What has been happening with home care, and what are the possibilities for the future? The forms and trends in home health services are discussed, new directions in home care are described, and their significance for future developments are pointed out. The emphasis on imaginative innovation is exciting.

HOME HEALTH SERVICES—PAST, PRESENT, FUTURE

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THIS paper presents a "happening"—today's activities in home care in the United States, and a projection of future possibilities; in other words, a picture of home care on the move. Throughout the Western world there is increasing interest in domiciliary care, the provision of appropriate health services in the home setting. In the United States this interest is manifested by increasing involvement in home care programs of diverse auspices and types of service offered.

Home care has numerous forms. It varies from programs offering single services such as nursing care of the sick at home, homemaker-home health aide, or meals-on-wheels, to multiservice patterns, the most sophisticated of which are coordinated home care programs. Previously, the most widespread program of home care was nursing care of the sick at home, whether provided by a voluntary nursing agency, an official health department, or other source. Since the advent of Medicare and its *Conditions of Participation for Home Health Agencies* spelled out in the original legislation (P.L. 89-97) and later in the Code of Federal Regulations,[1,2] emphasis is on providing services in addition to nursing, and today, the multiservice home health agency predominates.

From the standpoint of clinical medicine and public health, home care is beginning to take its rightful place in the continuum of health care. It is an adjunct not only to inpatient hospital care, where it is useful in pre- and post-hospitalization situations, but also in outpatient services and even in emergency room follow-up. It is proving helpful in averting or postponing hospitalization and in caring for patients with conditions inappropriate for any institutional care. Home care is also proving useful in community efforts to supply family-focused preventive and constructive health services.

Growth of Home Care

The growth of home health agencies throughout the nation over the past few decades shows striking differences according to administrative auspices (Tables 1 and 2, Figure 1).[3] Voluntary nursing agencies achieved their most rapid growth before 1954 and then settled into a steady, gradual increase. Data in the last year show that there has been a trend toward merger of agencies with resultant reduction in

numbers. Hospitals entered the home care field later, and after an initial rapid rise in hospital-administered programs they, too, settled into a steady gradual increase. The major growth in the past decade has been those new programs established in official health departments. Since Medicare, home care programs have been established in other than these traditional agencies and are now administered by extended care facilities, rehabilitation centers, and free-standing organizations created for this purpose. Prepaid group practices such as the Health Insurance Plan of New York City, the Group Health Cooperative of Puget Sound, Seattle, Wash., and the Kaiser-Permanente Programs of Portland, Ore., and Northern California also have established home care programs. Another group practice, the Fairmont Clinic of West Virginia, has an innovative home care program that reaches into the rural area through satellite home care units.

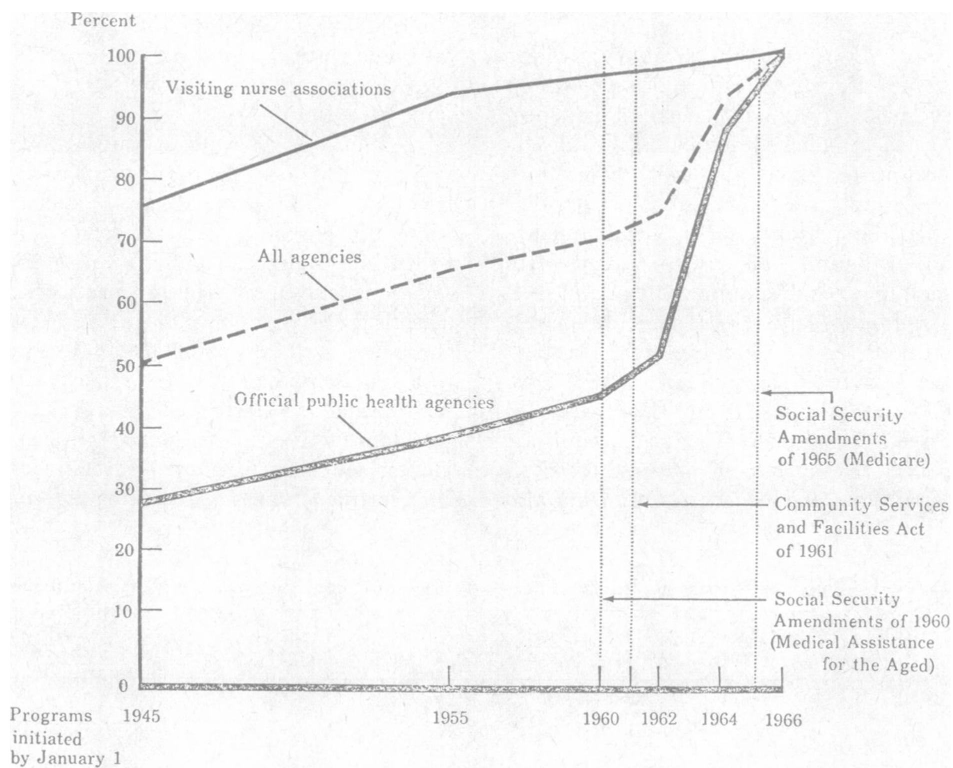
In January, 1969, three out of five of the 2,184 home health agencies certified for participation in the Medicare program were in official health departments, one in four in visiting nurse associations, and about one in thirteen was administered by a hospital (Table 2). There are striking regional differences in a predominant type of agency. In New England, where the voluntary approach is the typical community pattern, 68 per cent of the home health agencies certified under Medicare are in

Table 1—Types of home health agencies—number and per cent, years before Medicare

Type of agency	Prior to 1945	1945-1954	1955-1959	1960	1961	1962	1963	1964	1965-1966
					Number				
Total	685	874	948	973	1,008	1,169	1,254	1,305	1,356
Official health	167	228	271	286	318	455	527	569	612
Visiting Nurse Association	464	568	589	592	594	599	602	604	611
Combined government and voluntary	27	41	50	55	56	69	76	82	82
Other nonofficial	27	37	38	40	40	46	49	50	51
					Per cent				
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Official health	24.4	26.1	28.6	29.4	31.5	38.9	42.0	43.6	45.1
Visiting Nurse Association	67.8	65.0	62.1	60.8	58.9	51.3	48.0	46.3	45.1
Combined government and voluntary	3.9	4.7	5.3	5.7	5.6	5.9	6.1	6.3	6.0
Other nonofficial	3.9	4.2	4.0	4.1	4.0	3.9	3.9	3.8	3.8

Source: Public Health Service, Division of Nursing. Adapted from Table 6 "Services Available for Nursing Care of the Sick at Home."

Figure 1—Accumulative distribution of established home nursing care of the sick programs, by year program was initiated and by type of agency



Source: Services Available for Nursing Care of the Sick at Home, January 1966. PHS Publ. No. 1265 (revised 1967).

visiting nurse associations, while in the South where home care is a more recent development, 86 per cent of agencies are in official health departments (Table 3).

Growing Involvement of Many Health Workers

The trend in home care is toward a comprehensive array of physician-directed services. As a recognized form of medical care, responsible home care requires that every patient should have a responsible physician. Responsibility and involvement, however, are not always synonymous. The degree of physician involvement varies considerably. At its weakest, it is limited to referral of the patient to a home health agency with little or no subsequent physician contact. At best, physician involvement moves far beyond referral orders and minimal contact to a leadership role and participant partnership in a home care team. On such a team, the physician shares in a diagnostic appraisal, formulation of treatment plan, delivery or delegation of services, and periodic reevaluation as changes in the patient's condition or environment require.

Nursing service has been, and probably will continue to be, the keystone of home health services. However, medical social services, various therapies, nutrition consultation, home health aide or homemaker services, and such material supports as medications, appliances, supplies, and transportation are available in many communities to aid the physician and improve patient care.

Some comprehensive home care programs have as many as 15 disciplines available on full- or part-time basis.

Home Care and Comprehensive Services

All ages benefit from home care but since the advent of Medicare the major home care thrust has been toward that 10 per cent of the population 65 years of age and over. Since July 1, 1966, Medicare has provided basic guidelines in its *Conditions of Participation for Home Health Agencies* and established the fact that home care is broader than nursing alone by its definition of the home health agency function as "primarily engaged in providing skilled nursing services and other therapeutic

Table 2—Types of participating home health agencies—number and per cent, selected dates, October, 1966-January, 1969

Type of agency	October 1966	March 1967	January 1968	August 1968	January 1969
			Number		
Total	1,543	1,753	1,898	2,101	2,184
Official health	829	939	1,033	1,243	1,295
Visiting Nurse Association	494	549	569	538	541
Combined government and voluntary	81	93	98	105	108
Hospital based	79	133	150	161	173
Other nonofficial	60	39	48	54	67
Extended care facility based	4	n.a.	14	15	15
Rehabilitation facility based	8	n.a.	12	12	12
Miscellaneous	48	n.a.	22	27	40
Proprietary	n.a.	n.a.	n.a.	n.a.	20
			Per cent		
Total	100.0	100.0	100.0	100.0	100.0
Official health	53.7	53.6	54.4	59.2	59.3
Visiting Nurse Association	32.0	31.3	30.0	25.6	24.8
Combined government and voluntary	5.3	5.3	5.2	5.0	4.9
Hospital based	5.1	7.6	7.9	7.6	7.9
Other nonofficial	3.9	2.2	2.5	2.6	3.1
Extended care facility based	0.3	n.a.	0.7	0.7	0.7
Rehabilitation facility based	0.5	n.a.	0.6	0.6	0.6
Miscellaneous	3.1	n.a.	1.2	1.3	1.8
Proprietary	n.a.	n.a.	n.a.	n.a.	0.9

Source: Social Security Administration

Table 3—Participating home health agencies in nine Census Bureau divisions—number* and per cent, January, 1969

Type of agency	New England	Middle Atlantic	East North Central	West North Central	South Atlantic	East South Central	West South Central	Mountain	Pacific
					Number				
Total	368	313	308	177	324	210	229	76	156
Official health	86	119	191	114	255	197	208	49	75
Visiting Nurse Association	251	110	79	19	22	5	11	6	37
Combined government and voluntary	10	15	15	15	34	1	2	9	7
Hospital based	20	69	17	26	8	7	1	9	15
Other nonofficial	1	—	6	3	5	—	7	3	22
					Per cent				
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Official health	23.4	38.0	62.0	64.4	78.7	93.8	90.8	64.5	48.1
Visiting Nurse Association	68.2	35.1	25.7	10.7	6.8	2.4	4.8	7.9	23.7
Combined government and voluntary	2.7	4.8	4.9	8.5	10.5	0.5	0.9	11.8	4.5
Hospital based	5.4	22.1	5.5	14.7	2.5	3.3	0.4	11.8	9.6
Other nonofficial	0.3	—	1.9	1.7	1.5	—	3.1	4.0	14.1

Source: Social Security Administration
* Does not include 20 agencies classified as "other," 2 agencies in Puerto Rico, and 1 in Virgin Islands.

services."[1,2] Among home health agencies presently certified under Medicare one finds that in addition to nursing, 73 per cent provide physical therapy; 48 per cent, home health aide services; 20 per cent, medical social services; 22 per cent, speech therapy; and 16 per cent, occupational therapy (Table 4).

The *Conditions of Participation for Home Health Agencies* under Medicare require that an agency have at least nursing plus one other specified service. This reference to one additional service was necessary when Medicare started. In July, 1966, most home health agencies in existence could not have qualified for certification had more comprehensive services been required. *The stated intent of the law is for attainment of more comprehensive services.* This important principle applies equally to home health agencies and hospitals. It would be ludicrous to base hospital adequacy on the requirement that it have at least a nursing department and *one* of the following: surgical department, x-ray, laboratory, dietary department, *or* rehabilitation unit. Viewing this hypothetical absurdity, one can see that the requirement of nursing-plus-one-service in home health agencies is only the *floor* and not the ceiling. The rational and intended staffing goal is to add necessary services as needed to provide a comprehensive program appropriate for the community and the types of patients accepted for care.

Social Security data show that many

agencies are still at this minimal level of nursing-plus-one-service. Of 2,184 agencies certified by January, 1969, half were at minimum certification level (Table 5). When an agency's services are too limited, one of two things can occur: (1) it can restrict intake to the few conditions it is equipped to serve; or (2) it may accept patients without having the staffing versatility to meet those patients' needs.

If an agency restricts its intake, services should be added in response to clinical needs of patients in that community. Program evaluation of an agency will often show that patients who might benefit from home care are being rejected because necessary services are lacking. Others remain unserved because the agency, without operating experience with particular conditions of the patients, lacks confidence to move into new applications of care. Service expansion calls for thoughtful medical leadership, physician involvement in patient care, and dependable working connections with hospitals.

Comprehensiveness of service is desirable but must be built on the basic component of adequate nursing. Since Medicare, the added work load poses excessive stress on agencies where the amount of nursing service was already inadequate to meet community needs. In January, 1969, the Social Security Administration found that 43 per cent of certified home health agencies had staffs of only one or two nurses. In many localities these nurses carry general public health responsibility including work in well-child conferences, immunization programs, school health, and prenatal care. The desirability of close relationships between home care and traditional public health programs is obvious, but home care is too demanding a form of medical care to be casually superimposed on already overburdened health workers. A home care program should be adequately staffed by nurses and

Table 4—Number and per cent of certified home health agencies providing selected services, by type of agency: January, 1969

Type of agency	Number of agencies	Physical therapy		Occupational therapy		Speech therapy		Medical social service		Home health aide		Nutrition guidance	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All agencies	2,161*	1,571	72.7	352	16.3	477	22.1	432	20.0	1,042	48.2	393	18.2
Visiting Nurse Association	541	461	85.2	112	20.7	140	25.9	78	14.4	245	45.3	45	8.3
Combined government and voluntary	107	85	79.4	25	23.4	36	33.6	18	16.8	54	50.5	22	20.6
Official health	1,294	830	64.1	129	10.0	193	14.9	214	16.5	589	45.5	203	15.7
Hospital based	172	154	89.5	62	36.0	82	47.7	98	57.0	126	73.2	104	60.5
Rehabilitation facility based	12	12	100.0	11	91.7	10	83.3	7	58.3	5	41.7	3	25.0
Extended care facility based	15	12	80.0	5	33.3	7	46.7	5	33.3	11	73.3	9	60.0
Proprietary	20	17	85.0	8	40.0	9	45.0	12	60.0	12	60.0	7	35.0

* Based on 2,161 of the 2,184 certified agencies for which data were available.
Source of basic data: Social Security Administration (Type of agency and services provided from application form SSA-1515)

Table 5—Home health agencies providing specified numbers of services in addition to nursing service

Services in addition to nursing	January 1969 No.	%
Five	96	4.4
Four	130	6.0
Three	205	9.5
Two	574	26.6
One	1,155	53.5
Unknown	24	—
Total	2,184	100.0

other responsible health workers whose work assignments permit them to give dedicated attention to their patients. In addition, strong supports should be built into the program through close working interrelationships with all other health services and community resources.

The numerous one- and two-nurse agencies struggling against great odds point up the principle that insufficient care is *not* better than no care at all. The ancient medical admonition, "Do nothing to harm," is applicable to home care as to every other form of patient care. Patients inappropriately accepted by inadequately staffed, or inadequately functioning, home care agencies may be harmed, particularly, if their placement in that weak situation deprives them of appropriate care in another—perhaps institutional—setting. For example, a paraplegic in one home care program had been at home for seven years as a bed-bound patient. In addition to personal care which her own daughter provided, the patient was visited twice weekly by a nurse from a local agency. After seven years of this static situation, the daughter announced plans to marry. The agency, realizing the impossibility of continuing home care without a caretaker on the premises, recommended the patient's transfer to a rehabilitation hospital. Within six months, comprehensive care in that center enabled the patient to become so self-sufficient that she could return home and care for herself with a small amount of professional assistance from the home care service. In telling this true story, some people have referred to the miracle of the woman's return to self-sufficiency. We submit it as an example of the tragedy of seven wasted years due to inappropriate careplacement.

New Directions

Home care is moving into new and exciting areas, presaging the home health agency of the future. What is beginning to emerge? Programs of home health services are moving in two directions—improved services for specific disease entities already on the case load, and development of services for new groups of patients not now generally accepted for care. Parkland Memorial Hospital (Dallas, Tex.) has a program for the management of rheumatoid arthritis in hospital and at home which has clearly indicated a need to modify conventional techniques of care within the home. Because of the remittent nature and profound psychological effect of rheumatoid arthritis, the Parkland program supplements traditional methods of care in the home with patient and family education and counseling to provide both physical and psychological support.[4]

At a meeting in October, 1966, a Public Health Service Task Force on Emphysema and Chronic Bronchitis identified the need for home care for this group of patients, and stressed the need for new and specialized knowledge and training for personnel caring for such patients. The Task Force noted the general lack of services, programs, and facilities for the care of the patient with chronic bronchitis and emphysema. They

strongly recommended the development and support of such services, particularly home care programs for these patients.[5]

Generally speaking, the terminal patient with cancer is not accepted readily in home care programs. The use of home care in terminal illness calls for appraisal and reappraisal of the patient, his family, and his home to determine whether such care is suitable, and for how long. In one community, program evaluation revealed that not a single patient with terminal cancer had been admitted to the home although many cancer patients had remained in hospitals until death. The following year, a concerted effort by hospital and home care staffs resulted in home care for selected patients with terminal cancer. Patient and family response was encouraging. The patients were more at ease and required fewer sedatives and drugs for pain; the families were better able to cope with grief. In general, these terminal patients were better off, both physically and mentally, in the home setting.

Many diseases or conditions—some common, some unusual—have rarely been accepted in home care programs. For these, pilot explorations are needed to determine feasibility of home care, and where appropriate to delineate its modalities. For example, growing concern in the health field over the restricted number of patients who can receive intermittent renal dialysis in hospital centers suggests the need for dialysis at home. The development of a portable dialysis unit, and evidence that continuing intermittent renal dialysis can be carried on successfully at home, has been climaxed this year in a bill presented to the Congress suggesting support for both the establishment of community home care dialysis programs and the payment for such care under Medicare. Although this proposed legislation was not enacted, Blue Cross of Michigan is exploring potential coverage of such care for its insured members. A one-year project will pay for outpatient and home dialysis of members under the direction of six Michigan hospitals.

Similar attention has been addressed to other special groups. The home care program at Montreal Children's Hospital is an example of services for a specific age group. The major objective of this program is to improve, or at least maintain, the health care of selected children whose condition is deteriorating or whose treatment is failing under existing methods of follow-up care after hospitalization. The service is proving valuable in a wide range of conditions, not only after hospitalization, but as an adjunct to outpatient and emergency room care.[6]

At the International Congress on Home Help Services held in Germany, September, 1965, Britta Sjogren of the Royal Social Welfare Board of Sweden, speaking about their program, emphasized the use of home health aide services for sick children. She said, "The children who normally attend school or day nurseries or received day care in a family usually have to stay at home when they are ill, even if they only have a slight cold. Working mothers find this a great problem, as they are forced to stay away from work if the children cannot be supervised in some other way. Absence from work not only means reduced income for the mother but may also cause a deterioration in her position in the labor market."[7] One question our country might ask is how to provide responsible care for ill children of working parents when those children must be kept home under care.

In the United States, home care has rarely been involved in pre- or postpartum care. Boston City Hospital recently provided a combined program of home care and outpatient care for pregnant cardiac patients. In this project, a public health nurse provided services to

these pregnant women in their homes so that total prenatal care was enhanced and the problems of traveling to the outpatient department or of being rehospitalized because of the cardiac condition were minimized.[8]

Recognition of the need to provide comprehensive medical care for the social as well as medical problems of maternity patients in low income minority groups led to a home care program at Lincoln Hospital in the Bronx in 1965. Dr. Celia S. Deschin reports ". . . unlike a general medical home care program, the maternity home care program makes the substandard and hazardous living conditions of its patients parts of the treatment and follow-up. Its pioneering aspects consist of sound foundation for preventive health care where logically it should begin, with the birth of the child."[9] Among the benefits of the program was that 95 per cent of the mothers in the program returned to Lincoln Hospital for postpartum clinic attendance, as compared to 50 per cent of the general postpartum case load.

A current study of home care needs of yet another group is in progress at Beth Israel Hospital in Boston, Mass., where selected premature infants are being followed by the hospital's general home care program. This enables these infants to go home earlier than would be usual under traditional care, and supplies strengthening supports to the families at a crucial time.

There is need to explore the role of home care in mental health programs. Although some mental health programs, with the help of public health nurses from community agencies, have established services for individuals who have been discharged from mental institutions and need follow-up care, there is further need for home health agencies and mental health centers to work together to identify common needs and common goals for their respective patients. An exchange of personnel between these two agencies might improve the care of the patients served by both facilities. Furthermore, there is need for programs in which intensive care of the mentally ill can be provided at home by visiting psychiatrists, psychiatric social workers, or psychiatric nurses.

A home care program cannot stand alone. It requires working alliances with other care in other settings to be truly effective. Several experimental projects have combined home care with services in other facilities. The Cincinnati Alcoholism Clinic has completed a pilot program utilizing home visits by public health nurses in treating multiproblem alcoholic families. In addition to clinic visits by the husband and wife for diagnostic evaluation and treatment, a nurse visited the home each week and coordinated referrals to other agencies. The clinic staff felt that the nurse's outstanding contribution was maintaining continuous therapeutic contact with the families who otherwise would have been lost to the clinic.[10]

St. Luke's Hospital in New York City has instituted a home health nursing program for outpatients with heart disease. The addition of public health nursing visits as follow-up to the outpatient cardiac program has reduced the rate of hospitalization for congestive heart failure. The staff feels that an anticipatory home care program based in a community hospital "has great potential, both for improving the health status of patients with chronic illness and for bringing the hospital closer to its community."[11]

In Michigan, at the Saginaw Hospital, home care is combined with day care. Essentially bed-bound patients are brought to the hospital's rehabilitation department by special bus. There they receive social service, rehabilitative, and dental services in a day care setting. At the same time or subsequent to the day care, patients are provided skilled nursing and home health aide services in

their own homes. This admixture of day care and home care can be modified as the patient improves, decreasing the amount of time spent in the day care center and increasing the time spent at home until the patient reaches his maximum level of independence.

The Future

Information gained from present and past operations will affect other home care programs. Existing programs will be strengthened by knowledge of how to better care for specific diseases or conditions and will be encouraged to broaden case loads. Specialized home care programs, perhaps in teaching hospitals, will be established to care for individuals not usually included in general community programs. These are beckoning areas for medical care pioneers. There is room for imaginative innovation—providing that every effort be securely connected with the best professional strengths the community affords.

REFERENCES

1. U.S. Social Security Administration. Conditions, Home Health Agencies [Under] Federal Health Insurance for the Aged. HIM-2(3-66). Baltimore, Md.: The Administration, 1966. 30 pp.
2. ————. Conditions of Participation, Home Health Agencies [Under] Federal Health Insurance for the Aged—Regulations. (Code of Federal Regulations, Title 20, Chapter III, Part 405.) HIR-12 (9-68). Baltimore, Md.: The Administration, 1968. Ca. 17 pp.
3. U.S. Public Health Service and State and Territorial Directors of Nursing. Services Available for Nursing Care of the Sick at Home, January, 1966. Prepared by the Division of Nursing of the Public Health Service in cooperation with the State and Territorial Directors of Nursing. PHS Publ. No. 1265 (revised 1967). Washington: Gov. Ptg. Office, 1968. 74 pp.
4. Cohen, B. Stanley; Baum, John; Loggins, Beth; and Terry, Elaine. Home Care Program in the Management of Rheumatoid Arthritis. J. Chronic Dis. 39:631-636 (June), 1966.
5. Task Force on Chronic Bronchitis and Emphysema. Report of the Task Force—Task Force sponsored by the Chronic Respiratory Disease Control Program, National Center for Chronic Disease Control, Bureau of Disease Prevention and Environmental Control, U.S. Public Health Service and the National Tuberculosis Association, Princeton, N. J., October 16-20, 1966. Bull. NTA 53:23 (May), 1967.
6. Wherrett, Brian. The Coordinated Home Care Programme at the Montreal Children's Hospital: A Pilot Project in Comprehensive Ambulatory Care. Abstract of paper presented before Association for Ambulatory Pediatric Services, Sixth Annual Scientific Meeting, April 26, 1966, Atlantic City, N. J. (Abstr. No. 27, p. 14. Preliminary Program).
7. International Congress on Home Help Services. Proc. International Congress, held in Koenigstein, Germany, September, 1965. English translation; U.S. Welfare Administration Publ. No. 17. Washington: Gov. Ptg. Office, 1966. 102 pp.
8. Abramson, Julius, and Grosser, George H. New Approach to Care of Pregnant Cardiac Patient. Postgrad. Med. 38:604-607 (Oct.), 1965.
9. Deschin, Celia S. The Need to Extend Medical Services Beyond the Hospital of Maternal and Infant Care Is to Become Comprehensive. A.J.P.H. 58:1230-1236 (July), 1968.
10. Nurse Home Visits for Alcoholic Families. Chronic Illness Newsletter 18:3 (Aug.), 1967.
11. Hanchett, Effie, and Torrens, Paul R. A Public Health Home Nursing Program for Outpatients with Heart Diseases. Pub. Health Rep. 82:683-688 (Aug.), 1967.

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