

# NEIGHBORHOOD MEDICAL CARE DEMONSTRATION TRAINING PROGRAM

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## OBJECTIVES

The Neighborhood Medical Care Demonstration training program has three major goals: to provide residents in a low-income area with training and employment as health workers; to provide a neighborhood health center and its parent hospitals with trained medical personnel and to provide health personnel who bridge the language and cultural gaps between the professionals and low-income patients.

## PLANNING THE PROGRAM

Before the actual training began, ten weeks were devoted to informing the community of the program's existence, finding suitable training space, drawing up guidelines for screening and selection of applicants, and developing the core curriculum.

Numerous small meetings were held in apartments throughout the community, in which community residents were invited to discuss the training program. Other meetings were held with community leaders of social groups, tenants' organizations, churches and poverty programs in the area. Handbills were distributed to a variety of community agencies.

The Research Department initiated a complete apartment-by-apartment census of the neighborhood. The census interview pro-

vided the opportunity to mention the training program and interested residents were asked to submit their names to the staff.

All these proved effective ways of informing the community residents about the program, and within a few weeks 160 applications were received for 30 training openings. Since then, 750 applications have been received for 90 openings.

Early in the program, the search began for "on-the-job" training sites in which to place trainees following the "core curriculum." Initial contacts were made to explore possibilities of course credit, accreditation and licensure.

#### STAFFING PATTERN

The teaching staff was organized to enable each staff member to function as a generalist—as a teacher, a counselor, a site supervisor (for those trainees who enter the on-the-job phase in the hospitals) and a job developer. The schedule is made up to allow for this.

Each instructor developed much of his material in his own area of expertise. For example, the lawyer on staff is responsible for organizing and teaching the curriculum on community resources; nurses organize and teach basic health skills in the core program as well as develop and organize the program for the family health worker after the core program. The instructor in Basic Education has two assistants (trainees who were selected and trained after they completed the core program) who teach mathematics, English and high school equivalency preparation. Although they use programmed materials, much of their teaching material in English was created by them. Another instructor teaches health careers and an approach to job and work orientation, which enables trainees to work out career choice problems for themselves as well as their children and friends.

Developing a group of professionals into a functioning, interdisciplinary team was a difficult process. During the process of training trainees, the staff itself was being trained. Many had to learn counseling skills, teaching skills and administrative skills. In one year of operation, five staff members had to be replaced for reasons ranging from inadequacy of performance or pregnancy, to resignation

for better paying jobs. The remaining staff worked even harder to prevent the turnover from affecting the education of the trainees.

### *Selection and Screening Procedures*

All residents in the area of the Neighborhood Medical Care Demonstration who are between the ages of 18 and 55 are eligible to apply for the training program. Applicants to the training program are invited to come in for screening. A group interview is followed by a brief individual interview. Each group is composed of eight applicants, one group leader and one observer from the staff.

The first part of the interview lasts from 30 to 45 minutes and is used to describe the program and the role of the staff and trainees. In the second part, two hypothetical problem situations are presented and the applicants are asked to discuss among themselves their attitudes toward the problems and possible solutions. The group leader and observer make evaluations of each applicant on a rating sheet. Qualities considered favorable are resourcefulness, sensitivity and initiative. Those rated unfavorable are punitiveness, arrogance, insensitivity and unusual timidity.

The individual interview is used to determine the applicant's household status, welfare status and child-care problems. Priority in selection is given to heads of households, especially males, and welfare recipients.

Later in the same day, applicants are tested. The revised Beta—a nonverbal, noncultural intelligence test—is administered. The standard Montefiore application is used as a screening reading test. Screening occurs daily, but a final selection is made at the end of all the interviews. The size of the training group is limited to 30 for reasons of space and staff available.

### THE CORE CURRICULUM

The core training program, outlined in Appendix 1, was designed to remedy the high dropout rate evidenced in on-the-job training programs where trainees are not adequately screened, their job placement not well considered, their social situations not brought

into control, their self-confidence not ready for the challenge of the work world and certain basic communication skills often not developed. The core training time is a nurturing experience. The first tasks are to orient trainees to the health field and to prepare them for the on-the-job training in the chosen areas. Although medical professionals have a long period of training and preparation for their work situations, most people employed in "entry-level" occupations in medical institutions have little or no preparation. They are expected to learn their tasks and attitudes "on-the-job." High turnover, job dissatisfaction and poor work performance are characteristic of these employees. A "nurturing" pre-job preparation, therefore, is a major aim of the core.

The "core curriculum" is an eight-week, full-time, orientation program. The main courses are health careers, basic health skills, community resources and academic preparation. Field trips and guest speakers are scheduled at frequent intervals. In the first core training group, problems arose when equipment was ordered but arrived late; instructors had to be ingenious at developing materials of their own. Such hardships by and large were taken in stride by both staff and trainees, and accepted in good humor.

The 30 applicants accepted for the program are divided into two sections of 15, with attention paid to heterogeneity. The sections receive exactly the same courses. Class sessions in the first core program lasted one hour and 45 minutes, but have since been cut to 50 minutes. The instructors teach the same course twice in one day to cover both sections. Group participation and group discussion are encouraged. The guest speakers and field trips provide variety and allow trainees to gain more first-hand knowledge. Instructors serve as both teachers and counselors and counseling time is arranged to coincide with individual study time.

A weekly "town meeting" gives trainees the opportunity to discuss problems, grievances and plans. These meetings have varied considerably, but often prove to be very lively. The trainees' weekly logs are another outlet for the expression of grievances. The training director requests trainees to answer questions about their progress each week during the core program.

Evaluations of the trainees are done by their counselors. The trainees prove to be less anxious when they know their evaluations, even when they are less than satisfactory.

At the end of the eight-week course, graduation ceremonies are held. This symbolizes the completion of the orientation phase prior to entering on-the-job training.

### *Early Impressions of the Core Program*

Appreciable differences may be seen in the trainees before they enter the core program and after completing the eight weeks. They are more confident and more verbal. They are less intimidated by the "establishment." They show a general improvement in personal appearance and grooming, and a new pride in reaching their goal.

By the end of the program, the group spirit is such that the problem of "separation shock" arises when the trainees move to the on-the-job training at scattered sites. This phenomenon has been experienced in other programs: trainees leave a sheltered situation for the realities of the working world. In recognition of the problem, trainees, staff and the supervisors of the on-the-job training sites meet for discussion so that the transition will be eased.

At the end of the program, discussions are held at which trainees evaluate their experience and make suggestions for future changes and improvements in the curriculum and its organization, counseling and job placement. Several changes have, in fact, been made at the trainees' suggestion: more academic preparation time, more scheduled counseling time and fewer study sessions.

### *On-the-Job Training*

The eight weeks of the program have also provided the staff with a longer period in which to screen and make appropriate placements.

Trainees are placed according to their choice, interest, ability, aptitude and availability of the site. Thus far, graduates are being trained as obstetrical technicians, inhalation therapists, physiotherapy aides, recreation aides, laboratory technicians (hematology,

histology, bacteriology, chemistry), operating room technicians, record room technicians, animal handlers, medical secretaries, medical assistants and family health workers. Efforts are under way to expand present areas of training to include, for example, social service care aides, intensive care unit technicians and pediatric technicians.

The training sites at present include three city and voluntary hospitals, as well as the Neighborhood Medical Care Demonstration. More sites are likely to be added as new jobs are added to those in which trainees have been placed so far. Until they complete their training and are employed, trainees remain with NMCD. Counselors visit trainees regularly at their training sites and meet the supervisors of each site to determine the trainees' progress and to deal with any problems that may arise. Academic training continues for those who need high school equivalency diplomas; outside training institutions, i.e., the three hospitals, are asked to release trainees during work hours for this purpose. Cooperation in this respect has been good because the institutions recognize the need to continue preparation for licensure and because the trainees are paid through NMCD stipends. Where possible, the academic preparation continues even when trainees are employed full-time. Classes are held after work hours at the training center.

In some instances, the training institutions and training staff develop training materials jointly; in others, the institution already has well-developed training materials and curricula.

Although strong efforts are made to insure good training, the problem that arises most frequently is the inadequacy of supervision. Many of the sites are short of staff and the volume of the work makes it difficult for the site instructor to devote much time to the trainee. A cycle ensues: the staff shortage means that trainees cannot be given adequate supervision; the inadequate training results in a shortage of adequately trained personnel. Instructors and trainees are generally asked to have patience, and training time is extended to offset the problem. Counseling can mitigate frustrations also.

The training program started well before the opening of the first health center, thereby allowing time to train clerical workers, fam-

ily health workers and medical assistants who could be taken on staff at once. Curricula were prepared for these occupations and staff members were assigned to teach the courses.

#### THE FAMILY HEALTH WORKER

The family health worker program, outlined in Appendix 2, deserves special mention since it is the program's major innovation in health careers. Multipurpose workers with medical and social service skills have been proposed in the past, but few attempts have been made to train them and to integrate them into a functioning health care team. The family health worker is a subprofessional trained with nurse-aide and social-advocacy skills.

##### *Job Description and Training*

The family health workers' base is the health center; however, she spends most of her time in making home visits in the community. She is part of a team consisting of a physician, a nurse and a family health worker. She is assigned 20 to 40 families. Her day-to-day supervision is by the public health nurse on her team; overall supervision and continuing in-service training is by a family health worker supervisor (a public health nurse assigned to the training program).

The daily activities of the family health worker include a variety of health education, patient care and social advocacy activities. She instructs the new mother on how to bathe and feed the baby. She is alert to household hazards: fire traps, broken paint on walls. (A family health worker did the case finding on a child that was later hospitalized with the cerebral effects of lead poisoning.) In her training, strong emphasis is placed on patient education, case finding and the preventive aspects of medical care and the emotional factors influencing illness.

Her patient-care activities include checking vital signs (as on a known hypertensive patient recently discharged from the hospital); instructing in the care of a bedfast patient (bathing, skin care, changing dressings, irrigating catheters, giving an enema); carry-

ing out the exercises prescribed by a physiatrist, checking on a new diabetic patient to make sure she understands how to check her urine and is following her diet. The worker is able to collect a midstream urine specimen and to collect a venous blood sample.

In addition, she administers the health inventory forms (similar to the Kaiser Permanente health inventory), and the family and social forms to all members of the family.

During the course of her home visits, the family health worker deals with a variety of social and environmental problems—assisting a patient with heart disease to obtain a telephone through welfare, obtaining more suitable low-income housing for a large, young family. Initiative and imagination in the family health workers are stressed as part of their patient advocacy role.

Every morning the health worker meets with her public health nurse to go over her daily assignment. Once a week she meets with the physician, public health nurse, lawyer and social worker at the health team conference. Here they develop a health plan for each family seen in the past week. The family health worker spends several hours a week under the direct supervision of the training staff, continuing her in-service training and her work toward the high school equivalency.

The family health worker is trained for eight hours a day for 24 weeks. The first eight weeks of the course consist of the core curriculum, which covers basic health skills, a survey of health careers, community resources and remedial training in English, mathematics and science. The remaining 16 weeks are divided so that two-thirds of the time is allotted to health skills and one-third to community resources.

Health skills are taught by nurses, all with public health training or experience. The community resources part of the training is taught by a lawyer who is part of the training staff. Seminars are given by the community organizer, a social worker, a health educator, an anthropologist, internists, pediatricians, obstetricians, a psychiatrist and a physical therapist. Many guest lecturers and members of health center staff participate in the training.



### *Community Involvement in the Training Program*

The training staff developed the guidelines for screening and selection, the core curriculum and the job sites, but recognized the need to involve the community in the training program, as in all component parts of the Neighborhood Medical Care Demonstration. Community residents were asked to volunteer to become members of the ad hoc Advisory Board, the forerunner of the elected Advisory Board that was formed in July, 1967. The subcommittee on training evolved from the ad hoc board. Meetings were held once a month and were chaired by the training director.

Subcommittee members took part in the screening and selection of applicants to the training program. They assisted the staff in making decisions governing personnel practices for the trainees. It was at the subcommittee's suggestion that the staff adopt a three-day suspension rule for trainees who are chronically late or absent. When a debate arose among the staff as to whether to accept an applicant who may have been homosexual, the subcommittee recommended acceptance on the grounds that trainees would have to learn to work with all kinds of people. They lent moral support to the program by being strong advocates and interpreters of the Neighborhood Medical Care Demonstration in the neighborhood. Members of the elected Advisory Board have continued to take part in screening applicants, and a new subcommittee on training will probably be formed.

The fear that the subcommittee would use the training program as a means of patronage to get their friends—or themselves—into the program has not materialized. No employee or trainee may be a member of the Advisory Board. This rule may be the important factor in deterring patronage.

### *Development of Job Sites*

From the very beginning of the program, the training director and staff met with the personnel directors, supervisors and department heads of a number of health agencies to discuss placement for skill training after completion of the core curriculum. Many

of these agencies were reluctant to accept trainees: they had had unfavorable experience with training programs in the past. However, following site visits by the core trainees, or visits from representatives of these agencies to the program as guest lecturers, many changed their minds. They learned at first hand the difference made by screening and pretraining. The trainees were their own best salesmen.

Trainees have now been placed in the following on-the-job training areas: obstetrical technicians; research (IBM) technicians; rehabilitation aides; laboratory trainees in hematology, histology, chemistry, parasitology and bacteriology; operating room technicians; x-ray aides; record room personnel; medical assistants; and teacher-counselor assistants. These positions are in addition to the family health worker discussed above. Post-core training lasts from three months to one year, depending on the job and the requirements for licensure. A major aim in developing sites was to place trainees only where employment was likely.

#### PLACEMENT

From November 15, 1966, through October, 1967, a total of 109 trainees came into the training program. Ninety-five entered the core program, and 14 were trained in special programs that did not involve core training. Of the 14, six were homemakers who were trained in an eight-week period and all were placed. Eight were in the research department and were hired as coders, clerks, interviewers and so on for the demonstration program itself.

Of the 95 who entered the core, ten failed to complete the course because they were ill or failed to report for training, or could not resolve child-care problems. Eighty-five completed the core program, but nine were not placed in on-the-job training phase for much the same reasons as the ten who dropped from the core.

During the on-the-job phase, 11 were terminated because of illness, pregnancy, child care problems or family problems (husbands not wanting their wives to work).

Of the remainder, five are still in training and five have left for

college (two attending community colleges in the nursing programs) or better-paying jobs in other than the medical field. Sixty-six are now employed in the medical field as family health workers, x-ray assistants, inhalation therapy technician, obstetrical technician, recreation therapy assistants, occupational therapy assistants, hematology technicians, operating room technicians, clerical worker (file clerks, receptionists, secretaries) and medical assistants.

For many of those employed, the fact of employment itself is an achievement. For some, it has represented a gain of a sense of dignity by coming off welfare; for others it has been their first job; and for still others, job satisfaction has increased.

### *Cost of Training*

A full cost analysis of the program has not been done as yet. The first year's operating costs generally are high because of the time spent in developing materials. The cost per trainee is approximately \$1,500 per year; the bulk of the cost in trainee stipends (\$55 per week for three months, \$60 per week after that). For many of the trainees who have not worked before or who have been on welfare, the cost of training is small indeed when compared to their increased earning power, restoration of dignity and a newly discovered self confidence.

### *Licensure, Accreditation, College Credit and Upward Mobility*

Academic skill development continued throughout training, and employees are encouraged to obtain further schooling. The training program now includes a high school equivalency course for those who need it and plans are in motion to set up college preparation courses.

There has been an on-going effort to work out some form of accreditation, course credit equivalency or qualifying examination or licensure for trainees and employees of the program. Such accreditation is desirable for many, but it is an absolute necessity for those in the "new occupations," such as the family health workers. If the neighborhood health centers movement grows, pressure will grow to recognize the new occupations attendant on innovative

approaches to the delivery of health services. The family health workers have already been trained and are employed. Other innovative positions will include medical record abstractors to summarize medical charts for outside requests, and teacher-counselor assistants who will free the professionals for in-depth counseling and course preparation. Without accreditation and possible upgrading, such new positions are of strictly limited value. With it, their potential is enormous.

Negotiations have already begun with the City University of New York, several community colleges and the State University of New York at Old Westbury. The plans are ambitious and will almost certainly encounter the opposition inherent in the guild system of medicine. But early indications give cause for optimism.

Since a major cause of dropout from the core program has been child care problems, it is hoped that the community will be able to provide day care centers and to train foster care mothers. An in-service training program is also planned to train nurse aides to become practical nurses, once the barriers of licensure and accreditation are overcome.

#### SUMMARY

A training program, which would play a role in improving the delivering of health care, was started in November, 1966. Ninety-five trainees have completed an eight-week, pre-basic training "core curriculum" prior to entering the skill-learning phase of the job. Trainees are trained for traditional as well as innovative occupations in the health field, primarily in the technical area. They are trained to work either for the health center or parent hospital.

The community has been involved in the screening and selection process and has acted as a guide to the training staff in setting up personnel practices for the trainees.

A remedial program for trainees continues from the core to the on-the-job phase and after placement. Efforts are being made to gain some form of accreditation for the project through negotiations with existing academic institutions.

## APPENDIX 1.

### CORE CURRICULUM

#### I. Introduction

##### A. Outline of core curriculum—purposes

Working conditions—hours, pay, etc.

How we get in touch with you

What is expected of trainees

Relationships within training group

##### B. Your feelings about yourself and your work

In this training program and in your future health job, you will be responsible for many things:

1. Helping yourself

2. Helping the other trainees (one by one or in a group)

3. Helping other people

4. Helping the community

5. Helping the Neighborhood Medical Care Demonstration

To live up to all these responsibilities, you have to have self-confidence—you have to believe in your ability to “get things done.” The other trainees and the training staff should help you gain this self-confidence.

#### II. Health Careers

##### A. The different jobs—what they are and how you qualify for them

1. Laboratory technician

2. Physical therapy assistant

3. Family health worker

4. Operating room technician

5. Medical secretary

6. Animal handler

7. Laboratory technician

8. Other jobs may be planned later

(For each job—duties, qualifications, opportunities for advancement)

##### B. The hospital and its structure

##### C. The Neighborhood Medical Care Demonstration

1. History and program of health center

a. history

- b. philosophy
  - c. other programs around the country
  - d. meetings with the staff
  - e. present program
    - medical services
    - health education
    - training
    - community organization
    - legal and social services
    - research
2. Working in new kinds of jobs
- a. problems:
    - uncertainty about what is expected of you
    - uncertainty about future job openings
    - possibly having to settle for less pay because of lack of licenses or certificates
  - b. possibilities:
    - room for initiative, imagination (you can help design your own job)
    - setting examples for people all over the country to follow
    - new relationships with professionals
    - teamwork
    - teaching each other
    - helping professionals and community people to understand each other

### III. Basic Skills for Your Career

- A. Working with patients (or “clients” or “customers”—“patients” here means any resident of the community we serve)
1. Skills
- a. answering phone
  - b. greeting people—making patient feel comfortable
  - c. taking messages
  - d. recognizing problems
  - e. interviewing and probing when appropriate, neutral interviewing, leading questions, bias
  - f. making referrals and follow-up
  - g. helping professionals and patients to understand each other
  - h. asking questions
  - i. explaining to and informing patients
  - j. using judgment (what to tell patients)
  - k. how to contact patients

2. Medical ethics
  - a. why you must not repeat confidential information
  - b. danger of giving medical advice
  - c. patient's consent and control
  - d. tell him what you propose to do and ask whether he wants you to do it
3. How you feel about patients
  - a. being available so that people feel free to come to you with their problems
  - b. being sensitive to people's feelings, avoiding "bullying"
  - c. "doing with" instead of "doing for"
  - d. do not expect patients to be grateful
  - e. patients' rights
  - f. you are responsible for helping patients
  - g. encouraging patients to become helpers
- B. Working with the personnel office
  - a. finding a job
  - b. job interview
  - c. grooming
  - d. how to act
  - e. what to bring with you
  - f. applications and resumes
  - g. do not leave gaps
  - h. what you should tell
- C. Working with fellow workers
  1. Teamwork and cooperation  
the purpose is to help patients and to make work more livable
  2. The problem of rivalry
  3. The need for noticing and understanding the feelings of other workers
  4. The need for openness about what is bothering you
- D. Working with supervisors
  1. How do you hold a job
    - a. be reliable
    - b. be punctual
    - c. telephone in when you must be absent or late
    - d. admit when you have not done what you promised to do
  2. Learn on the job
    - a. ask questions
    - b. accept criticism
    - c. admit your mistakes and learn from them

3. How to cope with anger and frustration
    - a. understand someone else's feelings or point of view
    - b. have a sense of humor
    - c. be open, talk about what is bothering you
  4. Follow instructions
    - a. listen
    - b. take notes
    - c. read instructions
    - d. ask questions
  5. Keep your supervisor informed about your work
    - a. report to him
    - b. know when and how to keep written records
  6. Qualities that make you an outstanding worker
    - a. use good judgment (common sense)
    - b. be tactful
    - c. assert yourself
    - d. imagination (think of new ways to solve problems)
    - e. initiative (see what needs to be done and suggest to your supervisor that you should do it)
- E. Working with subordinates
1. respect the people whom you supervise
  2. be considerate
  3. know how to give instructions clearly and tactfully
  4. follow-up your instructions
  5. be courteous (don't bully)
  6. do not emphasize your status: make subordinates feel like equals; understand their feelings and their problems
- F. Personal problems related to work
1. payroll—paycheck
  2. budgeting
  3. child care
  4. phone
  5. insurance
  6. income tax
  7. medical care
  8. relation to neighbors
    - a. status, respectability, prestige
    - b. will your new job make you feel different from your neighbors? How? Is this good or bad?
  9. OEO stipends do not count as income for public housing and welfare purposes



#### IV. Social Problems and Legal Rights

##### A. Solving problems

1. a. what are the problems?  
b. what do you want to accomplish?  
c. what do you need to know?  
d. how can you find that out?  
e. what can you do to solve this problem?
2. Each week we will discuss the above three questions in one of these problem areas:
  - a. Police, arrests and bail
  - b. Welfare
  - c. Housing
  - d. Consumer problems
  - e. Family law
  - f., g. and h. these three are up to you.  
Possible topics are day care, narcotics, drinking, schools, old age, recreation, more on criminal law, legal services.

##### B. How do you find out what you want to know?

1. telephone (information, phone book, yellow pages, dialing collect, long distance, talking on the phone)
2. transportation  
map-reading, reading signs, reading schedules
3. letter-writing
4. newspapers and other media  
classified ads, want ads
5. dictionary and other references
6. library
7. asking questions
8. study skills

##### C. How to help others use community resources (See IIIA: Working with patients)

#### V. Basic Health Skills

##### A. Basic home nursing procedures

1. meeting needs for comfort, food, cleanliness
  - a. bedmaking
  - b. bed bath
  - c. feeding
2. cleansing enema
3. temp., pulse and respirations
4. handwashing

- 5. reduction of fevers
- B. Recognition of disease through personal observation
- C. First Aid
  - 1. artificial respiration
  - 2. burns
  - 3. wounds
  - 4. poisoning
  - 5. unconsciousness
  - 6. convulsions
  - 7. electric shock
  - 8. rat bite
- D. Family living
  - 1. what to buy, how to buy, budget, best buys, etc.
  - 2. best ways to clean in the home
  - 3. nutrition
- E. Family planning (birth control)
- F. Pregnancy
  - 1. anatomy and physiology
    - before birth
    - after birth
- G. Care of the aged
  - 1. common medicines
    - a. medicines and how they work
    - b. different ways medicines are given
    - c. giving advice about medicine
    - d. dangers in giving medicines
- VI. Academic Improvement
  - A. Basic education
    - 1. Arithmetic
    - 2. Reading
    - 3. Writing
  - B. Preparation for high school equivalency for on-the-job training
  - C. Vocational guidance for higher education

## APPENDIX 2.

### THE FAMILY HEALTH WORKER

The family health worker is a new type of paramedical worker being trained and employed by the Neighborhood Medical Care Demonstration. This is a medical project in the Bronx funded by the federal Office of Economic Opportunity through the Division of Social Medicine of Montefiore Hospital.

#### *Background and General Philosophy*

The family health worker was created to fill a gap in home care medical services. She (or he) combines many of the functions traditionally performed by public health nurses, nurses' aides, health educators and social workers—all in short supply. She has the advantage of being a resident of the neighborhood in which she is working, thereby having a better understanding of its problems. She is encouraged to see not only the physical ills of the patient, but the social ills as well. In an era of fragmentation she is encouraged to think of the patient as a whole person—a person whose health interacts with that of other family members and with the environment of the neighborhood as well.

#### *Qualifications*

To enter the 16-week training program, the family health worker must be between 21 and 55 years of age, and a graduate of the eight-week "core curriculum" course (which consists of remedial English and mathematics, basic health skills, a survey of health careers and a survey of community resources). Highest priority will be given to applicants who are residents of the area served by the Neighborhood Medical Care Demonstration.

#### *Training*

The 16-week training program is divided with approximately two-thirds of the time being allotted to health skills and education and one-third to community resources. Under health skills, lectures are given on anatomy and physiology, growth and development, physiotherapy, special diets, common diseases, family planning, techniques of interviewing and so on. Time is spent on various hospital wards and in the prenatal and pediatric clinics of Morrisania Hospital and home visits are made with public health nurses. Under community resources time is spent on community organization, welfare, housing, consumer, legal and school problems, mental illness, narcotics and Medicaid. Field trips are made at least once a week to appropriate institutions. The

emphasis is strongly on the family health worker's ability to act as an advisor to and advocate for the families under her care, encouraging them to solve social problems by individual and group action.

A continuing program of inservice education and supervision will follow the training period, with new skills training added at regular intervals as needed.

### *Job Description*

The family health worker will be based in the main health center and the satellite centers, but will spend most of her time making home visits. She will be assigned to work with 20 to 40 families (who have been seen at the health center and requested follow-up aid) as part of a team composed of the physician, nurse and family health worker. Her day-to-day supervision will come from the nurse on her team; she will also receive overall supervision and continuing inservice training from a family health worker supervisor(s) who is connected with the training program. Daily activities on her home visits would include such patient care activities as checking vital signs (as on a known hypertensive or patient recently discharged from the hospital), instructing in the care of and assisting a bedridden patient (e.g., bathing, changing dressings, irrigating catheters, giving an enema), checking to see that a patient on physiotherapy is doing his exercises or that a diabetic is following his diet, and collecting specimens. When necessary she may request the services of a homemaker. Emphasis is strongly placed on patient education, case-finding and the preventive aspects of medicine (e.g., she should be alert for ankle edema in a known cardiac). She will also administer the initial history form to the family when they request family medical services. During the course of these medical visits, the family health worker will deal with social and environmental problems as they arise, for example, assisting a diabetic on welfare who lives alone to obtain a telephone or advising a cardiac with a fourth floor walk-up on how to obtain more suitable housing. Initiative and imagination in the family health workers is stressed.

### *Opportunities for Advancement*

Lateral and upward mobility is being built in the program. The possibilities of licensure and of integration with more traditional programs (L.P.N., R.N., social case aid, etc.) are being explored. Possibilities for supervisory and training positions within the family health worker program are open. It is also anticipated that these people will eventually be employed by hospital home-care programs.

## COMMUNITY DEVELOPMENT AND HEALTH EDUCATION: I

### Community Organization as a Health Tactic

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That type of health education that concentrates on posters and pamphlets has not been remarkably successful. The neighborhood health center principle promoted by the Office of Economic Opportunity sets as a major goal the mobilization of community interest in health issues. An attempt to redress the balance of health care for low-income citizens is not, however, a simple matter of making traditional medicine more geographically accessible. Although geographic accessibility is an important need, other aspects of accessibility are more difficult to understand and design—namely, what may be called social accessibility.

To achieve a relevant design for health services, and to make those services relevant to community expectations and needs, requires the involvement of neighborhood residents in the operation and the involvement of their advice in policy matters of the centers.

At present, a debate rages about how best to mobilize community involvement in matters of health. This paper describes how the staff of the Neighborhood Medical Care Demonstration set out to meet the residents of the community and to learn their needs for, and expectations of, health care. A variety of techniques was used to involve the community in health issues, from training and employing residents in the delivery of health services to mobilizing them around issues of mutual concern.

The question of control—the idea of an advisory versus a policy-making board, the issue of maximum feasible participation—is another technique of using political devices in mobilization around health issues. A review of the pertinent literature, with a description of the Neighborhood Medical Care Demonstration experience, will be the basis of a subsequent article.

## BACKGROUND

The 55 blocks served by the Neighborhood Medical Care Demonstration bear little resemblance to the nineteenth century New England community that focused around its church, school and town hall. Here 45,000 people are crowded into two health areas (based on census tracts) arbitrarily defined as a community. The neighborhood is located one hour's subway ride north of midtown Manhattan. One approaches it via the Third Avenue elevated train—what remains of the “Third Avenue El.” Claremont Village, the area's choice residential facility—a conglomeration of high-rise, low-income, municipal apartment houses—lies in the southern part of the area. The Franklin Avenue area, to the east of the El, consists of several blocks of single dwellings and contains many of the area's affluent citizens. The Bathgate area, a residential neighborhood of five-story tenements surrounding a busy shopping area where stores have stalls opening onto the street, makes up the third pseudocommunity.

The area is rectangular in shape, bounded on the north by an elevated highway and on the east and west by large parks—empty, filled with broken glass, unused because of the physical neglect, the fear of muggings and the lack of police protection.

Thirty years ago the area was a thriving middle-income white area. The abandoned synagogue, an inactive boy's club, the white complexion of the school board and the politicians of the area are mementos of times gone by. After World War II, a rapid exodus took place in which the white population moved to the suburbs. A Negro migration (with roots in North and South Carolina) into

the area occurred in the 1940's and 1950's, followed by a Latin American (primarily Puerto Rican, but also Cuban) influx in the late 1950's and early 1960's. Now the population of the 55 blocks is nearly double that of 30 years ago. It is a young population: the average age is 24, while in New York City as a whole it is 35. Large families predominate. The white population that remains represents about five per cent of the total population: it is composed of elderly residents living mostly in the Claremont Village project.

Poverty and decay are in evidence everywhere. Men sitting idly on the apartment stoops during the daytime confirm the high unemployment rate. Many of the shops in the Bathgate area are boarded up, apartments are empty and the streets are strewn with garbage and abandoned cars. The shops, bargain stores, herb shops and fruit and vegetable stands change ownership frequently. Everywhere is the evidence of theft: metal gates protect shops, doors show signs of being jimmed and apartments are protected by several locks and by police dogs.

It is an area where health is an important priority,<sup>1</sup> but made secondary to other, more pressing problems: the need for employment—the unemployment and public assistance rates are high; inadequate police protection; the fear of the “thousands” of local drug users; housing problems; transportation problems—it takes two buses and 45 minutes to get to the nearest municipal hospital, and at night bus service is slow and taxis unavailable; educational difficulties—the usual problems of “ghetto education,” including overcrowding, understaffing and lack of programs for Spanish-speaking students. Of the health priorities expressed, dental care heads the list (half the children under the age of 12 have never been to a dentist); medical care for children and emergency services follow. Preventive care, as a result, is given low priority.

#### STAFF

Although nearly all staff members participate to some extent in neighborhood matters, a small unit devotes itself to community

development and health education as such. Its staff includes a professional community organizer, a health educator and three community-health educator assistants.

### *Who Speaks for the Community?*

A plethora of formal organizations is found in the area served, but fewer than ten per cent of the residents belong to any formal organization such as a church, social club, union or PTA.<sup>2</sup> An early task was to visit the 41 local agencies and outside groups servicing the area to coordinate Neighborhood Medical Care Demonstration activities with theirs. Less than ten per cent of the eligible residents voted in a national election<sup>3</sup> and less than four per cent took part in the local antipoverty elections. When the Neighborhood Medical Care Demonstration advisory board was formed, even after an extensive series of meetings and the use of various publicity techniques, only 52 people were able to obtain the 25 signatures required to qualify them to become delegates to the election convention. In any formal sense, no one speaks for even a small percentage of the community.

### *Reaching the Unorganized Residents*

The difficulties in acquiring the main health center and the first satellite center gave the staff the opportunity to develop relations with the community, only meagerly consulted prior to submitting the original proposal.

A storefront was opened in the center of the community to explain the program to community residents. It was poorly utilized. The staff then moved into areas more heavily trafficked—into laundromats, restaurants and so forth. The residents maintained a skeptical “wait-and-see” attitude: many promises had been made in the past, but few programs had come to function.

The staff met frequently with interested residents in their apartments for such meetings were in the organized element of the community, but many of their friends and neighbors who participated were not. The purpose of the meetings was to discuss community health problems and to get community reactions to the



program. The average attendance varied from four to six people. The staff often found difficulty in describing the program; when "family care" or "health center" were brought up, the only point of reference for most people was a municipal hospital outpatient clinic.

The value of the apartment meetings is difficult to assess. They were extremely time consuming, and it is doubtful that many individuals took away a meaningful grasp of the program. On the other hand, perhaps some community good will and support was generated. But the staff was made much more aware of the residents' experience in seeking and receiving health care. Neglect, abuse and frustrations had combined and contributed to a feeling of hopelessness, of fatalism. Now, trust had to be built on concrete acts if one was to hope for a true sharing of ideas. The meetings were of value in getting community reaction to the proposed program and to make modifications where indicated. For example, it became obvious that a major concern was to have an attractive, air-conditioned "medical arts" facility located in the community itself, rather than storefronts and the second-class service that storefronts imply. One also learned of the community's concern about the use of subprofessionals. A lengthy dialogue provided the assurance that subprofessionals were not to be used in lieu of doctors and nurses, but rather as extensions of doctors and nurses on the health team. In addition, the low priority given to health itself as a community concern was discovered. It was recognized that what was needed was a medical service that would meet the expectations of the community, and that only in the course of providing this service could preventive medicine effectively be implemented.

An additional effort to reach unorganized residents took the form of a total community census designed to serve as a community development tool as well as a mechanism for "straight research" and case finding. As it turned out, the census takers proved more effective in case finding and in attracting and referring people to the training program than in community development. Much misinformation as well as accurate information was conveyed; some people mistakenly believed they were being registered for the

health center, and, worst of all, an unknown group of people unlawfully pretended they were registering households for Neighborhood Medical Care Demonstration services and charged a fee.

#### MOBILIZING THE COMMUNITY AROUND HEALTH ISSUES

##### *Parents of Mentally Retarded Children*

By means of the community census, approximately 100 families in the community with mentally retarded children were identified. Simultaneously, a thorough assessment was made of existing facilities for the treatment, care and education of mentally retarded children. Two general meetings were held, which attracted some 40 of the 100 parents. A committee of parents was formed and is now working closely with the Neighborhood Medical Care Demonstration medical staff arranging for assessment of the children. The committee is also negotiating with the City of New York School Board for special classrooms, placing children in summer camps and arranging summer outings. The parents of mentally retarded children provide a successful example of organizing an otherwise unrelated group around a common health issue.

##### *A Youth Health Auxiliary*

Two youth groups, each with a membership of 25, have been organized into youth health auxiliaries. Many of the youths were referred from homes that had no male head of household. The aim of this program is to help young people include in their value system ideas that will guide them in making wise personal choices in health matters. Issues discussed include sexual behavior, venereal disease, narcotics, cigarette smoking and a variety of disease entities. A recreation program and guidance counselling have been added to the program. The auxiliary hopes to make films (8mm) on health-related subjects with their peers as a potential audience. The youths decide on content and priorities for the films, as well as all the activities of the group, with the assistance of a group worker. The program was developed under the guidance of a graduate student in community health education. He is currently

training other group leaders. If this pilot program is replicable, it holds great promise.

### *Training and Employing Community Residents*

The training of community residents and their utilization in the family health team has perhaps more than any other factor “sensitized” the health center to the neighborhood’s needs.

Suggestions for change of program, complaints about “forms” or attitudes of certain employees have been best communicated by residents who are in training or who work in the program.

Neighborhood Medical Care Demonstration policy is to employ community residents at all levels, other qualifications being equal. A list of each job opening is sent to all employment agencies and community groups in the area. A record of community people interested in working in the health fields has been abstracted from the census and these files too are tapped as job openings arise. Only if and when these sources fail to bring in suitable job applicants are outside applicants considered.

Numerous advantages accrue from the policy of hiring from the neighborhood. It broadens community support of the project and the employees serve as an informal communication link with the community; conversely, local employees communicate the underlying problems of the community to the agency. Local residents also serve as informal health educators and are important prime movers in organizing community programs. Beyond that, the policy also serves to upgrade the community financially by augmenting income and raising employment aspirations.

Problems arise, however, in the event of termination of employment. It is not difficult to hire local residents since local resources have been developed for employee referrals, but it is very difficult to fire a community resident. The community may view such an act as discriminatory and indeed may view in a negative light all the benefits expressed above. This arises precisely because of Neighborhood Medical Care Demonstration’s expressed devotion to community service. The problem is by no means hypothetical. A specific example arose in the termination of employment of a Latin Amer-

ican teacher-counsellor in the training program. That employee was a community resident who had derived community status as a “professional,” and who was pointed to by many as an example of someone who had “made it.” The agency, with extreme reluctance, terminated his employment on professional grounds. The repercussions were immediate and strong. A group of Spanish-speaking residents in the community picketed the Health Center for several consecutive days, protesting the firing and calling for immediate and public review of the case through the employee records involved. Accusations of discriminatory practices were voiced. The agency, although proceeding properly, was placed in an untenable position since it is impossible to review substantive charges of incompetence publicly without great personal harm to the person dismissed for this reason. It was therefore impossible to refute charges of discrimination satisfactorily. It proved very difficult for many people in the community to appreciate the situation in full. It may take a long time for the community to understand that if the agency hires local minority group people, it must also have the right to fire. It is extremely cumbersome for an administrator to function under systematic and total scrutiny in the area of employee relations.

#### *Ad Hoc Advisory Board*

One of the primary concerns of the Neighborhood Medical Care Demonstration in its first year was to set up a board of community residents to work closely with the staff. Because of the time it took to reach a significant number of community residents, and since philosophical problems of policy were to be ironed out, an ad hoc community advisory board was set up to act temporarily until a formal body could be elected. Meetings were held in the community to stimulate dialogue between community and staff, and here neighborhood residents stressed the need for a temporary advisory board. The board was set up without formal structure or membership. It was felt that all community residents should be eligible and encouraged to express their own viewpoints. Anyone who lived within the area served by the Neighborhood Medical Care Demonstration was a board member simply by virtue of attendance at meetings.

The first meeting was held in November, 1966. Attendance at this and subsequent meetings was sparse. On one occasion a group of regulars attempted to restrict membership to those few present at that particular meeting. This move was rejected since it ran contrary to the policy of encouraging the broadest possible representation. At another meeting the suggestion was made that attendance and community participation could be increased by dividing the area into three natural communities: one predominantly Afro-American (the Franklin area), one predominantly Latin American (the Bathgate area) and a third with an approximately equal representation of these two groups (the tenants of the Claremont Village housing project). The suggestion was adopted, and subsequent meetings were held in each sub-area, on different dates. This method successfully increased attendance and many people came who had rarely, if ever before, attended community functions.

Subcommittees, open to anyone who wished to serve on them, were established for the areas of medical care, training, research and the development of a formal community board, and they proved to be the most successful function of the ad hoc advisory board. The ad hoc Committee on Training advised on criteria for the training program's selection of trainees and for trainee discipline. The Committee on Medical Care decided whom the first satellite Health Center would serve, since it can provide service for only a fraction of the population—1,500 families, or 6,000 people, plus pregnant women and their families—some 8,000 of the 45,000 residents of Health Areas 24 and 26. The Committee suggested a registration system by which 500 families from each of the three sub-areas registered for the service of the Center on a first-come, first-served basis, with open registration for all pregnant women and their families. This plan was adopted in place of a previous one formed by the staff to serve one limited geographic area. Another committee helped plan and organize the ceremonies connected with the formal opening of the Bathgate Health Center.

### *The Advisory Board*

The Neighborhood Medical Care Demonstration's original pro-

posal called for a neighborhood health advisory committee. After the project was funded, considerable debate took place among the staff as to how much influence the board should have. Some of the staff felt that it should have no formal power and should be a strictly advisory body; some felt that it should be concerned with the training program and social aspects of the Neighborhood Medical Care Demonstration, but should have no say on medical services. One staff member thought the board should have complete control of the Neighborhood Medical Care Demonstration, with control of the grant and with powers of hiring and firing all staff. Another felt the grant from the Office of Economic Opportunity should go directly to the board and that a subcontract should be arranged between the board and health center staff. The debate was essentially that between the principle of an advisory board and that of a board of directors.<sup>4</sup>

#### *Selection and Orientation of the Advisory Board*

A board of 21 members was elected. Any community resident above the age of 21 who obtained 25 unduplicated signatures could stand as a delegate. Seven positions were available to each of the three "communities." A delegate election was held where 21 of the 52 delegates were elected by the delegate body as the advisory board.

The idea was that each board member and each delegate would be responsible to his 25 constituents and would call "town-hall meetings" regularly with his constituents for exchange of viewpoints and information.<sup>5</sup>

The 21 members of the first board underwent a 21-session orientation, the purpose of which was to give realistic understanding of the administering of a medical program to lay people without previous knowledge of this field. The various aspects of the program—its administration and financing; the philosophy of family medical care; the training component; and service evaluation—were all covered in seminars and supplemented with written material. Outside speakers were used to discuss the financing of medical care, group practice, quality control and the role of the hospital and health departments. Several sessions were devoted to bylaws and to parlia-

mentary procedure. An evaluation of the orientation is being completed, and the Board is now functioning. It has elected its own officers and set up subcommittees to advise on the various aspects of Neighborhood Medical Care Demonstration's program.

#### SUMMARY

The involvement of local residents is seen as an important ingredient in the successful design and operation of a community health center. The experience of one such center to reach out into the community is described, with particular emphasis on the difficulties encountered; and the mobilization of residents around two activities. These efforts are complemented with a third approach through an extensive training and employment program for local people. Finally, the critical issue of consumer control of health center policies and programs is raised; it will be discussed in a subsequent article.

#### REFERENCES

<sup>1</sup> Impressions from numerous apartment meetings.

<sup>2</sup> Brooke, R., unpublished material.

<sup>3</sup> Information from local Congressman's office.

<sup>4</sup> The idea of "control" and "maximum feasible participation" as a method of obtaining community involvement has been perhaps the most debated issue of the antipoverty program. The historical basis for the "maximum feasible" principle and its application and potential in health programs and in the Neighborhood Medical Care Demonstration in particular will be described in a subsequent article.

<sup>5</sup> The idea was suggested by T. Levin, Department of Psychiatry, Albert Einstein College of Medicine.