MONTEFIORE HOSPITAL NEIGHBORHOOD MEDICAL CARE DEMONSTRATION

A Case Study

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In 1964, the Office of Economic Opportunity legislation made funds available for development of neighborhood health centers. In October of 1965, the first neighborhood health center opened in Columbia Point in Boston, and was operated by Tufts University. Another health center opened soon afterwards in Denver. These were followed by health centers in the south Bronx of New York City, in Chicago, and in the Watts section of Los Angeles.

This article will offer the Montefiore Hospital Neighborhood Medical Care Demonstration (NMCD) as a case study, serving as an introduction to subsequent articles in this Volume, which deal with specifics of this and a related program.[1] It will, in addition, set out the program's original objectives and methodology, and after somewhat more than one year's experience, will attempt to discuss the rationale of those objectives.

THE NEIGHBORHOOD

The neighborhood chosen for the project is a 55-square-block area—two health districts located in a low-income area of the southeast Bronx. The area is blighted with run-down factory buildings, empty tenements and garbage-strewn streets. The gross "social statistics" confirm what the eye sees: a high unemployment

rate, many families on welfare, crowded housing, a high crime rate and extensive drug use.[2]

The neighborhood has undergone rapid deterioration. Thirty years ago the area was predominantly a white, working-class population utilizing the services of the numerous locally based physicians and dentists. In the early 1940's, and especially since World War II, the white population (and the health professionals) began to migrate out of the area. Because of the current scarcity of health professionals locally available[3] (now only five physicians, six dentists and nine pharmacists), the majority of the people in the neighborhood must turn for their medical care to clinics and emergency rooms of nearby hospitals, and to a variety of local folk-medical practitioners. The excessive utilization of a nearby hospital (Morrisania City Hospital)[4] is a case in point: in 1965, although this neighborhood comprised only seven per cent of Morrisania Hospital's patient population, the residents contributed 18 per cent of the emergency room visits, 24 per cent of the medical clinic visits, 31 per cent of the prenatal clinic visits and 35 per cent of the pediatric clinic visits. This impressive utilization was evident despite the fact that the area is a 45-minute bus ride from the hospital. The health status is measured by the infant mortality, tuberculosis and venereal disease rates, which were, in 1966, the highest in the hospital's district.

From the viewpoint of the hospital, the increasing utilization of its emergency room had reached critical proportions. Since the hospital opened in 1929, although the clinic population had doubled, the emergency room census had multiplied seven times. More disturbing was the fact that one-third of the patients using the emergency room were using it as their prime (often only) source of medical care.

Many problems were facing anyone interested in improving the health services in the southeast Bronx. Health facilities were poorly organized and inadequately staffed; health professionals were not locally available and no local cadre of nurses and ancillary personnel was available. Even though the "health" of the community was shockingly poor, the problems of daily living—unemployment,

lack of police protection, inadequate housing—were so overwhelming that issues of health were a secondary priority. It was in this context that the original proposal had been focused around three major objectives:[5]

(1) To provide comprehensive, family-centered medical care services for the inhabitants of a neighborhood where low-income families represent a significant element of the population.

(2) a. To involve and, where possible, to employ these neighborhood inhabitants in the organization, policy planning, operation and provision of services.

b. To develop training programs and facilities for introducing non-professionals into medical care service roles.

(3) To determine the feasibility of introducing similar programs on a large scale.

METHODOLOGY

The Medical Care Complex

Health services were to be organized around a central health center and two storefront satellites, the center to be the base of operations of family physicians and the satellite centers the bases of operations of public health nurses and neighborhood aides. The satellite centers were to provide preventive health services—immunizations, well-baby care, periodic injections—and the central health center was to provide care for "illness."

The basic health team of a physician, nurse and social worker was to coordinate all medical, nursing and social medical services. The hospital would be used for back-up ambulatory consultations and for hospitalization.

Training

A training program was described that would attempt to bring community residents into medical service roles. The demonstration was to show what segments of professional services could be done by specially trained nonprofessionals. A variety of new medical aide categories was described.

Community Development

For the purpose of mobilizing community interest in health issues, a neighborhood advisory board was considered. Residents in a city block were to be organized into health clubs to provide liaison between community residents with the health center staff.

Evaluation

An evaluation of each aspect of the program was proposed. The aim was to determine the success of the program in meeting its original objectives and to see if such programs were feasible on a larger scale.

A SUMMARY OF THE FIRST YEAR'S EXPERIENCE

Medical services are provided at Bathgate Health Center, a small, renovated "five-and-dime" store. It will later become a satellite to the main health center due to open in the summer of 1968. Bathgate Center is attractive, modern, brightly painted, well equipped and air-conditioned. It contains seven examining rooms and doctors' offices, a children's playroom, a nurses' station, a small laboratory, a pharmacy and electrocardiographic and x-ray facilities. The second floor is delegated to clerical space and a small conference room. Specialty clinics are not available. The center is organized so that the medical staff provides family medical care services for 8,000 people. A mother, for example, may come in with her children and see an internist the same morning that her children are being examined by the pediatrician of the family's health team. Specialists are used for consultation; most of the treatment is carried out at the center. Hospitalization generally is carried out at Montefiore Hospital on the service of the NMCD physician. At the present time, seven doctors, six nurses and 18 family health workers are on the staff.[6] When all 45,000 people in the community are served, it is planned to have 20 doctors, 30 nurses and 60 family health workers.

A health careers program has prepared and placed more than 100 community residents in on-the-job training sites; many of the

trainees have already been hired. The training program consists of two distinct parts: an eight-week "core," and subsequent specialized training. The eight-week core has three major foci: it introduces the broad range of vocational possibilities in the paramedical field so that trainees can make a more informed vocational choice; it seeks to liberate trainees from the culturally conditioned feelings of inadequacy and inability to deal with the environment, and it teaches basic health skills and methods of working successfully with colleagues. Later training is divided into two separate activities: on-the-job training in such areas as medical and laboratory technology, medical and clerical fields; and remedial education for high school equivalency and college preparation. The program is described in detail elsewhere in this journal; the training of the "new careerist," the family health worker, has been previously described.[7]

Community involvement has been encouraged; a neighborhood advisory board has been elected consisting exclusively of lay community residents.

Research methods have been established for the evaluation of health center services, the training program, and development of the community.

With the tempering experience of 18 months, it is useful to reexamine the objectives of the original proposal and to evaluate the methodology of achieving those objectives.

WHY FAMILY MEDICAL CARE?

The advantages of family medical care have been well documented.[8,9,10] The difficulties of organizing it are another matter. To structure a health agency for the convenience of the patient, and at the same time to provide economically feasible staffing patterns are significant administrative achievements. It is mandatory, however, that the complexity of fragmented modern medical services be managed not by the patient, but by the health professionals providing medical services. It is easy to say that a family should, in one visit, have the mother seen for prenatal check-up, the children

for well-child examination and the father treated for a persistent chronic ailment; the coordination of team activities to provide these services efficiently and economically is a major accomplishment. It is evident from the experience to date that considerable in-service education and experimentation are necessary to achieve an efficiently functioning and harmonious team.

The advantages of family medical care, where the medical and social problems are approached together, make the effort at reorganization seem worthwhile. The father's chronic ailment, which flares up at the same time as the mother's asthma, becomes evident only when a household unit is treated as a whole; the patterns of physical, emotional and social disease are much better delineated when every patient is treated in the context of his milieu.

Family medical care is no cure-all. With the present resources the severe social problems remain difficult, if not impossible, to solve. But family medicine, combining a social and medical approach, makes possible a whole new area of achievement.

WHY COMMUNITY DEVELOPMENT?

The community served by the Neighborhood Health Center is composed of residents who have been in one way or another deprived of personal medical care. Their contacts with medical services, in emergency rooms and clinics, have been such that health is now given a low priority and expectations are low. To overcome decades of neglect, one must mobilize community interest around health issues of mutual concern. Much is to be gained by bringing together people who share common problems and introducing them to the variety of available community resources. Every method of reaching the community must be attempted; through the formal agencies in the area, the school and apartment meetings and informal meetings with those generally not reached by the organized elements in the community. Sharing with community residents the know-how of operating an institution as complex and as technically difficult as the health center is another major responsibility of community development.

However, conveying the information about the health program to community residents is quite difficult. Even trainees who participated in the eight-week core training session during the early phases of the project (where one of the major purposes of the program was to familiarize them with the proposed health services), had trouble visualizing the program before they could point to concrete facilities. It is even more difficult to implement effective communication in the course of organizing the community where only brief encounters, such as apartment meetings, are possible.

The health of a community will not be improved solely by having each resident pay five visits to a physician each year—no matter how good the "quality" of care rendered during those visits; other elements affecting the health of the individual must also be dealt with—diet, housing conditions, accident hazards, sanitation services, problems of narcotics, alcoholism, crime and the educational system. It is no less important for a neighborhood health center to become involved in the coordination of these health-related activities than it is to provide high-quality medical care services to its patients.

WHY TRAINING?

As in most poor areas in the United States, the scarcity of health professionals in the southeast Bronx is acute. The dearth of health professionals servicing the area has been described. To provide adequate health services, one must develop techniques of attracting the health professional and paraprofessional to low-income areas. The entry of a new agency—the Montefiore Hospital, a teaching hospital with an affiliation with Albert Einstein College of Medicine—is one method of attracting doctors and nurses to low-income areas. With the national manpower shortage, however, it is unrealistic to believe that redistribution and reorganization of health professionals alone will solve the problems of providing sufficient health personnel in low-income areas. It is mandatory to redefine the roles of the doctor, nurse and other health professionals and to create new jobs for paraprofessionals to deal with the manpower

crisis. The great need for medical manpower, then, is a primary reason for health careers training programs.

From the viewpoint of the community, training is a priority of even greater importance. In an extensive series of dialogues with the residents of the community—more than 150 apartment meetings with small groups of people—the provision of jobs and training was found to stand above all other priorities. Training for good jobs with upward mobility in the health fields was found to be extremely attractive. The feeling was that a family could do much to maintain its health if the head of the household were employed and could provide his family with adequate housing, food and clothing.

The policy of training residents from the community itself and (other aspects being equal) giving preference to community residents in employment, is not without its problems. For every trainee accepted into the training program literally dozens are rejected, each one potentially angry with the agency. Each job available, especially in the paraprofessional area, attracts many applicants; and here, too, the unsuccessful ones are likely to be resentful.

Training provides the staff with other potential problems. Although the "aide" is useful to the hospital or health center, this category, in terms of prestige and income, has little interest for most of the low-income residents who would perform well at that level. Training for "middle-level" or technical jobs attracts a much larger resource of interested applicants, especially if these jobs offer upward mobility and training with college credit.

Training offers an additional asset. By attracting community residents as trainees (and employees), an important "bridge" is built between the professionals, who are of necessity almost always recruited from outside the area, and the neighborhood consumers. The importance of interpreting the program to the community and the needs of the community to the professionals has been dramatically demonstrated by the family health workers, who work as part of a team of a family health worker, a public health nurse, and a physician. One must be cautious, however, not to romanticize the subprofessional and the new professional. They are very human

—as are professionals. The "half-life" of the subprofessional, during which he still identifies with the consumer, may last less than 24 hours. Unless carefully supervised, he may begin to talk about "my clients" and "those people," and to act in the same way as he had been acted "upon" when he was on the other side of the establishment's desk. With all its difficulties, however, training has assumed a much more important role in the program than originally perceived.

WHY EVALUATION?

Evaluation as used in this program provides virtually instant feedback about the methods of operation—whether it is that one kind of medical training is inadequate or one segment of the community is not keeping its appointments in the health center. Rapid feedback of this kind is important for the staff to effect change or innovation.

The long-term evaluation of the program is of equal importance. The neighborhood health center as a new approach to the delivery of medical care services has captured the imagination of many people in the health field as well as of the media. Danger is inherent in accepting the idea of "neighborhood" and "family medical care" as "good things" prior to their careful evaluation. Already, evidence indicates that trainees who have been successfully employed begin migrating out of the area; whether a program can be launched to encourage people who better their employment status to stay in poor neighborhoods while conditions are being improved remains to be seen. It may be that the neighborhood as it is defined here is something that is dead in the era of jet travel and burgeoning suburbs, and that what should be underway is to organize medical care services on a regional basis and to provide people locked in the ghettos with transportation that would make them as mobile as their affluent counterparts. Whether the neighborhood health centers can do more than alter a few of the "gross" health "statistics" has yet to be determined. The difficulties of attempting a control study with the treatment-no-treatment model

provides ethical problems to the physician whose study uncovers disease in one community and does not provide treatment for that disease. The social scientist questions whether evaluation can be developed by using currently available techniques of measuring "health." The neighborhood health center vogue is flourishing with considerable commitment of personnel and money; it is essential that the centers themselves receive the most thorough evaluation as a matter of public policy.

SUMMARY

The Montefiore Hospital Neighborhood Medical Care Demonstration is used as a "case study" to describe the goals and operations of one of the Office of Economic Opportunity Neighborhood Health Centers. The original objectives—to provide family medical care, to train neighborhood residents in health service roles, to involve community residents as employees and in an advisory capacity in the operation of the Health Center, and the evaluation of this program—are described. A summary of the original proposal and the first year's operation is presented. With a year of experience the original objectives and methodology are reexamined.

REFERENCES

[1] Wise, H. B., Levin, L. S. and Kurahara, R. T., Community Development and Health Education: I. Community Organization as a Health Tactic; Fisch, S., Botanicas and Spiritualism in a Metropolis; Brooke, R., Research and Evaluation: An Audit of the Quality of Care in "Social Medicine;" Madison, D., Related Program: The Student Health Project—A New Approach to Education in Community Medicine.

[2] The area is described in more detail *in* Wise, Levin and Kurahara, *op. cit.*, in this issue.

[3] In the Bronx, the physician to population ratio is one to 700; in the area served by the Neighborhood Medical Care Demonstration, the ratio is one per 10,000.

[4] The municipal hospital affiliate of Montefiore Hospital.

[5] Wise, H. B., Montefiore Hospital Neighborhood Medical Care Demonstration, Proposal to the Office of Economic Opportunity, April, 1966, mimeographed.

[6] A neighborhood resident supervised by the nurse and trained in health and social advocacy skills.

[7] Wise, H. B., *et al.,* The Family Health Worker, *American Journal of Public Health,* in press.

[8] Silver, G. A., FAMILY MEDICAL CARE, Cambridge, Harvard University Press, 1963.

[9] Kark, S. L. HEALTH CENTER SERVICE: A SOUTH AFRICAN EXPERIMENT IN FAMILY HEALTH AND MEDICAL CARE IN SOCIAL MEDICINE, Johannesburg, South Africa, C. H. Culver, 1951.

[10] Williamson, G. S., Percham, *Lancet,* 250, 393–395, March 16, 1946.