts of cool water.

4. For chemical burns of the eyes, immediately wash eye out with clean running water and instill a drop or two of castor oil or mineral oil. Get medical care immediately.

5. Do not use cotton, do not apply oily ointment, do not open blisters.

CONVULSIONS

1. Have someone call the doctor immediately. Keep patient from hurting himself by putting padded stick or wadded paper between teeth. If convulsion is accompanied by high fever, give an alcohol sponge and cool packs.

CUTS AND ABRASIONS

1. If small, wash well with soap and water; apply clean dressing.

2. If large, do nothing except cover with sterile gauze, control bleeding, obtain medical care. Do not use strong antiseptic.

DOG BITES

1. Hold the wound under running water for about ten minutes washing wound thoroughly. Pour alcohol over the area or saturate cotton and apply with clean gauze. May bandage to keep alcohol-saturated cotton in place and notify the doctor immediately. Be sure the Health Department is notified.

EPILEPTIC CONVULSIONS

1. Do not restrain patient but try to prevent him from injuring himself by hitting nearby objects. Protect his tongue by placing a padded stick or wadded paper between his teeth. After the attack is over allow patient to sleep without disturbing or questioning him.

FAINTING

1. Keep patient in a prone position. Check pulse. If he does not revive immediately notify the doctor.

2. When consciousness returns give warm drink (coffee or tea). DO NOT ALLOW PATIENT TO SIT UP IMMEDIATELY.

FOREIGN BODY

1. In the ear
   If it is an insect, use intense light to attract insect, for other objects obtain medical care immediately.

2. In the eye
   Have patient hold eyelid closed without touching so that tears will accumulate and perhaps wash object out. If this is unsuccessful notify the doctor.

3. In the nose
   The object should be removed by a doctor as soon as possible. Pending removal, the patient should refrain from blowing the nose violently or blowing with one nostril held shut.

4. In the stomach
   If the object is not too far down in the throat, a quick slap between the shoulders with the head held down will sometimes dislodge it. A child may be lifted up by his feet or placed on a table so that his head hangs down. If this does not dislodge the object, call the doctor without further delay and take the patient to a hospital emergency department immediately.

FRACTURES

1. Have someone call an ambulance.

2. Do not move the patient but inspect for and stop hemorrhage. (American Red Cross First Aid procedures.)

3. Keep patient quiet, warm and prevent further injury and shock.

HEMORRHAGE

1. For internal bleeding - get to medical care as soon as possible. For control of bleeding from lungs or stomach keep patient as quiet as possible. Elevate head in lung hemorrhage. Icebags may be applied if available.

2. For hemorrhage from rectum, vagina or bladder - keep patient flat with foot of bed elevated 12 to 18 inches. Keep patient quiet and warm. Arrange for immediate medical care.

3. For nose bleeds - have patient sit with head held forward. Apply pressure on nostril toward middle partition of nose. Cold pack may be applied over nose. If bleeding continues notify the doctor or send patient to a hospital emergency department.

POISONING BY MOUTH

1. Call the family physician, report poison and amount, patient's condition.

2. If family physician cannot be reached call the local Poison Center where a physician is available twenty-four hours a day.

3. If no telephone is available, induce vomiting for all poison by mouth except strong acids or alkali. Vomiting may be induced by having patient drink as much as six glasses of fluid if he can. Such solutions as baking soda and water, soapy water, salt water, or warm tap water may be used, soapy water being especially good. Save stomach contents for lab analysis.

PUNCTURE WOUNDS

1. Cleanse area and cover with a clean dressing. Send patient to physician or emergency hospital department for protection against tetanus.

CATHETER CARE

1. An order for catheter insertion does not automatically include an order for irrigation--this must be ordered specifically.

2. Unless specific solution requested, catheters will be irrigated with sterile water.

DECUBITUS ULCERS

1. Decubitus ulcers will be cleansed with soap and water and sterile dressings applied until specific orders can be received.

ANTEPARTAL PATIENTS

1. Check T.P.R. and B/P. Report to physician or clinic if:

   a. Temperature is over 100
   b. Pulse is over 100
   c. Blood pressure is over 140/90

2. Check for edema, blurred vision, nausea, weakness. Report the presence of any of these.

POSTPARTAL PATIENTS

1. Report T.P.R. and B/P as for Antental.

2. Check for breast abcess, and abnormal condition of episiotomy. Report any of these.

APPENDIX S

DALLAS COUNTY HEALTH DEPARTMENT POLICIES FOR CARE OF THE SICK AND INJURED AT HOME

DALLAS COUNTY HEALTH DEPARTMENT

POLICIES FOR CARE OF THE
SICK AND INJURED AT HOME

1. NUMBER OF VISITS TO BE MADE WITH NO PHYSICIAN IN ATTENDANCE:

When a family calls for assistance, every effort will be made by the person answering the call to direct the person to a medical facility when the need presented is clearly for medical service. One visit may be made to a patient when the need is not clearly defined and there is no physician in attendance. Instruct the patient to see a physician and,then the PHN will assist in any necessary interpretation of orders.

2. FOR PATIENTS UNDER PRIVATE CARE:

When a family calls for assistance in nursing care, instruct the family to have the private doctor call the office and relate his orders for nursing care. If necessary, a visit may be made, but the attending physician must be notified and confirmation given for the PHN to visit in the home.

3. FOR PATIENTS UNDER TAX-SUPPORTED CARE:

When families ask for assistance in nursing care, notify the attending medical facility and ask for orders for home visiting.

4. MEDICAL ORDERS:

Written orders must be obtained on all cases (excluding preventive services such as MCH, Comm. Dis., Mental Health). Telephone orders will be honored but must be followed by written orders.

5. SELECTION OF A PHYSICIAN:

If family requests names of physicians, they may be directed to the Dallas County Medical Society. If they are unable to afford care, refer them to the appropriate hospital facility.

6. WHO MAY ORDER NURSING CARE:

Medical orders for nursing service can be accepted only from physicians or dentists licensed to practice in the State of Texas.

7. CONTENT OF MEDICAL ORDERS:

Drugs: Orders for administration of medication must include the name of the drug, exact dosage, frequency and route of administration, and anticipated duration of drug therapy. Since a nurse never administers a

drug unless she knows the name of it, all medications bearing the prescription number only must be verified with the pharmacy filling the prescription before the initial dose is administered; write the prescription number on the patient's record and identify according to the conversation with the pharmacy.

Catheterizations: Must include size of catheter, whether indwelling catheter is desired or bladder drainage only, amount of balloon inflate.

Enema: Type of enema requested, amount of liquid to be used.

General Information: All orders must include all diagnoses, whether the family member or other responsible person may be taught the procedure (if indicated and conditions are found favorable).

8. RENEWAL OF ORDERS:

Orders must be renewed in writing on all patients every two months.

9. WHO IS ELIGIBLE FOR NURSING SERVICES:

Services are available to all Medicare recipients and others who cannot afford this service from a private source.

10. SUPPLIES:

Supplies should be furnished by the patient, but if this is not possible, the agency furnishes these items.

11. FEES:

Fees are imposed only on patients under the Medicare program. See Medicare manual for details.

12. CONDITIONS UPON WHICH NURSING SERVICE MAY BE RENDERED:

a. Nursing services are rendered on the basis that the patient is homebound; that is, it is impossible, impractical, or hazardous to the patient's or his family's health and welfare for the patient to get to a treatment center.

b. Patient's condition must be such that his medical, nursing, or social needs can best be met in the home.

c. Home conditions must be such that adequate care can be given in the home (special equipment, safe surroundings, family willing to assist with personal care and provide adequate nourishment).

13. SERVICES AVAILABLE IN THE HOME:

a. Injections (I.M. or Sub Q) - - teach patient or family member if indicated.

b. Catheter Care:
   1. Change female catheters - - will not teach family this procedure.
   2. Will not change or insert male catheters.
   3. Catheter irrigations - - will teach family.

c. Enemas - - instruct patient or family in giving enemas. PHNs will give enemas for a short period of time, if necessary.

d. Colostomy Care - - teach family or patient.

e. Instruct families in bedside care, such as bed baths, clothing and linen changes, turning patients, prevention of decubitus ulcers, diet, general hygiene, testing urine for sugar and acetone, etc.

f. Change dressings. Teach patient or family to change dressing (if indicated), and the handling of sterile and contaminated materials.

g. Take blood pressure, temperature, and respirations readings.

h. Teach postural drainage, use of inhalation therapy equipment.

i. Irrigate chest tubes.

j. Feeding and Nutrition:
   1. Instruction in planning normal and special diets.
   2. Tube feedings - - preparing and giving, teaching family.
   3. Change and care of gastrostomy tubes.

14. SERVICES NOT AVAILABLE IN THE HOME:

a. Administration of intravenous or clysis fluids.

b. Administration of intravenous medication.

c. Private duty type nursing.

15. LENGTH OF SERVICE:

Length of service is preferably short term but depends upon the individual case. Emphasis is on teaching the patient or family to assume responsibility for patient's care.

16. RECEIVING REQUESTS FOR SERVICE THE SAME DAY:

Except for extenuating circumstances, requests for service on the same day must be received before 12:00 noon.

17. PHNs are expected to carry adrenalin in their nursing bags at all times.

APPENDIX T

VISITING NURSE ASSOCIATION OF DALLAS POLICIES FOR HOME HEALTH AIDE SERVICE AND HOME HEALTH AIDE PERSONNEL POLICIES

VISITING NURSE ASSOCIATION of DALLAS

HOME HEALTH AIDE PERSONNEL POLICIES

HOME HEALTH AIDE RESPONSIBILITIES

Each Home Health Aide of the Visiting Nurse Association assumes a responsibility for the service the agency gives the community. This includes loyalty and cooperation with co-workers. It is the Aide's responsibility to be on duty the stipulated hours and to follow the policies and procedures established by the Board of Directors and the administrative staff.

STAFF SELECTION

1. Qualifications -
   A. The Aide must be a mature woman with adequate knowledge of personal care procedure, food preparation, housekeeping procedures and child care.
   B. Should possess good judgement, patience, considerable skill in interpersonal relationships and a sense of humor.
   C. Should be able to read and write and follow written instructions and to converse easily on telephone.
   D. Should understand and respect the need for confidentiality in regards to details of assignments and problems of family involved.
   E. Should be able to deal with minor emergencies which might arise and to work under stress when a crisis occurs.
   F. Should possess good mental and physical health.
   G. Should be able to learn from class discussions and laboratory demonstrations.
   H. Should have ability to work under supervision.
   I. Should have had some training and experience in home management, child care, the aging and chronically ill.

2. Pre-employment Procedures:
   A. An application form for assembling data regarding qualifications and work experience must be filled out by the applicant.
   B. A personal interview is desirable to estimate the applicant's judgment, other personal qualifications, and to give the candidate an opportunity to learn about the services and meet with her prospective employer. The interview should be with the administrative staff of the agency.
   C. A health examination, including an X-ray of the chest and blood serology, is to be made at the employee's expense by a licensed physician to establish the applicant's physical status before employment. This provides opportunity for corrective measures before the employee begins work and guards against her undertaking responsibilities for which she is not physically equipped. The report is submitted to the agency.

3. Appointment Procedure - The appointment is made by the administrative staff.

   The probationary period is 3 months, during which a written evaluation will be made by the administrative staff.

SALARIES

Salaries are paid on the 15th and 30th of each month. Rate of pay is based on the annual allocation for the position as approved by the United Fund. Salary increments are based on merit, according to the salary plan established by the Board of Directors. Annual increments occur on November 1st, the beginning of the fiscal year.

4. Termination of Service - It shall be the policy that the Home Health Aide give one week notice in writing prior to leaving the agency. It shall further be the duty of the Executive Director when employing such personnel to bring this policy to the attention of any personnel so employed. Any person failing to give notice is not entitled to termination pay. If immediate dismissal is necessary, the employee shall receive terminal pay equal to salary for the customary period of notice. Earned vacation shall be added to the terminal salary.

WORKING TIME

1. The number of hours per week shall be forty hours, exclusive of lunch.
2. Holidays observed are New Years, Memorial Day, July 4th, Labor Day, Thanksgiving and Christmas.

VACATION TIME

1. A vacation of 10 working days.
2. Vacation time is not accumulative.
3. After the first year of service terminal vacation is to be given as due at 5/6 days for each month of service.
4. If a holiday falls in a vacation period the individual is entitled to an extra day. This day may be made up at a later time and not necessarily added to a vacation period.

LEAVES OF ABSENCE

1. Sick leave - pay during personal illness will be made on the basis of 1 day's pay for each month of completed service, to a maximum of 30 days. The agency may exercise the right to request the aide who is ill to be under the care of a local physician licensed in Texas.

2. No maternity leaves - Extensive leaves cannot be granted because the agency cannot fulfill its responsibility to the community when positions are vacant. If a vacancy exists at the time the Home Health Aide desires to resume employment she can be re-employed at her termination salary if it does not exceed the vacant budgeted position.

   When pregnancy is determined a written statement from the Home Health Aide's physician is required regarding her physical ability to continue field service. Termination is advisable approximately three months prior to expected confinement date or when the aide cannot fulfill her duties on the staff.

3. Family illness and death - Three days with salary is granted for terminal illness or death in the immediate family.

Deductions - FICA and withholding tax are automatically withheld. Hospitalization insurance premiums are withheld for those belonging to the agency group plan. Contribution payments to United Fund may be deducted from salary on a planned basis.

AUTOMOBILES

The Home Health Aide is required to provide her own transportation. In the event her automobile is not available due to mechanical failure or otherwise, it is her responsibility to make arrangement for transportation to fulfill her staff duties.

A stipulated allowance is made to the Home Health Aide for expense incurred in use of her automobile in line of duty. The allowance and insurance is not given with terminal vacation salary.

The agency provides a fleet insurance coverage for Public Liability and Property Damage. The agency pays the basic premium but the Home Health Aide pays any amount above the basic premium. The agency does not pay the cost of Medical payment coverage but the protection may be purchased by the Home Health Aide who has the agency fleet insurance. The agency has a copy of the fleet coverage policy on file and individual certificates are furnished to each Home Health Aide.

BENEFITS

Workman's Compensation is carried by the agency. Any accident occurring on duty must be reported immediately to the administration. A written report must be filed even though the injury does not indicate need for medical attention.

The Visiting Nurse Association is under FICA (Federal Insurance Contributions Act). In addition, the Community Chest Trust Fund provides a retirement plan with no cost to the employee. The employee is eligible for participation in the plan after two years of employment. A copy of the plan is available in the VNA office.

HEALTH PROGRAM - A report of a complete physical examination not more than one month prior to appointment is required by the agency.

1. Annual Physical Examination and Chest X-ray - the agency requires each employee to have an annual physical examination by her private physician. The employee may obtain gratis a chest X-ray and serology at the City Health Department on agency time and the report submitted to the agency.

2. Follow-up of Medical Recommendations - Every effort will be made by the agency to help the employee carry out the physician's recommendations, but no financial responsibility can be assumed by the agency beyond the service available within the agency program.

3. Immunizations: Vaccination against smallpox is required and should be repeated every three years. Tetanus - a series of three injection (or as recommended by manufacturer) at the time of or prior to employment is required and a booster as recommended by the employee's physician or the City Health Department thereafter. Other immunizations may be done as the need arises in the community. All immunizations and boosters may be obtained gratis at the City Health Department Clinics.

4. Dental Care - Each employee is urged to have periodic examination and care by her dentist. It is expected the employee will make appointments at times which do not conflict with the agency's work schedule. If an appointment must be made during duty hours, time off must be arranged with the administrator.

Approved by Board of Directors 2-23-67

VISITING NURSE ASSOCIATION of DALLAS
Policies for Home Health Aide Service

I. Definition:

Home Health Aide service is the program which provides for the employment, training, assignment and supervision of qualified non-professional personnel by the Visiting Nurse Association to complement the nursing service. The professional staff establishes with the applicants the need for service, consults with the nursing service supervisor and the responsible medical service for necessary orders before the initial assignment is made. The plan for the use of the Home Health Aide is a definite part of the total nursing plan set up by the professional nurse. Supervision is done by the visiting nurse or the home health aide supervisor who continually evaluate whether service given meets needs of the recipient.

II. Functions:

1. Service is available primarily where a health problem indicates the need.
2. It implements professional health services through provision of necessary personal health care for individuals during their physical and mental rehabilitation process.
3. It enables family members who must provide continuing personal care to an elderly, blind, or chronically ill member to have temporary periods of rest or relief on a planned basis.
4. It provides care for individuals in order to lessen stress on usual caretaker or to free for other family responsibility.
5. It may help to maintain a safe and clean environment, improve nutritional status of patients and encourage participation in social and recreational activities.
6. The service is NOT meant to substitute for institutional care when such is needed or indicated.

III. Intake and Service policies:

1. Referrals for service may be accepted from individuals, physicians, clinics and out patient departments and other health and welfare agencies.
2. All referrals must be evaluated by a conference with patient's physician and a home visit by a member of VNA nursing staff or the nurse supervisor of the Home Health Aide service. If the evaluation visit is not made prior to the assignment of the Home Health Aide the nurse must be present to participate in the patient's care with the Home Health Aide on the initial visit.
3. Supervisory visits by a staff nurse should be made periodically, depending on the patient's condition and the procedures performed by the Home Health Aide. A minimum of one visit a month is advisable.

The staff nurse may be providing professional nursing care under medical orders in addition to Home Health Aide service. Such visits may include supervision of Home Health Aide periodically.

4. The cost of supervisory visit is included in Home Health Aide service. The initial visit and later visits for evaluation of the patient's condition when complications develop or the physician orders a re-evaluation of the patient's condition may be charged as nursing visits.

5. A supervisory visit by the nurse and/or an order from the attending physician should precede discharge from service.

6. A service record is kept on each patient, including dates of service, reports of the nurse and Home Health Aide, conferences with physicians, etc.

7. No service can be given where there is a contagious disease. Service may be given where patient or family have upper respiratory infection but Home Health Aide and family should be instructed in protective measures.

IV. Procedures Home Health Aide may give:

A. Personal care
   Bath - patient in bed or on chair. No tub baths
   Shampoo - in bed or on chair
   Skin and back care - prevention of decubiti
   Oral hygiene

B. Body mechanics
   Positioning - in bed and chair
   Transfer activities - in bed and chair
   Aid ambulation - use of walker
   Range of motion exercises - simple as established by a physical therapist or visiting nurse.

C. General procedures
   Temperature, pulse, respiration
   Urine tests for diabetics
   Enemas - where no complications exist
   Douches - cleansing
   Tube feeding and care of tube - insertion of or changing of tube not permitted.
   Colostomy irrigation - where no complicating factors
   Catheter irrigation - removal if blocked but not the insertion or changing position of catheter.

D. The visiting nurse is to demonstrate and observe the Home Health Aide perform any procedure that must be specially adapted to the individual patient.

E. Light housekeeping, personal laundry, preparation of patient's diet or meal may be done where the major purpose of the visit is for personal care of the patient.

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ABSTRACT

The objectives of the study were to (1) define the scope of home care programs in general and the patients to whom they should be made available; (2) determine an estimate of the number of patients in Baylor University Medical Center, Dallas, Texas, that could be suitably treated by a home care program; (3) assess the degree to which Baylor University Medical Center and the community of Dallas, Texas, could support a home care program; and (4) determine the most suitable home care program for Baylor University Medical Center.

Literature pertaining to home care programs was researched; physicians' posthospital plans of management of patients age 65 and over after two weeks' hospitalization were surveyed; all inpatient medical records in the hospital were surveyed; and key personnel in the hospital and those associated with leading health agencies in the community were interviewed.

It was determined that Baylor University Medical Center had several factors limiting its ability to provide a home care program, but many of these could be overcome by various community health agencies. An initial modest home care program was recommended with gradual extension and expansion of the program over the next few years.