

# Expanding Roles for Health Assistants in a Model Cities Health Program

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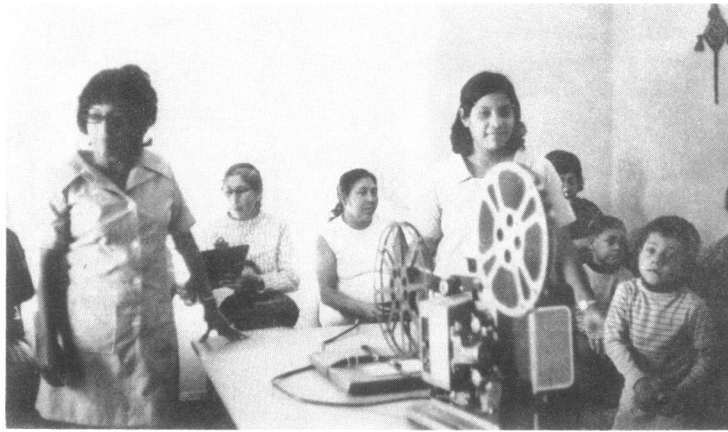
THE USE OF HEALTH ASSISTANTS has gained wide acceptance by public health and related agencies throughout the United States, as well as in many other countries, and many such programs report favorable results. Nevertheless, how health assistants are utilized varies greatly among the agencies (1-3).

The model cities health component of the Laredo-Webb County (Tex.) Health Department was planned basically as an outreach program using health assistants. The Community Health Assistance Project (the official title of the program) consists of two main components: (a) community health education and (b) an infor-

mation and referral system that is supervised by a social worker. The two components are vitally interrelated and complement each other; the health assistants play major roles in each. Broad utilization of health assistants was called for in

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*Health assistants show film in neighborhood center*

the Community Health Assistance Project, and their multipurpose roles have been gradually expanding since the inception of the Laredo Model Cities Program in 1971. The administrator and supervisory staff of the Laredo-Webb County Health Department believe that the wide-ranging uses of the assistants are a most effective approach that might serve as a model for agencies with varied community health responsibilities.

Currently 8 health assistants work in the model cities health component and an additional 10 in other parts of the health department. All are women whose ages range from 18 to 50 years. Most of them have high school graduate equivalency degrees. Of special interest is that the program's first health assistants were trained by Project Hope in its first domestic project.

### **Health Education Component**

The health assistants have taken part in a growing number of endeavors in community health education, their initial activity being participation in an intensive campaign to increase immunization levels among preschool children in the model cities area. A survey conducted by the health assistants in 1971 indicated that an intensified effort was needed to maintain the generally high immunization levels in Laredo (see table). These levels are especially important in light of Laredo's geographic location, both as an international port of entry and also its nearness to areas where outbreaks of diphtheria have occurred and where cases of poliomyelitis are still reported.

The health assistants began by keeping a special immunization file on all preschool children in their districts. The file allowed the health assistants to identify better the target population and

to check responses to referrals to immunization clinics.

A variety of approaches were used to reach the parents of young children. The overwhelming majority of the 13,716 residents of the model neighborhood area are Spanish-speaking, and presentations or "charlas," as they are called in Spanish, were conducted by the health assistants at local neighborhood centers, churches, or virtually any convenient place. Special visual aids in Spanish were developed for the presentations.

In addition to the neighborhood presentations the health assistants went into homes, where they used special modifications of their educational resource materials. The home visits were necessary because of the difficulty of reaching everyone via the neighborhood meetings. For example, mothers are reluctant to take small children outdoors for long in Laredo's consistent 100° F. summer temperatures, and mothers with several

### **Percentages of immunized children aged 0-5 years in the Laredo Model Cities area before and after an intensive immunization campaign, spring and summer 1972**

Immunization agent	Percent of children immunized		
	Model cities area, February 1972 <sup>1</sup>	Model cities area, August 1972 <sup>2</sup>	National average of poverty areas <sup>3</sup>
DPT . . . . .	72.0	81.1	58.4
Poliomyelitis . . . . .	65.5	70.3	54.3
Measles, ages 1-5 . . . . .	46.6	67.3	48.7
Rubella, ages 1-5 . . . . .	39.9	65.8	52.0

<sup>1</sup> Reference 4. <sup>2</sup> Reference 5. <sup>3</sup> Reference 6.

small children are unable to come to meetings.

The health assistants made direct referrals to the health department's immunization clinics. Responses to all referrals were checked, and call-back visits were assigned a maximum of three times in an effort to motivate the more hesitant parents to have their children immunized.

Six months after the special outreach program on immunizations began, a community health survey was conducted by the Laredo-Webb County Health Department in cooperation with the Texas State Health Department and the Public Health Service's Center for Disease Control. Immunization levels reported in this survey were compared with those from the health assistants' earlier survey (see table). The levels in Laredo's model cities area are now reported to be among the highest for any model cities area in the country.

The health assistants used similar approaches in teaching mothers infant care—formula making, prevention of diarrhea, and nutrition—at the health department well-child conferences (usually jointly with the nurse) and in the community. All of the teaching resource materials are in Spanish, and most of these were specially developed for the Laredo population. In all instances, the health assistants make referrals to the department's clinics when indicated.

A special checklist was developed to help the assistants identify health and social problems of community residents (see box). Essentially, the list reminds the health assistants to ask about immunization status of family members, obvious dental problems, whether pregnant women are receiving prenatal care, and if mothers are taking newborn infants to well-child conferences. The checklist also reminds them to observe or inquire,

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## Community Health Assistance Program Family Health and Social Services Check List

### I. HEALTH

#### A. IMMUNIZATION STATUS — TOTAL FAMILY

- Polio    DPT    Measles  
 Rubella

#### B. MCH FACTORS

##### MATERNAL

- Pregnancies in family?  
 Mother receiving prenatal care?  
 Where?  
 Who will deliver baby?

##### INFANTS

- Newly born babies in family?  
 By whom delivered?  
 Problems for either mother or baby?  
 P.K.U.?  
 Baby attending well-child conference?  
 Mother receiving postnatal care?

#### C. DENTAL HEALTH

- Observable dental problems?  
 Eligible for our services?  
 Family visit dentist?  
 Family have and use tooth-brushes?

#### D. MEDICAL CARE

- Where does family usually go to receive their medical care?

- Family or any member have Medicaid or Medicare?  
 Migrant family? Know about use of migrant clinic?  
 Any health problems?  
 Diabetics?  
 Vision?  
 Handicapped?

#### E. ENVIRONMENTAL HEALTH

- Peeling paint?  
 Uncovered garbage cans?  
 Broken screens?  
 Unvented space heaters?

### II. SOCIAL NEEDS

Need for social or related services:

- Homemaker services?  
 Day care?  
 Surplus commodities?  
 State welfare?  
 Vocational rehabilitation?  
 Employment services?

### III. GENERAL AND MISCELLANEOUS

- Mental health problems?  
 Drug or alcoholic abuse problems?  
 TB (skin testing)



*Health assistant (left) and social worker discuss case*

or both, about pertinent social and economic matters. The list is modified when necessary to keep abreast of program developments in the health department.

As the health component of the model cities program progressed, the health assistants began to expand their activities. Carbon monoxide and lead paint poisoning detection programs were conducted by the health department following a project N.E.E.D.S. (Neighborhood Environmental Evaluation and Decision System) phase II survey, which was carried out in spring 1972 with the Bureau of Community Environmental Management, Public Health Service. The effectiveness of the health assistants in these new programs is illustrated by the quickness with which they obtained the cooperation and participation of area residents.

A major task of the health assistants in the lead poisoning detection program was to obtain parental permission to test the blood of 100 children. The program coordinator allocated 3 weeks for this assignment, assuming that the assistants would have some difficulty in signing up sufficient children for the following reasons: (a) reported fears of having blood tests performed on children, especially for an exploratory program; (b) lead paint poisoning had not been discussed before in Laredo, and the concept was new to people; and (c) the assumption that there might be general apathy about this health hazard. Parental permission to test 130 children was obtained by the health assistants in only 2 days.

The assistants signed up 130 children because our past experience has been that, on a given day, a number of children will be unable to attend for one reason or another. One hundred and three children were brought to the clinic on

the day of testing, and all 14 of those children who needed to be retested returned.

Working with the department's sanitarians, the health assistants played an active role in the home followup to the lead detection program. They accompanied the sanitarians to the homes of children with blood lead levels higher than 40 mg per 100 ml of whole blood, helped the sanitarians find lead-based paint with special detectors, and worked with families in helping them take corrective actions.

Fortunately, Laredo does not have a large number of children affected by lead-based paints. Nevertheless, the assistants remain alert for signs of peeling paint, especially in houses with small children, and encourage parents to take whatever action necessary to prevent children from ingesting paint chips.

The health assistants were similarly successful in the carbon monoxide detection program. Although this was also a new program, the health assistants experienced no difficulty in getting residents of the model cities area to place special carbon monoxide detectors in their homes. The health assistants easily filled their quotas and received excellent cooperation from the residents.

In both new programs, the health assistants were able to broaden their outreach and be of service to the entire health department. Appropriate training and inservice education are obvious prerequisites to this broadened outreach. Staff of the Bureau of Community Environmental Management conducted the assistants' training for these two programs. They have also received inservice training in general environmental sanitation from the department's environmental health staff, and they can function in such tasks as promoting home sanitation and the screening of doors

and windows and so forth.

The health assistants are currently being trained to participate in a pilot program in school dental health; they will encourage parents to support the program in the home. Before the Federal Food Stamp Program was implemented in Laredo in 1973, the assistants underwent training in consumer education.

### Information and Referral Component

The information and referral component has two objectives: (a) to inform model neighborhood area residents about and to motivate them to use the services of the health department and (b) to inform residents about the services of all community agencies and to refer people in need to the agencies. A major reason for setting up the referral component was that many model cities residents said that they did not know about the services many community agencies offer. This lack of knowledge was serious, because a large percentage of the area's residents need various services that these agencies provide. Another reason for developing the information and referral component was to bring existing services and people closer together.

The information and referral system is an innovative attempt to use the skills and talents of a

sibility of carrying to the model neighborhood residents letters of referral to the respective agencies from which they are seeking assistance. The assistants ascertain responses to referrals either from the agency or by a followup visit. Approximately 55 to 60 referrals per month are made to community agencies. The majority are to the Laredo-Webb County Welfare Agency and the Texas State Department of Public Welfare's regional office. The health component of the model cities program received the major part of its funds from the State welfare department, and its regional office in Laredo works closely with the program.

Many social problems uncovered by the health assistants are extremely complex, and a few have been emergencies—families facing eviction, older citizens neglected at home and in need of immediate hospitalization, families without food, and so forth. Referrals have been made to virtually every community agency and to some out-of-city agencies and facilities. For the year 1972, the average rate of responses to community referrals was 75 percent. The introduction of a social worker into a public health program is not unique, but it is obviously a necessary step because of the interrelation of health and poverty.

The other basic responsibility of the health assistants is to refer model cities residents to health



*Health assistants leave the health department for their districts in model cities health program van*

social worker. The major, but not exclusive, source of intake for the social worker is the referrals brought by the health assistants. They bring the social worker a large percentage of the problems for which residents need the services of community agencies or the social worker's counseling or assistance, or both.

The health assistants are delegated the respon-

department clinics—general medical, immunizations, maternity, dental, chest, gynecological, screening, and well-child—and to other services such as environmental sanitation. The assistants make direct referrals to all these services, and the responses to their referrals are carefully checked. Special referral slips are used, and followup visits are made when appointments are broken in an effort to remotivate residents to use available

services. Many referrals to the clinics are a result of educational presentations conducted in the community.

In many instances, appointments must be made for persons referred for services because of the clinics' large caseloads. Both research and practical experience have shown that the longer the period between appointment date and referral date, the greater the chance that the appointment will be broken (7). For this reason, the health assistants check the appointment books of the various clinics each week and issue personal or telephone reminders 1 or 2 days before the appointment date. These reminders have proved effective in reducing broken appointments.

The percentage of broken appointments of model neighborhood area infants for well-child conferences is much lower than the percentage for infants from similar poverty neighborhoods in Laredo. The health assistants work closely with the district nurses on this matter. Evidence that the outreach of the health assistants is effective is the higher proportion of residents of the model cities area receiving health department services, compared with residents of similar poverty areas of the city.

The percentages of services of various clinics devoted to model neighborhood residents (8) follow:

<i>Health department clinic</i>	<i>Percent of services</i>
General medical .....	27
Well-child conferences .....	54
Maternity .....	49
Dental .....	30
Migrant .....	32
Immunizations .....	25
Tuberculosis .....	31

A 60 percent response rate to all referrals to health department services was achieved in 1972. This percentage compares favorably with reports from other outreach programs in operation throughout the country (9).

The health assistants have also worked in other general outreach activities. One has been to promote and increase participation in evening clinics for tuberculosis skin tests. The attendance at the three clinics held at centers in the model cities area in 1973 was much higher than at clinics held in other sections of town.

Promoting the health department's migrant clinic is another health assistants' effort. Each spring the assistants contact the migrant families in their districts and encourage them to visit the clinic for preventive services such as immunizations and

diagnostic services before they journey north. Special emphasis is given to visiting families who have not been aware of the clinic.

### **Rationale for Health Assistants' Role**

Using health assistants in a broad, multipurpose outreach of the entire health department is somewhat contrary to the philosophy that the health assistant should only assist professional staff with mundane duties. We contend that health assistants should have a broad, multipurpose role, particularly in those areas of the community where they have the capacity to serve perhaps better than anyone else. In many instances, the health assistants are best able to communicate with poverty groups, motivate them to use services, and to conduct certain types of educational programs.

In addition, the health assistants can help with all the interrelated problems and needs of a family, avoiding a fragmented approach. Of course, the health assistants alone cannot personally perform all the services that may be required; rather they may be able to perform some and refer those in need to public health nurses, sanitarians, or social workers who are better qualified to help. Obviously, it is necessary to have faith in the health assistants to hold this viewpoint. In the Laredo program, respect for the health assistants' capabilities was fostered by experience in various endeavors.

From a practical standpoint, having a group of health assistants trained to perform a variety of tasks gives the health department a flexible manpower tool. In the model cities health component, the health assistants are trained to assist in the department's migrant and general medical clinics and well-child conferences. When staff members are ill or vacationing, it is especially comforting to have a pool of broadly trained persons to call upon.

Utilization of health assistants in this manner is only possible, of course, if they are fully trained after they are selected, thoroughly oriented to the health department, and have a followup program of continuing education. Neither health assistants, nor anyone else, can be expected to function properly without preparation for the task at hand.

Constant inservice or continuing education has been necessary because of changes in the direction of programs as well as the changing health and community scene—for example, changes in welfare guidelines, new model cities programs, and so forth. A special inservice committee composed

of the program coordinator, social worker, health assistants, health educator, physicians, and nurses is responsible for planning the health assistants' inservice training. This training is supplemented by the department's regular inservice education programs and various workshops and seminars that are frequently sponsored in the community. Inservice education, both formal and informal, is planned as needed, rather than being scheduled on a regular basis.

Although a great deal of time and attention is devoted to training and education, we do not believe that it is the single key element in our successful use of aides. Instead of singling out one vital factor necessary for success, experience has proved that selection, training, supervision, and utilization of assistants are equally important and that a letdown in one area will adversely affect another. For example, if a health assistant is selected without care, it is doubtful that any amount of training or supervision will be of much help. Some particularly helpful reports in the literature were those of Goldstein and Camp (10) on selection, Hildebrand (11) on guidelines for utilization, Callan (12) on supervision, and Hoff (13) on training.

Closely related to these areas is the maintenance of the health assistants' morale. This aspect of personnel management is especially important because of its effect on productivity and the quality of work. Morale is especially important for those health assistants who may not seek, or be able, to progress up the career ladder.

Morale in the Laredo program has been good,

perhaps because the department's philosophy has meant that the assistants have a greatly varied workload. Variety has been achieved by occasional changes in emphasis (from immunization campaigns to lead paint poisoning to infant nutrition, for example) and by balancing outdoor work with regularly scheduled indoor clinic assignments. In this way, boredom is prevented and interest is maintained in the program.

Good morale is also fostered by involving the health assistants in program planning. Broad participation is one of the tenets of good planning; also, the health assistants are thus assured that they are both respected and important to the continuing development of the program. In addition, they are encouraged to plan a large portion of their fieldwork; they have the responsibility to plan carefully and constructively the use of their time.

### Conclusion

The roles of the health assistants in the model cities health component have expanded with experience and training into broad, multipurpose community responsibilities that have achieved notable results. The assistants have widened their responsibilities to serve as an outreach of the entire health department as well as to function in an information and referral component that brings the services of the whole gamut of the community's agencies to residents of the model cities area. It is hoped that this project might serve as a model for subsequent development of community outreach programs.

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