Second Draft
January 21, 1972
GMK

TENTATIVE CONTRACT PROPOSAL

A proposal to improve patient services and staff skills of several near Southside health service centers through coordination and communication among them, and augmentation of general resources

A report published in May of 1967 by the Hospital Area Planning Committee commented: "Active effort is required by all concerned to develop a good ambulatory program . . . in the center of the south side as rapidly as possible, . . ." Nearly five years have passed since this recommendation was made and documented. In that time, no new physicians have moved into the community, but other people have, including Spanish-speaking former migrant workers. The neighborhood conditions which foster ill health have worsened, and there has been no major commitment of resources by any health care institution to initiate the establishment of a "good ambulatory care pfogram" in the southside. Indeed, there have been no serious moves in that direction whatsoever.

The Southside community have not been sitting on their hands for five years, however. In an attempt to meet health needs and develop greater health resources within the community, four neighborhood health service centers have sprung up, two of them within the last few months. Each of them provides a limited range of services in a neighborhood setting, with patient advocacy and attention to broad health-related problems as a common thread woven among them. All have identifiable constituencies to which they relate as community organizations. And all are designed to serve those who cannot otherwise afford care.

Each of them, likewise, has handicaps of saale. It is clear that, individually, they are too small to reach more than a tiny fraction of the population-at-need. (Operating at present levels, all of the centers together

would have fewer than 15,000 patient visits per year. This compares to a "depressed Southside core area" population estimated between 100,000 and 120,000 by the Community Relations -- Social Development Commission's Planning and Research Department.) Ironically, their size is also a stumbling block to their growth. To serve even their few clients with some measure of competency requires the same staff skills, the same referral mechanisms, the same secondary resources demanded by a load several times the current one. Such arrangements are often facilitated by a steady, if small, flow of patients to various backup resources. A steady flow is difficult to maintain on such a small scale.

In such a situation, coordination and effective sharing of resources would foster realization of these goals:

-- to increase the range of health needs which can be met by the neighborhood health service centers

-- to more efficiently mobilize existing resources to provide patient care

-- to enable the neighborhood health service centers to serve patients on a more regular and continuous basis

-- to increase, through concerted action, the quantity and scope of available resources

-- to upgrade the skills of the staffs of the neighborhood health service centers, and thereby improve the quality of patient care

--to develop logical and identifiable entry points into the health care system.

At first glance, it would appear that a merger of these groups and consolidation of their resources is indicated. For several reasons, however, such an action would not only be very difficult, but also undesirable. One might be described as inertia, a general resistance of organizations to change. (It is similar in most respects to the resistance of larger institutions like hospitals to consolidation, except that institutional loyalties are likely to be personal loyalties as well in the smaller organization, and hence more intense.) Another reason is that many of the "ambulatory"

patients of these centers are dependent on their feet, and their feet alone, for getting to the clinics. A centralized facility would greatly reduce the accessibility of its services to the people whom it would be allegedly designed to serve.

The most important reason, however, is that such a consolidation would destroy much of the unique and essential value of these centers. Each is small enough to relate to its own community of face-to-face relationships. Each, then, is capable of effectively understanding and relating to the individual and varied needs of its patients, especially in the broad areas of health care which transcend the medical care delivery setting. And each, as a consequence, can nurture within their clients the feeling that they have a measure of control over their own lives, and that proper attention to their health is of great importance.

The development of coordinated services is a matter of considerable importance to all of the centers, for it would greatly improve our abilities to serve our clients. Based on conversations with the other centers, it is our conviction that such a development is not only a possibility, but also an attractive probability. We propose to plan for, foster and develop such coordination in the manner outlined below.

We propose to employ a nurse practitioner, supported by the part-time consultant services of a physician, to provide additional primary care services. In addition, we will employ community health workers to function in conjunction with this service and existing services, and to perform a general outreach function. With these as basic resources which can be shared with and utilized by other centers, we will provide technical assistance to all of the centers through development of staff training programs, record systems, referral and secondary resource arrangements, and serve as resource developers for the centers.

The nurse practitioner would provide health problem assessment, including patient instruction in self care, provision of defined medical treatment and securing needed physician care. She would make referrals to appropriate health resources, and serve as the person responsible for the management of a family's health problems. It is anticipated that she could serve an active caseload of 200 to 300 families with the assistance of community health workers and the physician consultant.

The community health workers would be responsible for most home visits, and for following up on patient visits to the nurse practitioner. They would serve as patient advocates, and as health care facilitators (assisting with translating, babysitting arrangements, transportation, etc.) In addition, they would be community organizers, functioning as catalysts in the development of group educational programs relating to health. Such programs might include a weight-watching club, nutrition or cooking classes, food budgeting classes, etc.

Technical assistance would be provided through the employment of a ~~p~~ planner. He would function as a resource developer, as an evaluator of existing programs, and would assist in the development of appropriate backup and referral arrangements. In addition, he would work with the project director, consultants and other staff and persons from other centers to develop joint staff training programs and other efforts to upgrade the skills and knowledge of the various center personnel.

HOPE, Inc. is a logical and appropriate source for such core resources. It already ahs some of the staff necessary to operate such a program. It has a Board of Directors representative of the local community, and including knowledgeable members of various health professions. And it has legal, non-profit, corporate status, enabling it to be a responsible recipient of funds.

It's program has been operating for almost two years, and has a relatively long history of successful cooperation with existing health resources.*

Such activities would require eight employees: a project director, a planner/evaluator, a nurse practitioner, a secretary-receptionist and four community workers. In addition, a considerable amount of consultant time would be required. Much of this would involve a physician to work in conjunction with the clinic and other resources for the nurse practitioner. Also required would be expert assistance with educational programs, both for staff and patient groups.

Planning would be directed toward:

- -- further assessment of health needs
- -- development of a local communications system
- -- standardized patient data
- -- creation of an appropriate referral system
- -- development of secondary resources for the nurse practitioner
- -- development of community health education programs
- -- development of staff training programs
- -- establishment of ongoing support mechanism
- -- means of concerted action to increase neighborhood health resources.

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*It operates a Well Baby Clinic in cooperation with the City of Milwaukee Health Department. It operates a Family Planning Clinic in conjunction with Planned Parenthood of Milwaukee, Inc. It operates a cooperative Prenatal Clinic for which the City Health Department provides nursing staff, Milwaukee County General Hospital provides an Obstetrics resident, the National Foundation (the March of Dimes) provides the equipment, and the Catholic Home and School League provides volunteer receptionists and clinic aides. Milwaukee County Institutions, the National Foundation, OEO's Emergency Food and Medical Services Program and Inner City Development Project have all assisted in furnishing and providing facilities for the Center. It sponsors nutrition classes in conjunction with University of Wisconsin extension. Also, it currently shares a nurse with the University of Wisconsin--Milwaukee School of Nursing, and has provided a setting for graduate field experience for nurses at Marquette University College of Nursing.