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ABSTRACT

Contents of this guide include: (1) a contrast of a typical community health program's operation in 1955 and in 1971; (2) descriptions of three comprehensive health centers based on visits and interviews with administrative personnel: The Matthew Walker Health Center, Nashville, Tennessee; Community Group Health Foundation, Inc., Washington, D.C., and The Martin Luther King, Jr. Health Center, New York City; and, (3) various appended materials having to do with the training programs for health center personnel run by each of the above comprehensive health centers. Appendix I includes the following materials from Matthew Walker Health Center: (1) content outline for orientation (syllabi: why a neighborhood health center; paraprofessional personnel; and the nature and meaning of work); (2) content outline of core curriculum (syllabi: communication; relationships between people; and human behavior and needs); and, (3) training evaluation. Appendix II includes outlines for college courses from Community Group Health Foundation, Inc. Appendix III includes the following materials from Martin Luther King, Jr. Health Center: (1) core curriculum outline; (2) job description: senior family health worker; (3) family health workers record; (4) the training staff; (5) trainee evaluation; (6) trainee survey of health careers; and, (7) research department: evaluation of training. (JM)

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A GUIDE FOR TRAINING DIRECTORS:
VISITS TO THREE COMPREHENSIVE HEALTH CENTERS

By Jeanne C. Barrett

CONTENTS

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I. INTRODUCTION

COMMUNITY HEALTH IN 1955

In 1955, all patients of the_____County Hospital prenatal clinic were required to arrive by 8 a.m. Then the doors were locked for the day. On entering, they wrote their names on slips of paper and passed them under a grilled window to a clerk. They left their urine containers at a second window, where the ledge held an assortment ranging from Mason jars to perfume bottles. Signs pointed to the waiting room.

The last arrivals leaned against the wall.

Patients waited in a huge room with a seating capacity of 500, in rows of old wooden theater seats. The theater was always filled, and the last arrivals leaned against the walls. Children ran wild and the din was deafening.

No names were called before 10:30, and those called first had arrived as early as 6:30 and waited for the doors to open at 7:30. The names were called over a loud speaker—not "Mrs. Lopez," or "Mrs. Sally Brown," just "Marie Lopez, Sally Brown"—and patients strained to hear them over the noise. They were not repeated; if a patient missed her name, she waited for a second run through the list. No one left the room for fear of missing her name.

They brought their sense of community with them.

The Mexican-American mothers arrived early, in groups, bringing their embroidery and other handiwork and all their children under school age. They gossiped and chatted away the hours, in English and in Spanish. They brought their sense of community with them and with that, created among themselves islands of interest and excitement over their pregnancies in the mass of anonymous pregnancy that surrounded them.

They sat in silence. . .

The black mothers were more individualistic. They arrived singly, sat apart from one another, and ranged in ages and attitudes from young and sullen to middle-aged and dignified. Many were accompanied by their husbands who stayed in the hall, leaning against the walls in embarrassed attitudes. Because they sat in silence, the black mothers seemed the most vulnerable and, at the same time, the most hostile to the conditions of the "theater."

White women usually elected to sit beside each other, even though they were strangers, and their first remarks were invariably variations on "I can afford a private doctor, but I just don't see the point of spending all that money when you can get it free here." They turned the pages of various women's magazines, featuring pink satin bassinets and New York models wearing gossamer maternity gowns—their link to the middle-class world.

Their clothes were filthy and they were starving.

Among the white women was one who was middle-aged, slatternly, and obviously mentally retarded. Pity was wiped clean by her constant smile and vacant pale blue eyes—there was "no one home" to pity. She brought her six tiny children each week—their clothes were filthy, their hair matted beyond recall, and they were starving. Their thin, white legs were covered with glaring purple bruises and they had chronic open sores on their faces and arms. This mother and her children were an island to themselves since other patients could not overcome the indignation roused by the sight of those suffering children. Yet, of all the people in the

room, this mother was at ease with her surroundings. She evidenced no loss. She needed no sense of community, no husband waiting in the hall, no white middle-class magazines to remind her she was a human being involved in a human act. She was what the system—the theater, the rules, the waiting—said to all of the women in that room: "shameful, mindless, pregnant animals."

When a name was called, the patient entered a curtained cubicle where a nurse handed her a white hospital shirt and instructed her to undress. Six waited in each cubicle, seated three-by-three on narrow benches against the walls, knees touching. Those whose names were called at noon waited another hour in the cubicles. Those who reached the examining table just five minutes to 12 were put in position, feet in stirrups, and they waited like that until a doctor returned from lunch.

The examination was short and brutal.

The examination was short and brutal, partly because of the nature of the examination, which is unpleasant in any circumstance, but also because the doctors and interns were openly contemptuous. One said to the nurse, "Well, let's start the parade." A nurse said to a new intern, "Well, what do you think of our circus?" There was no time for talk, unless the patient was overweight. One doctor admonished all the overweight mothers: "You're just making my job that much harder."

After the exam, patients returned to the cubicle to dress. On the way out, they picked up their empty, unwashed urine containers, which were set out on a bench by the door. If a patient asked for some vitamins, a doctor would grudgingly write a prescription which would admit her to the prescription waiting room. Same system. An hour later the patient would leave with a week's supply of calcium pills.

This was community health in 1955.

COMMUNITY HEALTH, 1971

Patients arrive by appointment.

At 8:30 a.m., at the Matthew Walker Health Center in Nashville, Tenn., the entrance is busy with minibuses and cars arriving and discharging patients, the first of the many who will be picked up throughout the day. Some patients arrive on crutches, some with children, and all are greeted and helped down the walk and into the building. The lobby, which is attractively and comfortably furnished, has a few people waiting, but not many. The patients arrive by appointment and are moved swiftly into one of four family care units called Family Suites, to the dental clinic, the physical therapy room, or elsewhere. The well children are taken to the playroom. The atmosphere is brisk but friendly—"taking care of business," which is comprehensive family health care.

At the health center, a patient can receive medical treatment from a family physician; dental care; X-ray and laboratory tests; health and nutrition information; free or low-cost prescriptions; social services; preventive health services such as physical checkups, immunization, health education, and family planning; behavioral or mental health care. At home, patients can receive care from public health nurses and neighborhood health workers. If a patient needs hospital care, that is arranged by the center as well. The center assesses the insurance coverage of the patient, negotiates services

for the medically indigent by the welfare department, or identifies Medicare information. The patient's health center physician follows his progress during his hospitalization.

The patient's family is included in treatment.

In addition to the direct services offered the patient, the patient's family is included in the "treatment." The family care team includes a doctor for adults, a doctor for the children, a nurse and nurse assistants, the neighborhood health worker and a public health nurse. Health problems related to family problems are explored: the employment situation of one or both parents, drinking problems, problems the children may be having in school, living conditions in their apartment or home, etc. And the center goes even further—it sends workers into the neighborhood to help the residents understand how to use the new service. A far cry from 1955.

What makes the difference. . .?

What makes the difference between 1955 and 1971? The county hospital was a traditional medical facility geared to offer only those services its professionals had been trained to offer. From their point of view, delivery of services meant offering specialized, traditional medical care to the indigent and operating a training center for nurses and interns. Within this traditional system, each patient was considered in light of some malfunctioning part of his body—if he suffered kidney disease, he was treated for that; if she was pregnant, she was treated for that. The services were offered according to a schedule convenient for the professionals. Thursdays were devoted to prenatal clinic; if this meant drawing all the indigent pregnant women in the area into a room to wait four to six hours for their minute with the doctor, so be it.

A schedule convenient for the professionals.

No doubt, in the eyes of the doctors and nurses and hospital administrators, they were doing the best they could. That the mechanism could not respond to the needs of the patients was not seen as a fault of the system itself, but the result of underfunding—just not enough money or personnel to handle such a massive task.

Just not enough money. . .

But even if unlimited funds had been forthcoming, the stepped-up services would have made the clinic just more convenient for the doctors, not the patients, and more traditional, not less. Stepped-up prenatal care, for example, would have continued to ignore the six impoverished children of the mentally retarded patient and would have only assisted her in bringing a seventh child into the world.

The evil. . .is poverty itself.

The health center in Nashville has a different concept of delivery of services. The evil which the center combats is poverty itself. The patient is a whole person to be treated for all the symptoms of poverty, not just his injured arm or damaged kidney. He, in turn, is a member of a family, and to combat the symptoms of poverty for one member means that the whole family must be similarly treated. The family in turn is part of a community and whatever the community contributes to his impoverishment must be confronted.

All levels of staff participate in seminars.

There is another difference between community health in 1955 and 1971. Off the lobby of the Matthew Walker Health Center in Nashville is a conference room with about 20 people seated around a table. They are participating in a drug seminar.

They wear the uniforms of nurses, public health nurses, neighborhood health workers, and doctors, as well as street clothes of administrators and transportation workers. The atmosphere is informal. Everyone contributes, and the discussion leader is quick to turn every response into currency. Upstairs, a remedial class in math and English is in session. In another classroom, a dental assistant is demonstrating a table clinic to be presented at a meeting of the state Dental Assistants Association. And off in a room by herself, another trainee is practicing keyboard drills on a typewriter, with the instruction manual propped up on the desk next to her.

Every team member, paraprofessional and *professional, must be trained.*

For the community health center to operate in the fashion it does, to deliver the services it does, every member of the facility must be trained. The neighborhood health worker is trained to go into the neighborhood and diagnose the services needed and to educate the residents on how to use the services. The transportation worker must know how to help the ill or crippled patient out of his house and into the bus or car—the patient's first contact with the center may be this worker. The doctors and other professionals must be trained to understand their patients and, in turn, to make themselves understood. The neighborhood health workers must similarly learn to communicate their patients' needs to other community service personnel, and to first uncover those needs. And all of the paraprofessionals, in turn, carry another burden—they, too, are moving out of poverty and they are in training not only to help others, but to help themselves, and to learn to work in a new way as team members.

Training is the key to the services delivered by the comprehensive health center. Training is the key to the atmosphere of the center as well—

> They (patients) are made to feel welcome, and are treated with warmth, respect, sympathy, and understanding—the most important elements in helping people in trouble, everywhere.

This paragraph is not found in a brochure advertising the center; it appears in an instruction sheet used by trainees—every member of the center staff—in their core course.

Training is the stepping stone to improved services.

Training is the key to delivery of services and if one person were to be pointed out as the single most important difference between community health 1955 and 1971, it would be the person who makes certain that the center practices what it preaches—the training director.

II. VISITS TO THREE COMPREHENSIVE HEALTH CENTERS

The training director has to play off objectives against the constraints.

Each training director faces a different situation—different needs, demands, constraints, and circumstances. Within these, the director is given specific objectives within an overall training program—orientation, core training, on-the-job training, remedial training, training for the GED, professional retraining, and accredited college training—and models with which to set them up.

Every training director has a "story" to tell.

In the play-off of objectives against the needs, demands, constraints, and circumstances, each health center has emerged with a different mode of training that reflects the uniqueness of the center. So, even working with the same models, the results are quite different; and in this sense, every training director has a "story" to tell.

That is why, when we selected three training programs to present as examples of "how to do it," we decided to present each training director's "story"—not just what was done, but how it was done and why.

THE MATTHEW WALKER HEALTH CENTER, NASHVILLE, TENNESSEE

The trainer is not matching traditional students with traditional curriculums.

According to Mrs. Judith Mann, training director of the Matthew Walker Health Center, the training director must recognize at the outset that she is not matching traditional students with traditional classrooms, traditional curriculums and courses of study, or traditional certificates. If that were the case, the job of training director would be an administrative one and would be a cinch—just hire the most qualified people and arrange to send them to college. Rather, the training director is charged with developing nontraditional training for nontraditional students to perform nontraditional services, and the traditional approaches will not suffice.

Traditional approaches will not suffice.

As a consequence, Mrs. Mann has provided concentrated and continuing on-the-job training to the staff of the center to give them the comprehensive skills needed to perform comprehensive family health care. "Accreditation is coming soon," she remarked, "but our first job was to get our staff trained to get this center operating and fulfilling the purpose for which it was built."

The first job is to make the center fulfill its purpose.

The Matthew Walker Health Center is an attractive new building located near the Meharry Medical College, the delegate agency. The Center serves a large area—a "neighborhood" by definition only. Because of the size and shape of the area, 80 percent of the patients require transportation to and from the Center.

Mutual planning is essential. . . involving everyone. . .and trusting them to carry out their parts.

Mutual planning is essential to reach the goal of training, which Mrs. Mann sees as the improvement of the delivery of services. This planning was in evidence even prior to bringing the service under one roof, when the medical, administrative and training departments were separated. Upon moving into their new building in 1969, the need for mutual planning became more evident. Being a one-man department, the success of the training department has been largely due to a staff that is willing to cooperate. "Mutual planning means, " in Mrs. Mann's words, "involving everyone concerned with the cause and trusting them to carry out their parts.

Supervisor support for released time is essential.

"As training director, my first priority is service and the training must not only meet delivery of service needs from every aspect, it also must not *interfere* with the delivery of service." As a training goal, this means that the training must reflect all the trainees' needs in performing their jobs—while they secure academic training for their personal improvement. From the point of view of the supervisors, it means that training must mesh with

trainees' schedule and not interfere with the delivery of service. Mrs. Mann emphasized that cooperative planning is also essential to gaining supervisor support for the trainee seeking additional training who needs released time for this advancement.

The training director is a planner, salesman, administrator, teacher.

She defines the role of the training director as an innovator, program planner, salesman, administrator, consultant, and teacher. "And when it's all done, the training director must be willing to stand back and even encourage the staff to take the credit—that's how it's done. For if the staff succeeds, the training program succeeds."

Because of her educational background—Mrs. Mann is a former teacher—she classifies her training methods as largely innovative and partly didactic. The orientation and core classes use typewritten materials generated in-house. Limited quizzes reinforce information about the health centers that is essential knowledge for all employees. Individual response and group interaction are also stressed, and the composition of the classes assures a variety of responses. All trainees participate in orientation and core to help them understand their roles in the health care process. Personal improvement of the trainee is also stressed. Courses are designed to help the trainee conduct his personal life as well as his work day in an organized fashion. Consumer education, nutrition courses, and basic physiology and anatomy not only help the trainees to help the patients, but also to understand and care for themselves as well.

The Center's development is reflected in course content.

Mrs. Mann has coordinated seven training sessions in orientation and core (see Appendix I), and says that "every one was different—every one reflected the development of the center, trainee input, improvements, and new ideas and information. That is why our training session outline is flexible."

The following partial list of the training programs implemented and attended by staff members during the present grant year (1970-71) reveals better than any discussion just how the program operates.

1. The drivers, neighborhood health workers, and nurse assistants received in-service training in first aid, mental health, and physical therapy. The course was held one hour a week for 14 weeks.
2. One Maintenance Department worker successfully completed a 30-hour supervisory course at Vanderbilt University.
3. Four secretaries are enrolled in all seven sections of the Certified Professional Secretaries Review Course, with two others enrolled in two courses each. The classes, held weekly for two hours, are offered by the Nashville Chapter, National Secretaries Association, in conjunction with the University of Tennessee.

Supervisory workshop in job instructor training. . .

4. A supervisory workshop in job instructor training was held at the Center for 19 supervisors. It was a five-day course, two hours a day, instructed by Mr. William Deaton, Tennessee State Department of Education. [An example of resourcefulness on Mrs. Mann's part. The state offers this service free to industries and institutions in Tennessee.]

5. In-service training for the dental and dental auxiliary staff has been scheduled for three weeks out of each month. The Family Suites are presently using their weekly team meetings for in-service education for all suite personnel.
6. The dental assistant training program has been expanded to include rotation through six clinics of Meharry's Dental School. Five dental assistants are presently enrolled in the correspondence course offered by the University of North Carolina. [This course provides a dental assistant certificate recognized by the professional dental associations. Plans are being made to administer the final tests at the Meharry Dental College.] One dental assistant enrolled in the correspondence course offered by the University of North Carolina is receiving typing instruction from the supervisor of secretarial services, to meet one of the requirements set by the school.

GED preparation...

7. The Metropolitan Board of Education approved a teacher to instruct a GED preparation course at the Center. Biweekly 1-1/2 hour classes are scheduled during working hours for 16 weeks; 12 employees are enrolled. One-hour remedial classes at the Center are held biweekly, with 10 employees presently enrolled.
8. Fifty-one employees from the Family Suites attended a Family Planning Workshop held one hour a day weekly for three weeks.
9. Two entry-level training classes for 37 service area residents began during May and June last year and will be completed during this grant year.
10. Approximately 60 employees attended orientation for staff members during this grant year. Orientation is scheduled for two hours daily for one week.

Graduation exercises for 60 residents...

11. The Center held its third graduation exercise for 60 service area residents in new health careers April 24, 1971.
12. A second-year trainee was enrolled as a senior student in X-Ray Technology at Meharry Medical College.
13. Three neighborhood health worker career ladders are presently listed on the Center's organizational chart: (1) community welfare assistant (these workers will receive their on-job training and be assigned to Social Services); (2) community nursing assistant (these workers will be receiving basically the same training as the home health aides and will work under the supervision of a Public Health Nurse); and (3) community organization assistant (assigned to community organization department). A curriculum for these positions is being planned.
14. Registration of one trainee in the State Area Vocational-Technical School to study to become a certified laboratory assistant, and of a second trainee in a correspondence course offered by American Medical Record Librarian Association to become a medical record technician. On-job-training at an in-patient hospital will also be arranged as a part of the technician training.

On-going programs and future plans include:

1. Teaching one pharmacy assistant to type, with instruction to be given at the Center by the supervisor of secretarial services.

In-service education for charge nurses.

2. Providing in-service education for charge nurses to assist them in their new role as coordinators of the Family Suites.
3. Continuing to ask the administration to develop the administrative policy necessary to begin the training for the Center's security guards.
4. Assisting in planning a two-day institute for all Nashville agencies that train entry-level outreach workers to discuss the feasibility of a generic Core Curriculum.
5. Continuing the series of discussions on narcotics and drug addiction for neighborhood health workers, public health nurses, and community organizer assistants.
6. At the request of the drivers and neighborhood health workers, developing a second series of discussions of mental health.
7. Developing in-service education for neighborhood health workers and community organizer assistants in legal aid services.
8. Completing plans for a Consumer Education Workshop.
9. Completing a released time and payment policy for outside education for nonprofessionals.
10. Developing individualized instruction to prepare employees to take college entrance examinations.
11. Developing a nurse practitioner curriculum, most of which can be taught at the Center.

LPN associate degree program.

12. Discussing arrangements to enroll employees without high school diplomas or the equivalent in a licensed practical nursing school offering an associate degree program, with the understanding that students would be subject to the same standard of performance and the credit would not be granted until admission standards were met.
13. Enrolling two medical record employees in a Basic Coding Workshop.

The next step. . .is state certification.

14. Setting up meetings with state professional organizations and the State Department of Education in order to receive curriculum approval of the neighborhood health worker, nurse assistant, laboratory assistant, etc. The next step after receiving approval is state certification.
15. Having each supervisor review and if necessary revise his entry-level curriculum; developing procedure manuals and outlines for departmental orientation.
16. Developing an individualized preemployment orientation program for new employees.
17. As a priority, making in-service training increasingly problem-oriented to improve the quality of care provided patients.
18. After all supervisors, department heads, division heads, and administrators have attended the Supervisory Workshop, continuing this workshop to further develop

supervisory skills and improve communication between supervisors, employees, and the administration.

19. Continuing to develop associate degree programs in health care administration, being planned by the Department of Family and Community Health of Meharry Medical College; developing a training program for the Health Council; developing the orientation program for medical students, interns, and residents [the Center draws medical personnel from Meharry Medical College]; and scheduling a first aid class for the dental assistants enrolled in the University of North Carolina Correspondence Course.

This review of ongoing and planned programs is not exhaustive, but does indicate the unique character of the Center's training program. The training is both group and individually oriented, indicating that the staff receive a lot of personal attention from the training director. The training is concentrated within the Center, reaching out for the resources and credentials offered by accredited institutions, but continuing to offer all the training in-house that it can.

Training is both group and individually oriented.

This approach allows the training department to be both responsive and flexible in setting up courses, as evidenced by the plans to meet the requests of drivers and neighborhood health aides for more mental health training and by the willingness to set up individual typing instruction for those who need it. Courses are made to fit the Center's schedule. For example, three members of the staff received instruction in teaching seminars on planned parenthood. The course was to be offered on a full-day training basis. But because the Center cannot release its staff for a full day, the course was revised to be offered in two sessions meeting on consecutive days, and offered twice to two separate groups so that staff supervisors could schedule released time without interfering with Center functions.

Courses are made to fit the Center's schedule.

The individual as well as group attention characteristic of this program also reflects the mutual planning effort—supervisors can report specific needs for the training department to meet, which a training director may not be aware of in the ordinary course of events.

But, Mrs. Mann stresses, no trainee should have to rely on personal affiliations and relationships or to "bargain" for their released time. Once a course has been set up to suit the demands and needs of the individual or the group, the supervisors then must be held to the schedule, provided there is no conflict with the ongoing services of the Center.

No trainee should have to bargain for released time.

A new training director setting up training in a new program would be well-advised to give professional staff orientation equal priority with staff development, according to Mrs. Mann. Because the Center rotates medical and dental students from the Meharry Medical College as well as students from other disciplines through some of its departments, the training director's input into their orientation enhances the overall goals of the Center.

COMMUNITY GROUP HEALTH FOUNDATION, INC., WASHINGTON, D.C.

Every city in the United States has a Tivoli Theater, a deteriorating structure with a baroque facade, gothic gargoyles, or Greek columns testifying to its bygone role as a social gathering place. The city's center has long since shifted to another location and deterioration of the old district has gone just about as far as it can on this side of condemnation. The stairs will take just so many feet, the floors just so many scrubbings, and the walls just so many layers of plaster, paint, and wall paper, and then they begin to sag, creak, splinter, and fall. But these old structures were built to last, and no matter how decayed their interiors, people will make them live—install hamburger stands and drug stores in them, and hold church meetings in them.

This side of condemnation...

The Community Group Health Foundation, Inc., training department is located in the Tivoli Building in Washington, D.C., on 14th Street—a street made famous in the 1968 riots. Across the street is the Health Center served by the training department. The residents in the neighborhood—the Upper Cardozo area—are poor and mostly black, but include a large Spanish-speaking community, many of whom are immigrants.

The atmosphere is one of construction.

Mrs. Annie Phillips, training director of the Foundation, cautions her visitors about the risks in using the elevator, and thus expects them to arrive slightly out of breath when they reach her fourth floor office. But once there, any depression engendered by the surroundings is wiped away—the atmosphere is not one of deterioration, but of construction. After two hours with Mrs. Phillips, the visitor leaves convinced that what is being built is not only working, but is here to stay.

Mrs. Phillips operates from an unshakable goal. "If you are going to promise career development, then make it *career development.*" But, she cautions, you don't arrive at a goal like this overnight. You start with a definition of the purpose of the training program from the point of view of how the paraprofessionals will be used—in administrative positions, to deliver direct medical/social services, to provide supportive patient services, etc. "That is, *how* do you intend to use the paraprofessional and *how much?*" Then you must get an understanding and a mutual commitment from supervisors to use paraprofessionals wisely, to preclude "expediencies"—either expecting too much or not allowing them to perform when they are able.

Mutual commitment from supervisors...

Next, according to Mrs. Phillips, is concentration on the selection process, which again requires a commitment from the supervisory staff. "Are you sure you've got the *right* people?" is a question that the training director faces, with the implication that the questioner knows who the "right" people are. In other words, the supervisors are going to reflect traditional criteria regarding who is "right" for the job, which would rule out the people you are supposed to be bringing into the system. "You can't make a silk purse..." and "You're reaching back too far, you'll have to train forever..." are the admonitions from people who would have the director be highly selective. She must continually support her reasoning and then back it up with results in the training.

Who is "right" for the job?

Released time is the third commitment and it must be agreed to even if it means an adjustment to schedules so that service will not be sacrificed. On the surface, this would seem to contradict the delivery-of-service emphasis of the Nashville center, but in fact all training will effect some short-run interruptions for the sake of long-run improvement in services, and both points of view should be interpreted in the context of achieving a mutual agreement for released time. If Mrs. Phillips' statement is stronger and perhaps more demanding than Mrs. Mann's, this is because she is scheduling released time for different purposes.

12 hours released time a week...

The Upper Cardozo neighborhood health center trainees are granted up to 12 hours released time a week, and their training schedule includes a high proportion of college courses from Federal City College. Courses are offered both on site and at the FCC campus. But transportation time and time for study are added to the trainees' days.

The trainees are acquiring 45 credits a year and their training schedule is a masterpiece of programming–fitting work, OJT, in-service training (core and orientation), and college courses into each trainee's day (see Appendix II). But within two years the trainees can receive the A.A. degree from Federal City College or a technical certificate from the Washington Technical Institute, if they choose. As Mrs. Phillips says, if you promise career development, then you have to deliver *career development*, and in the Washington, D.C., area, this means college credits.

If you promise career development...deliver!

The emphasis on college credits was in part by design and in part the result of taking advantage of a favorable opportunity. Mrs. Phillips had made overtures to three area institutions, including the sponsoring university, only to find "those doors closed. I mean, literally closed. Every dodge in the book was used. I made a 2 p.m. appointment with one administrator and after keeping me waiting for three hours, he rushed past saying, 'my secretary had you down for 2 a.m.,' so I knew there was no use trying there again."

Then Mrs. Phillips made contact with the Dean of Community Education Department of Federal City College.* "We wasted no time from that point on. He said to give him a curriculum, and I did. He found teachers interested in community education, and there was no stopping us after that. In a way, you can say that it was an opportunity that dropped in my lap."

She was ready with a curriculum.

Like Mrs. Mann, Mrs. Phillips is only too ready to hand the credit elsewhere, but the fact is that when FCC offered the opportunity, she was ready with a curriculum, able to design the courses almost overnight, and had the trainees ready to start.

Communication with FCC is formally set up in monthly meetings, but Mrs. Phillips also participates in the classes and counsels the teachers on how to present the material for the trainees. When her trainees complained in morning core sessions that the algebra lesson was over their heads, Mrs. Phillips sat in on the class and suggested that a trainee who did understand the lesson should explain it to the class. The student succeeded in

*Federal City College is a new institution mandated to serve the Washington, D.C., area population. Open enrollment and a commitment to urban problems characterize the college, along with low tuition rates and a community education emphasis.

translating it into everyday experience, the class caught on, and the instructor has been using the "student-to-student" instruction technique since. The trainees also take biology, English, social science, and humanities, with interviewing and psychology offered to the outreach workers.

"Student-to-student" instruction. . .

To gain credit for the core curriculum, Mrs. Phillips sent her resume to Federal City College and by virtue of her qualifications was accepted as a qualified instructor. Part of the core curriculum consists of field visits to day care centers, local hospitals, the Spanish Catholic Center, etc. Several "teach in" sessions were included in the core course. A representative from the Pride, Inc., "War on Rats" extermination department, lectured on public health; representatives from the Accident Prevention Bureau and the Poison Control Center of Children's Hospital presented seminars; and Change, Inc., the Cardozo CAA, presented a panel discussion on community action. The doctors and dentists of the center conducted the "teach-in" in their specialties, using films, demonstrations, and role playing.

"Teach-in" core. . .

Four credits per quarter for OJT are also granted by FCC. These courses are created by the supervisors, who prepare a subject syllabus and monitor and evaluate learning on the job.

Credits for OJT. . .

"During the first year, I registered the trainees and guided them through their courses, which we selected and redesigned. Next year, they are on their own," says Mrs. Phillips. This isn't as harsh as it sounds—funding will be sought to help the trainees pay their tuition for the next level in their chosen field. The students who desire associate degrees will select their specialty courses to fit in with their individual career plans. This can mean either continuing at FCC to acquire the A.A. degree or transferring to the Washington Technical Institute for technical training and certification as a laboratory or dental technician.

Next year, they are on their own.

Mrs. Phillips insists that her trainees maintain both their heavy work loads and training schedules which, she admits, means she spends a good deal of her time personally counseling the trainees. As a former teacher and student counselor, Mrs. Phillips has no difficulty filling this role.

Personally counseling the trainees. . .

Mrs. Phillips also spends a good deal of her time helping the trainees develop coping skills. For example, trainees often get discouraged when they cannot see the immediate relevancy of their courses. Mrs. Phillips defines relevant as meaning "what's important," and "that means not only convincing the teachers that what they teach should be related to the trainees' lives and jobs, but convincing the trainees that all of their learning is important, and that no one knows exactly how or when they'll use what they learn. The idea that everything learned must be immediately transferable to a specific situation is as wrong as the other extreme—teaching only the abstract. No one consciously recognizes what in his past training he is using when he makes decisions, acts, or learns something new."

There is also the problem of using standard English in the classroom. "I ask the students to respect the teacher's manner of speaking, just as I expect him to respect theirs. In fact, everyone talks several 'languages,' and I see no point in not letting standard

English become part of the learning process of the trainees. Standard English is the language of our society; trainees learn, use, and negotiate in standard English."

The wide age range of the trainees. . .

The wide age range of the trainees—19 to 53—would seem to have presented a problem, but according to Mrs. Phillips, what the older trainees lack in immediacy—concentration and energy—they make up for in motivation and experience.

"We bend our own standards to keep our trainees with the program, to be sure," she added. "I have one person responsible for calling a trainee every morning to get him up and down here. Now, as an adult, he should be expected to do at least that much by himself, but he can't, so we help him. I, as a counselor, cajole, threaten, tease, and otherwise motivate trainees who are slipping or who are afraid they can't keep up with the work, study, or otherwise make the grade. I have a bag of tricks. Maybe this would be regarded by some as reaching 'too far back,' or trying to make that 'silk purse,' but it is part of my job as I see it—how I help to offer career development to the people who would be overlooked by the traditional approaches."

I. . .cajole, threaten, tease.

In presenting the achievements of the training department, we have necessarily glossed over some of the problems, such as the initial hurdle of getting the Center executive committee to buy the idea of college training requiring 12 hours of released time.

Getting the executive committee to buy the idea. . .

A crucial problem facing the training department is that of replacement. Although hiring and training community residents is a component of the selection criteria, when openings occur from terminations, the workers are being replaced by people from outside the neighborhood. The problem of confidentiality is reported as a factor for hiring nonresidents. Some patients are reticent to reveal personal difficulties to neighbors, and there was an instance of a breach of confidentiality that brought the problem forward. But the answer lies in the training department's ability and willingness to respond with intensified training in any area that is revealed as a special problem—if they can stem the tide of hiring nonresidents to fill the positions.

Many problems, like this one, start at the executive level, rather than with the trainees. Mrs. Phillips is presently trying to set up staff development for the executives. Eight sessions of continuing education for the professionals will include training in leadership styles, communication, management or supervisory techniques, decision-making, issues and problems of the center, and how to implement solutions. Mrs. Phillips sees this not only as a problem-solving mechanism, but as a source for new ideas and a medium to translate them into plans and programs and to get them implemented.

Staff development for executives. . .

At the other end of the spectrum, she is also setting up in-service staff development for admissions clerks, maintenance clerks, elevator operators, etc. These people have not been included in the training so far and the effects of that are being felt. "The attitudes of some of our admissions clerks, for example, have hurt us—they see the patient first, and they need this training. Also, each member of the staff must fulfill a double role in a health center. The elevator operator or driver is as likely as the family

All staff members have dual roles.

health worker to face emergency situations involving a patient. I also see training as a communication device, to reduce isolation and allow each member of the staff to understand how he fits into the whole scheme. And this applies to the top executive staff as well."

While it might appear that the in-service training program for all staff at Nashville has flourished at the expense of college education, and that college education component at Cardozo has emphasized training one segment of the staff at the expense of in-service training for all, neither statement takes into account the length of time these programs have been in operation, that they are in the process of developing, or that they have followed the paths they did in response to their unique local needs and unique local opportunities. "You can't do it all at once; you start where you can and just keep pushing and pushing for the rest." This statement could have been made by either Mrs. Mann or Mrs. Phillips; and in both cases, the results—both what they have accomplished and what they have planned—fully justify the paths taken.

The results fully justify the paths taken.

THE MARTIN LUTHER KING, JR. HEALTH CENTER, NEW YORK CITY

The Martin Luther King, Jr. Health Center is one of the largest in the country, employing approximately 600 people, of whom two-thirds are paraprofessional employees. The Center is housed in a fairly modern five-story building in one of the most deteriorated sections of the Bronx, and serves a resident population of 45,000, some of whom live in a public housing complex nearby. Two departments are located outside of the Center, one in the public housing complex—the health advocacy branch—and the other, a satellite center, in the most depressed area of the Center's neighborhood. The training department is located in the main Center.

Health employees are highly unionized.

Location influences center programs, and the MLK Center faces conditions of a type and degree unknown outside of New York City. For example, health employees are highly unionized, which creates an extra set of considerations and negotiations in job development, work rules, salary scales, etc. The Center serves residents whose families have lived in the area for generations as well as the newly-arrived residents from the small towns and rural areas of the United States and from Puerto Rico, Cuba, and other Spanish-speaking countries. The area served is densely populated, which further aggravates the conditions of poverty. The traditional community and social services available to the residents are highly impersonal and mechanized, as well as largely ineffectual—even more so than in smaller towns and cities.

By the same token, the area is rich in some resources, including the cultural heterogeneity of the residents. Transportation problems are fewer, and education institutions of a wide variety abound. The cultural resources of the city are many and varied, but the poverty of the area surrounding the MLK Center acts as a barrier to those resources, creating a provincial poverty pocket in one of the world's most highly urbanized areas.

A masterpiece of administrative engineering. . .

The size of the MLK program is overwhelming and its success can be called a masterpiece of administrative engineering. In such a setting, the training program would be expected to be necessarily more collective and less personalized than in Washington, D.C., or in Nashville, and in some respects, it is. The organization of training is considerably more formal. However, the approaches used in training employ both individual and group interaction and thus guarantee that the program is responsive to the individual and does not become another monolithic, bureaucratic endurance race for the paraprofessionals.

"Our job is to develop individual talent."

Impressed on the system is the personality of its training director, Mrs. Stella Zahn, who sees the trainees as individuals. "Once you set aside any preconceptions of what poor people are like, you understand that they are a collection of individuals much like any other, and among them are people with a great deal of undeveloped talent. Our job is to find these people and to develop that talent, and you don't do this by thinking of them as groups. They may receive their training in groups, but they are always individuals and are selected, trained, and employed as individuals."

The mandate that governs the operations of the Center is to provide the residents of the South Bronx with one-stop, non-fragmented, comprehensive health care, and this is the mandate that governs the training program as well. According to Mrs. Zahn, such a comprehensive concept of service must be built into every aspect of the Center's operations, but especially into the training of the personnel who deliver the service—paraprofessionals and professionals alike.

Training starts during screening.

Delivery of comprehensive services means that every staff member must be knowledgeable about his job and able to interact effectively with people. "You might say that training actually starts during the screening of applicants," Mrs. Zahn explains. "Our screening procedure consists of two interviews and an examination, which are used to identify people who can perform and who are suited to health work." These take place in one day to save the applicant from having to make more than one trip. The first interview uses a group setting of eight applicants, one staff trainer or advisory board member, and a teacher/counselor (some of whom are paraprofessional teachers in training), who acts as the group leader.

The group leader first explains the training program to the applicants in detail. Then the applicants are encouraged to discuss hypothetical questions designed to measure qualities such as resourcefulness, aggressiveness, ability to relate to other people, etc. "Sometimes we can lose sight of the fact that some people have difficulty interacting with people. If we screen these people in, then we are hurting not only the service, but the people themselves and the community."

The second interview is with the applicant to determine whether he meets OEO selection standards (head of household, welfare recipient, unemployed or underemployed, resident of the target community, etc.). Finally, the applicants take the revised Beta Intelligence Test and fill out the regular application form, which serves as a reading test.

"This may sound too selective to some directors," Mrs. Zahn states, "but it has worked well for us. With a number of applicants to choose from, we must choose the ones who evidence interest and respond to the interviews. If our purpose were only to alleviate unemployment, then no screening would be used. But we are only hiring a very few of the many who need work, and delivery of services is our first goal. Therefore, our system helps us to find trainees who have the talent."

During the first day of core, trainees receive a detailed outline of the entire core curriculum for the eight weeks of training (see Appendix III). The courses include community resources, medical care organization, health careers, communication skills, math, and basic health skills. The concept of all courses is directed, however, at the individual and his relationships with his family, the community, and the work of the Center. The techniques used combine didactic approaches with group interaction. Mrs. Zahn is emphatic on the importance of the learning environment. "In addition to providing a comprehensive background in health, you must also create a learning environment that stimulates the trainees' interest, increases their confidence in their ability to learn and perform, and involves them in the learning process as much as possible. The trainees must believe that they have the skills they need, to have the confidence to make it."

The trainees must believe that they have the skills they need.

It is easy to say that the core curriculum is "basic, comprehensive, and related to the individual trainee," but to understand how these goals are accomplished, the courses must be described—to do less would do a disservice to the program.

Community resources is designed to make the trainees aware of community problems, the resources available to them, and how to identify problems, find information, and help solve them. Throughout the course, groups of trainees are responsible for teaching the class for one week on such topics as welfare, housing, narcotics, the police and criminal law, etc.

More traditionally academic in curriculum content, the *communication skills* course provides trainees with the time and support for honing basic skills—reading, vocabulary, spelling, public speaking, observing and recording, and grammar and composition.

Time and support are needed to have basic skills.

The same holds true for the *math course.* Instead of just one comprehensive course, the math curriculum is divided into several "mini-courses" that vary in content and duration. Trainees choose which they want and need, after taking placement tests.

Trainees with a fairly good background in math can take advanced math (college-level); consumer mathematics, which includes such topics as loans and interest rates, balancing a checking account, taxes, computing a welfare budget, insurance policies, etc.; and new math, which carries an important by-product for parents who need to help their children with their homework.

Trainees without a high school diploma or a GED usually take remedial or basic math and GED preparation, which includes study of high school math and test-taking techniques. These trainees can take the other courses as they increase their basic skills. Trainees accepted for on-the-job training take OJT math, which includes a review of percentages, an introduction to the metric system, and other computation skills.

The *basic health* course includes study of the growth processes from conception to old age, first aid, community health and environmental problems, and the care and use of medicines in the treatment of illness.

Health careers course.

The course on *health careers* is designed to prepare the trainees for jobs, to acquaint them with the prospects for mobility in the health field, and to help them make realistic job and career choices. Trainees study how health work differs from work in other human service fields and outside influences that affect their work: unions—what they can do for them and how and when to use them; the effects of automation, cutbacks, and job freezes; and job security versus professional security. They cover the rudiments of finding a job, job interviewing, and how to write a resume. While learning of job opportunities and job mobility, the trainees are also developing insight into their own potential and career aims.

Regarding this, Mrs. Zahn said, "When you have operated a training program for five years, you begin to get a sense of continuity—you find one of your first trainees is working as a nurse practitioner, with another on the way next year; someone you never thought would make it is employed outside as a certified lab technician; another has come up through the ranks from the first core group, to family health worker, to assistant director of training, and is now being interviewed by the board for the position of deputy program director. Every day you deal with frustration and failure, but then you look up and find that it works! It's what keeps us all on the job—the trainees, the trainers, and me."

Medical care organization is part of the curriculum.

A fairly recent addition to the core curriculum, the course on *medical care organization*, is designed to train the employee to act as a community advocate in the Center and as a Center advocate in the community. It not only helps the trainees see their roles and responsibilities in the Center and the community, but also takes advantage of their unique position of being both providers and clients of the Center's services.

Trainees can help keep the Center responsive.

The principal points covered during the course are the role of the Center in the community, the trainees' role in the Center, and what trainees can do to keep the Center responsive to the needs of the community it serves. The course surveys the development of medical delivery systems and the socioeconomic factors that affect the use of health services—cost, education, locations, etc. The longest section of the course is on the concept of comprehensive neighborhood health care and the importance of preventive medicine in terms of impact on the community. Representatives from each department make presentations to the class. The course concludes with a discussion of the process of change in the Center and how the trainees can facilitate the process using the community-based advisory board, turning to the person in charge, and following due process for patient rights (see Appendix III).

OJT provides specialty training.

On-the-job training is, by necessity, a time of specialization at MLK. The graduates of the core program can choose a field to go into from a long list of positions that includes coders, dental assistants, electrocardiograph technicians, family health workers,

inhalation therapists, laboratory technicians, medical clerical transcribers, obstetrical technicians, X-ray assistants, etc.

The length of time spent on OJT in each specialty ranges from three months to two years. The curriculum for each specialty is developed by members of the training department in cooperation with specialists in the field. In some instances, existing curriculums were adapted for use in the Center. For example, the curriculum for lab technicians was derived from materials developed by the Navy to train medical corpsmen, and the curriculum for physiotherapy aides from that developed by the Employee Development Division of the Los Angeles County Civil Service Commission for training physical therapy attendants.

Use already developed curriculums if they are appropriate.

One of the most demanding positions a trainee can go into in terms of learning a wide range of skills is that of family health worker. OJT lasts for four months under the supervision of a public health nurse.

During training, the family health workers spend two-thirds of their time learning health skills and the remainder studying community resources. The first several weeks are spent primarily in the classroom, practicing direct patient care skills, and studying the more academic side of health—anatomy and physiology, nutrition, general principles of first aid, common adult illnesses, techniques of interviewing, medical ethics, medical sociology, etc. The remainder of the time is spent in the field—in the home, in the hospital, and in the Center.

Staff can learn from each other.

When a family health worker finishes OJT training, she becomes the advocate at the Center for approximately 50 families. In-service training follows, with a series of reinforcement classes to discuss job-related problems. For example, family health workers having problems keeping patients on special diets can ask the nutritionist for suggestions. The career ladders for the family health worker and other positions appears in Appendix III, along with a description of the duties of a new position—the Senior Family Health Worker.

The instructor must stop thinking in stereotypes.

The single factor overriding every one of the above courses is the variety of approaches. Mrs. Zahn stated that in approaching training, the instructor must stop thinking in stereotypes. There should be as many approaches offered as there are learning systems—if one approach enriches some, it may be stifling others, and so two or more approaches should be used. Some learn best by the see-and-do learning track, others from the traditional textbook-lecture track. The point is to learn, and all the necessary ways should be employed.

"Unfortunately," Mrs. Zahn adds, "certification boards do not understand education that doesn't take place inside academic walls using traditional methods. *How* it is learned seems to concern them more than *what* is learned."

Concentrate on little victories.

Mrs. Zahn advises that certification and other external barriers are going to defeat the director who sets her sights either too high or too low. "If she thinks the 'system' can't be beat, she's in no better position than to believe that she's going to beat it. The best you can hope for is to bend the system when and where you can and to concentrate on little victories." When the New York

State Radiology Department refused to admit trainees without the high school diploma, Mrs. Zahn got them to "bend" to admit them, with the promise that they would work for both simultaneously and have the GED before they took their licensure examination. "The little victory broke no barrriers, but it did make the training possible." Now, the Supreme Court's decision (*Griggs* vs. *The Duke Power Co.*, March 8, 1971)* regarding tests and high school diplomas as discriminatory when not proved to be job related may have won the big victory.

"Is it training or education?"

"Another argument you hear in trying to get accreditation is: 'Is it training or is it education?' " Mrs. Zahn says, "This disturbs me, because I see it as a point of view which will only serve to remove the patient from classes on patient care, the client from courses on client service. What I mean is, certification agencies want proof that it is 'education'—formal classroom theory. But medical service education should take place at the bedside, in the home, and with the client. We saw this happen with physician training, nurse training, teacher training—they substituted education for training so that now these professionals can spend years studying theory without even seeing a patient or a child. And we know the results of this. I see this as the next battle—not to let it happen here, just to get those pieces of paper."

Almost everyone in the Center is involved in in-service training. Doctors and nurses attend lectures reinforcing the concept of providing comprehensive care. All new employees in the Center are given lengthy orientation sessions. A new worker in the personnel office, for example, has to learn that traditional academic achievement has little bearing on the Center's hiring practices and that performance is emphasized. Staff members who have been promoted to supervisory positions receive middle-management training in a series of seminars. Public health nurses spend many hours becoming familiar with the operations of the Center. They also take a walking tour of the MLK target community and attend lectures by departmental directors.

Middle-management training...

One of the ways MLK keeps the training attuned to the needs of the trainees is through continuous evaluation of the courses and the trainers. The Research Division has designed an evaluation procedure to provide feedback to the training department and to find the weak points of the curriculum. The evaluation provides a complete picture of what happened in training.

The objectives of the course and the curriculum are outlined by the trainers and teachers at the beginning of each course held at the Center. When the course is finished, the Research Department goes to work. They ask the course participants if they received the right training, enough training, and whether the teachers related to them as students and as a class. Then the information is fed back to the teachers with recommendations for change. It is also the Research Department's responsibility to find out the reasons any trainee drops out. (See Appendix III for an example report on the courses.)

*For a discussion of this, see *Career Development*, Vol. I, No. 3. Available from University Research Corporation.

III. SUMMING UP

The initial idea of training paraprofessionals and allied health personnel to deliver health services to the poor has not only proved to be valid, but has gone even farther than anyone expected. The paraprofessionals have surpassed expectations many times over in both performance and achievement. The training programs have also gone farther than anyone dared expect in loosening, bending, and even breaking down the traditional academic and professional barriers that have restricted entry into the health professions for so many years. Even more important, these programs are rewriting traditional medical guidelines and curricula, creating a new body of literature, experience, and philosophy. The traditional medical field is beginning to wake up to this new approach, but it is going to have to run fast to catch up with community health, 1971. Unfortunately, except where there are comprehensive health centers operating, community health for the poor in 1955 also describes community health in 1971.

Rewriting traditional medical guidelines and curricula.

These brief "visits" to three centers are not intended to show the whole picture, or even the complete picture in each center. But a new training director just glimpsing the enormity of the job may take heart in seeing that others who faced similar situations—to echo William Faulkner—did not just survive, they prevailed.

They prevailed.

Mrs. Phillips' office is located in the Tivoli building in Upper Cardozo; the Martin Luther King Health Center is located under the shadow of the 14th Street El in the Bronx; and Mrs. Mann's office at the Matthew Walker Health Center in Nashville looks out on an abandoned railroad loading yard. This is where training directors work. In the war on poverty, they can be said to be on the front lines.

This is where training directors work.

The programs in each of these centers reflect more than the needs and demands of community health 1971, they are also stamped with the personalities of their training directors.

Mrs. Mann and Mrs. Phillips both operate "one-woman shows," while Mrs. Zahn coordinates a large training staff. But in each case, unwavering determination of the directors to the ideal of training paraprofessionals to improve the delivery of service can be seen. Mrs. Mann is a low-keyed individual, calm and poised in any circumstance. But this calm masks a determination to get the right training for everyone who needs it and that will not accept "no" for an answer. She has put her special organizational abilities to work in creating an atmosphere that encourages center staff to "work for the cause." Mrs. Phillips manages her organization with a congenial smile that invites people to believe that things are a lot easier than they are. But Mrs. Phillips may be found downtown in Washington, D.C., on an afternoon, apparently window shopping. She isn't window shopping, she is "walking it off." "Then, when I come back, anger and frustration set aside, I start right where I left off, as if no one tried to stop me at all." Mrs. Zahn manages a large staff and an enormous operation, yet the well-springs for her driving efficiency are founded in a basically human approach to people, to training, and to service. Five years have not dimmed her

"Walking it off."

enthusiasm and, as she says, "all you have to do is look up and see that it works."

The visitor cannot help but be impressed, yet each of these exceptional people scoffs at the title of "exceptional." In each case, each insists that she was given the opportunity to do a job, she had some luck, and that she has a staff that comes through every time with more than enough. But the visitor is otherwise impressed. These training directors occupy what must be the hardest, most interesting, and most rewarding job in the world. This is the real message, in this guide to training directors.

Most rewarding job in the world.

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APPENDIX I

MATTHEW WALKER HEALTH CENTER*

SAMPLE CURRICULUM UNITS

CONTENT OUTLINE FOR TRAINEE ORIENTATION

1. Poverty
   - A. Its History and Meaning
   - B. Its Problems (movie)
   - C. The War on Poverty
2. Why a Neighborhood Health Center
   - A. Background
   - B. Purpose
   - C. Goal
   - D. Can We Fulfill All of Our Promises
3. Matthew Walker Health Center
   - A. Funding
   - B. Service Area (slides)
   - C. Internal Organization
   - D. Services Offered (movie on Health Center)
   - E. Eligibility Requirements for Services and Trainee Positions
   - F. Educational Programs
   - G. Tour of Building
   - H. Composition of Suites
   - I. Purpose of Screening Clinic
   - J. Use of Residents and Interns
   - K. Medical Student Rotation
4. Patient Welfare Services
   - A. Definition of Patient Welfare Service
   - B. How to use Social Service Department
   - C. How to use Legal Services
   - D. How to use Mental Health Services
   - E. How to use Playroom
   - F. Information and Registration
   - G. How to use Transportation
   - H. How to Hospitalize Patients
5. Health Center Procedures and Policies
   - A. Absence: how to report it, what will be paid by the Health Center, what is considered excessive and how it will be disciplined
   - B. Work schedule: starting and quitting time
   - C. Time keeping: time clock, time sheets, honor system
   - D. Coffee breaks: length, where to take them, how often
   - E. Lunch periods: length, facilities, where to take them
   - F. Official employee entrances and exits
   - G. Parking facilities
   - H. Pay: how paid, what day, where to go about pay problems, pay deductions
   - I. Security regulations
   - J. Lost and found
   - K. Collections and solicitations
   - L. Emergency provisions: fire, civil defense, etc.
   - M. Dress and grooming standards
   - N. Smoking, chewing gum
   - O. Accidents on the job: how and where to report them
   - P. Causes for discharge
   - Q. Personnel records
6. The Health Center Employee and His Relationship to Work
   - A. Roles and Responsibility
   - B. Peer Relations
   - C. Role of Supervisor
   - D. Understanding the Professional
   - E. What do Clients expect of you
7. Meharry Medical College and Hubbard Hospital
   - A. History
   - B. Relationship to Health Center
   - C. New programs at Meharry
   - D. Tour of Medical School and Hospital
8. Evaluation of Orientation

*Matthew Walker Health Center of Meharry Medical College, Training Department, 1501 Herman Street, Nashville, Tennessee 37208.

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SAMPLE UNITS

WHY A NEIGHBORHOOD HEALTH CENTER?

Ill health has been one of the reasons poor people have had little chance of ever rising from poverty. The health care that has been offered the poor has not aided their cause; the rate of disease, disability and premature death has been higher for the poor of all races than for the rest of our population.

Two-thirds of the persons in poverty are under the age of 18 or over 65. While most Blacks living in the United States are in poverty, the majority of people in poverty are nonblacks.

Not enough health services are available for the poor and the shortages are extremely critical in rural areas. Even when health services are available, many problems keep the poor from using them. The poor person seeking health care is frustrated by problems. A mother may have to travel from one clinic to another before her health needs and those of her children can be treated. This may mean hours of travel to services which are open only during working hours, long waiting periods, crowded rooms, and hurried and impersonal treatment by an overworked staff.

The patient may see a different physician each time he goes to the clinic. He and his doctor remain strangers to each other, with no opportunity for the development of the understanding and trust which is necessary in relating to the patient about his illness. The patient is mixed up by rules that are difficult to understand, degraded by rejecting attitudes, subjected to inconvenience and discomfort, and stripped of his sense of dignity and privacy. The end result: the poor seek health care only when it is necessary. Sometimes the poor neglect their health problems and postpone treatment until it is too late.

Untreated health problems of people in poverty affect their total life effort—going to school, getting a job, functioning as a member of a family. Poor health among people in poverty also affects the community in which they live and our entire nation.

The Neighborhood Health Center has been created to eliminate some of the poor's health problems mentioned above. The Neighborhood Health Center provides comprehensive (complete) health care with regular, high quality service for its patients. Many kinds of outpatient services under one roof and transportation for those who lack other satisfactory ways of coming to the Health Center are offered. Except for emergencies, all patients are seen by appointment. They are made to feel welcome, and are treated with warmth, respect, sympathy and understanding—the most important elements in helping people in trouble, everywhere.

At the Neighborhood Health Center a patient is seen not only as an individual but as a member of a family. The Health Center staff also recognizes that many health problems are closely related to family problems: is either parent working? Are both working? Does the father have a drinking problem? Is the youngster doing badly in school? Is the family living in an overcrowded apartment?

Through the Neighborhood Health Center, a patient can receive treatment from a Family Physician, Dental care, X-ray and Laboratory Test, Health and Nutrition Information, Prescriptions (free or low cost), Social Services, Preventive Health Services (such as physical check-ups, immunization, health education and family planning), Behavioral (mental) Health, and at-home care through Public Health Nurses and Neighborhood Health Workers. If the patient needs hospital care, it is arranged by the Health Center through an assessment of the insurance coverage of the patient, through negotiating services for medically indigent by the welfare department or by securing identifying Medicare information. The patient's Health Center physician follows him during his hospitalization.

The goal of the Neighborhood Health Center is not an easy one to accomplish. First, we must help educate our patients to understand and use this new system of care. In some cases, we may have to educate the providers of these services also. As you join our Neighborhood Health Center staff, we hope you will help us work toward our goal to improve the quality of care the poor receive. Remember you are now a "provider" of service, but never forget how it is to be on the "receiving end"!

REFERENCE

O.E.O., *The Neighborhood Health Center*, Washington, D.C.: Community Action Program, U.S. Government Printing Office, 1968.

THE PARAPROFESSIONAL PERSONNEL IN THE MATTHEW WALKER HEALTH CENTER

The importance of the paraprofessional personnel* in the Health Center is (1) to carry out necessary functions that do not require professional training, thereby freeing the professional to do the work he is uniquely prepared to do, and (2) to contribute to the development of new or different kinds of service. The goal of this new method is to improve the quality of the services and to reach more people in need.

Paraprofessional personnel have special talents of their own. Rather than being seen as inferior positions to professionals, paraprofessional personnel are in fact a part of the Health Center team with important responsibilities.

At this early state, paraprofessional personnel have not yet become an established part of all health service institutions. Paraprofessional personnel are not only part of a new approach to the improvement and delivery of services, but they are also helping to open new jobs for people who have up to now been denied meaningful employment in the health services. The success brought about by the first groups of paraprofessional personnel

*Definition of paraprofessional personnel: A person who assists the professional in providing services. Example: Medical Record Clerk, Dental Assistant, X-Ray Assistant, Pharmacy Assistant, etc.

will, to a large degree, determine the future acceptance of this approach both by health institutions and by society.

THE NATURE AND MEANING OF WORK

It is important for you as a trainee to examine your feelings toward work if you are to function to the best of your ability in the Health Center. Work can be examined on four levels: as a job, as a task, as an occupation, and as a career.

1. As a *job*—simple work with little or no emotional involvement or attachment.
2. As a *task*—some satisfaction, but still relatively an impersonal operation which he can take or leave.
3. As an *occupation*—one assumes responsibility which he begins to identify with.
4. As a *career*—it is a career when one identifies himself with his work and holds it as a primary source of self-fulfillment.

In order to carry out work at the Health Center effectively, a person must invest himself in his work. He must also find personal identity and dignity in his field of service.

REFERENCE

Shatz, Eunice; Fishman, Jacob R.; and Klein, William, *New Careers: Generic Issues in the Human Services: A Sourcebook for Trainers*, Washington, D.C.: University Research Corporation.

CONTENT OUTLINE OF CORE CURRICULUM*

1. Relationship Between People
   - A. Behavior
   - B. Influences
   - C. Understanding Behavior
2. Behavior
   - A. Complexities and Inconsistencies
   - B. Feelings About asking for and Receiving Help
   - C. Accepting Differences in People
   - D. Ethics and Confidentiality
3. Group Process
   - A. What Makes a Group
   - B. What Makes a Group Work
   - C. Two Major Types of Groups
   - D. Different Roles in a Group
   - E. Group Pressures and Values
   - F. Typical Problems of a Group
4. Communication
   - A. Definition
   - B. Methods of Communication
   - C. Communication Skills
   - D. Current Events
   - E. Black Political Power (slides)
   - F. We the Black People of the United States
5. Working on a New Job
   - A. Helpful Hints
   - B. Greeting the Public
   - C. Taking and Giving Telephone Messages
   - D. Can You Follow Instructions
   - E. How to Explain the Health Center
6. General Health Information
   - A. Alcoholism
   - B. Anatomy and Physiology
   - C. Dental Health
   - D. Doctor Specialty Titles and Services
   - E. Drugs and Drug Addiction
   - F. Family Planning
   - G. First Aid
   - H. Human Growth and Development
   - I. Hypertension and Heart Disease
   - J. Mental Health
   - K. Nutrition
   - L. Poisoning in the Home
   - M. Preventive Medicine
   - N. Rat Control Program
   - O. Tuberculosis
   - P. Venereal Disease
7. Community Resources
   - A. Role of Local Government
   - B. Legal Aid
   - C. Financial Assistance
   - D. Internal Revenue Service
   - E. Housing and Housing Code
8. Consumer Education
   - A. Food Budgeting
   - B. Comparative Shopping
   - C. Consumer Protection
   - D. Credit Rating
   - E. Cost of Credit
   - F. Action Creditors Can Take
   - G. Defenses of Debtor
   - H. Credit Ruses
9. Field Trips (Community Resources)
   - A. Metropolitan Health Department
   - B. Senior Citizens Center
   - C. Bill Wilkerson Speech and Hearing Clinic
   - D. Trip to be selected by Training Class
   - E. Trip to be selected by Training Class
10. Adult Education–GED Preparation Course (Schedules according to individual needs)
11. Health Careers
12. Evaluation of Orientation and Core Training

After the completion of Core training, the Director of Training will have semimonthly meetings with trainees throughout their skill/on-job-training.

*First week core training: full day
Second-fourth weeks core training: 4 hours
Skill/On-Job-Training: 3 hours

REFERENCES

Shatz, Eunice; Fishman, Jacob R.; and Klein, William, *New Careers: Generic Issues in the Human Services: A Sourcebook for Trainers*, Washington, D.C.: University Research Corporation.

Shatz, Eunice and Fishman, Jacob R., *New Careers: Generic Issues in the Human Services: A Manual for Trainees*, Washington, D.C.: University Research Corporation, 1969.

SAMPLE UNITS

COMMUNICATION

One thing that all kinds of human service work have in common is that they are "talking" and "listening" professions. A frequent complaint made by professionals and trainees both is that too much time is spent in talking and not enough time in doing. Unfortunately, people often fail in their attempts to communicate with each other. Often what is said is not heard correctly. Sometimes what is said is not what a person meant to say. People may think they agree on things when they really don't because each has a different understanding of what was said. Consequently, effective communication is always important. But when you are trying to help someone, clear communication is doubly important.

DEFINITION OF COMMUNICATION

It is a chain of understanding. A process by which messages, information and knowledge are given and received. It involves both an individual's feelings and attitudes as well as what is going on outside him.

Methods of Communication

A. Oral—a formal language used for widespread communication.
   1. Sublanguages
      a. Jargon—a shorthand in communicating. Examples: OEO, Metro, TV.
      b. Slang—an expression used as a passport to acceptance in different racial, cultural or economic groups. Examples: soul, hog, Kentucky oysters.

B. Visual
   1. Body gestures.
   2. Facial expressions.
   3. Signs of pleasure, agreement, disagreement, anger, indifference.

C. Written
   1. A time-saver in getting information to a large number of people.
   2. A permanent record (oral communication is temporary).
   3. Used for finding or reviewing information.

QUESTIONS FOR DISCUSSION:

1. What are some of the social, occupational, and educational advantages in being able to communicate in several sublanguages?
2. What purpose does visual communication play when a Health Center employee serves a patient?
3. What are the unspoken messages that both the giver and receiver of information relay? How might they help or block effective understanding?
4. Why is it important to always remember the tone of your voice and facial expression when greeting a patient?
   a. To the patient
   b. To the employee
   c. To the Health Center Program.

REFERENCES

Shatz, Eunice; Fishman, Jacob R.; and Klein, William, *New Careers: Generic Issues in the Human Services: A Sourcebook for Trainers*, Washington, D.C.: University Research Corporation.

Shatz, Eunice and Fishman, Jacob R., *New Careers: Generic Issues in the Human Services: A Manual for Trainees*, Washington, D.C.: University Research Corporation, 1969.

RELATIONSHIPS BETWEEN PEOPLE

People are complex and often hard to understand. Because they are so complicated, however, the study of people is both fascinating and challenging. As you and other members of your class begin to think about people, you may find yourselves asking questions like these.

What makes people tick? Why do they act the way they do? What motivates them? What can be expected of people at different ages and under different kinds of circumstances? Why do people respond to me in certain ways, and why do I respond to them as I do? In what ways do people interact with each other? In what ways do they communicate? How do people act in different kinds of groups? Why? What are some of the ways of changing the way they act? How can people be organized to function more effectively? How can I be more effective in getting people to understand my ideas, criticisms, problems, etc.? What does it mean to be in a "helping relationship" with someone?

Vocabulary Words—Use your dictionary to find the meaning of the following words:

1. criticism _____
2. fascinate _____
3. characteristic _____
4. emotion _____
5. psychology _____
6. motive _____
7. circumstances _____

The fact that sometimes a person cannot help another person is a real life situation. Nevertheless, the function of a Health Center employee is to try. Trying itself may relieve the patient because he knows someone else wants to help him. There is a relief in simply telling one's troubles to another.

BEHAVIOR

A. *Influences on Behavior*

1. Heredity is _____

_____

2. Environment is _____

_____

Why do you think the following persons behaved the way they did? What influences were there on their behavior?

Example: A child in elementary school refused to take his boots off. The teacher got into a real power struggle with him and finally sent him from the room because he kept refusing to obey, and wouldn't or couldn't talk about why he was refusing. Taken to the principal, he broke into tears, took off his boots and showed that he had on no shoes—only a pair of socks with big holes in them.

What might the teacher have done differently if she had known why the child was behaving as he did?

B. *What it means to understand behavior*

Adult behavior is normal in relation to what can be expected of other adults in similar situations. Child behavior is the same with the addition that it is seen in relation to the child's age. If one understands why a person is acting in a particular way, and then does not use that understanding to help, his knowledge is useless.

Example: A patient arrives at a health clinic for an examination. The doctor suspects that he may have cancer. The doctor tells him he is going to set up an appointment for further tests. The appointment is set, but the patient does not come in at the scheduled time. If the worker understands that the patient may be worried and fearful and that because of this he might consciously or unconsciously "forget" the appointment, he can call the patient beforehand to remind him and offer to accompany him to the clinic where the test is to be performed. The worker can talk with the patient about his uneasiness or suggest that he speak further with the patient about the test and why it is necessary.

A human service worker must understand that people may see things differently. He must become more aware that the patient may view himself and the world quite differently than he himself does. A person who is going through a crisis often needs help in sorting things out. If the worker allows himself to become as overwhelmed as the patient he can be of little help.

Example: A Black man cannot find a job. He is bitter and frustrated and feels that prejudice and discrimination are the major reasons that he is refused work. The worker can react in two ways: (1) He can identify with his client and get involved in an angry discussion of the unfairness of discrimination and how rotten the world is. (2) He can recognize the patient's anger and the fact that discrimination exists, but also explore other possible reasons for the man's unemployment, such as his inability to read and write English, how he handles himself in a job interview, etc. In this way he can identify with valid feelings of his patient, but also help him resolve the basic problem—employment—by being more objective than the patient is able to be at that moment.

C. 1. Write down an example describing the way someone acted that puzzled you.

_____

_____

_____

_____

_____

2. What part did heredity and/or environment play in the way they behaved?

_____

_____

_____

_____

_____

Finally, what does your behavior as a Health Center employee from the community mean to the people you are helping, your employer, and the neighborhood in which you live? Part of your unique value lies in your relationship to and knowledge of the persons living in our service area. Part comes from being an employee in the Health Center. You will probably have feelings about the Health Center and your friends and neighbors. What will happen to your loyalty? How will your friends react? If you gain respect from the patients, help them understand the Center, but do not lose your identity in the community, since you can help bridge the gap between these two worlds. Though not easy and difficult to accomplish, this should be one of your goals as a Health Center employee.

REFERENCES

Shatz, Eunice; Fishman, Jacob R.; and Klein, William, *New Careers: Generic Issues in the Human Services: A Sourcebook for Trainers*, Washington, D.C.: University Research Corporation.

Shatz, Eunice and Fishman, Jacob R., *New Careers: Generic Issues in the Human Services: A Manual for Trainees*, Washington, D.C.: University Research Corporation, 1969.

SAMPLE FORM

TRAINING EVALUATION

Before training another class, I would like your help in evaluating the curriculum used for your class. This will help to make our training program better.

Tell it like it is!

1. Do you think orientation helped you? ☐ yes ☐ not sure ☐ no
2. Did orientation seem to have anything to do with the other parts of your training? ☐ yes ☐ not sure ☐ no
3. Do you think you needed orientation as a part of the training program? ☐ yes ☐ not sure ☐ no
4. Do you think core training helped you? ☐ yes ☐ not sure ☐ no
5. Did core training seem to have anything to do with the other parts of your training? ☐ yes ☐ not sure ☐ no
6. Do you think you needed core training as a part of the training program? ☐ yes ☐ not sure ☐ no
7. What did you like best about orientation and core training? Explain. _____
8. What did you like least about orientation and core training? Explain. _____
9. For specialized training, check one of the following:
   - ☐ I would like to be taught one skill at a time.
   - ☐ I would like to be taught several skills at the same time.
10. Do you think specialized training helped you? ☐ yes ☐ not sure ☐ no
11. What did you like best about specialized training? _____
12. What did you like least about specialized training? _____
13. Do you think the training program was too short? ☐ yes ☐ not sure ☐ no
14. Do you think the training program was too long? ☐ yes ☐ not sure ☐ no
15. List any suggestions you have for the next training class. _____

APPENDIX II

COMMUNITY GROUP HEALTH FOUNDATION, INC.*

CURRICULUM OUTLINES

A curriculum has been charted by CGHF which combines health-service and community-service plans. A variety of courses have been designed to meet the needs of the individuals with disparate backgrounds and a variety of interests.

The course outlines are merely the skeleton of a creative curriculum designed by the Director of Training and instructors at Federal City College. Innovative methodology is used to develop the content so as to not merely export campus courses, but to expand and intensify the concepts of community education through experimental programs.

Practicum—For Health Workers and Seminar (OJT), 8 Credits, 2 Quarters.

1. Community Health
2. Community Setting
3. Direct Actions of Community Health Assistant
4. The Cooperative Role of the Community Health Assistants in the Health Team

Symposium, 8 Credits, 2 Quarters.

1. Orientation, Health Services, Health Careers
2. Community Health
3. Public Health Services
4. Human Growth/Development and Care
5. Survey of Dentistry
6. The Pharmacy in Neighborhood Health Center (NHC), Counseling, Use of Medications and Drugs
7. Radiology and Technology in NHC
8. Report of Field Projects

Mathematics, 3 Credits, 2 Quarters.

Course 1

1. Need for Mathematics in the Inner City (students will supply input)
2. Mathematics as a System
3. System of Numeration
4. Sets
5. Whole Numbers

Course 2

6. Integers
7. Rational Numbers
8. Real Number System
9. Applications

English, 6 Credits, 2 Quarters.

Course 1

1. A Comprehensive Definition of Communication
2. Skills for Improving Communication
3. Factors which Facilitate Communication
4. Reporting, Summaries and Recording

Course 2

1. Skills which Facilitate Studying
2. Study Skills
3. Analysis of Various Forms of Discourse

Biology, 8 Credits, 2 Quarters.

Course 1

1. Introduction
2. Cellular Organization
3. Scientific Method
4. Movement of Substances Across Cell Membranes
   Lab: Osmosis in Red Blood Cells
5. Blood Circulation
   Lab: Human Blood Pressure
6. Blood Composition
   Lab: Blood Smear

Course 2

1. Integumentary and Skeletal Systems
2. Muscular Systems
3. Nervous System/Sense Organs
4. Animal Reproduction
5. Animal Development
6. Photosynthesis
7. Leaves, Stems, Roots

An Introduction to Human Behavior for Outreach Workers, 3 Credits, 1 Quarter.

1. Introduction of Course
2. Human Development (Biological and Psycho-social influences)
3. Basic Behavioral Processes
4. Individual Differences
5. Personality Development (Social Factors in Behavior)
6. Behavioral Extremes
7. Applying Psychology
8. Synopsis

Social Science, 3 Credits, 1 Quarter.

1. Introduction

*Community Group Health Foundation, Training Department, 3313 13th Street, N.W., Washington, D.C.

2. Why Social Problems Develop—Approaches to their Solution
3. American Social Life: Systemwide problems
4. American Social Institutions in Crisis
5. Social Services
6. Law, Order and Justice

Interviewing for Outreach Workers, 3 Credits, 1 Quarter.

1. Opening the Interview
2. Phrasing Questions
3. The Client's Experience with Counselor
4. Overtalking the Client
5. Accepting the Client's Attitudes and Feelings
6. Silences in the Interview
7. Reflecting the Client's Feeling
8. Admitting Your Ignorance
9. Client Wants a Direct Answer
10. Control of the Interview
11. Bad News in the Interview
12. Counselor's Handling of Hostility
13. Structuring the Interview
14. Setting Limits on the Interview
15. Plans for Action
16. Summarizing the Interview
17. Ending the Interview

Black History 1619-1865, 3 Credits, 1 Quarter.

1. Slavery in Colonial America 1619-1783
2. Building a New Nation
3. Intersectional Strife Leads to War

APPENDIX III

MARTIN LUTHER KING, JR. HEALTH CENTER

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 Martin Luther King, Jr. Health Center (see below)

In order 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. Others

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

B. The hospital and its structure

C. The Martin Luther King, Jr. Health Center

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 or possibly having to settle for less pay because of lack of licenses or certificates
b. Possibilities:
Room for initiative and 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 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. Explain to and inform patients
j. Use 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
   1. Finding a job
   2. Job interview
   3. Grooming
   4. How to act
   5. What to bring with you
   6. Applications and resumes
   7. Do not leave gaps
   8. 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 his feelings and his 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 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 III. A.—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. Temperature, 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 the home
3. Nutrition

E. Family planning (birth control)

F. Pregnancy
1. Anatomy and physiology, before and after birth

H. Care of 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

JOB DESCRIPTION: SENIOR FAMILY HEALTH WORKER

A new career position developed at the Center is that of senior family health worker. Prior to developing the position, the family health workers had only a two-step career ladder—from trainee to fullfledged family health worker. Under this arrangement and because of union restrictions, the family health workers received neither increased responsibilities nor in-grade increases in pay. Senior family health workers will receive both.

There are only four selection criteria to become a senior family health worker:

- The workers must have been employed a minimum of one year by the Center.
- The workers must not be involved in any released-time education programs that take more than 20 percent of their work day.
- The workers are asked to take a written and oral situational exam, evaluated for performance and overall skills by the team nurse, and must have a recommendation by the team.

The job description shows a marked increase in responsibilities. The senior family health worker:

- Assists with the orientation of new members to the team, especially family health workers.
- Assists family health workers in the following areas: chart review, planning home visits, making home visits, writing records and reports, using agency forms, and in the referral and use of community resources.
- Assists specialty areas as resource personnel.
- Assists in planning and participates in programs for visitors, staff, students, etc.
- Helps coordinate the team, supplying communication between the PHN and the team.
- Assists with administrative procedures related to team operation and office management.
- Maintains responsibility for a limited number of families, to be determined by the team.
- Makes evaluative visits concerning medical, social, and psychiatric emergencies, under the direction of the PHN.
- Makes postpartum and newborn visits, with follow-up as indicated, including scheduling clinic visits.

As the senior family health worker gains in experience and OJT, she shares broadened responsibilities with the PHN in the following areas:

- *Administration:* time sheets, scheduling, etc.
- *Supervision:* coordination of family care, problem-family follow-up and coordination, review of records, counseling of patients and families, supervision of other family health workers, and establishment of team priorities.
- In-service training for physical examinations of prenatal patients and for well-child care services.
- Obtaining lab specimens as practical in the home for patients involved in routine on-going care, screening of new families, etc.

FAMILY HEALTH WORKERS RECORD

DATE: From _____ To _____

Directions: Place the names of the family health workers enrolled in the Basic Course in the spaces provided. On the first two (2) lines opposite each procedure, the family health worker instructor records her initials and the dates the demonstration was given and returned. On the third line, the instructor records her initials and the date a satisfactory ward practice was observed.

PROCEDURES	NAMES OF FAMILY HEALTH WORKERS				
I. Bed Making A. Basic					
B. Occupied					
C. Cradle					
D. Fracture					
E. Postoperative					
II. Patient Care A. AM & PM Care					
B. Bed Bath					
C. Tub Bath					
D. Sitz Bath					
E. Care of: 1. Back					
2. Dentures					
3. Feet					
4. Nails					

PROCEDURES
5. Incontinent
F. Assist Patients: 1. In and out of bed
2. To and from wheelchair
3. To and from stretcher
4. To dress and walk
G. Assist with: 1. Admission of patient
2. Discharge of patient
3. Transfer of patient
4. Care of patient's property
5. Physical examinations
6. Preoperative care
7. Postoperative care
8. Isolation technic
III. Restraints A. Ankle
B. Jacket
C. Wrist
D. Siderails

PROCEDURES
IV. Meal Service A. Prepare patient
B. Serve and collect trays
C. Feed patients
D. Pass drinking water
E. Provide extra nourishment
V. Elimination A. Pass and remove bed-pans and urinals
B. Measure intake and output
C. Give simple enema
VI. Treatments and Diagnostic Measures A. Take T.P.R.
B. Weigh patient
C. Collect Specimens: 1. Sputum
2. Urine
3. Stool
D. Fill hot water bottle
E. Fill ice bag and collar
F. Apply hot compresses
G. Apply cold compresses

PROCEDURES

VII. Housekeeping A. Assist with ventilation
B. Clean bedside unit
C. Clean auxiliary rooms
VIII. Care of Equipment A. Enamel and metalware
B. Glass
C. Plastic
D. Mechanical Appliances
E. Rubber Goods
F. Sterilizer
G. Bedpans and urinals
IX. Miscellaneous A. Answer telephone
B. Record on graphic sheet
C. Give Post Mortem Care
D. Assist with: 1. Fire Prevention Program
2. Accident Control Program

THE TRAINING STAFF

The staffing pattern of the training department is designed to facilitate comprehensive training. Each of the six trainers is a generalist, capable of handling a host of job responsibilities, including job development, job counseling, and OJT supervision, as well as classroom instruction. Each trainer is also responsible for developing OJT and core curriculum in his specialty, in cooperation with Mrs. Zahn and the supervisors of service departments. This generalist orientation enables the training staff to maintain a continuity of service to the trainees similar to the services the center provides clients.

In addition, the training department itself has paraprofessionals on the staff—teacher/counselor trainees who assist the trainers in the classroom and on the training sites. Everyone on the training staff is involved in the selection of the teacher/counselors, who are trainees who show leadership and teaching potential.

The teacher/counselor trainees are responsible for handling a great deal of the instruction in basic education and for providing tutorial help to trainees who need it. They also learn the duties and responsibilities of each trainer. In addition, the teacher/counselor trainees are in charge of preparing the standard, bi-weekly evaluations of every trainee in core.

TRAINEE EVALUATION

During core, all trainees are evaluated on a bi-weekly basis by the teacher/counselor trainees.

The evaluation form (copies of which are submitted to trainers and trainees) is divided into two parts—*basic skills*, which includes all the core courses, and *social interaction*, which covers such characteristics as concern for others, ability to listen, maturity, and grooming. Under *basic skills*, a trainee can receive one of four "grades": E for excellent; S for satisfactory; I for needs improvement, is working; and U for unsatisfactory, not working. Under *social interaction*, a trainee is rated on a scale of four: *1*, for good; *2*, for needs improvement; *3*, for no opportunity to judge; and *4*, for unsatisfactory. The form also has space for noting the number of days a trainee was late or absent during the two-week period.

TRAINEE SURVEY OF HEALTH CAREERS

The list of jobs the trainees study runs the gamut of health careers—from family health worker to speech and health assistant. Each trainee is given the list, which includes training sites and the number of slots each site has open.

All trainees learn to identify jobs—content, duties, requirements, demands—by preparing job descriptions after visiting six training sites. This activity not only increases their ability to observe, but also provides them with their own compendium of job possibilities. The job descriptions in turn can be used by the instructor to evaluate the efficacy of the course.

The trainees use a standard format to record their observations of a job. In the example below, the trainee

observed a technician in the pulmonary function laboratory at Einstein Hospital performing his job—

> "In the pulmonary lab many tests are performed to assess the functioning of the lungs in patients with respiratory difficulties and sicknesses, such as emphysema, asthma, bronchitis, etc. In some tests, blood must be drawn. This procedure is done by a doctor. The results of blood tests are given to the doctor so that he can determine what is wrong and how advanced the illness may be. Then the doctors determine what medication to give."

The trainee also described the tasks a pulmonary lab technician does and the extent of worker involvement—

> "The technician must perform many tests, which are done with many graph machines, different types of gases and also a number of recording machines. The technician must instruct the patient to cooperate and must try to make the patient feel relaxed. If the patient is not relaxed, the test must be repeated several times. One of the many tests is called a defusing test. This is done by having the patient breathe in and out gases from a tank, which is recorded on a graph. Then the technician must read them and give a report to the doctor. The technician also assists the doctor in drawing the blood and preparing equipment."

Under "Abilities Required," the trainee listed "accuracy, knowledge of basic math, willingness to learn, patience, and ability to put people at ease." The trainee also noted that the starting salary for this position ranges from $125 to $140 a week and that the incumbent receives all normal hospital benefits.

Under "Advancement Potential," the trainee observed that the technician can either become more specialized, or he can go into research or management. Under "Sacrifices," the trainee listed the length of training—3 to 6 months—and the need to continue studying as more tests and machines are developed. She also noted that technicians frequently work alone.

The above amply demonstrates the efficacy of on-site observations and job descriptions as a job selection technique. The trainee not only observes the job, but translates it in terms of its relation to the medical field and to the trainee's own career aspirations.

RESEARCH DEPARTMENT: EVALUATION OF TRAINING

Evidence of the Research Department's method of evaluating the effect of training is shown in a report prepared by Ron Brooke, Director of Research, on the evaluation of family health workers who had just completed on-the-job training (in 1970).

The evaluation covered four areas—curriculum, training staff and lectures, trainee overview, and general assessment of morale and concepts—three of which were based on the trainees' responses.

EVALUATION REPORT

Nine aspects of the curriculum were commented on by the trainees:

- *Anatomy and physiology*—The trainees reported that the course started at too high a level. They felt, however, that it was a very important course that warranted more time for presentation. They also noted that the lecturer (a registered nurse) needed an anatomic model, especially since she could not draw very well.
- *Pediatrics*—This section of the curriculum was presented by a doctor. The trainees thought that it was very interesting and that they gained a great deal of confidence in their ability to learn because they mastered the highly technical vocabulary and concepts.
- *General home nursing practice*—In spite of initial difficulties, trainees thought the course was good. They noted that at first the content was boring, repetitive, and incoherent, but that after the public health nurse tied things together, they all perked up.
- *Occupational and physical therapy*—This section was presented primarily by employees of the training institutions. The trainees reported they had to push to receive any demonstration of techniques.
- *Prenatal and Postpartum care*—The trainees rated this course very high because the public health nurse did an excellent job of tying the variety of information presented together at the close of the section.
- *Medical sociology and interviewing*—The trainees reported they thought more time should be spent on this section and that the scope of the course should be broadened. They also indicated that it should be presented toward the end of OJT.
- *Community resources*—The trainees were strongly in favor of expanding and extending the scope and length of this course. They indicated that more attention should be given to the medical resources available locally and in the greater New York metropolitan area.
- *Home care*—This course was also conducted from a training site. The trainees were most unhappy with this part of the curriculum and indicated that they felt the training site should be changed.
- *Hospital Field Work*—This course was also conducted from a training site, and trainees reported that they learned many procedures.

The trainees gave all the Center training staff and lecturers "E's" for excellent.

Comments made concerning trainees' overview of OJT touched on several issues. The trainees thought they should get a higher stipend after finishing the program. They also indicated that the content should be more extensive and broader in scope, and that more attention should be given to studying human behavior. They also suggested that the post-training period should be longer.