A Model Neighborhood Program at a Los Angeles Health Center

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This paper is based on one presented to the United States-Mexican Border Public Health Association on March 30, 1971. Tearsheet requests to Dr. Geraldine B. Branch, 1522 East 102d St., Los Angeles, Calif. 90002.

The Demonstration Cities and Metropolitan Development Act of 1966 (Public Law 89-754) provides for a program designed to demonstrate how the environment and the general welfare of people living in slum neighborhoods can be improved in U.S. cities of all sizes (*1*). The act provides up to 80 percent of the approved cost of developing comprehensive demonstration programs.

The purposes of the demonstration programs are to (*a*) rebuild or revitalize large slum areas, (*b*) expand housing, (*c*) expand job and income opportunities, (*d*) reduce dependency on welfare

payments, (*e*) improve educational facilities and programs, (*f*) combat disease and ill health, (*g*) enhance recreational and cultural opportunities, (*h*) reduce the incidence of crime and delinquency, (*i*) establish better access between homes and jobs, and (*j*) improve the living conditions of people in Model Neighborhood Areas (*2*).

In March 1969 a model cities program was being planned by the County of Los Angeles Board of Supervisors. This program was called "model neighborhood" to distinguish it from the model cities program which was to be administered by the City of Los Angeles.

Organization and Community Participation

A questionnaire was mailed to all registered voters in the Florence-Firestone area of Los Angeles. Fourteen percent of the total population responded, and 80 percent of the questionnaires mailed were returned (*3*). The reason for this seemingly low number of people to whom questionnaires were sent is that many residents of this area do not register to vote. However, the responses did reveal to the planners what the residents considered to be their needs (*4*). The questionnaire was also designed to reveal the neighborhood's priorities.

The model neighborhood area was divided into 16 geographic units. The residents of each unit elected five representatives. The person with the highest number of votes was designated to be a member of the excutive committee while the other four candidates were designated to be members of the neighborhood community council.

These 16 community councils met in the neighborhood, and they were advisers to the professional staff and executive council. The community councils also were the liaison with all other members of the community.

On July 19, 1969, all of the councils had an open meeting to which all members of the community and all agency staffs (providers) in the community were invited. People were assigned to certain workshops, but they were not compelled to remain in a specified workshop. All proceedings were taped. At the end of the day, a general session was held, where a summary was made of the day's work and priorities were set.

Following this meeting the staff of the model neighborhood program invited the providers to write proposals in order to get monies to meet the needs of the community. The providers met with the area councils and used the needs and priorities in writing the proposals. Baseline data were provided by the agencies and the Center for Communicable Disease Control.

After a provider wrote an outline of the proposal, the model neighborhood's community improvement analyst assigned to the health component of the model neighborhood total proposal (which also included education, employment, housing, recreation, transportation, and job training) perfected it. The proposal was then reviewed and approved by the professional task force and the community councils. In July 1970, the model neighborhood program was funded by the Department of Housing and Urban Development.

Florence-Firestone Area

The Florence-Firestone subcenter serves eight census tracts within the South Health District. It is one of 23 health districts serviced by the Los Angeles County Health Department. Each district is administered by a physician-administrator.

The Florence-Firestone area has a population of 48,000; 56.7 percent are Negroes, about 38 percent are Mexican-American (many speak Spanish only), and the remainder are white, Oriental, and American Indian. The median annual income is $4,846. The average citizen has 9.3 years of formal education. The neonatal death rate is 19.6 per 1,000 live births. Immunization levels are 70 percent for diphtheria, pertussis, and tetanus, 40 percent for poliomyelitis, and 60 percent for measles (*4*).

The purpose of the demonstration project in the Florence-Firestone area is to improve the level of health by providing both preventive and therapeutic medical services sufficient to reduce the incidence of disease, health deficiences, and drug addiction to the much lower countywide incidence.

Before the model neighborhood program, the Florence-Firestone Health Center was offering county-funded services in communicable disease control, well baby care, venereal disease control, immunization, diagnosis, and referral. A tuberculosis control clinic, held weekly, was federally funded. Prenatal care, hospital delivery, postpartum and family planning, high-risk infant care, and dental care for pregnant women only were offered under a maternal and infant care project which was federally funded.

The model neighborhood program extended these services by adding a family care clinic, where all members of a family would be seen by an internist or a general practitioner; a pediatric

clinic for infants and children up to 16 years of age; a gynecology clinic; a drug abuse clinic; a dental clinic; and a small medical laboratory. The response to the model neighborhood dental program was so great that the county instituted and funded a dental clinic for children through 6 years of age.

Implementation of the Program

The board of supervisors signed the contract for the model neighborhood program in August 1970, and planning for increased services, recruitment of personnel, and orientation began immediately. The Florence-Firestone Health Council was active in all of this planning and recruitment.

Family care clinic. Because the model neighborhood program was different from the usual health center program, the health center staff met often with the consultant and administrative staffs in the process of developing district procedures and priorities. Each of these groups also had a chance to express its concerns. These discussions led to the decision to institute one new clinic at a time.

The health officer's clinic, originally a walk-in diagnostic, referral, and immunization clinic, was expanded to a walk-in family care clinic to determine the real needs of the community and the utilization level. In April 1970, before expansion, the health officer's clinic treated 363 patients. In May there were 343 patients and in June 367. In July, when the health officer's clinic was expanded, 443 patients were seen; however, it was found that families rather than individual persons were being counted. In August, the figure rose to 689 patients.

As patients came into the family care clinic, their needs were documented and a list was made of the most frequently needed drugs. These drugs were requisitioned from the county health department. Prescriptions were written for patients until the requisitions were filled. The patients who were under Medi-Cal were able to have their prescriptions filled at the neighborhood pharmacies which had been approved by Medi-Cal. Most of the drugs requisitioned were being supplied to the clinic within 2 months after it was opened.

In the meantime, the workload at the expanded health officer's clinic became so heavy that it was decided to retain the health officer's clinic as a walk-in immunization, diagnostic, and referral service and to provide family care by appointment. The family care clinic was officially opened on September 2. Approximately 20 scheduled patients and four emergency walk-in patients were seen during each 4-hour session. At first four sessions were held per week; at present there are six sessions per week. A full-time public health general practitioner conducts all the family care clinic sessions in order to provide continuity of care. The average number of patients seen each session varies between 18 and 20 during the period studied (table 1).

A community worker who assists in the family care clinic is an interpreter and makes home visits. She evaluates the home situation, counsels the family, explains the health center services, and makes appropriate referrals. She also reports particular conditions to the social worker, nursing staff, or sanitarians.

Patients seen in the family care clinic who need special prenatal care are referred to obstetrical

Table 1. Clinics at Florence-Firestone Health Center, by type of clinic and average number of patients attending per session, September 1970-January 1971

Clinics	September	October	November	December	January
Family care, total sessions	284	309	308	344	426
Number of sessions	14	17	15	17	23
Average number patients per session	20.3	18	20.5	20.2	18.5
Dental, total sessions	109	161	174	128	118
Number of sessions	18	20	21	18	18
Average number patients per session	6	8	8.3	7	6.5
Pediatrics, total sessions		12	51	91	152
Number of sessions		2	3	8	12
Average number patients per session		6	17	11.4	12.7
Gynecology, total sessions			60	60	39
Number of sessions			6	6	7
Average number patients per session			10	10	5.6
Drug abuse, total sessions			40	133	107
Number of sessions			13	22	20
Average number patients per session			3	6	5.4

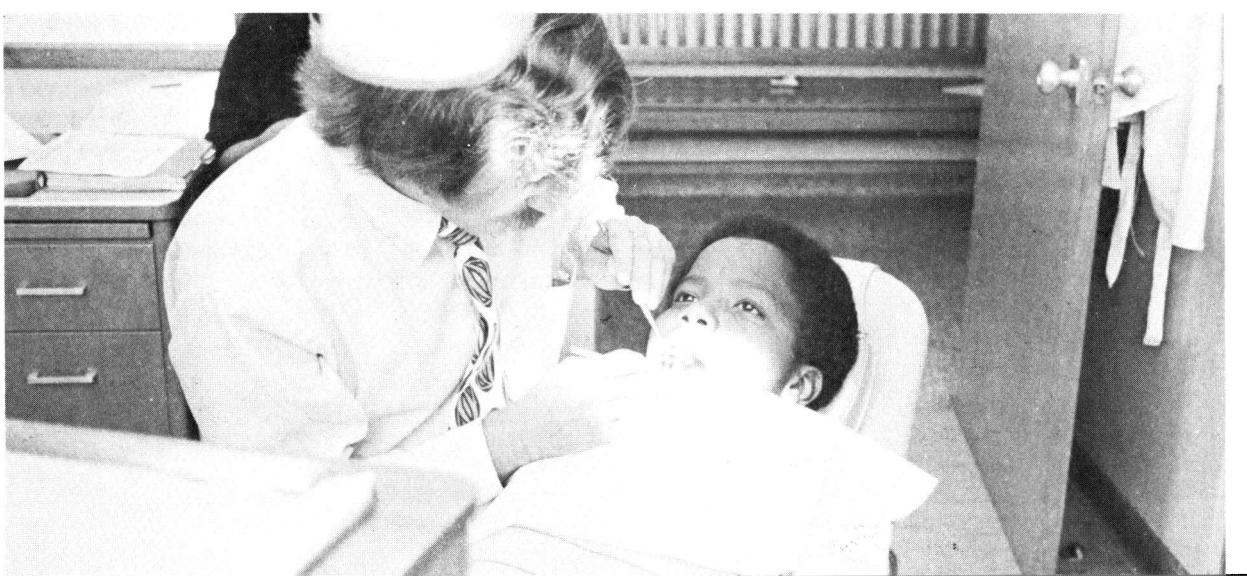
Community workers screen patients in family planning clinic

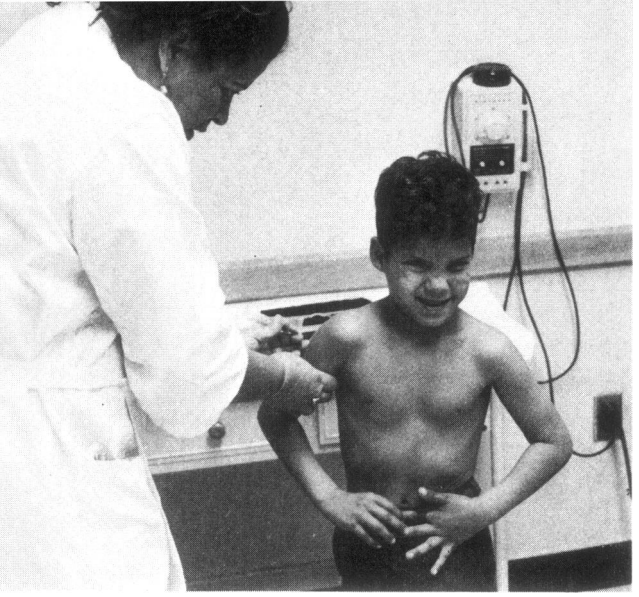
care in the health center or to the Los Angeles County-University of Southern California Medical Center for special workup or hospitalization. When the patient is discharged from the hospital, the liaison nurse notifies the center which then follows up the patient. Medicines which are available are dispensed free of charge at the Florence Firestone Health Center.

Dental clinic. The dental clinic was started on September 2, 1970, with five sessions per week. A dental clinic for pregnant women only, sponsored by a maternal and infant care project, had been established earlier; this clinic continues to care for pregnant women. The model neighborhood's dental clinic initially provided care for all other patients. However, shortly after it was opened, priorities had to be set. These priorities are (*a*) emergency care for patients of all ages who are in pain or have an infection and (*b*) maintenance dental care for patients 7 years old and over (a county-funded clinic was started for children under 7 years old).

A dentist and dental assistant attend each clinic session. An oral hygienist sees patients by appointment. The services offered include emergency extractions, fillings, prophylaxis, and dental health education. Patients requiring orthodontic care and prosthetics are referred elsewhere. The health center has X-ray equipment, but it does not have a dental laboratory. About six to eight patients were seen each session during the period studied (table 1).

Children over 7 years get maintenance care in the dental clinic



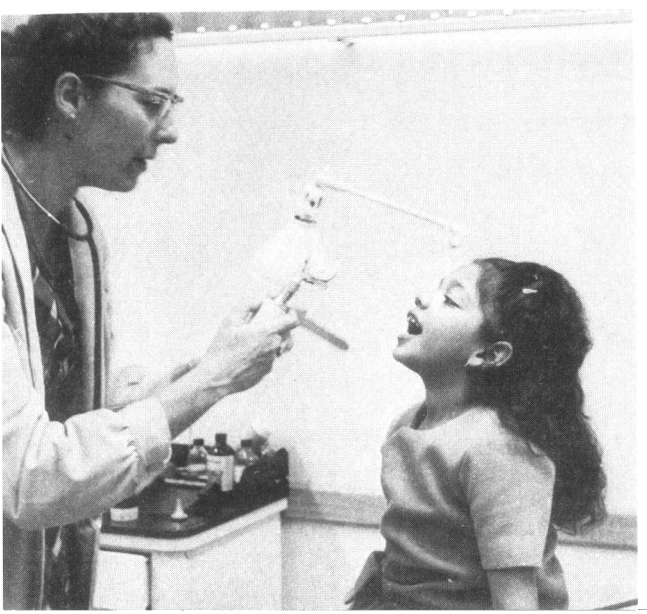


Immunizations are part of center's services

Pediatric clinic. Patients from the family care, health officer's, well baby, and dental clinics who needed pediatric care were referred to the clinic clerk for booking onto a waiting list for the pediatric clinic, which was officially opened on October 20, 1970. A board-certified pediatrician conducts the clinic. In January 1971 the clinic sessions were increased from two to three a week. Patients from birth to 16 years of age who need special care and followup are seen by appointment in this clinic. Twenty scheduled patients and four emergency walk-in patients are allotted for each clinic session. The average number of patients seen per clinic session varied from six to 17 during the period studied (table 1).

Drug abuse clinic. Originally, the drug abuse clinic at Florence-Firestone was designed to care for teenagers and young adults. This was the priority set by the community council and the health council. Before the clinic opened, the health educator and community worker as well as members of the health council met with groups to tell them about the new service and invite them to refer patients to the clinic as soon as it was opened.

Children in the model neighborhood receive care at the pediatric clinic's 3 weekly sessions



The district health officer invited community agency representatives, community council representatives, and community residents to meet with the consultant and district staff to discuss this new service. It was pointed out that the clinic should not be held in the health center which was next door to the sheriff's station. The reasons for this were as follows.

1. Drug abuse patients would not use a facility that was located so close to a law enforcement facility.

2. Incoming calls to the health center went through the sheriff's switchboard. The switchboard operator answered all incoming calls "sheriff's station," certainly a deterrent to drug abuse patients who might be seeking help.

3. The health center parking lot shared a dividing wall with the sheriff's parking lot. Because of vandalism, a sheriff with a gun was stationed on the top of this wall to intercept intruders.

4. The drug abuse patients would be afraid of being arrested before they could enter the clinic or upon leaving the clinic.

There was a need for a halfway house in the area for patients who were seeking help but had no homes. Some of these were youngsters who had been evicted by their parents. At this meeting a committee was formed to locate a suitable place in the area and recommend it to the project director.

However, no funds were budgeted for a halfway house. The district health officer reported the results of the meeting to the model neighborhood councils and the decision was made to open the clinic in the health center and see what would happen.

On November 9, 1970, the drug abuse clinic opened officially. The people who came for care were heroin addicts 19–47 years of age. The clinic is held daily from 1 to 9 p.m. Patients of all ages with drug abuse problems are admitted for detoxification and medical treatment. Individual and group counseling are offered to all patients by a

Public health investigator takes a patient's history in the drug abuse clinic, which is held daily

team which consists of a psychiatric social worker, a public health nurse, a public health investigator, a clinic nurse, a physician, two community workers, and a neighborhood volunteer. An average of five patients are seen per clinic session; but these are not always the same five patients. Patients come and go. Of the total 70 patients seen as of February 10, 1971, two who were heroin addicts remained "off drugs" for more than 6 weeks.

Because there is no methadone maintenance program in this clinic, patients who are confirmed heroin addicts and who have a history of felonies or misdemeanors, or both, are referred to another health center for care. Addicts who do not want methadone maintenance but who are not suitable for outpatient care are referred to Metropolitan State Hospital for inpatient care. Those who are in a very toxic condition are sent to the Los Angeles County University of Southern California Medical Center.

Despite all the problems, the community and the staff wish to continue the clinic and patients continue to come. The drug abuse clinic uses the case-management team approach. Each worker has a patient with whom he works individually and for whom he is responsible. All the other members of the team give supportive services.

When a patient arrives at the clinic, he is greeted by a receptionist who directs him to the community worker. The community worker, an ex-addict, talks with the patient and decides whether to send him directly to the physician-nurse team for care or to the psychiatric social worker for counseling. The patient is then assigned to his caseworker who, along with the other members of the team, gives the patient psychological support. The two patients who had quit heroin "cold turkey" brought their friends to the clinic for care. Parents of some of the patients have "signed up" to be volunteers.

Gynecology clinic. The women's clinic started on December 2, 1970. At present, there are two sessions per week, one of which is held from 5 to 9 p.m. The same general-practice physician who conducts the family care clinic serves this clinic. Gynecologic conditions usually treated in a physician's office are treated in this clinic. About 10 patients were seen per clinic session (table 1).

Laboratory

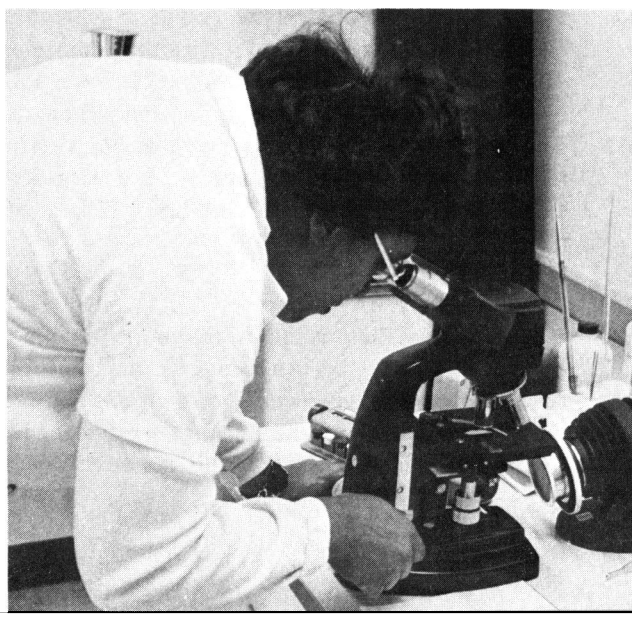
The Florence-Firestone center has a small laboratory and one clinical laboratory technologist. A limited number of tests are performed in this laboratory. However, other tests are performed at the main county health department laboratory. At present the following tests are available:

Blood: Complete blood count, sickle cell preparation, heterophile (monospot test), glucose (semiquantitative), bleeding and clotting time, and hemoglobin and hematocrit.

Urine: Routine urinalysis, bilirubin (qualitative), urobilinoiden (qualitative), and pregnancy test.

Microscopic examination: Darkfield for *Treponema pallidum,* gram stain, and wet mounts for *Trichomonas* and *Monilia.*

Technologist performs clinical tests at the center's small laboratory



Problems

When the model neighborhood budget was originally submitted, each person had a desk and chair. However, the budget was cut before the equipment was purchased; thus, new personnel had no office equipment. Space became a premium after the new program began because of increased utilization and lack of adequate equipment.

The sudden increase in attendance in all existing clinics as well as the high utilization in new clinics caused a sudden increased demand for drugs, supplies, instruments, and equipment that were not forthcoming.

Even though the program is federally funded and the district health council and the staff had recruited and found many residents who needed work and who had applied for available jobs, the applicants were not hired. This was especially true of the clerical and community workers. The clerks had taken but had not passed the county civil service examinations, and the community workers were considered ineligible. The community residents were offered positions as trainees, which they refused to accept.

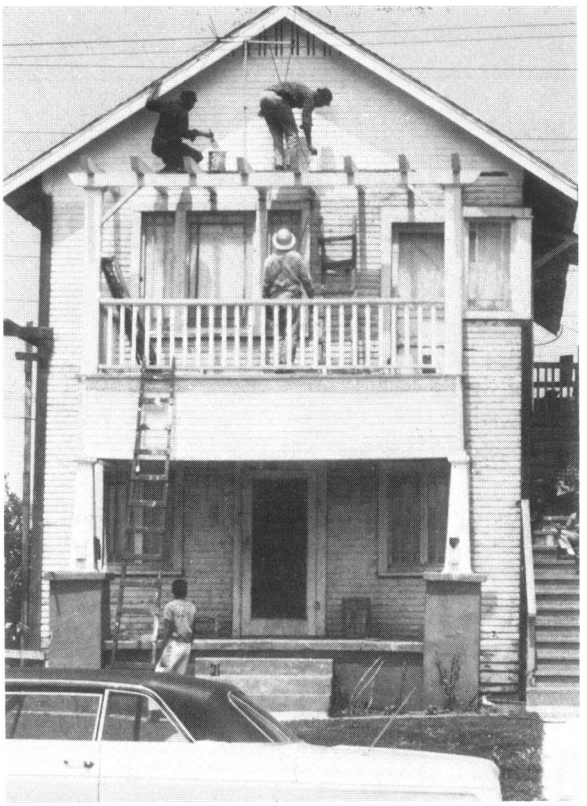
With the increased patient load and with many family members attending different clinics at the same time, the present method of recordkeeping is incompetent and time consuming.

At the time of a financial crisis in the county, plans had been made to begin the alcoholic rehabilitation clinic. The staff had been hired and were being oriented. The target date for opening the clinic had been set; but when the county "freeze" came, it was learned that no more new clinics, including those that were federally funded, would be instituted.

Many staff members have found it difficult to change from the traditional health department services to the new services. Some also are bothered by the fast introduction of so many new and different services. Generally, however, the personnel have made a good adjustment, are very dedicated, and are interested in being a part of the change.

Environmental Health

A survey of the housing in the model neighborhood area showed 16.3 percent of it deteriorating. Absentee landlords owned 75 percent of the dwellings in the area. Two sanitarians are assigned to the Florence-Firestone area, and the environmental health program has extended the service as follows:



Neighbors help spruce up a house

1. Bilingual sanitarians are teaching ecology to senior high school students and residents.

2. The sanitarians attend model neighborhood council meetings where they discuss with the council the environmental problems of the area and plan for improvement.

3. The sanitarians involve the Firestone rubbish district when complaints about missed rubbish pickups increase because of the transition from one hauler to another.

4. The sanitarians have brought about closer cooperation between the health department and other county agencies such as the fire department, the building and safety department, and the assistant manager of the model neighborhood program.

5. Consumer protection activities have increased three times so that all markets and food establishments receive better supervision.

6. The sanitarians have informed neighborhood residents concerning accident prevention. As a result of this education, a numbr of hazardous conditions were recognized by residents, reported, and consequently corrected (table 2).

Cleaning up a vacant lot in the model neighborhood

Conclusions

Through the Florence-Firestone model neighborhood program, the Los Angeles County Health Department gained experience in planning health services with the community and with other agencies.

Persons in the community respond well when they participate early in planning for health services, when these services are made accessible to them close to their homes, and when they are the kinds of services the people need.

Better coordination of services within the health center and with other county departments was evidenced by the cooperation of the department of hospitals, the fire department, the probation department, and the department of social services.

Better continuity of patient care was made possible by having a patient see the same physician at each visit, by having all clinics conducted the same way, and by the teamwork of all disciplines (nursing, health education, social work, and nutrition).

The model neighborhood program provided employment for local residents who are dedicated to the task of improving their own area and helping their neighbors.

Many of the problems encountered in the program resulted from lack of preplanning with the county civil service commission and the new career program to hire community residents who did not meet the eligibility requirements or who could not pass the county civil service examinations. Much of the staff's "future shock" was due to the swift institution of new programs. Although the staff knew that these programs were coming into the health center, they were really not psychologically ready to receive them.

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(*1*) U.S. Senate: Demonstration cities and metropolitan development act. P.L. 89–754, 89th Cong., S. 3708, Nov. 3, 1966. U.S. Government Printing Office, Washington, D.C., 1966.

(*2*) U.S. Department of Housing and Urban Development: Improving the quality of urban life: A program guide to model neighborhoods in demonstration cities. HUD PG–47. U.S. Government Printing Office, Washington, D.C., 1967, ch. 1, p. 1.

(*3*) Board of Supervisors, County of Los Angeles: Model neighborhoods programs: Midterm statement, Nov. 18, 1969, p. 1.

(*4*) Board of Supervisors, County of Los Angeles: Model neighborhood program. First year comprehensive demonstration plan: 1970 health. pp. 15–17, 97–100.

(*5*) Waldrop, R.: Methods of reaching the unreached in community disease control demonstration. Atlanta, Ga., September 1969. Processed.

Table 2. Environmental health inspections conducted in the Florence-Firestone Model Neighborhood Area, November 1970-March 22, 1971

Month	Inspections		Citizen complaints	Total	Total corrected [1]
	Food	Housing			
November	75	250	56	381	93
December	64	178	37	279	84
January	50	160	51	261	184
February	45	101	53	199	145
March	31	62	35	128	163
Total	265	751	232	1,248	669

[1] Within a reasonable time, depending upon the condition of the premises, all official notices and official inspection reports were abated. Some premises required repeated reinspection and public health education of the owners or tenants before deficiencies could be corrected.