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REHABILITATION FACILITIES AND THE HILL-BURTON AMENDMENTS *

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The Medical Facilities Survey and Construction Act of 1954 broadened the Hospital Survey and Construction Program to include and emphasize facilities for providing services for the chronic ill and impaired. These amendments authorize an appropriation of two million dollars for grants to the States, on a dollar for dollar matching basis, to survey the need for and to develop State plans to meet the need for chronic disease facilities, nursing homes, diagnostic or diagnostic and treatment centers, and for rehabilitation facilities. This survey and planning money remains available until expended. The minimum allotment for survey and planning purposes to any of the States is $25,000. The maximum allotment to a State is controlled by the population of the State.

An additional authorization of 60 million dollars annually to assist in paying part of the cost of construction of these facilities earmarks 10 million dollars each for nursing home and rehabilitation facilities, and, 20 million dollars each for chronic disease facilities and diagnostic or diagnostic and treatment centers. These appropriations are authorized for the fiscal years 1955, 1956, and 1957. This coincides with the present statutory time limitation of the Hospital Survey and Construction Program. The 60 million dollar authorization is in addition to the annual authorization of 150 million dollars contained in the basic law.

The modus operandi of the broadened program is essentially the same as the original program with the initiative for acquiring facilities and the operation of the completed facilities resting with the local community. The State

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and Federal Governments act in cooperation with the sponsors of the projects to enable them to construct the facilities of the type needed and placed where the need is the greatest within the State. The project application for construction funds must be of high priority, in accordance with the State plans, and approved by the Federal and State agencies administering the program. Each State determines the amount of Federal participation for each project. Federal matching funds will be a minimum of 33-1/3 and a maximum of 66-2/3 percent of the cost of constructing and equipping of each defined project depending on one of several options the State agency may choose. In general, the new amendments are an inducement to States and local communities to provide the facilities for the care of the chronic ill and impaired which are greatly needed and for which there will be an ever-increasing demand due essentially to the characteristics of our total population and the controlling elements of good medical care.

Rehabilitation facilities were eligible under the existing Hospital Survey and Construction Program if they were part of a hospital. The new amendments authorize, in addition, assistance for the construction of rehabilitation facilities when <u>not</u> part of a hospital.

The annual appropriation of 10 million dollars for rehabilitation facilities authorized by the 1954 amendments will be allotted to the States on the basis of the existing statutory formula, the controlling factors of which are the State's population and per capita income. The minimum allotment to any State is 50,000 for rehabilitation facilities. Two or more States may pool Federal grants for construction of a rehabilitation facility. Funds allotted for rehabilitation facilities may be used for no other purpose. This feature is different from the funds allotted for chronic disease hospitals, nursing homes, and diagnostic or diagnostic and treatment centers which may under certain circumstances be transferred from one category to another.

The foregoing is a recital of the salient features of the Medical Facilities Survey and Construction Act of 1954, Public Law 482, 83rd Congress.

It is most fitting to consider the implications in the Act in regard to rehabilitation facilities and programs. The Act has important implications for (1) inter-professional collaboration and performance; (2) community health planning; and (3) for health promotion and chronic disease control.

The term rehabilitation facility is defined in the Act as "a facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical, psychological, social, and vocational evaluation and services under competent professional supervision, and in the case of which the major portion of such evaluation and services is furnished within the facility; and either (A) the facility is operated in connection with a hospital, or (B) all medical and related health services are prescribed by, or are under the general direction of persons licensed to practice medicine or surgery in the State".

The reference to integration in the definition is recognition of a basic principle of rehabilitation - the indispensability of effective inter-professional cooperative effort for the rehabilitation process. Teamwork is not a new concept or activity either in clinical medicine or in public health. Teamwork in rehabilitation whether directed toward helping a severely handicapped individual to live and work with what he has, or toward developing a coordinated community program of rehabilitation services is exceptionally complex and often difficult. Even though the goal of the rehabilitation process may be specifically defined the very nature of the problem requires that the goal be sought through professional services and skills that vary widely in character and methods. Members of the "rehabilitation team" come from professions and skills that are in different stages of development and refinement, and, vary greatly in prestige status accorded by our culture. Even technical vocabulary developed and used in each professional field or skill complicates effective cooperation and understanding by making communication slow and difficult. The essentiality of

bringing to the person with disability all of the services needed to restore him to complete or partial independence forced and demanded recognition of the inter-professional and inter-skills cooperative endeavor as a must in the rehabilitation process. What needs to be faced directly and objectively is the meaning of the team approach and the most effective ways of securing inter-professional and inter-skills cooperation. It is absolutely necessary for the rehabilitant and I ask who else matters if we are to do our job.

In modern medicine, from the expansion of scientific knowledge and the increasing complexities of diagnostic aids, and therapeutic and supporting services, as well as from the social changes resulting from the trend toward an industrial, urban life we find the phenomenon of specialization. With medical specialization has come increased focus upon the need to consider the "patient as a whole". Current trends in medical education are toward a better understanding of the appropriate balance of physical, mental, emotional and social factors in illness and disability. Moreover, general skills in medicine are being identified as including skills in teamwork and in use of consultants. The need for the development of specific training for cooperative work with colleagues is increasingly regarded as essential. There is still much to be done on identifying leadership and participating roles in the medical team as well as on methods of synthesizing the contributions of adjunctive services.

There is need for definitive analysis of problems, practice and ways to achieve successful inter-professional functioning. Chief among these are the nature of team leadership, ways of coordinating services to a given individual or in program planning, and when, how, and to whom responsibility for the patient's rehabilitation program should be shifted and to what degree as his needs change.

Many health problems in the past have been solved through joint planning between health groups, community groups, and voluntary health agencies. The Hospital Survey and Construction Program is just such a cooperative endeavor.

Its 2300 approved projects representing over 109,000 hospital beds, 463 public health centers and many adjunctive service facilities totalling nearly 1 billion 650 million dollars, of which 618 million dollars is Federal money and 1 billion 232 million is State and local funds demonstrates what can be achieved in less than nine years.

In developing a program for rehabilitation facilities a fact-finding job is essential to defining the needs of communities for such facilities. The new amendments provide for a survey by the States of existing facilities in the field of rehabilitation as a prerequisite to developing a plan to meet these needs.

Generally speaking, the chain of rehabilitation services offered in general hospitals, in special hospitals, or in highly developed rehabilitation facilities for the treatment of severe impairments is no stronger than its weakest link. Often the weakest link is the availability and accessibility of resources in the rehabilitant's home community.

In many instances rehabilitation efforts succeed or fail because the nature and quality of the continuing services available in the patient's home community during that all important period following discharge from the hospital or rehabilitation facility are unrealistic in terms of community employment opportunities. Furthermore, if needed medical or nursing supervision cannot be continued in the patient's community, if home pressures or unhappy family relationships precipitate another breakdown, if vocational training is not followed by help in securing employment, the gains made in a special rehabilitation setting will have been lost and the patient's confidence undermined.

The comprehensive rehabilitation facility with its wide range of services although specifically authorized by the new amendments are not the only needs in this field. All communities need to make provision for services to the physically and mentally impaired persons for rehabilitative services which they can feasibly support and which are adapted to their needs and resources. These services are a part of the health maintenance program of any community.

Such community rehabilitation projects might grow out of or be centered in a hospital rehabilitation program; they might be part of a broad chronic disease control plan, or, they might be sponsored by social agencies, workmen's compensation agencies, or a combination of agencies interested in problems of the disabled. The plea is for a cooperative and coordinated endeavor at all times.

Experience has indicated that no "blue print" can be imposed upon any community. The variables in stage of development, existing health, welfare, education and employment resources and recognition of need for services are numerous. In many communities, however, these programs are the focal point for case-finding, evaluation and referral. For here, although the services may be limited, the problem is identified and the appropriate resource in the larger urban center sought. Furthermore, complex disabilities may be referred to facilities with the essential elements of a comprehensive rehabilitation program.

These are but a few of the implications for community planning. Community planning of the highest order needs to be attained if the comprehensive rehabilitation facilities intended by the Act are to meet the needs existent today. Not every community will be planning a comprehensive rehabilitation facility. Many communities will be needing help in understanding the nature and extent of the problem. Greater progress can be made if the community is left free to determine its own method of solving its problem. The survey money, if well used, should aid these communities in solving the basic problem of careful planning and pooling of resources in order to avoid costly duplication of facilities as well as filling in gaps in needed services for disabled persons.

Advances in medicine and the application of public health measures have been influential in permitting more of us to reach the ages of senior citizens. We still lack measures to prevent or cure many chronic diseases which partially or totally disable. The result has been a need for providing disabled persons

with help in learning to live and work with what they have left competently and graciously. We must guard against man's reaction to his own disabilities in an adverse manner emotionally. Until medical research discovers the cure for and methods of preventing residual disability for such conditions as poliomyelitis, multiple sclerosis, diseases of the heart and blood vessels, arthritis, to name but a few of the many incapacitating illnesses, representatives of the health professions must depend upon and utilize the techniques of medical specialists, psychological and social services, education, vocational training, placement, and selective job placement in helping disabled persons to attain their full potentialities for useful and satisfying lives.

Community-wide planning for care and treatment of the chronically ill is still in the embryonic stage. More attention will need to be given to the application of rehabilitation techniques for chronic disease control in order to avoid human and economic waste. In no other area of activity is there a greater challenge to the health professions for devising new methods for the control of chronic disease and for health promotion and health maintenance. To keep a disabled person functioning at a desirable level of efficiency implies a continuing program of health maintenance and health promotion. The development of adequate rehabilitation facilities and services becomes, therefore, essential, along with prevention, diagnosis, and treatment. In fact, just as it has become difficult to draw a hard and fast line between preventive and curative services so too it is becoming difficult to separate clearly curative and rehabilitative services. It is my opinion we should not try to do so as these elements of medical care are inseparable in the over-all program of health maintenance for the individual.

The modern health facilities including rehabilitation facilities have exteriors which have "eye-appeal". Their interiors are clean-cut, attractive, dignified and well-balanced. Their design follows the architectural axiom that

form follows function. A word picture of the health program to be carried on in the facility made by the various health professionals is the starting point for the architect. His creative ability and ingenuity will float wastefully unharnessed and to a great extent powerless without that program description.

Again, I must emphasize that the beauty and grace, the implied usefulness and inherent potential for good of the functionally designed health facility, by and of itself, is but the instrument of man and the vehicle by which health services reach those in need through program of service and lives of devotion.

Finally, all these plans, methods of and for rehabilitation facilities and programs are but idyllic dreams without that priceless ingredient - the trained and experienced worker. I trust and hope that we will utilize the opportunities provided in the new amendments relating to rehabilitation facilities to develop and train rehabilitation workers. If we do we may soften somewhat man's inhumanities to man. I would like to.