Effective Use of Patient Resources: A Training Guide for Family Physicians

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Effective use of resources available to patients in their homes, in their neighborhoods, and in their communities can give the family physician much assistance in the provision of total health care to his patients and their families.

Patients' resources can be divided into two broad categories – "Personal" and "Institutional"" Examples of the former are family, church, neighbors, unions, etc. Institutional resources can be public or private, and they cover a broad spectrum of services. Patients' needs for dignity and independence are best served by Personal resources. Institutional resources should be used only for those services that cannot be met any other way. Success in using any resource requires an orderly five-step process which is presented and discussed in this paper.

The well-accepted concept of the family physician as manager of total health care for patients implies knowledge of how and where to obtain those services the family physician himself cannot provide. The purpose of this paper is to present an orderly guide for family practice residents, new physicians, and other health professionals in the use of resources in such a way as to enhance their breadth of patient health-care management.

Many of the methods to be discussed were developed in the process of teaching the residents, at the Family Practice Center of Deaconess Hospital, how to recognize patient needs and then find resources to meet them. In laying the groundwork for using available resources in Buffalo, our faculty and residents were able to develop and discover many extra services for our Center patients.

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Basically, there are five steps which can be followed to ensure effective use of available resources for patients (Figure 1).

1. Understand the needs of individual patients using a time-limited agreement ("Exploratory Contract") to assess problems and develop a therapeutic patient-doctor relationship.
2. Motivate the patient to use the necessary referral resources using a treatment agreement ("Therapy Contract").
3. Maintain contact with patient and resource to ensure continuity of care.
4. Know the resources accessible to patients.
5. Evaluate the resources and learn how they prefer to render their services.

When a patient presents a complaint to his doctor, evaluation and treatment can be complex. Recovery can lag behind reasonable expectation. Hidden personal problems which can delay recovery are often troublesome to detect.

Successful outcome of treatment may depend on the physician's sensitivity to these "hidden problems." Some physicians have a natural, often unconscious reluctance to become involved with patient problems that are "overwhelming" because they are unaware of available solutions. Employing the guidelines for using resources set out in this paper, the physician can handle those problems that are within his expertise and refer the others to appropriate resources.

Understanding Patient Needs

Medical, emotional, and social problems are often so intertwined that great skill and patience are required to sort them out. The process cannot be hurried. A poorly timed, poorly prepared referral is apt to be interpreted by the patient as a rejection. Such a patient may not follow through on a referral or even return to the family physician. The use of patient-doctor "contracts" for exploring health problems and implementing treatment plans is an effective tool for achieving rapport and results.

The Exploratory Contract

Frustration and misunderstanding can be avoided from the outset if the doctor makes clear to the patient that with each new health problem, from one to three office calls might be needed to explore and understand the difficulty. A time-limited agreement for this can be formalized by doctor and patient into an "Exploratory Contract." During the Exploratory Contract period the physician and patient work on discovering and assessing not only the patient's physical and emotional problems, but also his physical and emotional strengths. In addition to medical facts, the physician should seek to know about his patient's general finances, family and other intimate relationships, hobbies, career aspirations, religious feelings, etc. The Exploratory Contract period has the added advantage of giving the physician time to develop a potent therapeutic tool, the warm understanding that fosters the healing process.

When sufficient data are collected, a problem list can be made, and solutions can be discussed in preparation for developing a "Therapy Con-

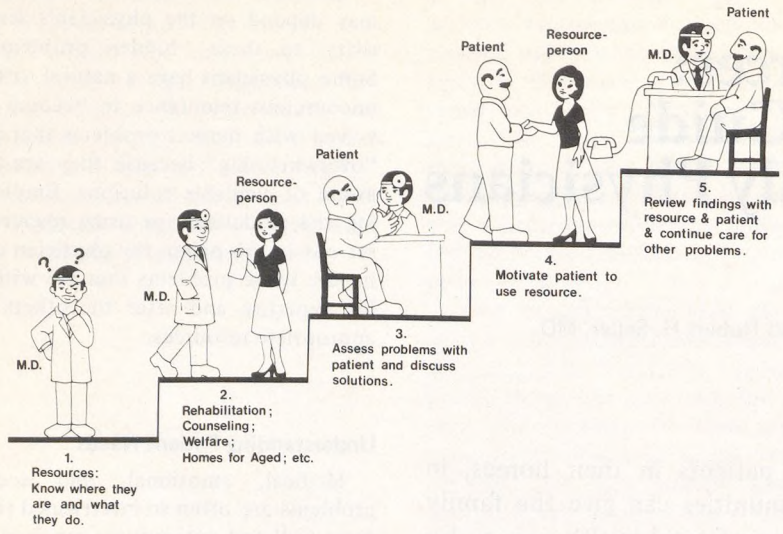

Figure 1. Steps to a successful referral to a comunity resource.

tract." It is important to be sure that the patient understands and agrees with the physician's conclusions.

Sometimes the doctor and patient will not agree on what is most important (eg, suicidal patients with multiple social problems have been known to insist that their only problem is a painful joint). The physician may have to begin the Therapy Contract with the patient's solution, but he can renegotiate the Exploratory Contract in order to give himself more time to develop the kind of rapport needed to handle the real problems. Assuming the solutions the patient and physician have worked out together fit the patient's potential and peculiarities, the next step is to decide which problems will be treated by the physician and which could be referred to outside sources.

Knowing Which of the Patient's Problems to Refer

Knowing which problems to refer in the areas of child behavior, marital discord, depression, delinquency, etc, requires the time-consuming technique of counseling. Interest, training, and skill vary from doctor to doctor. In general, if the physician does the counseling and there is no improvement within a prearranged specified time, and if a good resource exists, referral is in order.

Sometimes a less expensive resource, such as a competent social agency, is more appropriate than physician office visits. When this is the case, the patient should be informed and be allowed to make the choice. If a doctor uses a social agency in the way he would use another medical consultant (essentially as another means of facilitating his care of the patient), the quality of the patient's life will be much enhanced, and the family physician can remain the coordinator of the various facets of his patients' health care.

Motivating Patients and Using a Therapy Contract

When the patients have reached an agreement concerning the health problems and their solutions, the next step is to assess the patients' motivation to carry out the treatment plans which may include referral. Problems arise because certain patients are very accepting of "help," but are often incapable of following through. Direct questions, such as "How much are you willing to do to become well?" are helpful, especially with alcoholic, obese, and emotionally disturbed patients. Once motivation is established, the patient and doctor can design a treatment agreement (Therapy Contract) to carry out their plans.

Maintaining Contact with the Patient and Referral Resources

Whether the physician refers a patient to a medical colleague, to a community service, or decides to confer with the family or neighbors, the approach is much the same. The patient should understand why he needs another resource, and know what to expect from the resource and how to use it. The physician must follow-up referral by maintaining contact with both the resource and his patient. Asking the patient to report his impressions of the resource is often reassuring to the patient and permits the physician to assess the effectiveness of the referral source.

Knowing the Resources

The resources for patients can be divided into two broad categories, "personal" and "institutional." The following principle can help the physician understand when to use each resource.

Principle: Use Patients' Personal Resources Whenever Possible.

Corollary: When Personal Resources are Inadequate or Unavailable, Use Institutional Resources.

Personal Resources

A patient's personal resources are his family, neighbors, friends, church, lodges, and union. Since sick people seem to recover faster if they can remain in their own environment, it is wise to use family and/or close associates in the treatment plan whenever possible. Normally, such people are available to care for the patient during all hours, and they have a personal stake in the patient's recovery.

To use personal resources, the physician must first evaluate the capacity of a patient's family to provide the necessary support and care. Together the physician, patient, and family can develop a management plan. In the process of devising this plan with the patient and his personal resources, it is therapeutic to permit these individuals to work out the details. De-

emphasizing helplessness and dependency allows the family and patient to share in the decisions relevant to the illness and recovery. It is a healthy focus and strengthens the feeling of ability to cope with the illness.

If the family is disinterested, nonexistent, or mentally or physically indisposed, the availability of help from neighbors, employers, and friends can be explored.

Institutional Resources

These are resources to which a doctor can refer his patients, or can consult when he needs to solve a patient's particular problem. Because communities vary in the kinds of services available, we present a brief overview of institutional resources commonly found in the United States (Table 1).

Public Agencies (Tax-Supported)

Patients and doctors alike can easily become confused when faced with the mixture of federal, state, county, and local programs and agencies available in a community. In general, public agencies provide the following:

Financial services:

1. Departments of public welfare (usually administered by counties); money for home relief, aid to dependent children, and food stamps.
2. Supplemental Security Income; (SSI, federal).
3. State Employment Agencies; unemployment benefits.
4. Social Security Insurance (federal).
5. Medicare and Medicaid (mixed administration).

To receive the above services, patients must meet eligibility requirements which are usually rigid, but vary widely even between adjacent communities.

Health services: Health departments can represent federal, state, and/or local governments in the prevention and control of diseases and hazards affecting public health. They usually provide maternal and infant care projects; nursing services; home health services; hospital inspections; public health education and information; child welfare (adoptions, foster home care); and hospitals (Veterans Administration, special clinics). Two particular categories deserve mention:

1. Mental health services: Special hospitals, counseling centers, alcohol programs, drug programs, and outreach programs.
2. Government departments for special problems: the Agricultural Extension Service, for rural areas; offices for the aged, the blind, the handicapped, etc.

Employment services: Job listings; vocational testing; vocational rehabilitation; and special job training.

Schools: Intelligence testing; special classes (retarded, autistic, learning disorders); assistance in handling special problems of young patients; pre-school screening.

Fire and Police: Disaster and emergency assistance.

Family and Domestic Relations Court: Supervision of delinquents; child placement; counseling; and assistance with family violence problems.

Public agencies are designed to serve a large volume of people. Rapid turnover, insufficient trained personnel, overcrowded schedules, and inadequate funds have resulted in a depersonalization that often emphasizes the onus of having to ask for help. The added agitation caused by the overlapping functions, and the complexity of eligibility requirements often exacerbates the physical symptoms of already sick patients. Sometimes it seems that only the very callous and the very clever are able to cope with the system. How to ease patients' entry to public agency systems is discussed later.

Voluntary Agencies (Private)

Voluntary agencies are those supported by voluntary contributions of time, money, and/or equipment. Their usefulness is often dependent on the sophistication and attitudes of their founders and current supervising persons. As with public agencies, their functions sometimes overlap and duplicate. Personnel may be professional or have no training at all.

At present, virtually no voluntary agency provides continuing financial support. However, many are set up to provide money in emergency situations on a short-term or "single-shot" basis. Also, very few voluntary agencies provide total health care, because Medicaid, Medicare, and various insurances now cover most health expenses. As a result of changes in methods of funding and changes in national health needs, many volunteer groups now seek out uncovered areas to serve, or they experiment with new ways to solve care problems. They can often be enticed to help a doctor with a particular patient thereby inventing a new service. The special advantage of some voluntary agencies is the ability to offer extended, intensive, individualized attention.

Voluntary services can roughly be divided into two groups: (1) Sectarian (financed by religious groups) and (2) Non-sectarian (financed by private donations). The main difference between them is in the derivation of financial support. Both groups charge fees for their services based on a sliding scale. Sectarian agencies do not refuse care on the basis of religion. The doctor is free to refer his patient to the agency where he feels his patient will feel most comfortable.

Sectarian Agencies

Churches have a long tradition of providing help to people in need. The range of services provided depends on the philosophic orientation and the financial status of each religious denomination.

Sectarian services are provided by individual churches as well as by churches organized on a city, state, or national basis. Certain denominations support and administer single agencies that deliver multiple services in many cities. In metropolises, these agencies maintain satellite offices within easy reach of patients. Examples of these agencies are:

1. Catholic Charities: Some services are homes for the aged, retarded, chronically ill; out-patient psychiatric clinics; family counseling centers; homemaker services; day care centers for children and for the aged; etc.
2. Jewish Family Services: The same range of services are provided as by Catholic Charities, with small differences. Counseling personnel are usually required to have an MSW degree. Their vocational guidance clinics are especially good.
3. Salvation Army: Services are similar to those offered by Catholic Chari-

Table 1. Comparison of Services Available from Institutional Resources

Services for Patients	Common Public Resources			Common Volunteer Resources (Private)				
				Sectarian Services		Non-Sectarian Services		
	Welfare	Health	Schools, Courts, Police, Other	Large "Single" Agencies	Other	Large "Family" Agencies	Special Emphasis Groups	Other
Financial support (full or partial)								
Cash:								
Long-term:	Always	None	None	Never	Never	Never	Never	Never
Short-term:	Always	None	None	Occasionally	Occasionally	Occasionally	Rare	Rare
Emergency or single-shot:	Occasionally	None	None	Frequently	Frequently	Frequently	Rare	Occasionally
Payment of health care	Medicaid & Medicare	Some free services	None	Some free services	Some free services	Some free services	Some free services	Some free services
Eligibility standards	Defined by law	None, and/or law, or both	Defined by law	Defined by each agency (rarely limited to religious basis)		Defined by each agency (usually very flexible)		
Psychiatric problems	None	Federal, state, and local hospitals and clinics	Some examinations, no treatment	Clinics in cities, few hospitals	Rare	Clinics in cities, few hospitals	Rare	Rare
Custodial Care for aged, retarded, severely handicapped, or delinquent	None	Federal, state, county, and local "homes"	Rare	Frequent	Some	Frequent	Rare	Some
Counseling and information or referral services	Some	Some	Some	Always	Some	Always	Always	Some
Legal aid	None	None	Occasional (courts)	Occasionally	Rare	Rare	Legal Aid (Always) Other (Rare)	Rare
Graduate degrees	Very rare	Some (varies)	Frequent (schools) Some (courts)	Frequent in cities	Some	Frequent in cities	Rare	Rare
Housekeeping and nursing services	Some	Some	None	Some	Rare	Some	Rare	Rare
Genetic counseling, inexpensive contraception and abortion service	None	Some	None	Some	Rare	Some	Planned Parenthood (Always) Other (None)	None
Foster homes, adoptions, child protection	Frequently	Rare	Some	Some	Some	Some	Rare	Rare
Vocational guidance	Some	None	Some (schools)	Some	Rare	Some	Some	Occasionally

ties and Jewish Family Services, with a greater emphasis on disaster and emergency services and care for homeless men. Dental services are provided in some areas.

Non-Sectarian Agencies

Non-sectarian agencies evolved when groups of public-spirited citizens perceived a need to provide certain services for their community and organized to meet that need. Originally financed by the founders, the burden became too great, and new agencies were developed for the sole purpose of gathering funds. These agencies are known variously as United Way, United Fund, etc. They are found throughout the United States. In addition to gathering funds, they gather statistics, set agency standards, and participate in community planning. Perhaps their most useful service is the publication of a directory that lists all the agencies, service clubs, and medical facilities in a given community. A physician may obtain a personal copy of the directory from them for a nominal fee.

Other kinds of non-sectarian agencies are:

1. Family Service Societies: Services are essentially the same as those of Catholic Charities and Jewish Family Services. Counselors are normally required to have at least an MSW degree.
2. Special emphasis groups such as: Planned Parenthood; out-patient psychiatric clinics; child guidance clinics; American Cancer Society; Leukemia Society of America; Arthritis Foundation; Parents Council for Retarded Children; League for the Handicapped; American Lung Association; and Cystic Fibrosis Foundation.
3. Children's Aid Societies: Many services for children from conception to age 16.
4. Visiting Nurse Associations: Services are physical therapy; speech therapy; and home health aides; nursing services; etc.
5. YMCA: Services can include youth guidance; drug education; counseling; and recreation.
6. Legal Aid Societies: Legal services to low-income people of all ages.
7. Community improvement groups.
8. Red Cross: Disaster aid; transportation; services for members of the armed forces and their families.

Other voluntary helping groups are service clubs such as the Lions, who serve the blind. Rotary Clubs and Chambers of Commerce have rotating service projects. A physician's call to the current top official with a reasonable request usually brings results. Newspapers, private hospitals, clinics, professional organizations, private benefactors, and trust funds are other resources that can be used in behalf of patients.

Table 2. Comparison of Availability of Services by Population

Service	Availability in Rural Areas (Population less than 5,000)	Availability in Urban Areas (Population over 50,000)
Legal aid	Scant	Always
Counseling	Scant	Always
Professionally trained personnel	Some	Frequent
Financial aid	Always	Always
Cash — Long-term	Always	Always
Short-term	Public - scant	Always
Emergency	Volunteer - some	
Complete health care	Scant	Frequent
Custodial care	Scant	Frequent
Psychiatric facilities	Scant	Frequent
Housekeeping and nursing assistance for patients	Scant	Frequent
Special Services for Handicapped	Scant	Always
Foster homes, adoptions, abortions, and contraception	Some	Always
Vocational rehabilitation	Scant	Frequent

Rural Resources

Because agencies are usually sparse and small in rural areas, a physician has to be more versatile to find solutions for a rural patient than for his urban counterpart. Personal resources have to be stretched and exploited. It may also be necessary for the physician or patient to do a bit of organizing and improvising within the limits that exist in the area.

The following rural resources may be helpful: (1) Agricultural Extension Services; (2) volunteer fire, police,

Table 3
Procedure for Evaluating an Agency

1. Make a formal appointment with the director.
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2. Check the adequacy of the physical facilities. Can the patient reach them safely and easily?
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3. Speak with the director and personnel who will treat your patients. Try to arrange to have one key person as your future contact resource. Learn exactly what the agency does.
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4. Check on professional training.
↓
5. Learn agency's treatment, eligibility, and intake policies. What kind of referral information do they need from the physician?
↓
6. Arrange for continuing exchange of relevant patient information.

rescue, and ambulance persons; (3) service clubs, including 4H Clubs; (4) schools and Parent/Teachers' Associations; (5) hospitals, clinics, and hospital social workers; (6) private individuals; (7) community development clubs; (8) nurses and social workers living in the area, but not employed; (9) nearby pharmacists, and (10) the local library (Table 2).

Local government health agencies and public health nurses are always helpful. A town nearby may have a United Fund or related group. Often there is also a Research and Planning Council, or a Council of Social Agencies. All of these agencies can provide the family practitioner with information and introductions to local ministers, school officials, and political leaders who may be helpful.

Evaluating and Using Resources

Too much of a burden may be put on both sick patient and doctor if the doctor waits until the last moment to begin a frantic search for community resources. Time can be saved by obtaining information before it is needed. One way for a doctor, especially when setting up a new practice, to know which resources are dependable is to thoroughly investigate the community.

The physician should take an in-depth look at the community, checking the distribution of schools and churches, housing conditions, the industrial centers, shopping centers, etc. He should try to get a "feel" for the economic, cultural, political, and health picture in the district by talking to political people, school people, etc. Afterwards, before time demands get too heavy, it is wise for the physician and his staff to visit the resources their patients may possibly need. This will enable the staff to participate more effectively in patient care problems. When visiting agencies to evaluate their services, the routine in Table 3 should be followed.

This kind of personal contact with agencies helps ensure that the doctor and his patients will receive special attention. Most agencies are very cooperative. Once the physician understands an agency, he can refer patients with confidence. It is like sending a patient to a surgeon he respects, rather then finding one from the phone book.

After the physician and his patient have decided that a referral is in order, the physician can proceed as follows: (1) telephone the appropriate agency person and discuss the reason for the referral, giving pertinent patient history; (2) arrange an appointment procedure for the patient; (3) plan for "mutual feedback" on patient's progress (this has the added benefit of giving the doctor a means to evaluate the effectiveness of the agency); and (4) write a follow-up letter to the agency summarizing the details of the telephone contact (to prevent misunderstanding).

The follow-up letter should include: (1) identification data of patient, family members, etc; (2) reason for referral; (3) pertinent history and prior treatment relevant to referral problem; (4) relevant findings, questions, and failures; and (5) details of the feedback plan.

In conclusion, the health-care management provided by a family physician is an orderly process that should include the matching of those needs the family physician cannot meet to the appropriate community or personal resources. This matching requires a working relationship with the available resources.

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