THE MONTEFIORE EXPERIENCE*

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IN July 1966 the Montefiore Hospital Neighborhood Medical Care Demonstration (N.M.C.D.)[1] received a funding of 1.9 million dollars from the federal Office of Economic Opportunity. The program was developed in the Division of Social Medicine of Montefiore Hospital in the Bronx, N.Y., and was designed to demonstrate a new approach to comprehensive medical care.

The neighborhood chosen for the project is a 55-square-block area —two health districts—located in a low-income neighborhood in the southeast Bronx. Approximately 11,000 families (45,000 people) live there; this population is equally divided, Afro-American and Latin-American, with about 5 per cent white. The area is blighted with run-down factory buildings, empty tenements, and garbage-strewn streets. The gross "social statistics" confirm what the eye sees: high unemployment, many families on welfare, crowded housing, high rate of crime and of the use of drugs.

The vast majority of people in the neighborhood have received their medical care from clinics and emergency rooms of nearby hospitals and from the five general practitioners in the area. The nine pharmacists are a vital part of the medical care network. "Botanicas," spiritualists, and faith healers provide a great number of people with folk medicine services.[2] Continuity, follow-up, and preventive medicine services are difficult to provide. The infant mortality is twice that of a more affluent area only 40 city blocks away.**

When in full operation the Neighborhood Medical Care Demon-

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**Infant mortality—health areas 24 and 26, compared with north Bronx.

stration will be organized around a main health center and two satellite centers offering comprehensive ambulatory and home, medical, and dental care services. The program has three major components: a health careers program to provide the project with needed vitailty, scarce technical and subprofessional health personnel; a program of community development and health education aimed at mobilizing and coordinating health and health-related services in the area; and the provision of comprehensive ambulatory care, which is the subject of this presentation.

During the first year of operation the N.M.C.D. has set up a small center to provide comprehensive family medical services for approximately 8,000 people within its designated target area. Renovation has begun on a major health facility with the capacity to serve all the residents of Health Areas 24 and 26. This facility will open in the summer of 1968; the small center, which is currently functioning, will become a satellite of the larger center. This one-year period of relatively small operation has allowed us to develop our concept of family medical care and to pinpoint the problems in the provision of such care.

Historical Antecedents

The Peckham[3] Experiment in Great Britain provided the antecedents for health maintenance programs. Later in South Africa the Kark institute of Family and Community Health developed principles of health record-keeping and health maintenance.[4] Perhaps the most significant study of family medical care was conducted by Silver[5] in the Family Health Maintenance Demonstration where, from 1950 to 1958, he provided family medical care for several hundred middle-income families of the Montefiore Medical Group. Since that time, family medical care has been undergoing demonstration in a number of centers across the country.

The concept of Family Medical Care which we have evolved is based on several premises:

1) That comprehensive ambulatory and home care could be delivered to a community most effectively through a single, integrated agency.

2) That such comprehensive care must include attention to the social and cultural conditions of the families under care.

3) That comprehensive care requires the close integration of physi-

cians, nurses, and other health workers into teams to deal with the problems of each family as a unit.

4) That the efficient provision of care requires modifying the role of each health worker.

The Health Team

To achieve these goals the N.M.C.D. brings physicians together in group practice, and physicians, public health nurses (PHN), and family health workers (FHW) in team practice. In the context of this team practice traditional roles have been reexamined and redefined.

Each team comprises an internist, a pediatrician, a public health nurse, and a family health worker. Additional resource staff such as lawyers, anthropologists, and community workers are available to the team as needed, and they usually participate in the team conference.

The concept of a team that works as a unit with the families under its care was necessary to bring together the highly specialized professionals which characterize the American medical scene today. The members of the team work side by side in the health center during their clinical sessions. Adults and children are seen at the same team session: there is no division into pediatric or medical clinics. Thus a mother is able to be seen by her doctor and have her children seen by theirs, at one site, at one time. The nurses, who have a greatly expanded clinical role, see patients in the same area. This area localization of the clinical practitioners on the team permits informal consultation and communication between the members of the team. Communication also occurs at a weekly team conference.

Because such a model of care was new to all the staff, the structure and function of the team conference was left deliberately flexible. It was set up not only as a problem-solving session, but for information exchange and for inservice education of the team members. The goal is to review all families at a formal conference but, because of the urgency of the problems of certain families, we have fallen far behind. The public health nurses select the cases for presentation and lead the discussion of each presentation. The program which we have formulated includes an introduction by the nurse, a presentation of the family composition, home setting, and social problems by the FHW, who will have visited the home, an open discussion during which any team member presents observations he has made of members of the family

or advice on a problem presented, and the meeting ends with a formulation of a plan of care for the family made by the nurse. It is the nurse's specific responsibility to formulate and coordinate the family-care plan.

The Role of the Public Health Nurse

In addition to being the coordinator of family care, the nurse has assumed two other roles—that of a practitioner who emphasizes preventive care, and of a supervisor of the FHW's on the team. The role of practitioner was developed for several reasons. Although much of our training as physicians emphasizes the importance of preventive care, the practitioner who is pressed to provide curative services to sick patients often neglects it. Some of the routine aspects of preventive care also do not require extraordinary training, and could well be added to the role of a public health nurse. The N.M.C.D. nurses are trained in well-baby care, and the prenatal and postpartum management of the uncomplicated pregnancy.

The Role of the Family Health Worker

The role of the FHW has developed in response to several needs. Many of the home-nursing services ordinarily provided by the professional nurse and many of the social casework services ordinarily provided by a graduate social worker can be performed by a well-trained nonprofessional. In addition we recognized, as have many others, the need for a "patient advocate," someone to bridge the gap between the medical establishment and the patient in need of service. This need is particularly acute in a low-income area such as ours, but is probably present, although perhaps unrecognized, in any practice. The FHW's are trained to represent the patient in his encounters with medical and social service agencies, including our own, i.e., to be the patient's advocate.

The Role of the Physician

The physician's role in N.M.C.D. has been altered by the emphasis placed on family medical care, and by the introduction of new roles for the PHN and FHW. The physician is able to call in other members of the team, generally the PHN and FHW, to assist him in the care of patients. However, by virtue of being a part of a team and not

a totally independent practitioner, he must also be responsive to the opinions of other team members regarding the care of the patient. In many instances the PHN or FHW will have a much better understanding of a family than will the physician treating an individual within it, and the format of the team conference insures that these opinions will be voiced. The physician has the final authority regarding patient care; however, because of the valuable social and psychological insights often expressed by the PHN and FHW, agreement is generally achieved on problems in these areas. The physician is also called upon to do a great deal of teaching, both informally in the team conference or formally in the PHN or FHW in-service programs.

Problems

This style of practice has not been without problems. It may be useful to review some of these and our plans for alleviating them.

The concept of family. The concept of a team caring for a family as a unit is relatively new to many professionals. There is a tendency among professionals to limit their consideration of a patient to their own specialty interest and to see the patient out of the context of his family. The fragmentation of care among the many specialty clinics of the typical teaching hospital is one such familiar manifestation. Some of the N.M.C.D. staff continue to consider problems only according to the disease specialty and not in the context of the family setting. The intellectual understanding of the usefulness of family medical care has yet to be fully translated into operational change.

Communication. Although working side by side encourages informal communication, and while the team conference offers the opportunity for the exchange of information, the team still has difficulty in keeping its fellow members informed on a family's progress.

The traditional method of record keeping has been altered to a family record-keeping system. The present format of presentation, however, does not facilitate each member's reading all the material in the medical record.

Lack of flexibility. The development of new roles is a cause of anxiety among all health workers. Physicians, in particular, are reluctant to involve other health workers in the decision-making process. The issue of care for a family is displaced by the issue of authority. Our early experience indicates that the smooth functioning of a team is

TABLE I.—ORIENTATION PROGRAM

Informational Needs

The family
- The family as a social unit
- The psychodynamic structure of family: strengths and weaknesses
- Middle-income versus low-income families—are there differences?

Community resources
- Hospitals, health depts., nursing agencies
- Facilities for children and aged
- Welfare Department
- Housing agencies
- Employment agencies
- Schools
- etc.

Viewpoint of minority groups

Spanish classes

Preventive Medicine—A Review

Physicians	Nurses
Medical and dental priorities	Team coordination and administration
The budgeting of time during an office visit	Principles of supervision
Office management of psychiatric illness	Well-baby care
	Pre- and post-natal care

OPERATIONAL NEEDS

Communication
- Informal
- The conference
- The chart
- T. Group
  - Roles
  - Decision making

dependent for the most part on the flexibility of the physician.

Training and new roles. Problems have arisen because of the attempt by N.M.C.D. to develop simultaneously several new concepts or roles in medical practice. The development of the nurse practitioner and the nurse as a central coordinator of care and supervisor of family health workers has taken place simultaneously with the development of family health workers and the integration of professionals into a team. In one sense, these simultaneous innovations have been a blessing in that traditional modes of practice have been broken down and new roles assigned as circumstances require. However, difficulty arises in that the professionals, particularly the nurses, are being asked both to develop a new

role for themselves and to supervise the performance of the family health workers, whose roles have been incompletely defined. We anticipate mitigation of this problem as we gain experience and, through constant interchange and adjustment, we hope to elucidate the role of each worker within the team context.

In-service education. It is clear from the foregoing presentation that resolution of the problems which we have encountered and the development of effective team practice will require an extensive orientation and ongoing in-service education program (see Tables I and II) for all members of the health team.

Each member needs additional training in two areas: the informational, i.e., the assimilation of facts, procedures, and techniques to carry on family medical care as outlined, and the operational, or group interaction area, which will permit more effective functioning of the team:

1) The physician—informational needs: the internist and pediatrician have little information about each other's areas of expertise. There is a need to share information in the clinical area which involves entire families. A review of the management of the more common psychiatric disabilities and their therapy by a family-centered approach has been requested by all physicians on the staff. The physicians also need information on the family and the community being served from the viewpoint of the social scientist, the epidemiologist, and the legal profession.

Operational needs: the physicians need training in group dynamics and experience in the interdisciplinary approach to family medical care. In part this will be achieved by providing greater exposure to, and participation in, the training of the PHN's and FHW's.

2) The public health nurse—informational needs: the nurse needs extensive seminar and clinical experience in prenatal and well-baby care, with the emphasis on the clinical management of the uncomplicated well baby or pregnancy, and the detection of abnormalities which must be brought to the attention of the physician. This will be carried out in our own center and the inpatient setting of the hospital. She needs information and clinical experience to enable her to develop a larger role in family counseling.

Although the nurse is generally better prepared to deal with the social resources in the community than the physician, she needs additional exposure to the resources in the community being served.

Operational needs: the roles of supervising Family Health Workers

TABLE II.—ORIENTATION SCHEDULE (FIRST WEEK: TENTATIVE)

Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*
	Spanish classes			
History of program				
Aims of orientation	Orientation to community resources	Visit to training program	*Community resources* School	*Physicians* Office psychiatry; *Nurses* Team management
		or	or	*Community resources*
The family as a treatment unit	*Physicians* Office psychiatry; *Nurses* Well-baby care	Research department	Day center	Day hospital
		or	or	Recreation center for elderly
		Health education	Welfare department	
Spanish class	Team conference	Medical audit	Responsibilities in health center	Meeting with advisory board
		Physicians	*Nurses*	
	Tour of community	Home visit with FHW	Prenatal care	Visit to hospitals
		Introduction social services		Montefiore or Morrisania or Bronx State
The health team	Epidemiology and health priorities	Sharing experiences "T" group		Patients

and coordinating team care have proved difficult for some of the nurses to assimilate. Effective functioning in these areas will require additional training in the techniques of supervision and a clearer definition of what is meant by "coordination of team care." In order to function effectively as a coordinator the nurse must learn to accept a larger role in family-care management with the change in the traditional physician-nurse relation which this implies. This change will be toward greater responsibility and authority for the nurse in the provision of care, and will come about only as the nurse gains confidence in her role and the physicians learn to accept her expertise and greater authority. We plan to use the techniques of role-playing and the "T" group to improve this interaction and better integrate all the members of the health team into a unit.

3) The family health worker—informational needs: the FHW's require periodic upgrading or renewal of their skills in nursing tasks, interview techniques, and utilization of community resources. In addition, we are instituting, in cooperation with two psychiatric institutions, a program to give the FHW an exposure to psychiatric evaluation and family counseling.

Operational needs: the FHW's require reinforcement of their importance as members of the team. The supervision afforded by the nurses varies considerably, often being too lax in terms of general supervision and too rigid in the performance of their nursing functions. This has tended to make the FHW's function more in the social than in the health area.

Evaluation

In-service training will be carried out with a period of full-time orientation and a continuing program of in-service education. Before-and-after attitude questionnaires will be used. In addition, the ongoing medical audit, which sets out to evaluate the content and quality of medical care given in the health center will focus on changes in behavior of the various professionals as compared, let us say, to traditional group practice units.

Summary

The background and first year experience of the Neighborhood Health Center operated by Montefiore Hospital and Medical Center

in the Bronx are discussed. Particular attention is devoted to the problems of providing family medical care. The roles of the health team members are described. Informational deficiencies of the team members, as well as dysfunction of the team operation, are described. An outline of the content of an orientation and in-service training program is presented.

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