This is an incomplete edition of VOLUME I,

PROPOSAL FOR COMPREHENSIVE
HEALTH PLANNING

All pages considered crucial to the intent of the proposal are included here. Other work, denoted here by missing pages, is in process of completion.

Foreword to the Proposal

THIS PROPOSAL REPORTS WORK SUPPORTED BY AN ORGANIZATIONAL GRANT TO THE COMMUNITY COUNCIL OF THE ATLANTA AREA FROM THE U. S. PUBLIC HEALTH SERVICE, AND CONTAINS RECOMMENDATIONS FOR THE ESTABLISHMENT OF A PERMANENT COMPREHENSIVE HEALTH PLANNING AGENCY FOR THE METROPOLITAN ATLANTA AREA. THE PROPOSAL CONSISTS OF THREE VOLUMES: PROJECT SUMMARY, BUDGET AND STAFF, AND TASK FORCE REPORTS.

Agency Responsible

The Community Council of the Atlanta Area, supported by organizational grant No. 41008-01-69 from the U. S. Public Health Service, has been the agency responsible for conducting the work and, with the cooperation of many other offices, groups, and organizations, making the recommendations herein for the establishment of a permanent comprehensive health planning agency for the Metropolitan Atlanta Area.

Staff

The material was prepared by the Comprehensive Health Planning Project staff, directed by Raphael B. Levine, Ph. D., under the general supervision of Duane W. Beck, Executive Director of the Community Council of the Atlanta Area.

Consultation and Other Assistance

A number of persons gave continuing support to the Project on consultant basis, and several hundred persons from governments, health professions, educational institutions, commerce, and the population of health "consumers" gave invaluable assistance in the compilation of information and in the formulation of conclusions. The staff tenders its sincere thanks to all these individuals.

Funding

50% of the costs of this effort were borne by the Public Health Service grant mentioned above. The remainder was contributed by local sources, including county governments, foundations and the Community Chest, public, private, and voluntary health organizations, and individuals. The community owes much gratitude to these donors.

Organization of the Proposal

The proposal is divided into three volumes: project summary, budget and staff, and task force reports. Each pair of facing pages makes up a self-contained "story". The gist of each "story" may be gained from the bordered summary material alone, with details added in the text and illustrative material.

COMMUNITY COUNCIL OF THE ATLANTA AREA

Eugene T. Branch, Chairman of the Board
Duane W. Beck, Executive Director
A. B. Padgett, Chairman, Committee on
Comprehensive Health Planning

COMPREHENSIVE HEALTH PLANNING PROJECT

Raphael B. Levine, Ph. D., Director
Alloys F. Branton, M.B.A., Assoc. Director
Harriet E. Bush, Director of Research
Clifford Alexander, Jr., Environmental Planner
Katharine B. Crawford, Organization Liaison

Mary Lou Ashton, Senior Secretary
Mildred W. Thorpe, Secretary

CONSULTANTS (on continuing basis)

Frank A. Smith, Atlanta Metropolitan Mental Health Assoc.
Loretta B. Roberts, RN, Community Council of the Atlanta Area
Ella Mae Brayboy, Community Council of the Atlanta Area
William F. Thompson, Administrator, Cobb County Health Department
Carolyn L. Clarke, Health Educator, Gwinnett County Health Department
Edna B. Tate, Health Coordinator, Economic Opportunity Atlanta

ORGANIZATION OF THE PROPOSAL

Volume I. Summary of Project
- Section 1. Introduction and Supportive Material
- Section 2. Narrative Project Summary
- Section 3. Appendices

Volume II. Budget and Staff
- Section 1. Budgetary Material
- Section 2. Personnel

Volume III. Task Force Reports

TABLE OF CONTENTS

Page

Foreword to the Proposal i

SECTION 1. INTRODUCTION AND SUPPORTIVE MATERIAL

A. Description of the Area

Planning for Planning: Technical and Community Involvement Aspects 2

The Atlanta Area, the Planning Area 4

Atlanta Area Governmental Units, Current Population 6

Standard Metropolitan Statistical Areas Close to the Atlanta Area 8

Atlanta Area, a Place of Growth and Variation . . 10

Population Trends Require Review of Health Needs 12

The Planning Area Observes Other Programs and Anticipated Expansion 14

Organizational and Procedural Arrangements for Comprehensive Health Planning 16

Cooperative Arrangements made for Funds, Personnel, Facilities and Services 18

Planning is Based on Commonly Available Date . . . 20

B. The Atlanta Area's Need for and Ability to Support Comprehensive Health Planning

Principal Teaching and Service Facilities in the Atlanta Planning Area 22

Implications for Comprehensive Health Planning in Environmental Health Fields 24

Atlanta's Urban Redevelopment Project Program . . 26

Page

Atlanta's Model Cities Program 28

Relationships with the Georgia Regional Medical Program 30

The Urban Life Center: A Solver of Urban Health Problems for the Future 32

Local Health Departments in the Atlanta Area . . . 34

Major Voluntary Health Groups and Professional Associations in the Atlanta Area 36

Water and Sewer Districts. 38

Facilities, including Hospitals, Nursing Homes, Outpatient Clinics and Neighborhood Health Centers 40

Existing Manpower Resources 42

Economics of the Atlanta Area as Related to Health Services 44

SECTION 2. NARRATIVE PROJECT SUMMARY

A. Project Outline

Goals and Objectives of Comprehensive Health Planning. 48

Community Council has Extensive Involvement in Health and Planning 50

Organizational History of the Applicant 52

Scope of Program Health Concerns 54

Cooperative Arrangements with Participating Agencies 56

Health Planning Process: Systems and Retrieval. . 58

Information Gathering and Analysis Techniques . . 60

The Need for Planning, Programming System for Comprehensive Health Planning 62

Procedure for Policy Implementation 64

Example of Experience: Cobb County Comprehensive Health Planning 66

Page

Community Involvement in Comprehensive Health Planning 68

Atlanta Area Coordination with the Office of Comprehensive Health Planning, Georgia Department of Public Health 70

Facilities and Equipment Available for the Staff of the Applicant Agency 72

B. Supporting Data

The Plan has Continuing Input from Existing Resources 74

Personal Publications. 76

C. Work Program

Current Problems Carried Over. 78

First Year Activities. 80

Phasing into Systems Analysis 84

Future Development 86

D. Agency Organization

Staff Organization 88

Council Organization 90

Council Membership 92

Nominating Procedures. 94

Training for Council Effectiveness 96

By-Laws of the Council 98

Planning for Planning: Technical and Community Involvement Aspects

SUMMARY:
IN ORGANIZING THE ATLANTA METROPOLITAN COMMUNITY FOR COMPREHENSIVE HEALTH PLANNING, EXTENSIVE ACTIVITIES IN TWO MAJOR ASPECTS HAVE BEEN NECESSARY: THE TECHNICAL ASPECTS OF IDENTIFYING, PROJECTING AND SEEKING POSSIBLE SOLUTIONS TO HEALTH PROBLEMS AND THE COMMUNITY INVOLVEMENT ASPECTS OF BRINGING TOGETHER THE VARIED ELEMENTS OF THE COMMUNITY INTO A PARTNERSHIP FOR HEALTH PLANNING AND POLICY-MAKING.

Technical Aspects

The technical objectives of this project have been (1) to identify the community's principal health problems and the probable, most urgent planning efforts which will have to be undertaken by the permanent organization during its first year of existence — 1970; and (2) to specify the numbers and qualifications of the technical staff who will be needed to carry out such planning. Some of the activities bearing on these objectives have been:

- identification and scoping of health problems through the medium of technical "task forces;" some 25-30 of these groups have worked up descriptions of problem areas, trends, resources, obstacles and suggested solutions to the problems;
- identification of planners and planning groups whose work is directly or indirectly in health areas; some 50 of these have been named and approached for fuller understanding of their work; a major portion of the technical task of the metropolitan planning staff will be to coordinate the activities of these planners to avoid duplication and to "cross-fertilize" their activities;
- developing a "systems approach to planning for the health field;" this involves cost-benefit analyses, the building of community health "system"models, etc.;
- education of as many citizens of the community (and being educated by them) about health problems and comprehensive health planning as possible;

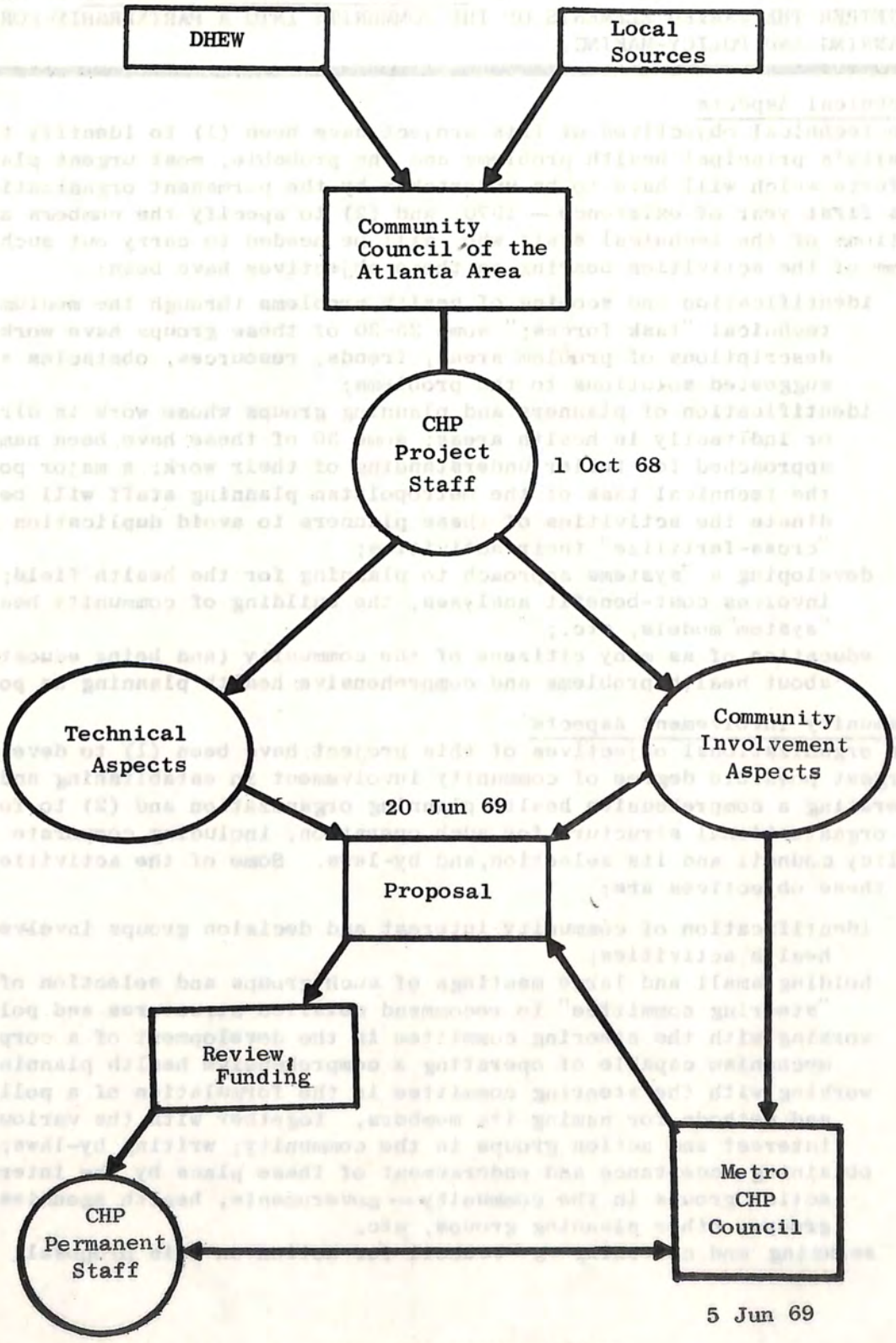
Community Involvement Aspects

The organizational objectives of this project have been (1) to develop the largest possible degree of community involvement in establishing and operating a comprehensive health planning organization and (2) to formulate an organizational structure for such operation, including corporate identity, policy council and its selection, and by-laws. Some of the activities bearing on these objectives are:

- identification of community interest and decision groups involved in health activities;
- holding small and large meetings of such groups and selection of a "steering committee" to recommend detailed structures and policies;
- working with the steering committee in the development of a corporate mechanism capable of operating a comprehensive health planning agency;
- working with the steering committee in the formulation of a policy Council and methods for naming its members, together with the various health interest and action groups in the community; writing by-laws;
- obtaining acceptance and endorsement of these plans by the interest and action groups in the community — governments, health agencies, consumers' groups, other planning groups, etc.
- selecting and convening a council for action on this proposal.

ESTABLISHMENT OF METROPOLITAN COMPREHENSIVE HEALTH PLANNING AGENCY

"Organizational" funding



The Atlanta Area

SUMMARY:
THE ATLANTA AREA, PRESENTLY INCLUDES SIX COUNTIES. THIS IS NOT IDENTICAL WITH THE OFFICIAL BOUNDARIES OF THE CENSUS BUREAU, WHICH DEFINES THE ATLANTA AREA AS A STANDARD METROPOLITAN STATISTICAL AREA CONSISTING OF FIVE COUNTIES. TO MAKE THIS DISTINCTION THESE BOUNDARIES ARE DEFINED.

BOUNDARIES: Atlanta Area: Douglas, Clayton, Cobb, DeKalb, Fulton and Gwinnett counties.

Atlanta Area (SMSA): Clayton, Cobb, DeKalb, Fulton and Gwinnett counties.

PRESENTLY:

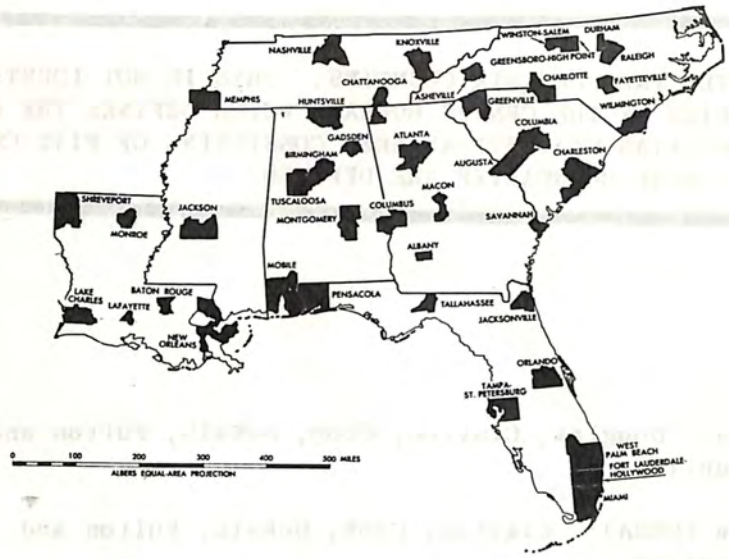
ATLANTA AREA IS:

- the "regional capital" of the Southeastern United States resulting from continued growth and a central transportation network;
- the "major growth center" in the State of Georgia; and
- the central "regional city" for the ATLANTA AREA and contiguous counties.
- the "medical center" for the surrounding counties.

THE ATLANTA AREA COMPREHENSIVE HEALTH PLANNING DESIGN:

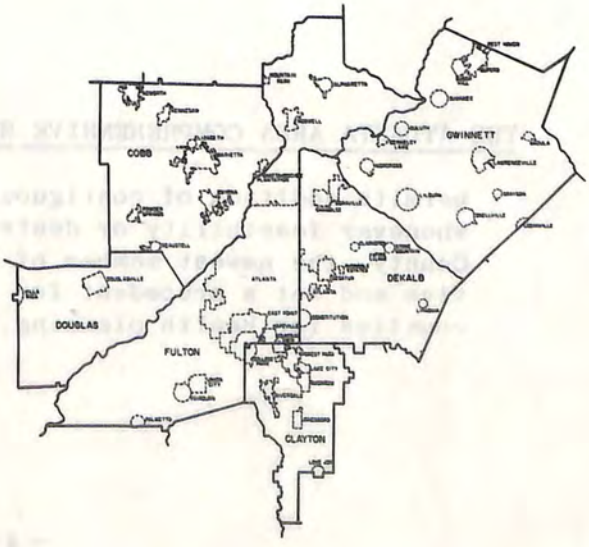
permits addition of contiguous counties or other planning areas whenever feasibility or desirability are indicated. (Douglas County, the newest member of the ATLANTA AREA has shown initiative and set a precedent for non-SMSA's joining its sister counties for health planning.)

SOUTHEASTERN UNITED STATES



STATE OF GEORGIA

SIX COUNTY ATLANTA AREA



Atlanta Area Governmental Units and Current Population

SUMMARY:
BESIDES THE SIX COUNTIES, THE ATLANTA AREA CONTAINS APPROXIMATELY 50 INCORPORATED MUNICIPALITIES, OF WHICH 10 HAVE POPULATIONS OF MORE THAN 4,500. THE LARGEST CITY, ATLANTA, COVERS PORTIONS OF FULTON AND DEKALB COUNTIES, AND HAS A POPULATION IN EXCESS OF 500,000. THE TOTAL POPULATION APPROXIMATES 1,300,000.

The Atlanta Area, Compared with the Standard Metropolitan Statistical Area

The Atlanta Area SMSA is comsposed of five counties:

County	Population (1968)
Fulton	605,400
DeKalb	353,500
Cobb	174,600
Clayton	78,700
Gwinnett	59,800

Douglas County, with a population of 23,900, is the sixth county that makes up the entire six-county ATLANTA AREA for purposes of comprehensive health planning.

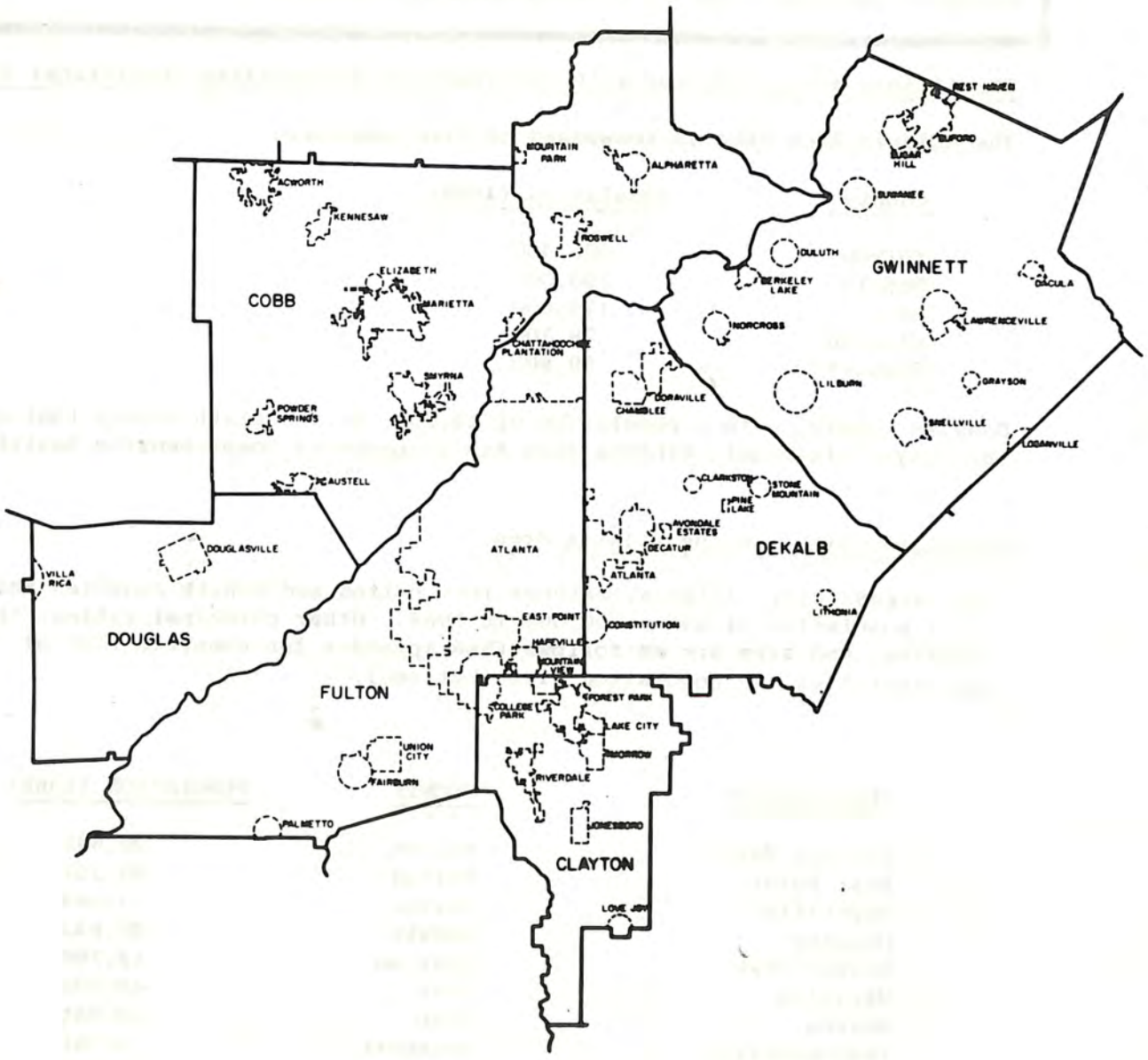
Principal Cities in the Atlanta Area

The largest city, Atlanta, extends into Fulton and DeKalb counties and had a population of about 500,000 in 1968. Other principal cities, their counties, and size are as follows (See Appendix for complete list of municipalities and population distribution.):

MUNICIPALITY	COUNTY	POPULATION (1968)
College Park	Fulton	20,691
East Point	Fulton	39,257
Hapeville	Fulton	9,268
Decatur	DeKalb	20,943
Forest Park	Clayton	18,766
Marietta	Cobb	28,003
Smyrna	Cobb	16,365
Lawrenceville	Gwinnett	4,561
Douglasville	Douglas	6,000

NOTE: These figures are estimates made by the Atlanta Region Metropolitan Planning Commission, 1 April 1968.

ATLANTA AREA



Nearby Cities Affect the Market and Service Patterns of the Atlanta Area

STANDARD METROPOLITAN STATISTICAL AREAS CLOSE TO THE ATLANTA AREA:

Within a 100-mile radius of the ATLANTA AREA (SMSA) there are 14 smaller SMSA's which are close enough to affect the economy, commerce and health service trade patterns of the ATLANTA AREA. These are:

Macon
Columbus
Chattanooga
Albany
Augusta-Columbia
Birmingham-Tuscaloosa
Montgomery

Huntsville
Gadsden
Greenville
Asheville
Charlotte
Knoxville
Nashville

Atlanta Area, a Place of Growth and Variation

SUMMARY:
THE ATLANTA AREA IS A RAPIDLY GROWING METROPOLIS WITH BOTH URBAN AND RURAL TERRAIN AND WAYS OF LIFE. THE MAJOR DEMOGRAPHIC CHARACTERISTICS INDICATE A CONTINUING PRESSURE AND A GREAT CAPACITY FOR INCREASED AND APPROPRIATE SERVICES.

Major Characteristics:

AGE of the population is young: The number between 20 and 29 will double between 1960 and 1980.
DENSITY of population covers a wide range: 5 to 52 persons per acre.
SIZE is expanding: 27% increase from 1960 to 1967, passing 2 million by 1980.
CLIMATE is warm and humid: 48 inches annual precipitation.
URBANIZATION is increasing moderately: 6% from 1960 to 1967.
EDUCATIONAL opportunities are numerous: About 175 schools, nine 4-yr. colleges, 6 special purpose institutions, 3 area technical schools.
OCCUPATION's largest demand is in retail and wholesale trade, government, service business, manufacturing.
INCOME varies greatly: One county with 36% over $10,000 another with 25% below $3,000.
CAPITAL INVESTMENT was near 300 million from 1963-1967, much of this for transportation equipment.
TRADE is active: 3 interstate highways intersect, 8 airports with 800 daily flights, 13 railroad lines of 7 systems.
FINANCIAL headquarters of Sixth Federal Reserve District.
OFFICE SPACE abundant: Fifth in nation.
COMMUNICATIONS extensive via telephones, mail, 4 daily and 20 weekly newspapers, 5 television and 19 radio stations.

Note: This information taken from "Atlanta Silhouettes," ARMPC, Atlanta, Georgia n.d.; "The Georgia Piedmont Regional Economic Investment Plan," State Planning Bureau, Office of the Governor, Atlanta, Georgia, n.d.

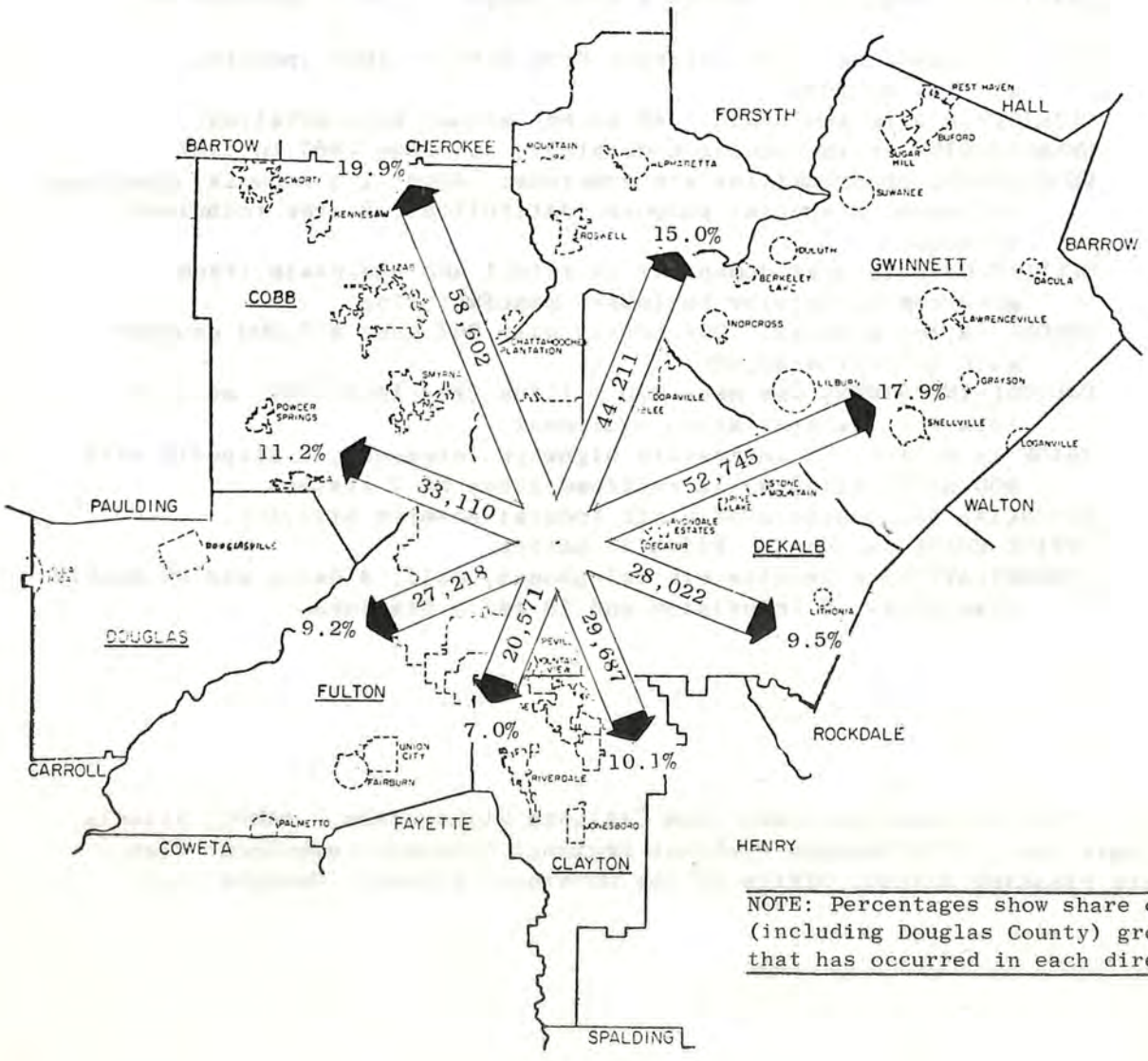
1960 - 1980 Population, Estimates and Projections

County	1960[1]	1965[2]	1970	1975	1980
Fulton	556,326	599,300	649,425	704,046	829,163
DeKalb	256,782	350,400	485,541	658,520	757,518
Cobb	114,174	150,900	209,722	281,481	337,019
Clayton	46,365	66,000	93,483	135,988	161,126
Gwinnett	43,541	54,600	58,077	66,192	76,094
Douglas[3]	16,741	21,339	29,700	36,500	45,000
Total	1,033,929	1,242,539	1,525,948	1,882,727	2,205,920

(1) U.S. Census
(2) Long-Range Plan, Hospital and Health Planning Dept., CCAA, Atlanta, Ga., Jan. 1968, p. 6 (mimeographed).
(3) Douglas County Figures, 1965-1980, interpolated from Land Needs, 1968, Douglas County, Ga., ARMPC, Table D.

DIRECTIONS OF POPULATION GROWTH 1960 - 1968

ATLANTA SMSA



NOTE: Percentages show share of SMSA (including Douglas County) growth that has occurred in each direction.

Population Trends Require Continuous Review of Health Needs.

SUMMARY:
THE NUMBER OF PEOPLE IN THE AREA IS GROWING AT A RATE OF 2.8% ANNUALLY. THERE IS ALSO A MARKED INCREASE OF YOUNGER AND OF OLDER PERSONS. THE MIGRATION OF PERSONS INTO THE AREA FROM NEARBY TOWNS AND PLACES IS ACCOMPANIED BY A GROWTH TOWARD THE OUTER COUNTIES.

Text:

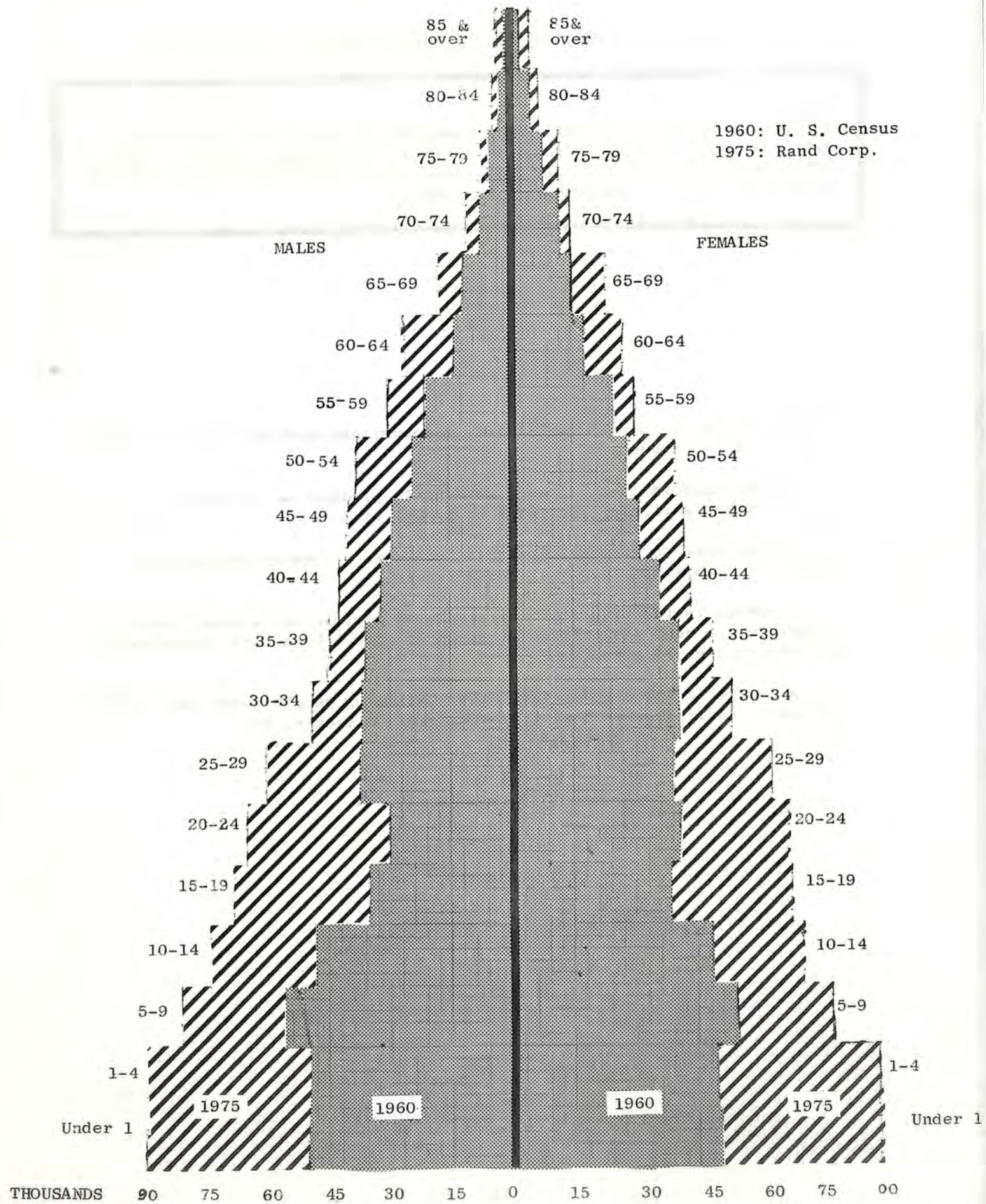
The needs for health facilities, manpower and services must be anticipated well in advance.

Present information allows a reasonable prediction of the size, constituency and settlement patterns of groups of people.

An increase in numbers of people indicates a greater demand on the amount of facilities, manpower and services.

A change in the proportion of people in certain age groups indicates a change in the need for particular types of care - home care, impairments, maternal and child care, etc.

A change in the geographical distribution of people indicates a need for review of environmental health, communicable diseases, etc.


85 & over
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
1-4
Under 1
MALES
FEMALES
1960: U. S. Census
1975: Rand Corp.
1975
1960
1960
1975
THOUSANDS
90 75 60 45 30 15 0 15 30 45 60 75 00

The Planning Area Boundaries Observe other Programs, Anticipate Expansion

SUMMARY:
THE STATE OF GEORGIA IS DIVIDED INTO MANY DIFFERENT AREAS, DISTRICTS AND REGIONS FOR SPECIAL PLANNING OR IMPLEMENTATION OF PROGRAMS AND ACTIVITIES. SOMETIMES THE FIVE COUNTY "STANDARD METROPOLITAN STATISTICAL AREA" OF ATLANTA IS USED AS A UNIT. SOMETIMES PROGRAMS ARE SUBDIVIDED BY COUNTIES OR COUNTIES ARE COMBINED IN OTHER WAYS. THE SIMILAR JURISDICTIONAL AREAS ARE CONVENIENT AND THERE IS A TENDENCY TOWARD MAKING BOUNDARIES OF RELATED PROGRAMS IDENTICAL. IN ANTICIPATION OF THIS TREND AND EXPANSION OF ATLANTA (SMSA) BY THE BUREAU OF CENSUS, THE COMPREHENSIVE HEALTH PLAN WILL HAVE ADJUSTABLE BOUNDARIES.

AREA GROUPINGS[1] →

(1) Much of this material taken from An Atlas of Multi-County Organizational Units, Department of Geography, Univ. of Ga., 1968

PROGRAMS, REGIONS, AREAS, AND DISTRICTS	Douglas	Gwinnett	DeKalb	Fulton	Clayton	Cobb	Operates Outside Area
Area Planning and Development Commission	2	2	2	2	2	2	no
Superior Court Circuits	35	19	34	2	9	10	yes
Industrial Development Division (Ga. Tech.) (◆)	Ca	A	A	A	A	A	yes
Civil Defense: Operational Areas, Control Centers	7	7	7	7	7	7	yes
State Nurses Assoc. Districts	13	9	5	5	4	13	yes
Community Action Agencies	23	10	8	10	4	X	yes
State Representative Districts	27	22	117-119	120-141	35	101-103	yes
Congressional Districts	7	9	4	5	6	7	yes
State Senatorial Districts	31	48	41-43	34-40	44	32-33	yes
Cooperative Extension Service Districts	6	6	6	6	6	6	yes
Georgia Hospital Assoc. Districts	NW	NE	A	A	A	A	yes
Economic Development Regions (★)	A	A	P	P	P	P	yes
State Highway Department Division	6	1	6	6	3	6	yes
Vocational Rehabilitation Services (☆)(□)	A	D	D	A	D	A	yes
Vocational (Medical/Behavioral) Areas	A	A	A	A	A	A	yes
Georgia Regional Medical Program (■)(◇)	WC	N	N	WC-N	WC	N	yes
Metro Atlanta Council Local Govts.	A	A	A	A	A	A	no
Soil & Water Conservation Districts	12	8	7	7	8	7	yes
State Employment Service Districts	23	3	3	3	17	23	yes
Office of Economic Opportunity (●)	T	A	D	A	Cl	X	yes
Community Council Social Planning Areas	X	36-38	39-49	1-29	50-52	30-35	no
State Dept. of Family & Children Services Districts	7	9	5	5	4	7	yes
Farmers Home Administration Districts	1	2	2	1	1	1	yes
Soil Conservation Districts (◆)	Ca	D	D	D	D	D	yes
Federal Judicial Districts (■)	N	N	N	N	N	N	yes
State Highway Department Divisions	6	1	6	6	3	6	yes
Federal Land Bank Association Districts	2	9	9	9	9	9	yes
Vocational-Technical School Area ◆	Ca	Cl	Cl	A	G	M	yes
Forestry Districts	4	9	9	9	4	7	yes
Georgia Bureau of Investigation Districts	9	2	1	1	1	9	yes
Medical Facility Service Areas	D2	R3	D1	B1 D3	D3	D2	yes
Public Health Districts	28	29	36	38	30	28	yes

X Does not participate
(★) Appalachia & Piedmont
(☆) A Atlanta District
(□) D Decatur District

(■) N Northern District
(◇) WC West Central District
(◆) Ca Carrollton District
Cl Clayton District
M Marietta District

(●) T Tallatoona

Organizational and Procedural Arrangements for Comprehensive Health Planning

SUMMARY:
THE PROPOSED COMPREHENSIVE HEALTH PLANNING AGENCY WILL BE STRUCTURED SO AS TO BE IN CLOSE COORDINATION WITH THE METROPOLITAN ATLANTA COUNCIL OF LOCAL GOVERNMENTS AND WITH THE COMMUNITY COUNCIL OF THE ATLANTA AREA. THE ARRANGEMENT ALSO ENCOURAGES COOPERATION AND COORDINATION WITH THE ATLANTA REGION METROPOLITAN PLANNING COMMISSION, THUS INVOLVING ALL THE AREA'S MAJOR PLANNING AGENCIES. OTHER PLANNERS IN HEALTH OR HEALTH-RELATED FIELDS WILL BE INVOLVED TO VARYING DEGREES.

Applicant:

In order to facilitate interaction of the major planning groups in the metropolitan area, the Metropolitan Atlanta Council of Local Governments (MACLOG) will be the applicant agency for comprehensive health planning. In order to do this, MACLOG is taking action to change its status as a voluntary association and become an incorporated entity. In the event that the necessary legal arrangements require more time than is available prior to submission of this proposal, the interim applicant agency will be the Community Council of the Atlanta Area, Inc. (CCAA). The organization for supervising and conducting comprehensive health planning is indicated herein as the Metropolitan Comprehensive Health Planning Council (Metro CHP Council).

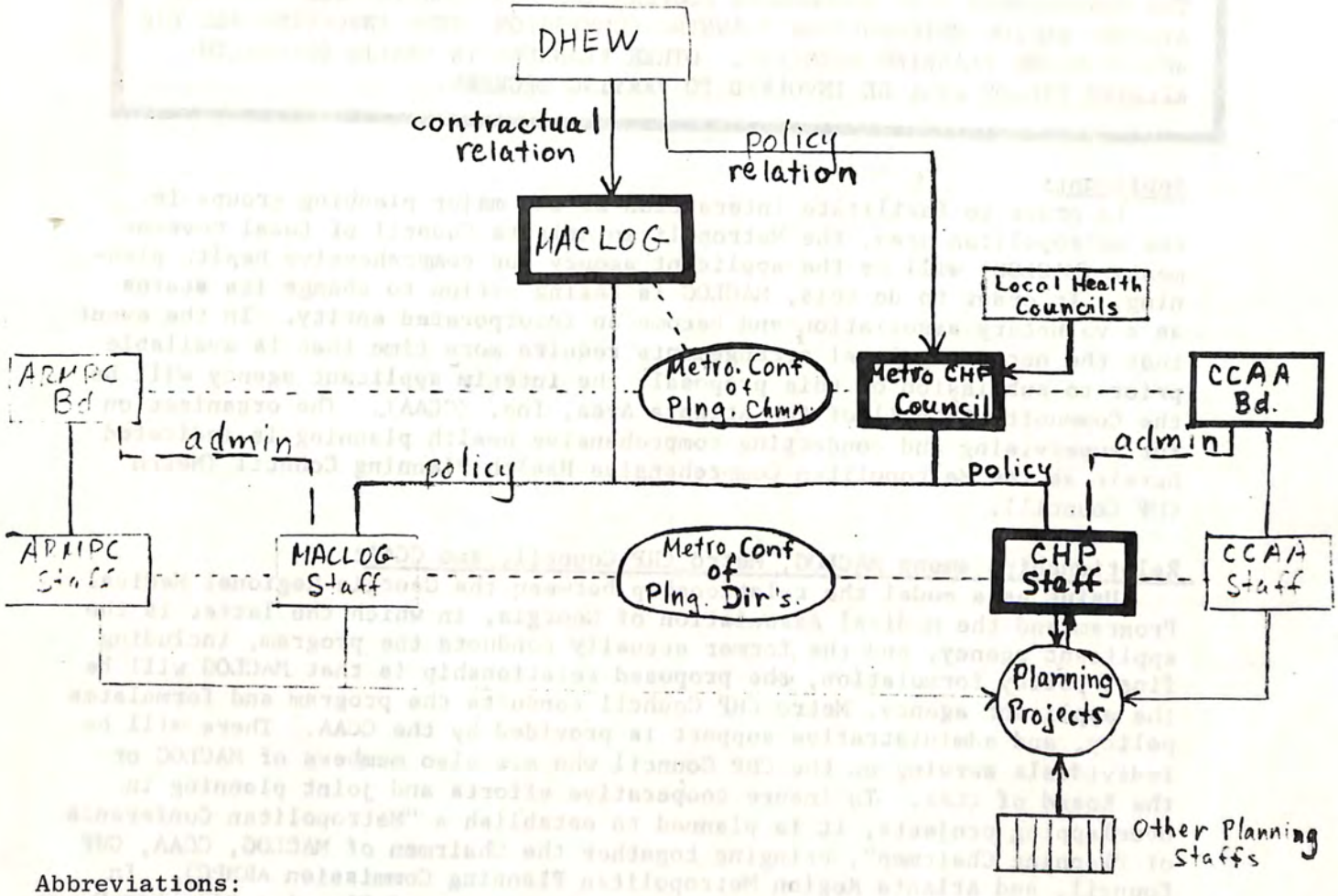
Relationships among MACLOG, Metro CHP Council, and CCAA:

Using as a model the relationship between the Georgia Regional Medical Program and the Medical Association of Georgia, in which the latter is the applicant agency, and the former actually conducts the program, including final policy formulation, the proposed relationship is that MACLOG will be the applicant agency, Metro CHP Council conducts the program and formulates policy, and administrative support is provided by the CCAA. There will be individuals serving on the CHP Council who are also members of MACLOG or the Board of CCAA. To insure cooperative efforts and joint planning in overlapping projects, it is planned to establish a "Metropolitan Conference of Planning Chairmen", bringing together the Chairmen of MACLOG, CCAA, CHP Council, and Atlanta Region Metropolitan Planning Commission ARMPC). In addition, there will be a "Metropolitan Conference of Planning Directors", bringing together the executives of the four agencies. From time to time, other planners will be invited to participate in these conferences. It is anticipated that joint staff activities will occur where projects involve physical planning (ARMPC), social planning (CCAA), health planning (CHP), and other forms of planning such as crime and delinquency (MACLOG). Of course, major portions of health planning will continue to be done in other planning staffs, such as hospital authorities, city and county planning offices, etc. These will be coordinated, insofar as health aspects are concerned, by the Metro CHP staff.

Facilities:

MACLOG, CCAA, ARMPC, and CHP will be housed in the same building. This close proximity will make possible sharing of numerous facilities, such as library, public information, duplication and mailing, etc. For additional information, see the section on Facilities in the second Section of this proposal volume.

ORGANIZATION FOR COMPREHENSIVE HEALTH PLANNING

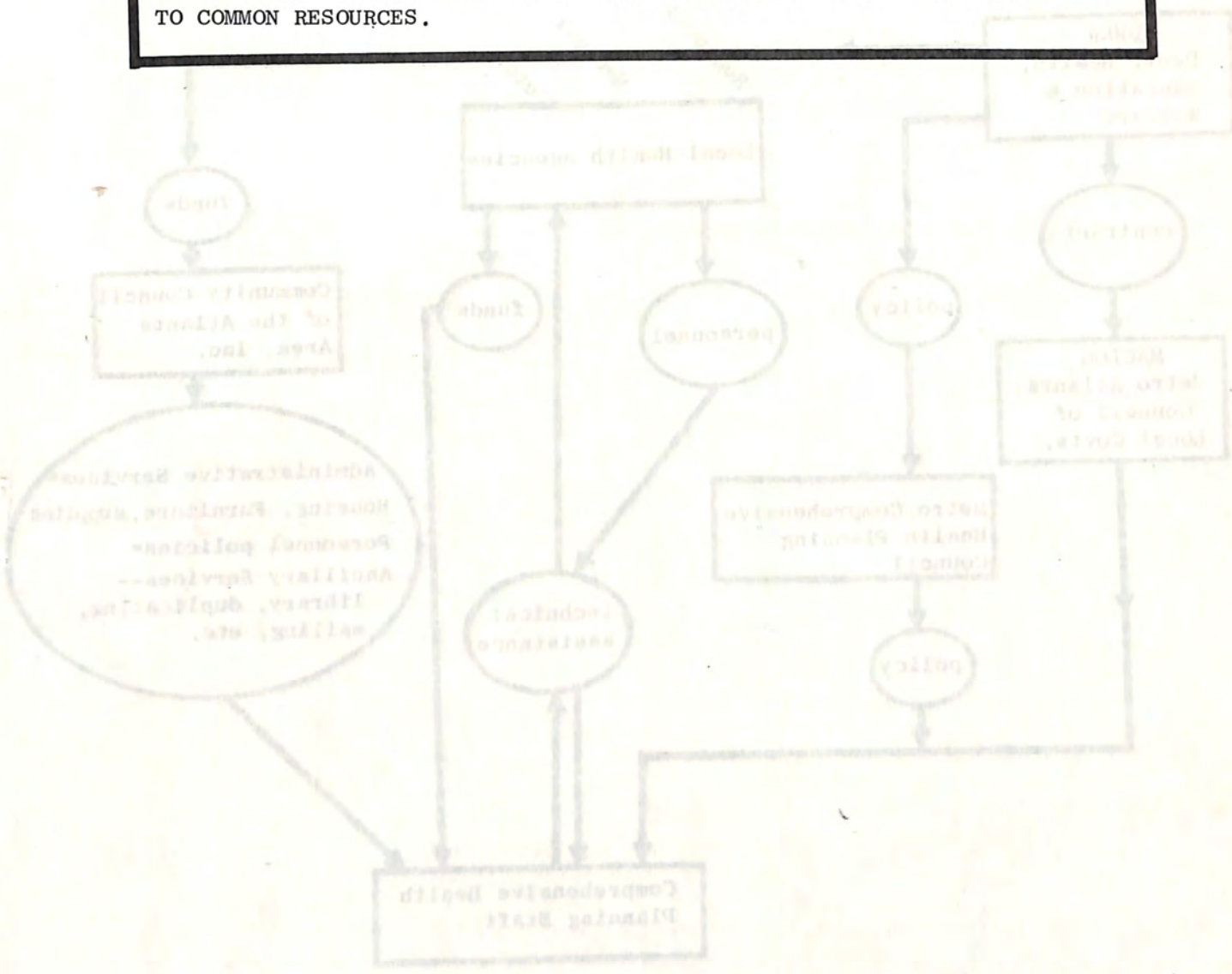


Abbreviations:

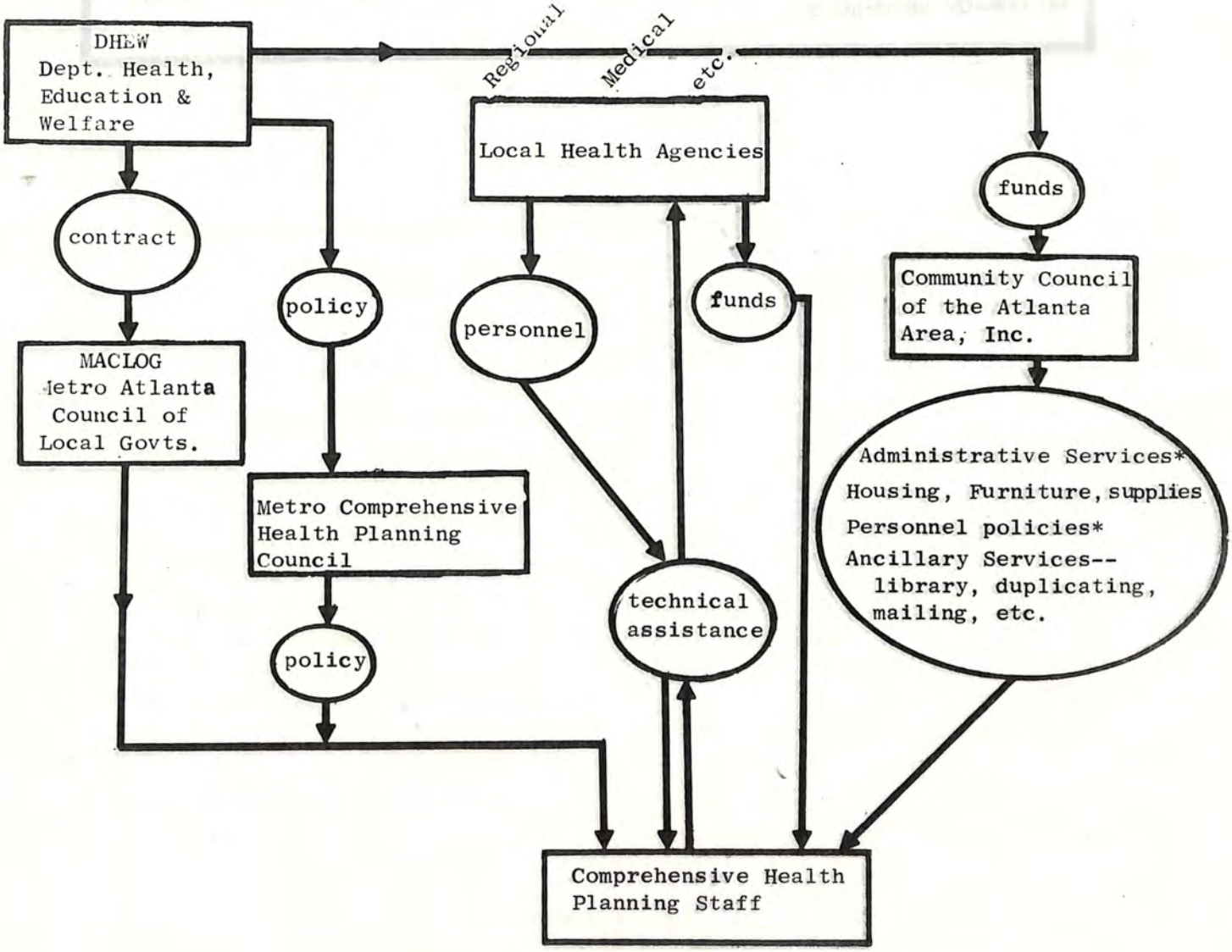
ARMPC = Atlanta Region Metro. Planning Commission
CCAA = Community Council of the Atlanta Area
CHP = Comprehensive Health Planning
DHEW = (U.S.) Department of Health,Education & Welfare
MACLOG = Metro. Atlanta Council of Local Governments
Bd = Board
Conf = Conference
Dir's = Directors
Chmn = Chairmen
Plng = Planning

Title: Cooperative Arrangements made for funds, personnel, services, facilities

SUMMARY:
THE COMPREHENSIVE HEALTH PLAN IS AND WILL BE LINKED FORMALLY WITH THE APPROPRIATE ORGANIZATIONS TO ASSURE THE JOINING OF ALL HEALTH EFFORTS TO COMMON RESOURCES.



COOPERATIVE ARRANGEMENTS WITH OTHER PROGRAMS



*See Appendix for Details.

Planning is Based Upon Commonly Available Data

SUMMARY:
THE LOCAL RESOURCES FOR QUANTITATIVE DATA IN THE HEALTH CARE FIELD ARE RATHER LIMITED BOTH IN AMOUNT, AVAILABILITY, AND COMPARABILITY, THE COMPILATION OF INFORMATION IN A CENTRAL CENTER WARRANTS PRIORITY FOR FUTURE PROBLEM-SOLVING. SOCIAL, ECONOMIC, AND DEMOGRAPHIC STATISTICS ARE MORE FULLY DEVELOPED THAN HEALTH DATA. BOTH ARE OFTEN SCATTERED AND FAR FROM IDEAL. INFORMATION ALONG THESE LINES IS AVAILABLE AND COMMONLY USED FROM MORE THAN A DOZEN SOURCES.

Implications for Comprehensive Health Planning in Environmental Health Fields

SUMMARY:
THE METROPOLITAN ATLANTA AREA HAS MADE NOTABLE STRIDES TO IMPROVE ENVIRONMENTAL FACTORS IN RECENT YEARS. NEARLY EVERY AREA CONCERNED HAS HAD SOME PREVIOUS WELL-PLANNED PROGRAMS. THE ROLE OF COMPREHENSIVE HEALTH PLANNING WILL BE THAT OF COORDINATING EFFORTS, ENCOURAGING IMPLEMENTATION, AND INCREASING EFFICIENCY IN OPERATION.

Text:

Environmental Health programs being developed or recommended for the Metropolitan area include:

1. Water and sewer plan implementation - a natural follow-up to current water and sewer planning should include recommendations for long range pollution control systems and management of water resources.
2. Up-dating open space and recreation plan and program for the metropolitan area.
3. Capital improvements programming: a continuation of the work ARMPC is doing now.
4. Metropolitan Solid Waste Plan - MACLOG.
5. Mobile Home Park - ARMPC - Study of requirements on location.
6. Vector Control Program - EOA - Demolition Project.
7. Comprehensive study of problems and possible long-range solution for solid waste and garbage collection and disposal.
8. Development of a long-range plan for industrial and office parks throughout the area - ARMPC.
9. A study of future housing requirements: as they relate to population forecasts, income, employment, and location. This study is now being held in abeyance.
10. Up-dating of Airport Plan - ARMPC.
11. Study, up-date and revise all elements of land development and facilities plans.
12. ARMPC - The need for nature preserves and related outdoor recreation facilities has been established. Implementation is now needed.
13. Flood control project by Corps of Engineers.
14. Atlanta Housing Authority: re-develop public housing area; rat control; health clinics for project area; and neighborhood renewal project (yearly basis).
15. Georgia Safety Council: organizing Teen Safety Councils in all high schools in the state of Georgia; conducting industry safety seminars throughout the state; driver improvement for truck drivers; driver improvement through the defensive driver course; conducting injury control program.

ONE OF THE great community benefits of urban renewal is the removal of unsafe, unsanitary and inadequate buildings.

ATLANTA HOUSING AUTHORITY

Auditorium-Convention Hall Complex

McDaniel Street construction

The Urban Life Center - A Solver of Urban Health Problems For the Future

SUMMARY:
THE NEWLY ORGANIZED URBAN LIFE CENTER AT GEORGIA STATE COLLEGE, WHEN FULLY OPERATIONAL, WILL PROVIDE A DYNAMIC INSTRUMENT FOR SOLUTION AND PREVENTION OF HEALTH AND HEALTH RELATED PROBLEMS. IT FOCUSES THE RESOURCES OF THE MAJOR EDUCATIONAL INSTITUTIONS IN THE ATLANTA AREA AND THE STATE OF GEORGIA ON BROADENING THE INTELLECTUAL BASE OF THE POPULATION, ENHANCING THE PROFESSIONAL AND CULTURAL COMMUNITY, INTENSIFYING AND DIRECTING MOTIVATIONAL POTENTIAL AND PROVIDING SERVICES INVOLVING PEOPLE AS INDIVIDUALS AND GROUPS.

Purpose:

Early in January, 1969, the Urban Life Center and the City of Atlanta were designated one of six national research centers on urban problems. (These centers were selected by the National League of Cities acting under contract with Departments of Housing and Urban Development and Health, Education and Welfare.) This network of "Urban Observatories" represents an effort to concentrate efficiently and economically the resources of higher education in the assault on urban problems.

Concept:

The guiding concept is that the new problems of the cities necessitate new approaches to academic organization and operation. An important feature is the inter-disciplinary approach to the study and solution of urban problems. Emphasis is placed upon the concentration and coordination of talents from all relevant disciplines and organizational units to effect sound solutions to urban problems.

The Urban Life Center embodies four basic organizational components:

- The School of Urban Studies which provides the academic training and research foundations.
- The Urban Public Service Division is structured to provide specialized activities, including short courses, institutes, conferences, public seminars, lecture series, workshops, community extension service activities, etc.
- The Inter-University Urban Cooperative seeks to coordinate and direct the resources of all the institutions of higher learning, in the surrounding area, aiming for cooperation with a minimum of effort duplication.
- The Observatory will facilitate the effective operation of the other components of the Urban Life Center. Data collected by the Observatory will serve as one of the bases for training programs in the School of Urban Studies and those conducted by the Division of Urban Public Service. It is designed to work systematically with community agencies and organizations to coordinate data and develop meaningful working relationships relevant to urban problem-solving.

THE URBAN LIFE CENTER

BOARD OF REGENTS

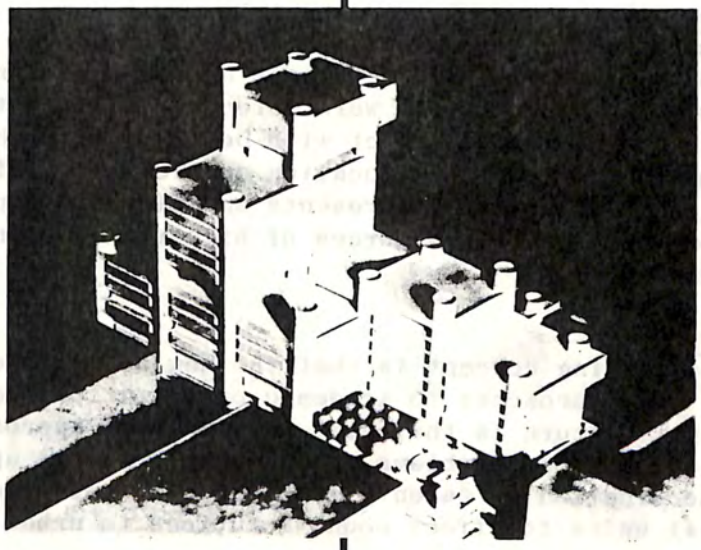
GRADY HOSPITAL

UNIVERSITY SYSTEM

GEORGIA STATE COLLEGE

STATE GOVERNMENT AGENCIES

LOCAL GOVERNMENT AGENCIES



SCHOOL OF URBAN STUDIES

DIVISION OF URBAN PUBLIC SERVICE

INTER-UNIVERSITY URBAN COOPERATIVE

URBAN OBSERVATORY

HEALTH AND HEALTH RELATED INSTITUTIONS

Local Health Departments, Atlanta Area

CENTERS AND CLINICS

Fulton County

Main Center & offices
Adamsville
Alpharetta
Ben Hill
Buckhead
Center Hill
College Park
Collins
East Point
Fairburn
Hapeville
Howell Mill
Jere Wells
Lakewood
Roy W. McGee
Neighborhood Union
Northeast
Palmetto
Red Oak
Rockdale
Roswell
Sandy Springs
South Fulton
Techwood

DeKalb County

Main Center & offices
Doraville
Kirkwood
Lithonia
North DeKalb
Scottdale
Southwest Dekalb
Stone Mountain
Tucker

Cobb County

Marietta
Acworth

Cobb County (cont'd.)

Austell
Mableton
Powder Springs
Smyrna

Clayton County

Main Office
Forest Park
College Park
Fayetteville

Gwinnett County

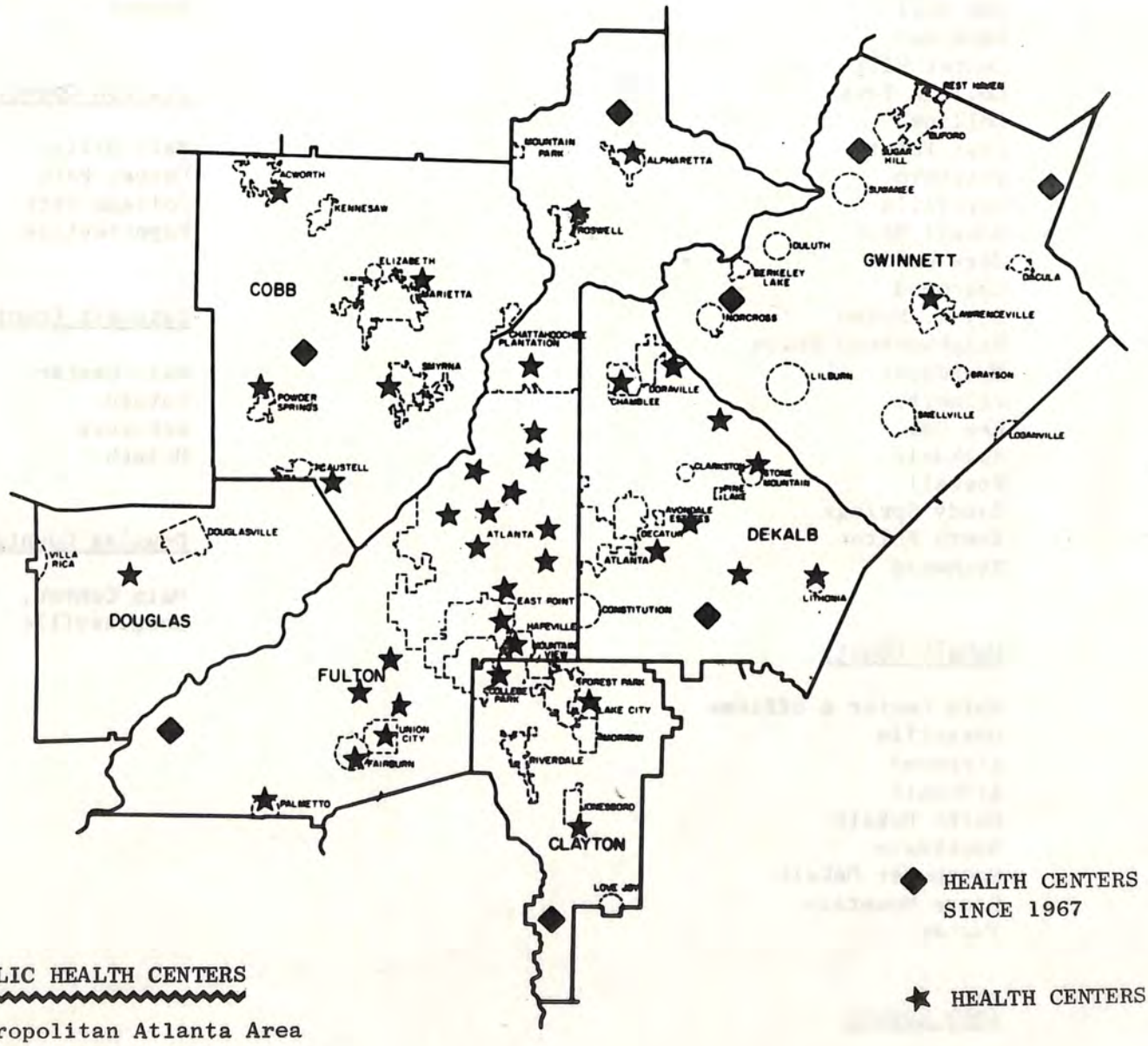
Main Center
Buford
Norcross
Duluth

Douglas County

Main Center,
Douglasville

County	Financing State Allotments July '67 - June '68	Centers	Manpower	Admission by Service		
				Mental Health	V.D.	T.B.
Fulton	$ 403,181	24	425	7,479	83,109	6,919
DeKalb	269,127	9	199	2,925	63	3,363
Cobb	122,271	6	47	2,169	128	1,089
Clayton	52,049	4	38	964	6	517
Gwinnett	18,760	4	21	484	4	595
Douglas	21,119	1	8	*	14	*

*not readily available



◆ HEALTH CENTERS SINCE 1967

★ HEALTH CENTERS

PUBLIC HEALTH CENTERS

Metropolitan Atlanta Area

1968

WATER AND SEWER DISTRICTS IN THE ATLANTA AREA

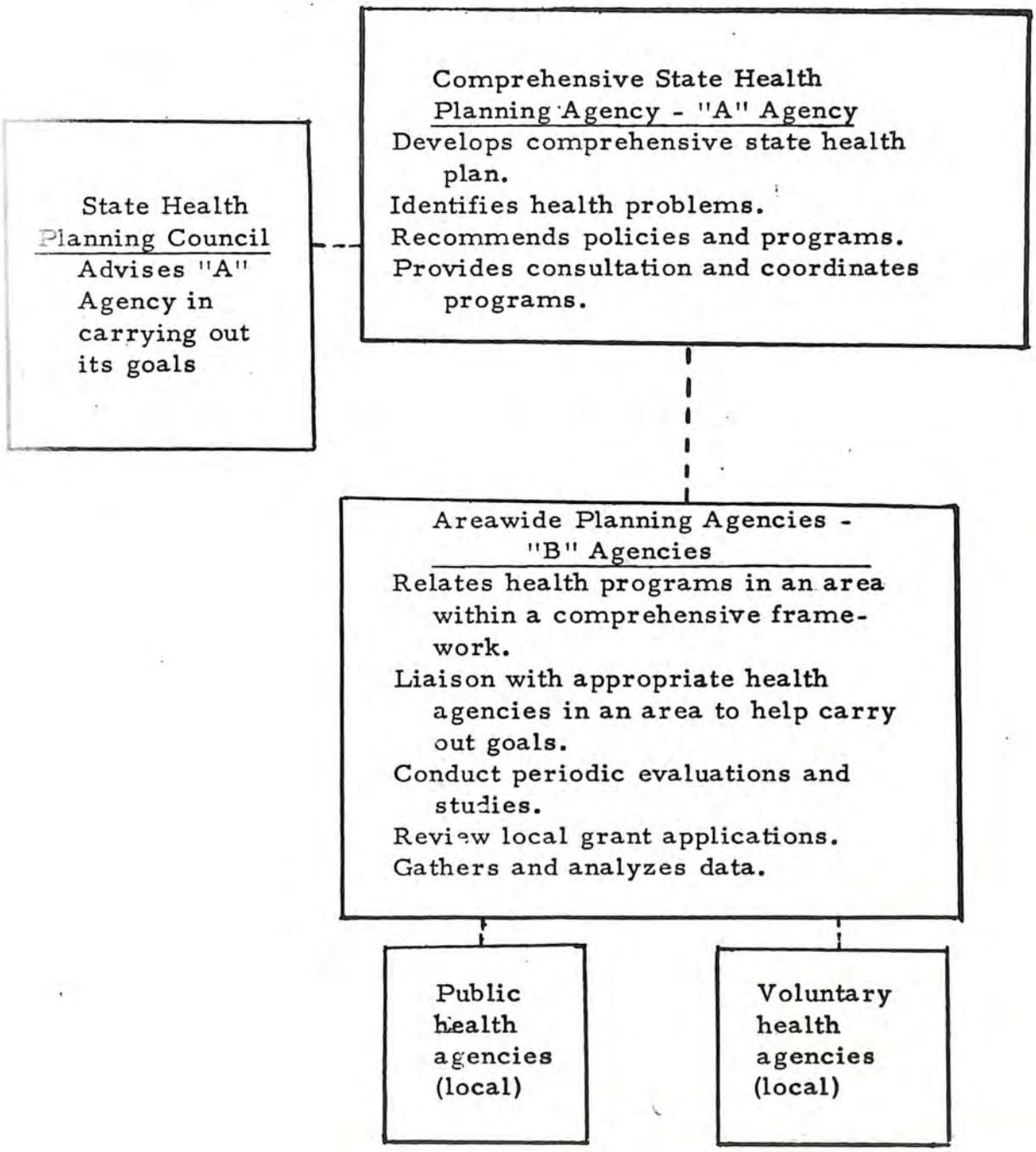
SYMBOL LEGEND

- SECONDARY SEWAGE TREATMENT
- PRIMARY SEWAGE TREATMENT
- UNTREATED SEWAGE
- POTABLE WATER INTAKE

ATLANTA REGION METROPOLITAN PLANNING COMMISSION
900 Glenn Building Atlanta, Georgia 30303

EXISTING FACILITIES

1. Atlanta - R. M. Clayton Plant
2. Atlanta - Sandy Creek Plant
3. Atlanta - Utoy Creek Plant
4. Atlanta - South River Plant
5. Atlanta - Intrenchment Creek Plant
6. Atlanta - Flint River Plant
7. Fulton County - Industrial Waste Plant
8. Fulton County - Marah Creek Plant
9. Fulton County - Morning Creek Lagoon
10. Jointly Owned Camp Creek Plant
11. Fairburn - Northside Plant
12. Fairburn - Southside Plant
13. Palmetto Plant
14. Alpharetta Lagoon
15. College Park - Southeast Plant
16. Clayton County - Flint River Plant
17. Clayton County - Rock Cut Road Lagoon
24. Atlanta Army Depot Plant
25. DeKalb County - Shoal Creek Plant
26. DeKalb County - Snapfinger Creek Plant
27. DeKalb County - Lagoon
28. Lithonia - East Sewer Outlet
29. Lithonia - South Sewer Outlet
30. Conyers - South Sewer Outlet
31. Conyers - North Sewer Outlet
32. Norcross Lagoon
33. Lawrenceville Plant
34. Lawrenceville Lagoon
35. Buford Plant
36. Cumming Lagoons
37. Acworth Plant
38. Kennesaw Plant
39. Marietta - West Side Plant
40. Marietta - South Side Plant
41. Marietta - East Side Plant
42. Marietta - Southeast Side Plant
43. Lockheed Plant
44. Cobb County - Church Road Plant
45. Cobb County - South Cobb Plant
46. Smyrna - Bohannon Creek Plant
47. Austell Plant
48. Douglasville Plant


Comprehensive State Health Planning Agency - "A" Agency
Develops comprehensive state health plan.
Identifies health problems.
Recommends policies and programs.
Provides consultation and coordinates programs.
State Health Planning Council
Advises "A" Agency in carrying out its goals
Areawide Planning Agencies - "B" Agencies
Relates health programs in an area within a comprehensive framework.
Liaison with appropriate health agencies in an area to help carry out goals.
Conduct periodic evaluations and studies.
Review local grant applications.
Gathers and analyzes data.
Public health agencies (local)
Voluntary health agencies (local)

Community Council of the Atlanta Area inc.

EUGENE T. BRANCH, *Chairman of the Board of Directors*
CECIL ALEXANDER, *Vice Chairman*
JOHN IZARD, *Vice Chairman*
MRS. THOMAS H. GIBSON, *Secretary*
DONALD H. GAREIS, *Treasurer*

DUANE W. BECK, *Executive Director*

ONE THOUSAND GLENN BUILDING, 120 MARIETTA ST., N. W. ATLANTA, GEORGIA 30303 TELEPHONE 577-

May 23, 1969

Donald F. Spille, Ph.D.
Executive Director of Metropolitan Atlanta
Mental Health Association
209 Henry Grady Building
Atlanta, Georgia 30303

Dear Dr. Spille:

As you know a proposal will be sent to HEW, Washington, in early June, setting up a mechanism for comprehensive health planning in the metropolitan Atlanta area, and requesting a 5-year grant to assist with such planning.

HEW must be assured that the proposed comprehensive health planning will have cooperation of all parties and agencies involved.

This is to request that you write us a letter, as soon as possible, assuring us of your cooperation in this project.

Sincerely yours,

Raphael B. Levine

Raphael B. Levine, Ph.D.
Director, Comprehensive
Areawide Health Planning

RBL:az
Encl.

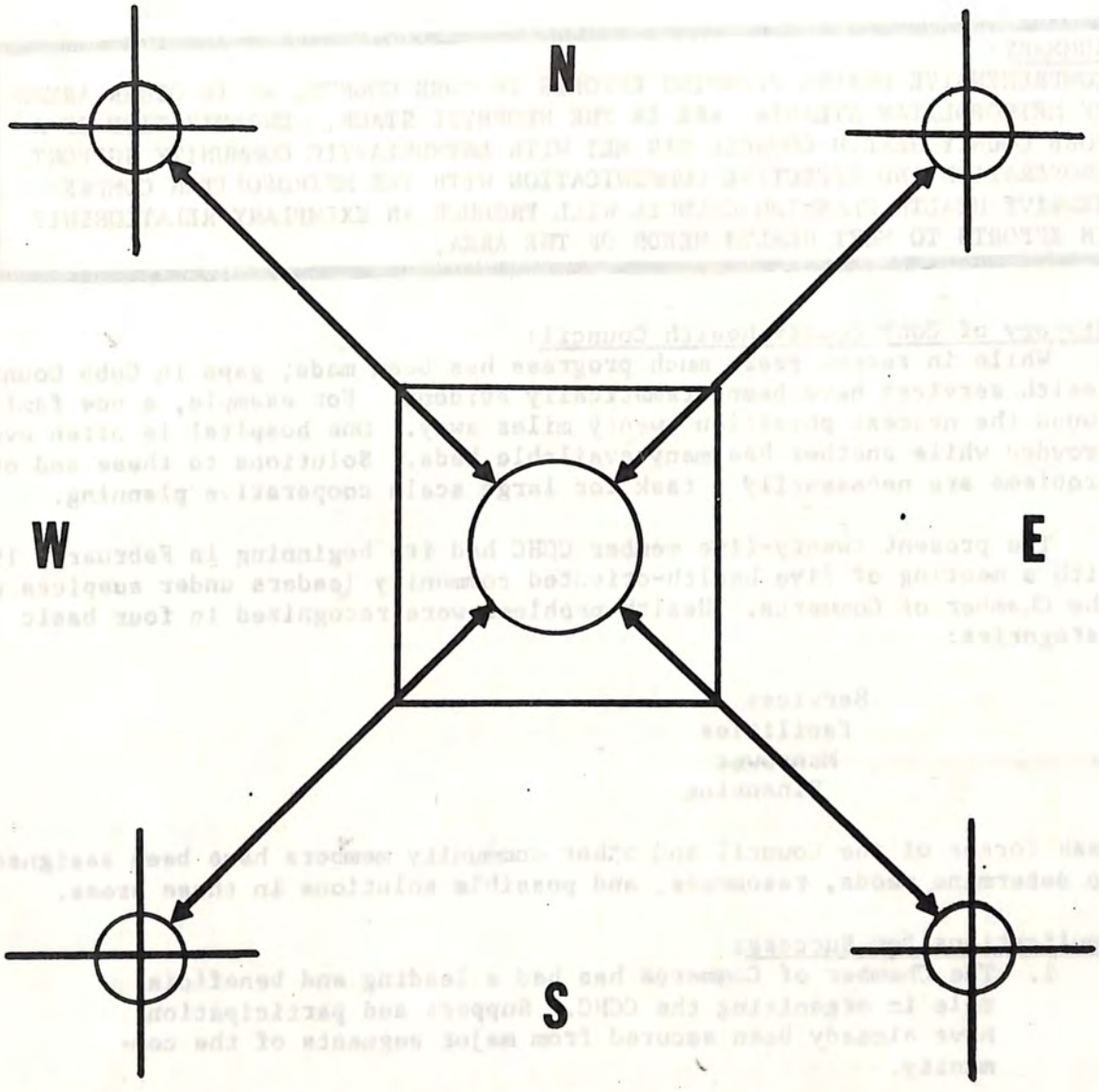
Community Involvement in Comprehensive Health Planning

SUMMARY:
DOCUMENTED HEREIN (SEE APPENDIX) ARE INDICATIONS OF SUPPORT FOR COMPREHENSIVE HEALTH PLANNING FROM COMMUNITY ORGANIZATIONS AND GOVERNMENTAL AGENCIES. IT IS ANTICIPATED THAT COMPLEMENTARY RELATIONSHIPS OF MUTUAL BENEFIT WILL BE SOLIDIFIED IN THE EARLY STAGES OF PERMANENT OPERATION.

Note: Letter of the opposite page has been sent to following groups in the six-county area:

- County Commissions
- Mayors of Cities
- Medical and Dental Societies
- Nursing Associations
- Hospital Council
- Nursing Home Association
- Chamber of Commerce
- Colleges and Universities
- Health Care Centers
- Voluntary Health Agencies
- Representative Organizations of the Poor and Near-Poor

ORGANIZATIONAL CHART OF COMMUNITY DEVELOPMENT IN COMPREHENSIVE HEALTH PLANNING



Key:

25-member core of planning efforts to direct task force assignments.

Chamber of Commerce Board of Directors.

Local County communities. These communities will be analyzed and local citizens (with a wide range of representative types) will be asked to participate in discussions. Some representatives to consider will be age, race, sex, income, geographic location, etc. The basic philosophy is to establish task force and community involvement simultaneously and then pool these thoughts into final recommendations. This obviously is an oversimplification of the process and many problems will have to be overcome if efforts are to be successful.

Sub-Areal Health Councils. Cobb County: Example in Experience

SUMMARY:
COMPREHENSIVE HEALTH PLANNING EFFORTS IN COBB COUNTY, AS IN OTHER AREAS OF METROPOLITAN ATLANTA, ARE IN THE NEOPHYTE STAGE. ORGANIZATION OF A COBB COUNTY HEALTH COUNCIL HAS MET WITH ENTHUSIASTIC COMMUNITY SUPPORT. COOPERATION AND EFFECTIVE COMMUNICATION WITH THE METROPOLITAN COMPREHENSIVE HEALTH PLANNING COUNCIL WILL PRODUCE AN EXEMPLARY RELATIONSHIP IN EFFORTS TO MEET HEALTH NEEDS OF THE AREA.

History of Cobb County Health Council:

While in recent years much progress has been made, gaps in Cobb County's health services have been dramatically evident. For example, a new family found the nearest physician twenty miles away. One hospital is often overcrowded while another has many available beds. Solutions to these and other problems are necessarily a task for large scale cooperative planning.

The present twenty-five member CCHC had its beginning in February, 1969, with a meeting of five health-oriented community leaders under auspices of the Chamber of Commerce. Health problems were recognized in four basic categories:

Services
Facilities
Manpower
Financing

Task forces of the Council and other community members have been assigned to determine needs, resources, and possible solutions in these areas.

Implications for Success:

1. The Chamber of Commerce has had a leading and beneficial role in organizing the CCHC. Support and participation have already been secured from major segments of the community.

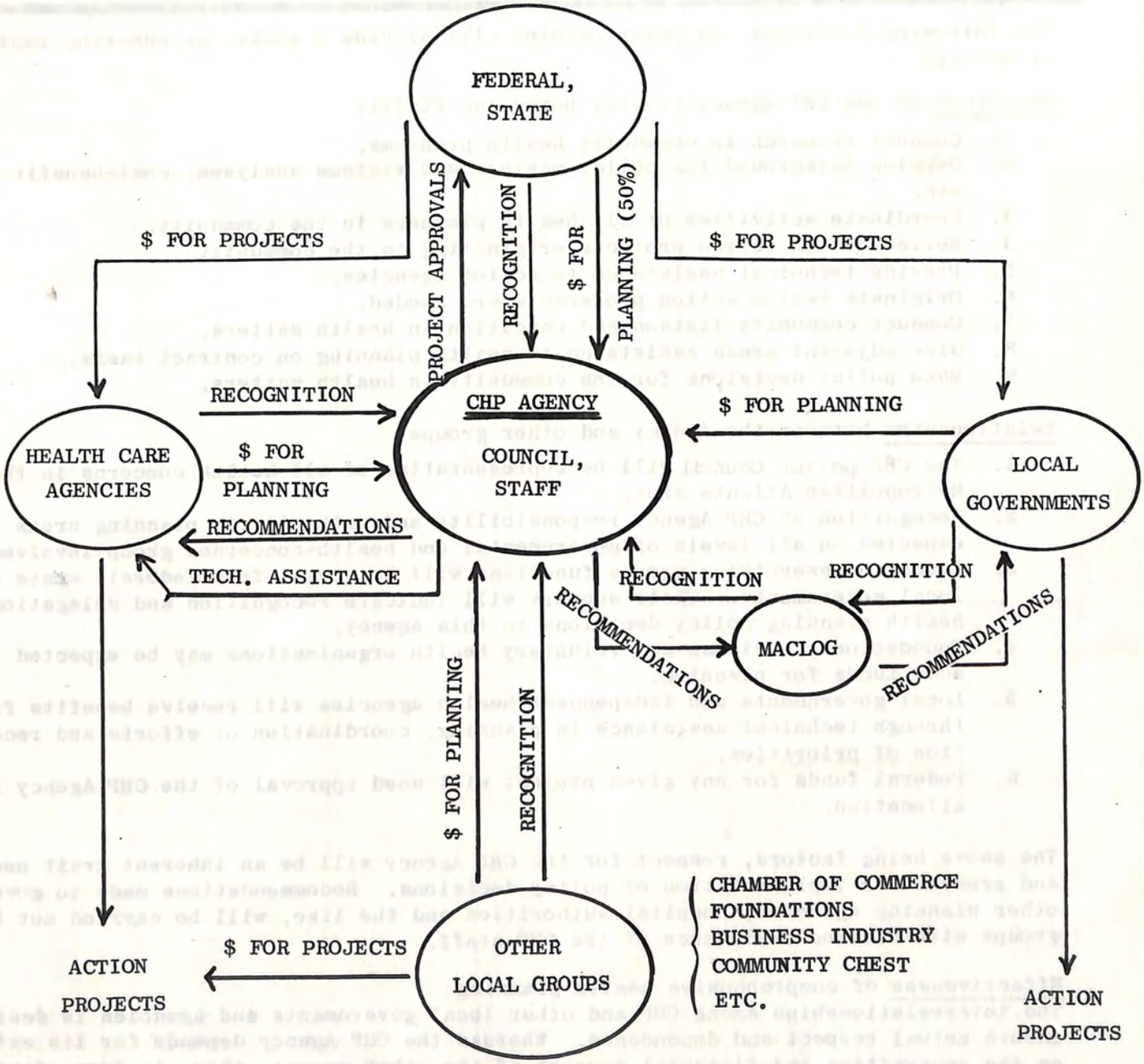
2. Planning involves government officials, health providers, and consumers working together to improve the total health system.

3. From the beginning, members of the CCHC have recognized the potential for inter-relationship with the Metropolitan Council. Understanding and coordination of efforts will combine resources leading to the solution of health problems.

Implications for Overall Local Liaison

The Cobb County Health Council is farther advanced than those in other counties and neighborhoods, although beginnings have also been made in Gwinnett and Clayton Counties. Basically, these local Councils serve two major purposes: (1) they extend the capability of the metro Council to spotlight special needs in local areas, and (2) they bring into participation additional citizens who generate citizen information activities and buil support for CHP.

POLICY - RECOGNITION - SUPPORT - ACTION



Procedure for Policy Implementation

SUMMARY:
FUNCTIONS OF THE METROPOLITAN CHP AGENCY WILL INCLUDE RESEARCH, COORDINATION OF VARIOUS GROUPS, AND POLICY DECISIONS IN THE HEALTH FIELD. AS A PLANNING BODY, THE COUNCIL AND STAFF WILL DEPEND UPON ACTION GROUPS FOR IMPLEMENTATION OF ITS POLICY. FEDERAL, STATE AND LOCAL GOVERNMENT RECOGNITION OF THE AGENCY WILL BE KEY FACTORS IN THE ABILITY TO INFLUENCE ACTION WHICH WILL IMPROVE HEALTH FACILITIES AND SERVICES.

The following functions and relationships will provide a basis for ensuring implementation of policy.

Functions of the CHP Agency (Policy Board and Staff):

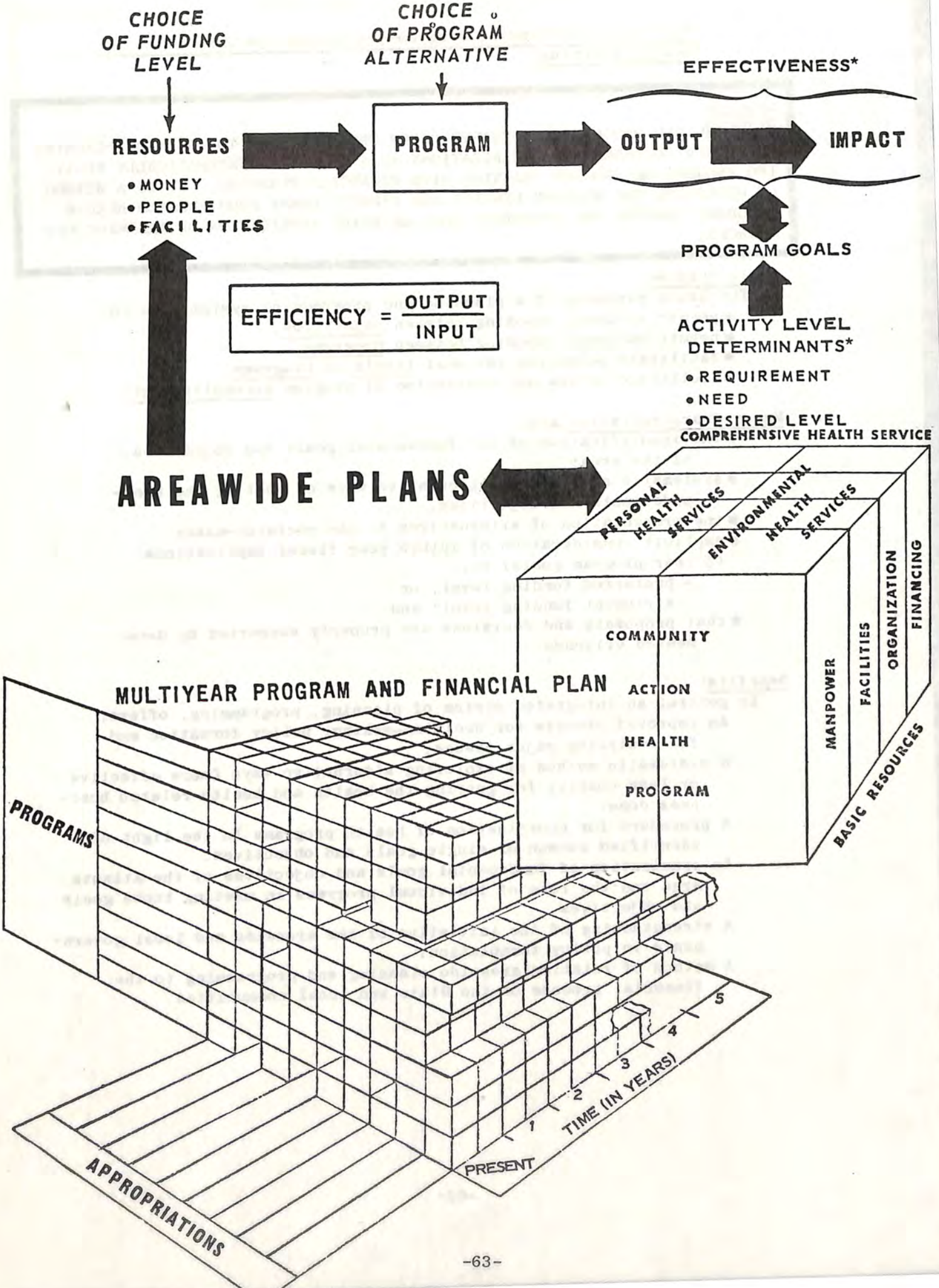
1. Conduct research in community health problems.
2. Develop background for policy-making; use systems analyses, cost-benefit analyses, etc.
3. Coordinate activities of all health planners in the community.
4. Review health action projects originating in the community.
5. Provide technical assistance to action agencies.
6. Originate health action projects where needed.
7. Conduct community liaison and education in health matters.
8. Give adjacent areas assistance in health planning on contract basis.
9. Make policy decisions for the community in health matters.

Relationships between the Agency and other groups:

1. The CHP policy Council will be representative of all health concerns in the Metropolitan Atlanta area.
2. Recognition of CHP Agency responsibility and authority in planning areas is expected on all levels of governmental and health-concerned group involvement.
3. Funds for exercising agency functions will be sought from federal, state and local governments. Their support will indicate recognition and delegation of health planning policy decisions to this agency.
4. Foundations, business and voluntary health organizations may be expected to provide some funds for planning.
5. Local governments and independent health agencies will receive benefits from CHP through technical assistance in planning, coordination of efforts and recommendation of priorities.
6. Federal funds for any given project will need approval of the CHP Agency for allocation.

The above being factors, respect for the CHP Agency will be an inherent trait necessary and present for implementation of policy decisions. Recommendations made to governments, other planning agencies, hospital authorities and the like, will be carried out by those groups with desired assistance of the CHP staff.

Effectiveness of comprehensive health planning:
The interrelationships among CHP and other local governments and agencies is designed to insure mutual respect and dependence. Whereas the CHP Agency depends for its existence on the recognition and financial support of the other groups, they, in turn, depend on the existence and recognition by State and Federal offices of the CHP Agency for much of the Federal funding they require. And whereas the CHP Agency depends on the respect for its competence and fairness by local groups for its effectiveness in originating new plans, the local groups depend on the CHP Agency review for implementation of plans which they originate. Thus, it is in the interests of all that relationships begin and continue on a harmonious and mutually helpful basis.


CHOICE OF FUNDING LEVEL
CHOICE OF PROGRAM ALTERNATIVE
EFFECTIVENESS*
RESOURCES
• MONEY
• PEOPLE
• FACILITIES
PROGRAM
OUTPUT
IMPACT
PROGRAM GOALS
EFFICIENCY = OUTPUT / INPUT
ACTIVITY LEVEL DETERMINANTS*
• REQUIREMENT
• NEED
• DESIRED LEVEL
AREAWIDE PLANS
COMPREHENSIVE HEALTH SERVICE
PERSONAL HEALTH SERVICES
ENVIRONMENTAL HEALTH SERVICES
COMMUNITY HEALTH PROGRAM
MANPOWER
FACILITIES
ORGANIZATION
FINANCING
BASIC RESOURCES
MULTIYEAR PROGRAM AND FINANCIAL PLAN
ACTION
PROGRAMS
APPROPRIATIONS
PRESENT
1
2
3
4
5
TIME (IN YEARS)

The Need for Planning Programming System for Comprehensive Health Planning

SUMMARY:
PLANNING AND PROGRAMMING SYSTEMS OFFER GREAT PROMISE TO AREAWIDE PLANNING AND OTHER GOVERNMENTAL ORGANIZATIONS AS A MEANS OF SYSTEMATICALLY RELATING PROJECT OR PROGRAM PLANNING WITH FINANCIAL PLANNING. IT IS A METHOD OF OBTAINING THE MAXIMUM BENEFIT AND EFFECTIVENESS FROM RELATED HEALTH PROGRAMS THROUGH THE EFFICIENT GOAL-ORIENTED APPLICATION OF AREAWIDE RESOURCES.

Basic Purpose:

The basic purposes of a planning and programming system are to:

- permit rational choosing between objectives,
- permit rational choosing between programs,
- facilitate selecting rational levels of programs,
- facilitate review and evaluation of program accomplishment.

Major Characteristics are:

- the identification of the fundamental goals and objectives of the area;
- systematic analysis of alternative ways of meeting the areawide goals and objectives;
- the presentation of alternatives to the decision-maker;
- explicit consideration of future year fiscal implications (5-year program goals) at;
  - preferred funding level, or
  - stringent funding level; and
- that proposals and decisions are properly supported by documented evidence.

Benefits:

In general an integrated system of planning, programming, offers:

An improved process for decision-making, policy formation and for analyzing major issues.

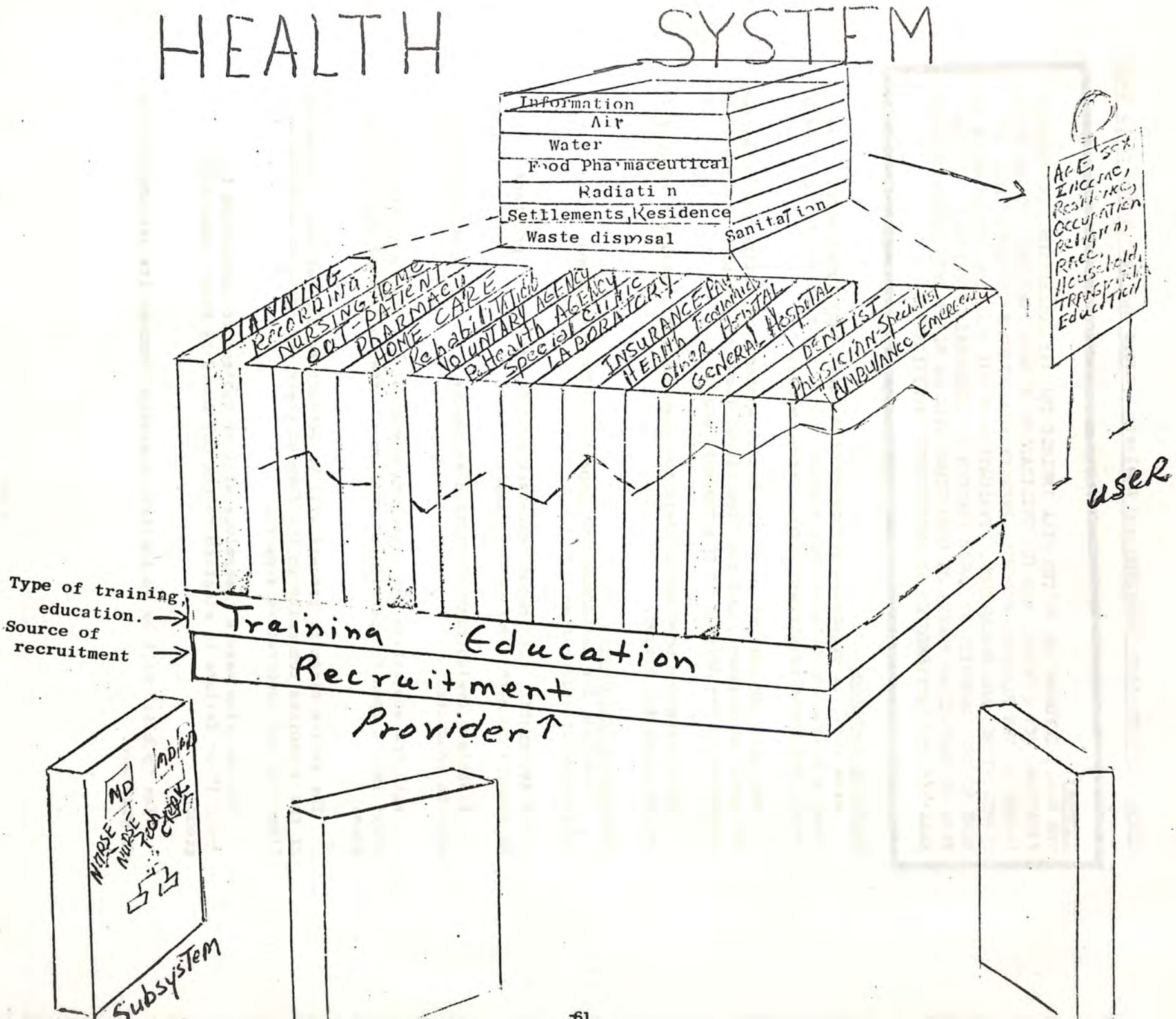
A systematic method of exploring alternative ways (more effective or less costly) for getting the health and health related business done.

A procedure for coordination of health programs in the light of identified common or single goals and objectives.

An examination of fundamental goals and objectives of the Atlanta Area and the role of individual programs in meeting those goals and objectives.

A strengthening of the initiative of the areawide and local governments in policy formulation.

A method of relating areawide planning and programming to the financial process of the State and local communities.


HEALTH SYSTEM
Information
Air
Water
Food Pharmaceutical
Radiation
Settlements, Residence
Waste disposal
Sanitation
PLANNING
REARING
NURSING HOME
OUT-PATIENT
PHARMACY
HOME CARE
Rehabilitation
VOLUNTARY AGENCY
P. Health AGENCY
Special CLINIC
LABORATORY
INSURANCE-PAY
HEALTH Technician
Other Hospital
GENERAL HOSPITAL
DENTIST
PHYSICIAN-Specialist
AMBULANCE Emergency
AGE, SEX
INCOME
RESIDENCE
OCCUPATION
RELIGION
RACE
Household
TRANSPORTATION
Education
USER
Type of training, education.
Source of recruitment
Training
Education
Recruitment
Provider
ND
NURSE
NURSE
Subsystem

Title: Information Gathering and Analysis Systems and Techniques to be Used

SUMMARY:
THE BASIC INFORMATION SYSTEM WILL INCLUDE THE (A) COLLECTION, (B) QUANTIFICATION, (C) STORAGE, AND (D) UTILIZATION OF DATA PERTINENT TO THE OTHER PHASES OF THE PLANNING PROCESS, PROBLEM AND RESOURCE DETERMINATION, IMPLEMENTATION, AND EVALUATION. EVALUATION OF THE PLANNING ITSELF SHALL BE DONE BY THE COMMUNITY AT LARGE THROUGH ITS EXERCISE OF SUPPORT. EVALUATION OF PARTICULAR PHASES OR OPERATIONS WILL BE BUILT INTO COSTS-BENEFITS ANALYSIS AND SUPPLEMENTED BY INDEPENDENT INVESTIGATION.

Research Technique

Data shall be organized according to a total functional model; i.e., under a scheme which takes into account units, their relationship to each other, and their relationship to a larger whole.

The units or subsystems of the health system, the entire health system, the total environment, and the "functional flow" of the user through it is suggested in the diagram on the opposite page.

This technique provides a basis for costs-benefits analysis of alternative plans for action.

Evaluation Technique:

A baseline for measurement of impact will be the purpose of an initial collection of information.

A systematic, continuous feed-back on effectivenss of programs will be built into each program in a simple manner.

Elaborate evaluations of particular phases or troublesome operations will be conducted.

Both the subjective and objective appraisal of efforts in terms of their impact upon the particular problem and the long-range goal will be made.

The entire planning process will be subject to the periodic evaluation of the organized community in the form of their extending or withdrawing financial and cooperative support.

The decision makers themselves will be subject to evaluation by "recall" or failure to election to the CHP Board by their respective groups.

The "public" will be an implicit evaluator through its use and non-use of programs.

PRIORITY AREAS FOR COMPREHENSIVE HEALTH PLANNING EFFORTS

Loading on health manpower - quantity and utilization.

Loading on health facilities - quantity and utilization.

Discrepancy between needs and care received by the poor.

Maternal and child health; family planning.

Mental Health

Environmental sanitation; pollution, waste disposal.

Public health and prevention; vector control.

Emergency health services.

Injury control.

Dental problems.

Drug abuse and alcoholism.

Degenerative and chronic diseases.

Citizen role in prevention and care.

Costs of health care; insurance patterns.

Scope of Program Health Concerns

SUMMARY:
A PRINCIPAL EFFORT DURING THE ORGANIZATIONAL PERIOD HAS BEEN TO IDENTIFY THE HEALTH PROBLEM AREAS OF THIS COMMUNITY WITH SUFFICIENT PRECISION TO BE ABLE TO PROJECT THE SCOPE OF THE PERMANENT PLANNING AGENCY'S FIRST YEAR OF OPERATIONS, AND DETERMINE THE STAFF NEEDS THESE OPERATIONS ENTAIL. OF THE MORE THAN 40 SUCH PROBLEM AREAS IDENTIFIED BY THE STAFF, 27 WERE STUDIED IN SOME DETAIL WITH THE ASSISTANCE OF AS MANY "TASK FORCES", DRAWN FROM THE COMMUNITY AT LARGE, AND INCLUDING HEALTH CONSUMERS AS WELL AS HEALTH PROVIDERS. SOME 14 PROBLEM AREAS HAVE BEEN IDENTIFIED AS MOST LIKELY TO DEFINE THE SCOPE OF THE FIRST YEAR'S PROGRAM.

Need for Identification of Health Problem Areas

Although the staff during this organizational period is not in a position to perform actual planning for this community, and therefore does not need the detailed information about community health problems and prevention and care mechanisms which will be necessary for a systems analytical approach to planning, it was necessary to identify the health problems with sufficient precision to be able to project the scope of the permanent planning agency's first year of operations. This scope, in turn, determines the size and skills which will be needed in the permanent staff.

Study of Health Problem Areas

During initial staff conferences, augmented by consultants from a number of health fields, and through the mechanism of two large community "technical aspects" meetings, more than 40 problem areas were identified as needing attention and improvement in the metropolitan health picture. These were divided into priority categories on the basis of the impressions developed to that time, and about half of them were designated as needing further study. This, in turn, was accomplished through the mechanism of problem area "task forces".

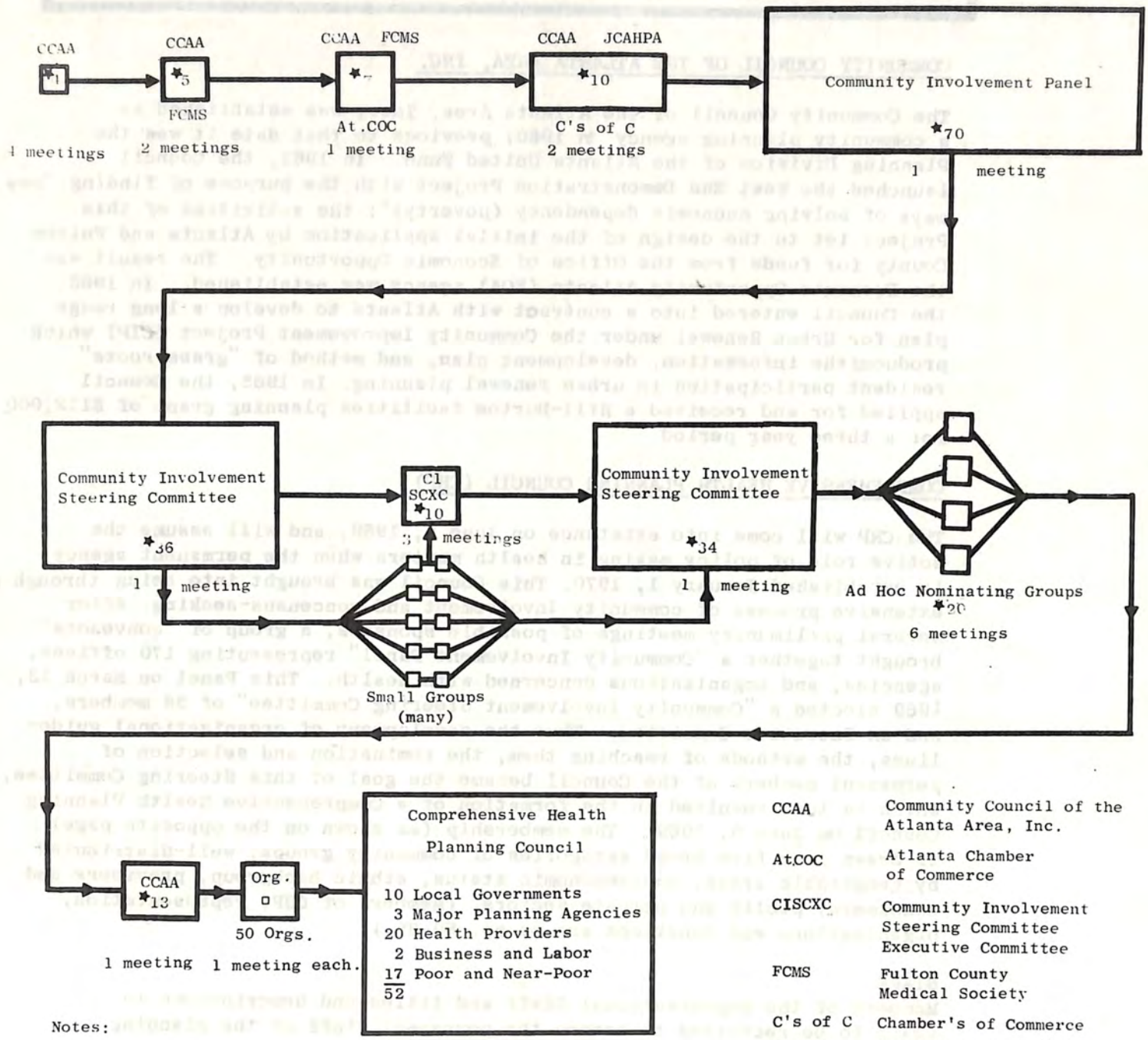
Problem Area Task Forces

Groups of interested and knowledgable persons in the community were asked by the various staff members to form "task forces", each of which was to study one of the assigned problem areas in the detail necessary for determining the scope of the 1970 comprehensive health planning effort. The task forces ranged in size from two or three individuals to more than 20. They were given instructions as to how to go about gathering their data and how to report their findings (see Appendix), and were assisted and encouraged by one of the staff. Some 27 of these task forces were eventually formed, and their reports, in many cases quite voluminous, are presented in Volume III of this proposal (in condensed form). A great deal of thanks is due to these hundreds of people, health providers and consumers alike, for the insight which they contributed to the understanding of this community's problems.

Scope of the 1970 Effort

The 14 problem areas shown on the facing page now seem likely to define the scope of the first year's efforts of the permanent comprehensive health planning agency.

COMMUNITY INVOLVEMENT ROUTE FOR BUILDING A POLICY BOARD BY CONSENSUS



CCAA	Community Council of the Atlanta Area, Inc.
At.COC	Atlanta Chamber of Commerce
CISCXC	Community Involvement Steering Committee Executive Committee
FCMS	Fulton County Medical Society
C's of C	Chamber's of Commerce
JCAHPA	Joint Committee of Area Health Professional Associations

Notes:

- ★ indicate number of people at meeting(s).
- □ several members per organization

Organizational History of the Applicant

SUMMARY
THE COMMUNITY COUNCIL OF THE ATLANTA AREA, INC., A NON-PROFIT CORPORATION CHARTERED UNDER THE LAWS OF THE STATE OF GEORGIA WILL ACT AS THE APPLICANT AGENCY FOR COMPREHENSIVE HEALTH PLANNING. POLICY IN THE HEALTH ACTIVITIES WILL BE FORMULATED BY THE COMPREHENSIVE HEALTH PLANNING COUNCIL (CHP COUNCIL), WHICH WAS BROUGHT INTO BEING BY A COMMUNITY INVOLVEMENT PROCEEDURE RESULTING IN SUBSTANTIAL CONCENSUS. THE STAFF WILL CONSIST OF THE CHP ORGANIZATIONAL STAFF, AUGMENTED BY ADDITIONAL PROFESSIONAL AND SUB-PROFESSIONAL MEMBERS.

COMMUNITY COUNCIL OF THE ATLANTA AREA, INC.

The Community Council of the Atlanta Area, Inc., was established as a community planning agency in 1960; previous to that date it was the Planning Division of the Atlanta United Fund. In 1963, the Council launched the West End Demonstration Project with the purpose of finding "new ways of solving economic dependency (poverty)"; the activities of this Project let to the design of the initial application by Atlanta and Fulton County for funds from the Office of Economic Opportunity. The result was the Economic Opportunity Atlanta (EOA) agency was established. In 1965, the Council entered into a contract with Atlanta to develop a long range plan for Urban Renewal under the Community Improvement Project (CIP) which produced the information, development plan, and method of "grass roots" resident participation in urban renewal planning. In 1965, the Council applied for and received a Hill-Burton facilities planning grant of $112,000 for a three year period.

COMPREHENSIVE HEALTH PLANNING COUNCIL (CHP)

The CHP will come into existance on June 5, 1969, and will assume the active role of policy making in health matters when the permanent agency is established January 1, 1970. This Council was brought into being through an extensive process of community involvement and concensus-seeking. After several preliminary meetings of possible sponsors, a group of "convenors" brought together a "Community Involvement Panel" representing 170 offices, agencies, and organizations concerned with health. This Panel on March 13, 1969 elected a "Community Involvement Steering Committee" of 36 members, and an Executive Committee. Thus the development of organizational guidelines, the methods of reaching them, the nomination and selection of permanent members of the Council became the goal of this Steering Committee, which in turn resulted in the formation of a Comprehensive Health Planning Council on June 5, 1969. The membership (as shown on the opposite page) is drawn from five broad catagories of community groups; well-distributed by geographic areas, socioeconomic status, ethnic backgroup, providers and consumers, public and private sectors. (Members of CHP, representation, organizations and functions are on pp. 80-85.)

STAFF

Members of the Organizational Staff and titles and descriptions to staff to be recruited to become the permanent staff of the planning agency are listed on pages 78 and 79.

BACKGROUND OF HEALTH PLANNING EFFORTS

(1)

Health Planning with:

Economic Opportunity, Atlanta, 1964.

Hill-Burton and National Institute of Mental Health, continuous.

Georgia Regional Medical Program, continuous.

Home Health Care Service, 1969.

Nursing Homes, 1967

Ga. State College, Kennesaw College, DeKalb College, Clayton Junior College, medical personnel training, 1967.

Fulton County Medical Society: Southside Comprehensive Health Center, Vine City Health Services. 1967.

Appalachian Funds, 1967.

Model Cities Program, 1968.

Areawide Comprehensive Health Planning, 1969.

Studies: hospitals, nursing homes, services, patients, physicians, senior citizens.
(1)

Related Planning:

Community Improvement Program: Atlanta Urban Renewal
Senior Citizens Agency
Alcoholics Program
Information and Referral
Recreation: Atlanta Parks and Recreation
Community Participation organizations
Neighborhood Central Information Files.

(1) See Appendix for more complete descriptions.

Community Council Has Extensive Involvement in Health and Planning

SUMMARY:
ONE OF THE PRIMARY INTERESTS OF THE COMMUNITY COUNCIL, ATLANTA AREA, INC., IS THE HEALTH OF THE COMMUNITIES, THE FAMILIES, AND THE INDIVIDUALS OF THE METROPOLITAN AREA. ACTIVE SUPPORT AND PARTICIPATION IN PLANS AND PROGRAMS RELATED TO HEALTH HAVE BEEN CONDUCTED SINCE 1960. THE COUNCIL HAS WORKED CLOSELY WITH FEDERAL, STATE, AND COUNTY AND CITY AGENCIES, PROFESSIONAL AND VOLUNTARY GROUPS AND INDIVIDUALS TO RAISE THE LEVEL OF HEALTH.

Current Status:

The following paragraph taken from "Narrative Plan for Comprehensive Health Planning" by which the Governor designated the Georgia Department of Public Health as planning agent for the State of Georgia attests to the capacity of the applicant planning group:

> "There are only three staffed organizations in the state directed by boards adequately representative of the total community which are engaged in human resources-health planning. These are the Community Council of the Atlanta Area Inc. the United Community Service of Savannah-Chatham County, Inc., and the Georgia-Tennessee Regional Health Commission. The Department has maintained liaison with these agencies throughout their existence because of their broad interest in human resources planning This relationship is expected to continue."

Goals and Aims of the Planning Project:

SUMMARY:
THE PRINCIPAL GOAL OF AREAWIDE COMPREHENSIVE HEALTH PLANNING IS THE SAME AS THAT FOR STATE AND NATIONAL LEVELS: "PROMOTING AND ASSURING THE HIGHEST LEVEL OF HEALTH ATTAINABLE FOR EVERY PERSON". LOCALLY, THIS MEANS DEVISING AND ADOPTING STRATEGIES FOR THE USE OF HEALTH RESOURCES WHICH WILL MATERIALLY RAISE THE LEVEL OF HEALTH, PROGRESSIVELY, IN THE ENTIRE COMMUNITY. SUCH A TASK IS SEEN AS A PROBLEM IN "SYSTEMS" ANALYSIS AND DEVELOPMENT, BY WHICH BACKGROUND FOR POLICY DECISIONS MAY BE GENERATED. MAXIMUM PARTICIPATION BY ALL CONCERNED ELEMENTS IN THE COMMUNITY WILL BE NECESSARY FOR SUCCESSFUL IMPLEMENTATION OF POLICY.

In 1966, the United States Congress enacted Public Law 89-749, the "Partnership for Health" act. Under this law, the States, and through them, areas within the States, must assume responsibility for comprehensive health planning. The Congress declared that "fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts. and participation of individuals and organizations; that Federal financial assistance must be directed to support the marshalling of all health resources--national, State , and local--to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts".

The term "comprehensive" means that every aspect of the health picture in the six-county metropolitan area must be taken into account in the planning process. This includes not only the treatment of illness and injury, but their prevention, and the compensation for any lasting effects which they may leave. Thus, in addition to the manifold activities of medical and paramedical personnel in the variety of health treatment facilities, planning must consider environmental controls of the air, water, soil, food, disease vectors, housing codes and construction, waste disposal, etc. It must consider needs for the training of health personnel, for the improvement of manpower and facilities utilization, and for the access to health care. It includes the fields of mental health, dental health, and rehabilitation. It must be concerned with the means of paying for preventive measures and for health care.

The term "planning" means, first, that problem areas and potential problem areas in the entire field must be identified,and their magnitudes assessed. The trends of the problems must also be assessed, and projected for future years. Technical and organizational bottlenecks must be identified, and "planned around". Second, the community's resources in meeting its health needs must be equally carefully identified and projected, in terms of professional and subprofessional skills, facilities, and financial resources.

Third, since a considerable amount of planning is already being done for a number of projects, hospital authorities, counties, and municipalities, which affects the community's health picture, ways must be found to make maximum use of this capability, and coordinate it into a community-wide comprehensive planning effort. Finally, planning must preserve and encourage the highest level of professional competence in the entire health system, and must make use of the insights of all concerned in the community health system.

The overall task of putting together such an organization is thus seen to be a problem in "systems" analysis and development. Since the total resources of the community are likely to remain smaller than the demands which an ideal health system will place on the resources, rational and just methods of assigning priorities to the various needs must be developed. A cost-benefit analysis is essential to any such decision process, and, considering the literally hundreds of specific health needs in the community, it is likely that the cost-benefit model must rather soon make use of modern computer techniques.

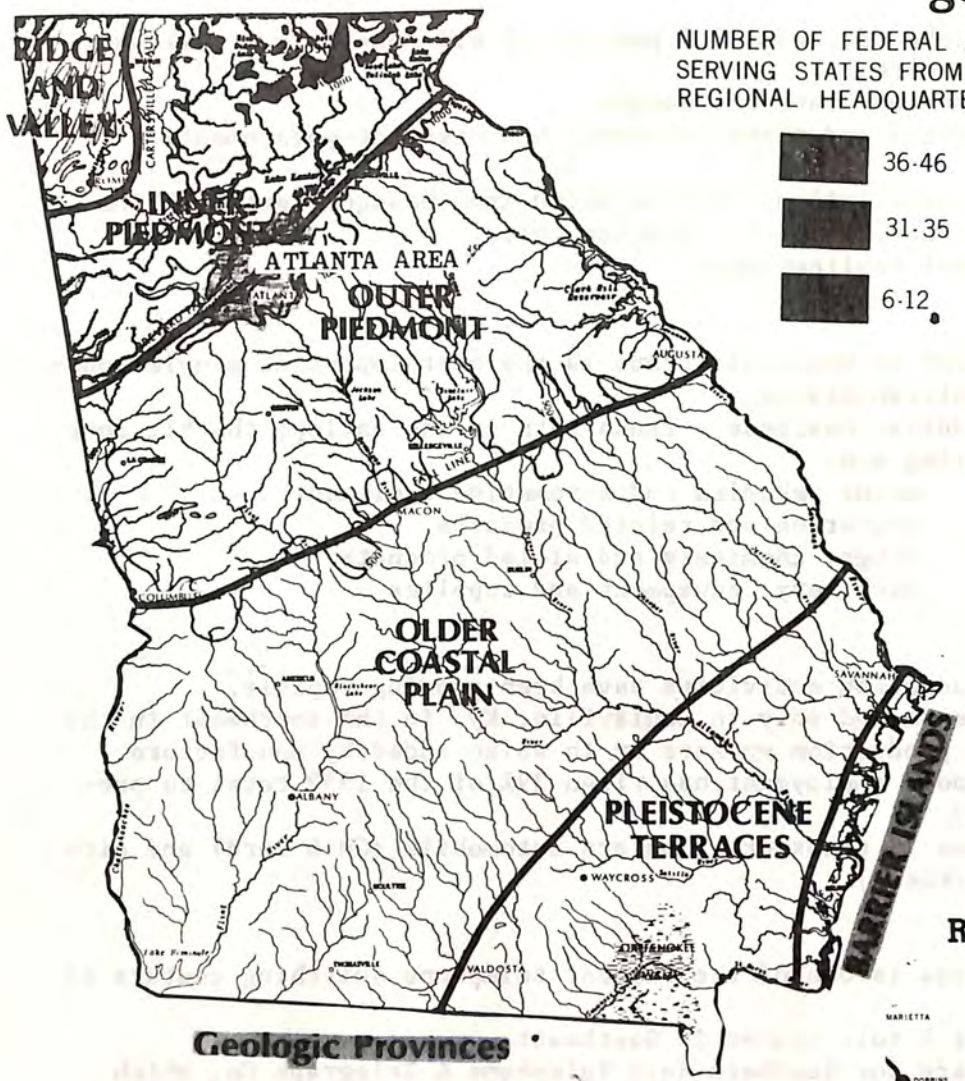
The Partnership for Health law requires that such planning be done with people rather than for people. Therefore, maximum participation of health "consumers", health professionals, governmental units and agencies, and other community organizations is a necessity. The law is telling the States and communities that they will be given increasing responsibility and power to determine their own best health interests. In order to exercise this power most effectively, a maximum degree of concensus must be attained among those community elements concerned with health. To this end, participation of such elements is mandatory, so that a true "partnership for health" among governments, health providers and consumers, rich and poor, black and white, urban and rural, may be achieved.

* * * * *

GOAL FOR 1975:

from Atlanta Journal and Constitution
25 May 1969
"Tumbleweeds" by Tom K. Ryan

STATE OF GEORGIA



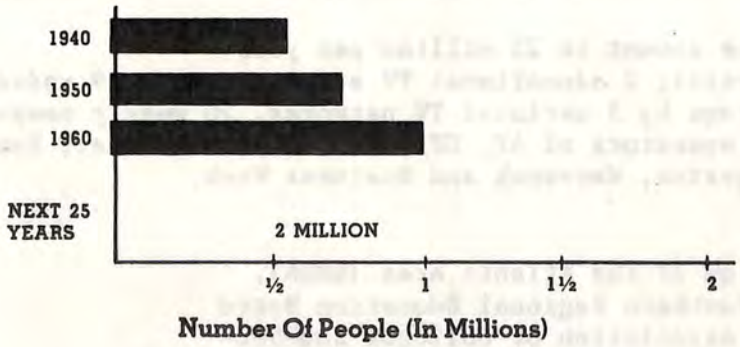
Geologic Provinces

government

NUMBER OF FEDERAL AGENCIES SERVING STATES FROM ATLANTA REGIONAL HEADQUARTERS.

Rapid Transit Is A MUST . . .

ATLANTA POPULATION



REGIONAL CAPITAL OF THE SOUTHEAST

- provides jobs for over 13.5 percent of all non-agricultural wage and salary workers;
- capital for the State of Georgia;
- houses federal and state, regional and district governmental offices;
- military installations such as Third Army Headquarters, Dobbins Air Force Base, Naval Air Station, etc.;
- U.S. Federal Penitentiary.

Wholesale Trade

- Concentration of wholesale trade is the most important single index to metropolitan status
- 4 billion dollar business - ranks 13th in the nation; the big four in wholesaling are:

  motor vehicles and automotive equipment
  groceries and related products
  drugs, chemicals and allied products
  machinery, equipment and supplies

Manufacturing

Atlanta's production activities have been growing rapidly.

- Atlanta is second only to Louisville, Ky. in the southeast in the number of production workers or in value added by manufacture.
- Durable goods employment has risen 39% of the 1952 total to present 47.5%
- Major items in transportation are automobile (GM & Ford) and aircraft (Lockheed).

Communications

- Atlanta Area is one of the largest telephone switching centers in the U.S.
- Only Class I toll center in Southeast
- Headquarters for Southern Bell Telephone & Telegraph Co. which serves nine states and Southeastern headquarters of American Telephone & Telegraph Co.
- Atlanta Western Union office is one of 15 automatic high speed switching centers in the nation (it handles approximately 2 million telegrams a month)
- Gross postal receipts amount to 25 million per year
- Atlanta has 3 commercial, 2 educational TV stations; over 19 radio stations, news coverage by 3 national TV networks, 20 weekly newspapers and regional operators of AP, UPI, Wall Street Journal, New York Times, Time Magazine, Newsweek and Business Week.

Higher Education

A major regional function of the Atlanta Area (SMSA).

- Headquarters of the Southern Regional Education Board and for the Southern Association of Colleges and Secondary Schools.
- There are a number of recognized colleges and universities in the Area of great importance to its economic potential.

The Economic Status of the Atlanta Area

SUMMARY:
THE ATLANTA AREA HAS MANY SPECIFIC URBAN PROBLEMS. WHILE GENERALLY PROSPEROUS DUE TO ITS GROWTH AS AN INDUSTRIAL, BUSINESS, FINANCIAL, EDUCATION, COMMUNICATION AND TRANSPORTATION CENTER, THERE ARE SIGNIFICANT AREAS OF BLIGHT, UNEMPLOYMENT AND INADEQUATE COMMUNITY FACILITIES. THE VARIETY AND QUANTITY OF INTERNAL TRAFFIC FLOW PROBLEMS IN THE VITAL MOVEMENT OF GOODS AND PEOPLE CONTINUOUSLY REQUIRE THE DESIGN AND CONSTRUCTION OF MASS TRANSIT AND CIRCUMFERENTIAL HIGHWAY SYSTEMS. POPULATION INCREASES, IMMIGRATION OF WORKERS FROM RURAL AND OTHER URBAN CENTERS, LONGER LIFE SPAN, TECHNOLOGICAL INNOVATION AND MEDICAL ADVANCEMENTS HAVE CREATED HEAVIER BURDENS ON HEALTH AND HEALTH RELATED SERVICES AND FACILITIES, BOTH SHORT AND LONG TERM. THE ATLANTA AREA PRESENTLY NEEDS APPROXIMATELY 1800 BEDS FOR MEDICARE, MEDICAID AND TREATMENT FOR THE "MEDICALLY INDIGENT". AS TRENDS INDICATE CONTINUED ECONOMIC GROWTH WITH RELATED POPULATION INCREASE, THERE WILL BE EVEN GREATER NEED FOR ADDITIONAL HEALTH FACILITIES AND MANPOWER RESEARCH TO SOLVE UNEMPLOYMENT, LABOR AND HEALTH RELATED PROBLEMS.

Topography:

The Atlanta Area is centrally located in the Southeast and stands alone as the only metropolis in its population class south of Washington and east of Dallas and Houston.

- Economically similar to other inland regional centers such as Kansas City, Minneapolis, St. Paul and Dallas.
  - Developable land areas abound in every direction.
- Physically, the Atlanta Area is:
  - --located in the Piedmont region which lies south of the Appalachian region and north of the Coastal Plains region;
  - --north of Georgia's fall line and bisected to some extent by the Brevard fault;
  - --characterized by low rolling hills containing metamorphic and igneous type rocks;
  - --generally blessed with a warm, humid climate (average winter low=45°; average summer high=77°)
  - --ideally suited for impoundment of almost any size lakes due to its annual average precipitation of 48 inches;

- Pine and a few other hardwood trees are found throughout the Area.
- Water for the Area comes from the Chattahoochee River, several creeks and lakes.
  --Lake Lanier and Allatoona Lake are within 50 miles of Atlanta
- The reddish clay-soil of the Area is moderately fertile, but susceptibility to erosion has diverted much of the land to less demanding uses such as pasture and forests.

- Notable Features:
  --Stone Mountain (a granite peak and State Park), reputedly the world's largest granite monolith
  --Kennesaw Mountain, an historic Civil War battle site

Transportation

Key to the Area's economic growth.

-Railroads - 13 main lines of 7 railroad systems radiating in all directions.

-Interstate Expressways - Six legs scheduled to go through the area

-Air Transport - Six major airlines serve the area; two of the airlines are headquartered in Atlanta. 800 scheduled arrivals and departures daily.

-Waterway Transport - has potential for both recreation and trade.

Finance

One of the most significant forces in the ATLANTA AREA (SMSA) is its economic growth as a financial center. Factors effecting the financial growth are:

- selection for Federal Reserve bank (based on flow of trade in 1914)
- headquarters for Sixth Federal Reserve District
- growth in Atlanta's correspondent bank relationships

Business

ATLANTA AREA (SMSA) is an office "Headquarters city" with continued business growth indicated for the future.

- since WW II more than 8 million square feet of rentable office space has been built
- leader in advertising, blueprinting, photocopying, research, and development, etc., in Southeastern United States.

Manpower

(See chart page 42, Health Manpower Resources, 1968)
(See chart page 13, Population Distribution by Age and Sex)

Major problems in the Area's working population will arise from:

- inexperienced individuals, in large numbers, born in the 40's and 50's who will enter the job market in the 60's and 70's;
- women, who increasingly tend to accept regular employment;
- middle-aged males, industry's supervisory personnel pool, who will scarcely increase in number;
- older people, growing in numbers, who will create a demand for retirement homes, medical care facilities and passive recreation equipment; this will affect construction and industrial production;
- impact of automation which will accelerate competition for available jobs.

Government

Government is big business in the ATLANTA AREA.

SELECTED RANKINGS & CHARACTERISTIC OF GEORGIA (From State Data & State Rankings, Part 2 of 1966-67 edition of Welfare Trends)

HEALTH MANPOWER

	U.S. Rank
Physicians	38
Dentists	48
Professional Nurses	43
General & Special Hospital Admissions	48
Mental Hospital Admissions	19
Tuberculosis	27
Expenses (total)	47
Expenses (General Short-term)	39
Expenses (General Long-term)	2
Expenses (Mental)	46

Existing Manpower

SUMMARY:
THE NUMBER OF PRIVATE PHYSICIANS AND DENTISTS AVAILABLE TO THE PATIENT IN THE 6-COUNTY AREA IS ALMOST THE SAME AS THE NATIONAL RATIO. OTHER PARTS OF GEORGIA HAVE RELATIVELY FEWER PHYSICIANS AND ABOUT HALF AS MANY DENTISTS FOR THE POPULATION. REGISTERED NURSES ARE CONSIDERABLY MORE ABUNDANT IN THE ATLANTA AREA THAN NATIONALLY OR ELSEWHERE OVER GEORGIA. THE NUMBER OF SANITARIANS ALSO COMPARES FAVORABLY WITH OTHER AREAS.

THE COMPARISIONS MADE HERE ARE NOT RELATED TO NEEDS, WHICH IN MANY CASES IS GREATER IN METROPOLITAN AREAS, THAN IN SMALLER AREAS.

HEALTH MANPOWER RESOURCES, 1968

Area	Physicians		Dentists		Registered Nurses		Sanitarians
	Private Practice	Persons per Phy.	Registered	Persons per Dentist	Active	Persons per Active Nurse	
Douglas	6	3983	7	3314	34	493	1
Gwinnett	16	3738	9	6478	81	538	3
Clayton	20	3935	14	5564	125	371	2
Cobb	135	1294	52	3242	358	319	7
DeKalb	216	1637	109	3452	1,571	164	1
Fulton	864	701	419	1440	1,730	322	35
6 County	1257	1031	603	2152	3,899	266	49
Georgia	3165	1143	1296	3744	12,368	502	
U.S.	188772	1036	90716	2157	909,131	329	324

National & State data are taken from Health Resources Statistics,1968,U.S. Dept. HEW

Sanitarians: Provided by Mr. Furman B. Hendrix, R.S., Ga. Society of Professional Sanitarians, May, 1969.

Nurses: Roster of Registered Prof. Nurses, Board of Examiners of Nurses for Ga.,1968.

Dentists: Office of Dental Health, Ga. Dept Public Health, June, 1968.

Physicians: Bio-Statistics Service, Ga. Dept. Public Health

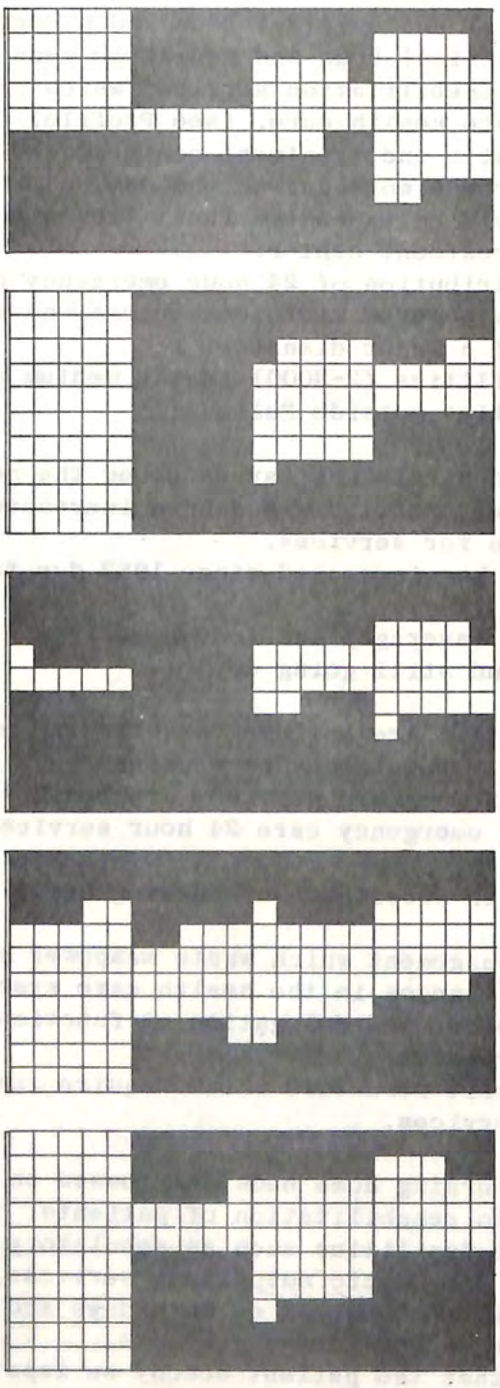
For more complete table see Appendix.

* PROFILE OF PERCENTAGE OF NEEDS MET AND UNMET FOR HEALTH FACILITIES IN HILL-BURTON SERVICE AREAS, ATLANTA, SMSA, 1968

KEY

% Met Needs ■

% Unmet Needs □



	Population
MARIETTA AREA Cobb, Paulding, Douglas	209,200
SOUTH FULTON AREA South Fulton, Clayton Coweta, Fayette	221,700
DECATUR AREA DeKalb, Rockdale North Fulton	437,200
CITY OF ATLANTA AREA	460,000
LAWRENCEVILLE AREA Gwinnett, Barrow, Walton	95,800

* Based on the Georgia State Plan for Hospitals and Related Facilities, Revised 7/1/68, Branch of Medical Services and Facilities Planning, Georgia Department of Public Health

Facilities: Indluding Hospitals, Nursing Homes, Outpatient Clinics and Neighborhood Health Centers

SUMMARY:
THERE MUST BE DESIGNED A COMMUNITY PLAN FOR THE USE OF FACILITIES IN AN ORGANIZED ARRANGEMENT OF MEDICAL RESOURCES SO AS TO BRING THE INDIVIDUAL, WHEREVER LOCATED, INTO CONTACT WITH HIS PHYSICIAN AND OTHER MEMBERS OF THE HEALTH CARE TEAM AT THE LEVEL OF CARE THAT HE REALISTICALLY NEEDS.

Problem:

1. General shortage of medical and surgical beds and a corresponding underutilization of obstetrical beds and pediatric beds
2. Need for development of rehabilitation services which prevent or lesson the demand for acute health care. (see Profile)
3. Lack of extensive diagnostic and treatment centers, and of night clinics to serve the poor who work during the day.
4. Lack of agreement on providing expensive facilities such as a community radiological treatment center.
5. Lack of geographical distribution of 24 hour emergency care services; need for an independently powered radio communications system between hospitals in the event of a major disaster.
6. Lack of nursing home facilities (2-3000) in the medium price range, and particularly in counties outside Fulton.

Current Status

1. Utilization of general hospitals has far exceeded the population trend; particularly in metropolitan areas have increased population brought additional demand for services.
2. The average patient stay has increased since 1962 due to Kerr-Mills and Medicare programs.
3. The cost per patient day (average) has increased from $12.95 in 1950 to $43.97 in 1967 and still going up.

Trends

1. At least six major hospitals are building or planning nursing home units and two are planning ambulatory care units.
2. Organized Home Care and Homemakers services are beginning to be sought.
3. Hospitals are developing emergency care 24 hour services with full-time paid physicians.
4. Utilization committees in hospitals and nursing homes are gaining status.

Obstacles

1. Traditions in patient management which waste manpower and facilities.
2. Lack of money for major changes in the health care system.
3. Underutilization of manpower and delegation of functions to lesser trained patient care personnel.
4. Distorted insurance benefit structure which require inpatient status to pay for diagnostic services.

Possible Solutions

1. Build new hospital and nursing home beds only based on effective demand.
2. Give greater attention to rehabilitation of patients.
3. Develop progressive care facilities such as ambulatory self care.
4. Develop "Day Hospitals" diagnostic outpatient services, night clinics.
5. Operate full services of the hospital on Saturdays and Sundays, or "round the clock" double shifts for surgery etc.
6. Remove the stipulation that the patient occupy an inpatient bed in order to get insurance coverage for diagnostic and minor treatment services.

The Plan Has Continued In-Put from Existing Resources

SUMMARY:
NOT ONLY HAS THE INVOLVEMENT OF RELATED GROUPS REDUCED THE THREAT OF CHANGE, BUT IT HAS BROUGHT INTO REALITY THE BASIC THEME OF THIS PROPOSAL: PARTNERSHIP -- SOUGHT AND DEVELOPED. THE COMMUNITY COUNCIL'S HOSPITAL AND HEALTH PLANNING STAFF HAS BEEN IN CLOSE TOUCH, BOTH FORMALLY AND INFORMALLY, WITH OTHER RELATED PROGRAMS, PROJECTS, ACTIVITIES AND RESOURCES. NUMEROUS PRIVATE AND PUBLIC ORGANIZATIONS HAVE CONTRIBUTED IN SIGNIFICANT WAYS TO THE PREPARATION OF THIS PLAN AND HAVE BEEN INCORPORATED INTO THE DESIGN FOR A CONTINUING PLANNING PROCESS TO IMPROVE THE LEVEL OF HEALTH IN THE ATLANTA AREA.

Methods of Involvement:

Joint board members (mandatory and voluntary)

Staff exchange

Review procedures

Referral arrangements

Information exchange

Consultation (formal and informal) (1)

Umbrella organizations

Staff meetings (regular and called) (1)

Committee and Task Force memberships

(1) See Appendix for Chart of INTERAGENCY RELATIONSHIPS: HEALTH PLANNING, which lists some specific contacts.

Current Resources:

FEDERAL	Dept. Health, Education, Welfare, Community Profile Center (info. exchange, consultation) Communicable Disease Center (consultation)
REGION	Office Economic Opportunity (info. exchange) Dept. Health, Education, Welfare (info. exchange, consultation) Dept. of Labor, Dept. of Labor Statistics (consultation, info exchange) Emory University Medical School (consultation)
STATE	Dept. of Public Health: Planning Office, Office of Comprehensive Health Planning, Office of Bio-Statistics, Branch of Environmental Health, Facilities and Construction Division, Licensure Division (info. exchange, consultation, board members, review) Univ. of Ga. Center for Management Systems, (info. exchange, consultation), Georgia State College (consultation), Ga. Tech, School of Sanitary Engineering (consultation, info. exchange) Georgia Hospital Association (consultation) Medical Association of Georgia (consultation) Ga. State League for Nursing (staff exchange) Ga. Nursing Home Assoc. (staff exchange) Health Insurance Council (info. exchange)
AREA	Atlanta Region Metropolitan Planning Commission (info exchange, consultation, board members) Georgia Regional Medical Program (umbrella organization, review) Georgia District Hospital Association (consultation, joint board) Atlanta Area Society of Registered Professional Sanitarians (info. exchange, consultation) Metro. Atlanta Mental Health Association (staff exchange) Ga. Society for Crippled Children & Adults (consultation, info. exchange, staff exchange, joint board) Visiting Nurses Association (staff exchange, joint board) Ga. State Nurses Association Training Program (staff exchange) Blue Shield & Blue Cross (info. exchange, consultation) American Cancer Society, Georgia Div. (joint board, consultation) Ga. Heart Association, Inc., (joint board, consultation) Community Chest, Agency Relations & Allocations Division (joint board/staff) Senior Citizens Service of Metro Atlanta, Inc. (staff exchange)
LOCAL	Model Cities (consultation, staff exchange) Atlanta University (consultation) Economic Opportunity Atlanta (staff exchange, consultation, joint board) County Public Health Depts. (staff exchange) Fulton County Medical Society (consultation, joint boards) Cobb County Medical Society (consultation) City of Atlanta, Air Pollution Control Division (consultation, joint board) Atlanta School System, P.T. Association and Adult Education (info. exchange)

The Comprehensive Health Planning Staff

SUMMARY:
THE FUNCTIONS OF THE COMPREHENSIVE HEALTH PLANNING STAFF ARE (A) TO CONDUCT RESEARCH IN COMMUNITY HEALTH PROBLEMS, (B) TO DEVELOP BACKGROUND FOR POLICY-MAKING THROUGH SYSTEMS ANALYTICAL METHODS, (C) TO COORDINATE THE ACTIVITIES OF ALL HEALTH PLANNERS IN THE AREA, AND (D) TO PERFORM CONTRACT SERVICES AND TECHNICAL ASSISTANCE ACTIVITIES. THE STAFF INCLUDES A DIRECTOR OF COMPREHENSIVE AREAWIDE HEALTH PLANNING AND OTHER PROFESSIONAL AND SUB-PROFESSIONAL PERSONS.

Planning Functions

The planning functions of the staff consist of two major sections: (a) the coordination and review of plans originating in the health and health-related offices throughout the community, and (b) the origination of plans in areas not covered by other offices and agencies. The latter is expected to consist in large part of systems-analytical studies, including cost-benefit analyses, which cover the entire range of health problems and possible solutions.

I N C O M P L E T E

COMPREHENSIVE HEALTH PLANNING STAFF
INITIAL ORGANIZATION

Director
Secretary 4

Associate Director
Systems Research & Evaluation

Systems Analyst
Research/Evaluation Planner
Environmental Health Planner
Liaison Planner
Statistician
Secretary 3
Secretary 2

Associate Director
Admin. & Organizational Liaison

Organization Liaison
Neighborhood Liaison
Plan Review/ Technical Assistance
Secretary 3

The Metropolitan Atlanta Council for Health (Comprehensive Health Planning Council)

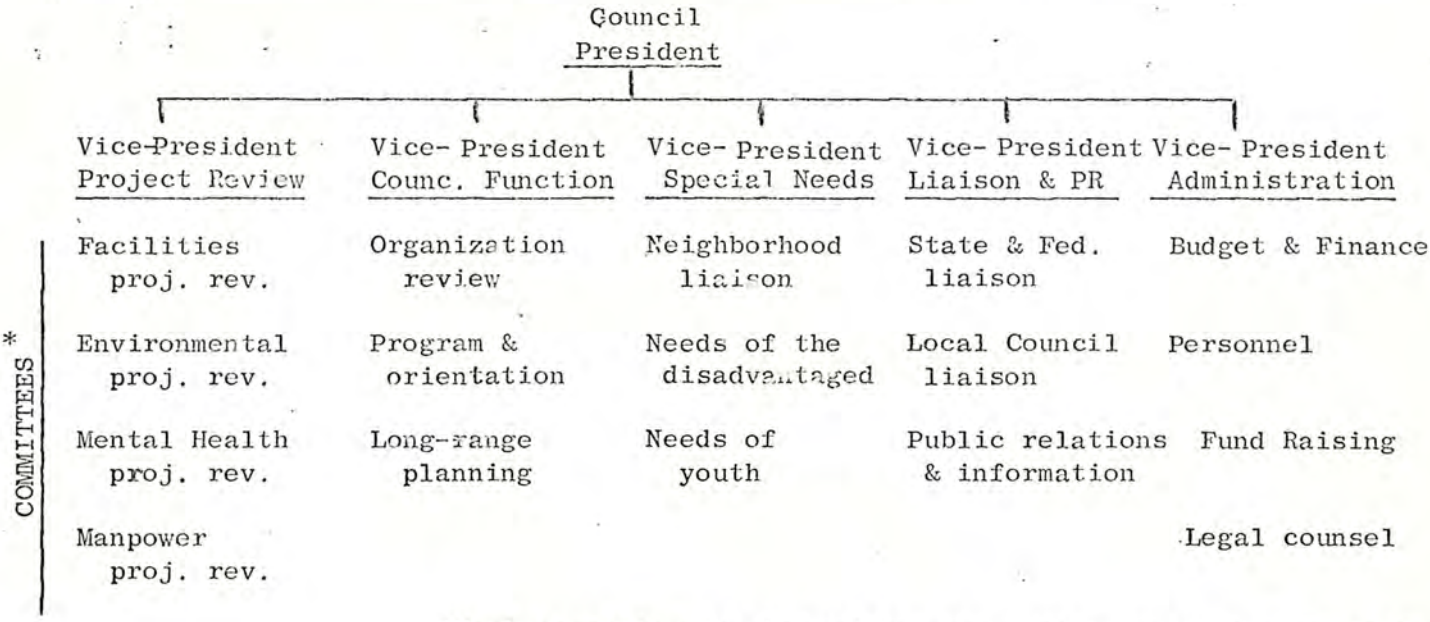
SUMMARY:
THE FUNCTIONS OF THE METROPOLITAN ATLANTA COUNCIL FOR HEALTH ARE (A) TO MAKE POLICY FOR THE METROPOLITAN COMMUNITY IN HEALTH MATTERS AND (B) TO SET POLICY FOR GUIDANCE OF STAFF ACTIVITIES. THE COUNCIL REVIEWS HEALTH ACTION PROJECT PLANS ORIGINATING WITHIN THE COMMUNITY, AND ORIGINATES HEALTH ACTION PLANS WHERE NEEDED. THE COUNCIL IS RESPONSIBLE FOR CONDUCTING COMMUNITY LIAISON AND EDUCATION IN HEALTH MATTERS.

Council Structure

As provided in the By-Laws, the Council is structured as a "working board". All policy matters are decided by the full Council. To facilitate such activity, the Council will form several groups of committees for specific tasks, each group supervised by a vice president. The committees will report to the Council, and recommend actions in their areas of competence. A number of the committees will work closely with the staff in such areas as project review and community liaison.

I N C O M P L E T E

COMPREHENSIVE HEALTH PLANNING COUNCIL - STRUCTURE



*Each committee is chaired by a Council member; Vice-Presidents of Council oversee and encourage activities of the groups of committees shown.

Executive Committee:

President of Council

Vice-Presidents (5)

Secretary

Duties:

Carry on activities between Council meetings; recommendations subject to Council review

Nominating Committee:

Selected from membership of Council, with due regard to makeup of the Council.

Duties:

Nominate a slate of officers prior to the annual meeting

Nominate a new nominating committee prior to the annual meeting

Nominate organizations, on a rotating basis, which will name members of the Council to take office at the next annual meeting

Nominate replacements for vacancies as they occur

Personnel Committee

Selected from Council membership and community at large.

Duties:

Recommend selection and salary of Director for Council action

Formulate personnel policies, including salary ranges

Membership on the Council

SUMMARY:
MEMBERSHIP ON THE COUNCIL SHALL BE DRAWN FROM TWO MAJOR GROUPINGS: THOSE WHO WILL SERVE BY VIRTUE OF OFFICE IN A MAJOR PLANNING ORGANIZATION OR LOCAL GOVERNMENT, AND THOSE WHO SERVE THROUGH BEING NAMED BY APPROPRIATE ORGANIZATIONS OF HEALTH PROVIDERS AND CONSUMERS. MEMBERSHIP IS DRAWN FROM SOURCES BROADLY REPRESENTING THE ECONOMIC, ETHNIC, AND GEOGRAPHIC BACKGROUND OF THE COMMUNITY.

I N C O M P L E T E

MEMBERSHIP ON COUNCIL - Scheme 6

Number	Group	Selected/elected by
3	MACLOG, CCAA, ARMPC	virtue of office (chairmen)
6	County commissions	virtue of office (chairmen)
1	City of Atlanta	virtue of office (mayor)
3	Municipal governments of counties	municipal associations or county commissions (in rotation)
20	Health providers:	
	4 MD's	medical societies (in rotation)
	1 MD, psychiatry	Ga. Psychiatric Assoc.
	2 DDS's	dental societies (in rotation)
	2 Public health	public health departments (in rotation) (recommended: 1 MD, 1 other specialty)
	2 Health facilities	hospital, nursing home associations, etc. (both private and authority-- in rotation)
	1 Medical educator	school of medicine
	1 Paramedical educator	allied sciences schools, etc. (in rotation)
	1 RN	nursing associations (in rotation)
	2 Voluntary health agencies	CCAA Permanent Conference and State Association of voluntary agencies (in rotation)
	1 Social worker	NASW local chapter
	1 Skilled paramedical	technical associations (in rotation)
	1 Semi-Skilled paramedical	organizations, if any; otherwise nominated as an individual
	1 Health ins. industry	Health Insurance Council
17	Poor and near-poor	
	7 EOA's	Atl-Gwinnett, Clayton, DeKalb-Rockdale
	2 Model Cities	
	3 PTA's	Cabbagetown, Cobb, Douglas (others in rotation)
	5 other organizations	NWRO, Southside Health Center, TUFF, NAACP, Urban League (1 each) (others in rotation)
2	Business and labor	Chambers of commerce, unions (in rotation)
52	TOTAL	

The term of "virtue of office" members to coincide with occupancy of office. Term of other members, three years, one-third rotating off each year. "In rotation" indicates that at successive elections different organizations or groups within the same category will be asked to select members.

A nominating committee of the Council will be responsible for assuring such rotation. For the first election ad hoc nominating committees in the major categories above are being asked to submit names of organizations, for review by CCAA Executive Committee.

Title: Working to Ensure Effectiveness of the CHP Council

SUMMARY:
THE METROPOLITAN COMPREHENSIVE HEALTH PLANNING COUNCIL IS A NEW KIND OF POLICY MAKING GROUP. EFFECTIVENESS WILL BE MEASURED BY THE EXTENT TO WHICH MEMBERS PERFORM SPECIFIED FUNCTIONS OF BOARD MEMBERSHIP. A WIDE RANGE OF COMMUNITY RESOURCES WILL BE USED IN TRAINING FOR BOARD ACHIEVEMENT.

Characteristics of the CHPC Board:

- Consumers and providers, economic and ethnic mix, geographic distribution.
- Veteran policy-makers and persons with little group and no policy-making experience.
- Wide range of educational and social backgrounds.

Traditionally, health providers and consumers (particularly low income groups) have not planned together or worked as equals.

Perception of health problems will be influenced by the special interest which each member represents.

Thus, successful functioning of the Board will depend upon effective participation of members both as representatives of subgroups and as citizens in the community of solution.

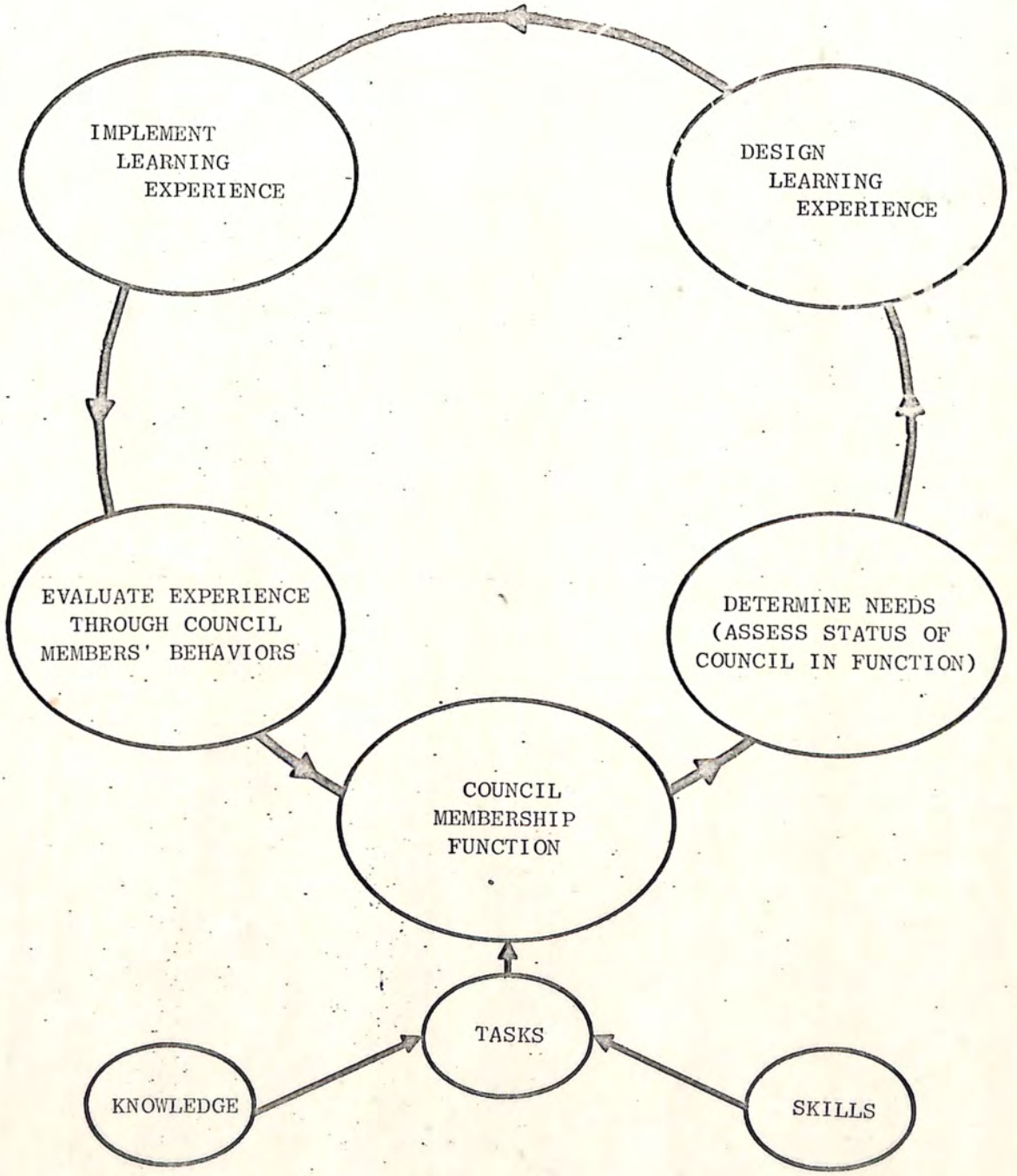
Some Specific Training and Familiarization Activities

After the Council's initial action of accepting responsibility for the policy aspects of comprehensive areawide health planning in this metropolitan community, beginning 1 January 1970, some $6\frac{1}{2}$ months will elapse before the Council is called on for official functioning. During this period, a number of activities are planned for the purpose of familiarizing the Council members with the extent of the health planning actions which they will be called on to evaluate and guide. The period will also be used to acquaint the Council members, one with another, so that they can select Personnel Committee and Nominating Committee members most effectively, several months prior to the Annual Meeting in January, 1970.

Some of the training and familiarization activities contemplated are:

- o introduction to principal health problems in the area
- o field trips to health facilities and areas of severe health need
- o training in effective Council and committee participation
- o experience (with Community Council staff) in reviewing planning projects
- o introduction to systems analytical procedures, and methods of basing decisions on cost-benefit analyses, etc.
- o joint meetings with other planning groups and with health activity staffs

TRAINING for COUNCIL EFFECTIVENESS



By-Laws of the Council

SUMMARY:
THE BY-LAWS OF THE COUNCIL ARE DESIGNED TO FACILITATE MAXIMUM POSSIBLE PARTICIPATION IN HEALTH POLICY MATTERS BY THE MEMBERS OF THE COUNCIL, AND TO "BUILD BRIDGES" TO LOCAL ORGANIZATIONS CONCERNED WITH HEALTH MATTERS. THEY SPECIFY THE BROAD FUNCTIONS OF THE COUNCIL AND STAFF, BUT ARE INTENDED TO PROVIDE FOR SUFFICIENT FLEXIBILITY THAT THE COUNCIL CAN COPE WITH CHANGING AREA CONFIGURATIONS AND HEALTH NEEDS.

The By-Laws consist of 13 Articles:

I.	Name and Location
II.	Purpose
III.	Membership
IV.	Duties and Powers of the Council
V.	Meetings
VI.	Officers and Executive Committee
VII.	Committees
VIII.	Legal Counsel
IX.	Audit
X.	General
XI.	Adoption
XII.	Associate and Affiliate Memberships
XIII.	Ammendments

Important Provisions:
Some of the principal by-law provisions are shown on the facing page (99).

Other By-Laws:
Current By-Laws of the Metropolitan Atlanta Council of Local Governments and of the Community Council of the Atlanta Area, Inc. are included in the Appendices to this volume of the proposal.

CHP COUNCIL - PRINCIPAL BY-LAW PROVISIONS

A. Council Membership and Terms

1. Chairmen of major agencies (3) and of county commissions shall serve for the duration of their terms
2. Representatives of organizations shall serve three-year terms (except for some elected at the first election); 1/3 of these shall be selected each year.
3. Two three-year terms, maximum
4. Majority shall be health "consumers"
5. Approximately 1/3 shall be poor and near-poor consumers
6. Selection process shall take into account geographic and ethnic distributions in the community
7. Selection process shall be determined by a nominating committee made up of Council members. In selecting organizations and groups who will name members to the council, the nominating committee shall achieve rotation among eligible groups and organizations. Typical eligible organizations or groups are indicated in the following:
   a. municipal governments group: municipal associations
   b. health providers group: medical societies, dental societies, hospitals and other facilities, mental health professional organizations, public health departments, voluntary health organizations, nursing associations, skilled paramedical associations, unskilled paramedical groups, social work agencies, educational institutions, insurance councils.
   c. business and labor groups: chambers of commerce, labor organizations
   d. poor and near-poor: EOA's, PTA's, HUD projects (e.g. Model Cities), voluntary agencies (e.g. Urban League, Legal Aid), spontaneous organizations (e.g. Welfare Rights, TUFF, etc.)
8. Alternates may be designated; specifically understood that they act for regular members

B. Council Meetings

1. At least six per year (contemplate monthly)
2. Quorum is 20 voting members
3. Majority of voting members shall decide
4. Roberts Rules govern

C. Council Structure

1. Officers nominated by nominating committee, or from floor; elected by majority vote of Council
2. Executive Committee shall consist of the officers (7)
   handles business between Council meetings
   actions subject to review by Council at next meeting
3. Nominating Committee selected from members of the Council
4. Personnel Committee selected from Council members and others
5. Other standing and ad hoc committees as needed .

BY-LAWS

ARTICLE I - NAME AND LOCATION

1. The name of this organization shall be "The Metropolitan Atlanta Council for Health", hereinafter referred to as the "Council".

2. The Council's principal office shall be located in the City of Atlanta, Georgia.

ARTICLE II - PURPOSE

1. The principal objectives and purposes of the Council are:

A. To establish and maintain comprehensive areawide health planning activities, identifying health needs and goals of the overall community and its sub-areas to stimulate action to coordinate and make maximum use of existing and planned facilities, services and manpower in the fields of physical, mental and environmental health.

B. To establish a system for gathering and analyzing data on the characteristics of health problems in this area.

C. To recommend goals and methods of achieving them, and to make policy decisions for the community in health planning matters.

D. To coordinate activities of all health planners in the community.

E. To collaborate with adjacent health planning areas, and to perform health planning services on a contract basis for adjacent area units, as requested.

F. To review health action project plans originating in the community.

G. To provide technical assistance to public and voluntary action agencies in preparing plans and procedures for the attainment of health goals; to provide similar assistance to Georgia State health planning efforts.

H. To originate health action project plans where needed.

I. To provide continuing liaison and informational services to ensure communication of planning progress to the general public and the appropriate agencies and organizations involved in carrying out the intent of Congress as set forth in Public Law 89-749 relating to comprehensive areawide health planning.

ARTICLE III - MEMBERSHIP

1. The Council shall be composed of not less than thirty-five (35), nor more than fifty-five (55) members. Members shall be drawn from the following organizations and community groups, broadly reflecting economic, ethnic, and geographic background distribution of the area:

A. Members by virtue of office shall serve for the duration of their terms of elective office:

1) Chairmen of County Commissions
2) Chairmen of major planning agencies
3) Mayor of the City of Atlanta

B. Members named by community agencies and organizations

1) Organizations naming members shall be designated in the following categories:

a) Municipal governments
b) Health providers
c) Business and labor
d) Poor and near-poor consumers

2) At the first election, the term of office for one-third of these members shall be fixed at three years; the term of an additional one-third of these members shall be fixed at two years; and the term of the final one-third of these members shall be fixed at one year. At the expiration of the initial term of office of each respective member, his successor shall be named to serve a term of three years. Members shall serve until their successors have been elected and qualified. No member shall serve more than two (2) consecutive three-year terms.

3) The selection process for these members shall be determined by a Nominating Committee of Council members. In selecting organizations and groups who will name members to the Council, the Nominating Committee shall achieve rotation among eligible groups and organizations.

C. A majority of the Council members shall be non-providers of health services.

D. Approximately one-third of Council members shall be poor and near-poor consumers.

E. Each organization shall be authorized to file with the Secretary of the Council the names of alternate members, not to exceed the number of representatives to which it is entitled. Any regular member of the Council may call upon alternate(s) from his organization to attend and

to vote in his stead at any meeting which the regular member is unable to attend.

F. Organizations other than those constituting the Council at the time these rules and regulations are adopted may be invited to name representatives in a stated number to the Council upon recommendation by the Nominating Committee and approval by the Council at any meeting of the Council, provided that ten (10) days advance notice of such proposed action is mailed to each member at his last known post office address.

ARTICLE IV - DUTIES AND POWERS OF THE COUNCIL

1. The Council shall be the final authority for approval of activities proposed in planning actions, and on all matters of policy related to comprehensive areawide health planning.

2. The Council shall consider the annual budget presented by the Budget and Finance Committee, and after any revision, it may determine to be advisable, it shall adopt the same. It shall make such subsequent revision on the budget as it may deem advisable after consultation with the Budget and Finance Committee and the Director of Comprehensive Areawide Health Planning.

3. It shall have the power of approval of the President's appointments of committee chairmen and legal counsel.

4. It shall appoint the Director of Comprehensive Areawide Health Planning, and fix the terms of his compensation, tenure, and responsibilities, giving due consideration to the recommendations of the President and the Personnel Committee.

5. It shall appoint the auditor as provided in Article IX of these BY-LAWS.

6. It shall require periodic reports on operations from the various committees and from the Director of Comprehensive Areawide Health Planning.

7. It shall fix the time and place of the Annual Meeting of the Council.

8. It shall pass on applications for admission to the Council of additional adjacent areas desiring to participate in comprehensive health planning with the metropolitan Atlanta area.

ARTICLE V - MEETINGS

1. The Council shall hold at least six (6) regular meetings per year, to be called for the first Thursday in the scheduled month, or on such other convenient day as may be decided from time to time by majority vote.

2. Special meetings may be called by the President and shall be called by the Secretary at the request of fifteen (15) members of the Council.

3. Notice of each meeting shall be mailed to each member of the Council at his last known post office address at least ten (10) days in advance of the meeting.

4. Twenty (20) members of the Council shall constitute a quorum for the transaction of business at any meeting of the Council; the presence of less than a quorum may adjourn a meeting until such time as a quorum is present.

5. A majority in number of members present and voting at a meeting at which a quorum is present shall be required for approval of any action by the Council.

6. Each member of the Council is entitled to one (1) vote at any meeting at which he is present.

7. No proxy votes shall be allowed. A duly appointed alternate member, however, may vote in the absence of a regular member representing the organization for which he is designated alternate. In such case, the alternate member shall be considered a member for the purpose of determining a quorum.

8. The Council may act by mail, wire, or telephone between regular meetings, but in such case the concurrence of a majority in number of members shall be necessary and shall be subject to confirmation at the next meeting of the Council so that such action shall be recorded in the minutes.

9. The first meeting of the Council, after January 1 each year, shall be considered the Annual Meeting for the seating of new members named by organizations, and election of officers and nominating committee members.

10. The Administrative Year of the Council shall extend from Annual Meeting to Annual Meeting.

ARTICLE VI - OFFICERS AND EXECUTIVE COMMITTEE

1. Officers

   A. Officers of the Council shall be a President, five (5) Vice-Presidents, and a Secretary, who shall be elected annually from among members of the Council by a majority vote of members present and voting at the Annual Meeting.

   B. Officers so elected shall serve for one year, or until their successors have been elected. No officer shall hold the same office for more than three (3) consecutive terms.

   C. Vacancies in offices occuring between Annual Meetings of the Council may be filled by election by a majority vote of members present and voting at any meeting of the Council. Officers so elected shall serve until the next Annual Meeting of the Council.

2. President

   A. The President of the Council shall be the chief officer

of the organization and shall preside at all meetings of the Council and Executive Committee. The President shall, subject to the approval of the Council, appoint the chairmen of all committees, except the Nominating Committee, and shall be a member, ex-officio, of all committees; and shall, with the Secretary, sign all obligations authorized by the Council which may be beyond the authority of the Director of Comprehensive Areawide Health Planning; and shall, with the approval of the Council, appoint legal counsel.

3. Vice Presidents

A. There shall be five or more vice presidents, who shall assist the President, and shall coordinate the activities of groups of committees of the Council. These officers shall be designated Vice-President for Council Function, Vice President for Liaison and Public Relations, Vice President for Special Needs, Vice President for Project Review, Vice President for Administration, and such others as the Council may designate.

4. Vice Presidents may preside

A. A Vice President shall preside at any meeting of the Council or Executive Committee in the absence of the President, and in such case shall have all the responsibilities and perform all the duties of the President. The order of precedence for this function shall be: Vice President for Council Function, Vice President for Liaison and Public Relations, Vice President for Special Needs, Vice President for Project Review, and Vice President for Administration.

B. The Vice Presidents shall have and perform such other duties as may be assigned by the President or by the Council.

5. Secretary

A. The Secretary of the Council shall handle the general correspondence of the Council and shall cause notices to be sent of all regular or special meetings of the Council.

B. He shall cause minutes to be kept of all meetings of the Council, and shall see that these minutes are distributed to members of the Council within a reasonable period of time after each meeting.

C. He shall preside at meetings of the Council in the absence of the President and the Vice Presidents and in such case shall have all the responsibilities and perform all the duties of the President.

D. The Secretary shall have and perform such other duties as may be assigned by the President or the Council.

5. Executive Committee

A. The Executive Committee shall consist of the President, Vice Presidents and Secretary of the Council.

B. Duties of the Executive Committee shall be to handle matters pertinent to Council business during intervals between meetings of the Council.

C. Actions and recommendations of the Executive Committee shall be subject to Council review and approval at the next meeting of the Council.

ARTICLE VII - COMMITTEES

1. Statutory Committees

A. A Nominating Committee shall be elected from members of the Council, with due regard to the makeup of the Council. The duties of the Nominating Committee shall include:

1. Nominating a slate of officers prior to the Annual Meeting.

2. Nominating a new Nominating Committee prior to the Annual Meeting.

3. Nominating organizations, on a rotating basis, which will name members of the Council to take office at the next Annual Meeting.

4. Nominating replacements for vacancies as they occur.

B. A Personnel Committee shall be elected from Council membership and the community at large. The duties of the Personnel Committee shall include:

1. Recommending selection and salary of Director for Council action.

2. Formulating personnel policies, including salary ranges.

The Chairman of the Personnel Committee shall be a member of the Council.

2. Other Committees

A. Other standing and ad hoc committees may be designated, elected or appointed, as needed. Chairmen of all standing committees shall be members of the Council.

ARTICLE VIII- LEGAL COUNSEL

1. Legal counsel shall be appointed by the President with the approval of the Council. All matters involving interpretation of State and Federal law, local ordinances, and tax questions shall be promptly referred to such counsel for opinion and advice.

ARTICLE IX - AUDIT

1. The fiscal records of the comprehensive areawide health planning activities shall be audited annually by a certified public accountant, appointed by the Council. The auditor's report shall be filed with the records of the organization.

ARTICLE X - GENERAL

1. Waiver

   A. Any notice required to be given by these By-Laws may be waived by the person entitled thereto.

2. Contravention

   A. Nothing in these By-Laws shall contravene applicable rules and regulations, procedures, or policies of the U. S. Public Health Service, or of the Georgia Office of Comprehensive Health Planning.

3. Parliamentary Procedure

   A. The latest revision of Robert's Rules of Order shall cover the parliamentary procedure at all meetings of the Council and of the Committees, where not in conflict with these By-Laws.

4. Publicity

   A. No publicity releases to the media shall be made or authorized by any organization represented on the Council, or by any member of the Council without prior clearance by the Director of Comprehensive Areawide Health Planning.

5. Acceptance of By-Laws

   A. Any organization accepting invitation to designate membership on the Council shall by their acceptance attest to their active participation and to their agreement to abide by these By-Laws.

ARTICLE XI - ADOPTION

1. Effective date

   A. These By-Laws shall become effective immediately upon adoption by the Council.

ARTICLE XII - ASSOCIATE AND AFFILIATE MEMBERSHIPS

1. Associate Membership

A. At the discretion of the Council, sub-areal comprehensive health councils may be admitted to associate membership in the Council. The Council shall fix general qualifications for such associate membership.

B. As a condition of associate membership, sub-areal comprehensive health councils shall admit to membership all members of the Council residing in the area of the sub-areal council.

C. Each associate member council is entitled to send an observer to meetings of the Council.

2. Affiliate Membership

A. At the discretion of the Council, organizations other than sub-areal comprehensive health councils may be admitted to affiliate membership in the Council. These may include such organizations as voluntary health agencies, professional societies, citizens' associations for health concerns, etc. The Council shall fix general qualifications for such affiliate membership.

B. Each affiliate member organization is entitled to send an observer to meetings of the Council.

ARTICLE XIII - AMENDMENTS

1. Method

A. These By-Laws may be amended or repealed by a majority vote of the members of the Council present, and voting at any meeting of the Council at which a quorum is present, provided that written notice of such proposed changes shall have been sent to all members not less than ten (10) days prior to the date of such meeting.

STEERING COMMITTEE

Mrs. Thelma Abbott
521 W. Columbia Avenue
College Park, Georgia

Hon. S. S. Abercrombie, Chairman
Clayton County Commission
Clayton County Courthouse
Jonesboro, Georgia 30236

Hon. L. H. Atherton, Jr.
Mayor of Marietta
P.O. Box 609
Marietta, Georgia 30060

Miss Dorothy Barfield, R. N.
Chief Coordinator of Nursing Services
Georgia Department of Public Health
47 Trinity Avenue
Atlanta, Georgia 30334

Mr. G. X. Barker, Ex. V. P.
International Brotherhood of Electrical Workers
Fifth District Office
1421 Peachtree Street, N. E.
Atlanta, Georgia 30309

Hon. Ernest Barrett, Chairman
Cobb County Commission
P. O. Box 649
Marietta, Georgia 30060

Dr. J. Gordon Barrow, Director
Georgia Regional Medical Program
938 Peachtree Street, N. E.
Atlanta, Georgia 30309

Mr. M. Linwood Beck, Executive Director
Georgia Heart Association
2581 Piedmont Road, N. E.
Atlanta, Georgia 30324

Mr. Herschel T. Bomar, Chairman
Douglas County Commission
Douglas County Courthouse
Douglasville, Georgia 30134

Hon. William H. Breen, Jr.
Mayor of Decatur
c/o First National Bank Building
Decatur, Georgia 30030

Dr. Napier Burson, Jr.
Baptist Professional Building
340 Boulevard, N. E.
Atlanta, Georgia 30312

Hon. T. M. Callaway, Jr.
DeKalb County Commission
c/o Callaway Motors
231 West Ponce de Leon Avenue
Decatur, Georgia 30030

Mrs. Mary June Cofer
443 Oakland Avenue
Atlanta, Georgia 30312

Mr. Gary Cutini, Regional Rep.
Health Insurance Council
Life of Georgia Building
600 W. Peachtree
Atlanta, Georgia 30308

Dr. F. William Dowda
490 Peachtree Street, N. E.
Atlanta, Georgia 30308

Mr. J. Wm. Fortune
Mayor of Lawrenceville
290 Old Timber Road, S. W.
Lawrenceville, Georgia 30245

Mr. Drew Fuller
Fuller & Deloach
1726 Fulton National Bank Bldg.
Atlanta, Georgia 30303

Miss Jo Ann Goodson, R. N.
Wesley Woods
1825 Clifton Road, N. E.
Atlanta, Georgia 30333

Mr. Fred J. Gunter, Administrator
South Fulton Hospital
1170 Cleveland Avenue
East Point, Georgia 30344

Dean Rhodes Haverty
Georgia State College
School of Allied Sciences
33 Gilmer St., S. E.
Atlanta, Georgia 30303

Mr. Maynard Jackson
Emory Community Law Firm
551 Forrest Road, N. E.
Atlanta, Georgia 30312

Mr. Purch L. Jarrell
Route # 1
Box 24
Duluth, Georgia 30136

Hon. Walter M. Mitchell, Chairman
Fulton County Commission
409 Administration Building
165 Central Avenue, S. W.
Atlanta, Georgia 30303

Mr. John L. Moore, Jr.
Attorney-at-Law
C & S National Bank Building
Room 1220
Marietta and Broad Streets
Atlanta, Georgia 30303

Dr. William W. Moore, Jr.
Suite 616
1293 Peachtree Street, N. E.
Atlanta, Georgia 30309

Mr. A. B. Padgett, Trust Officer
Trust Company of Georgia
P. O. Drawer 4655
Atlanta, Georgia 30302

Mr. Dan Sweat
Assistant to Mayor
City of Atlanta
City Hall
Atlanta, Georgia 30303

Dr. Charles B. Teal, Jr.
Gwinnett County Health Department
300 South Clayton St.
Lawrenceville, Georgia 30245

Mr. Bill Traylor
1397 Oxford Road, N. E.
Atlanta, Georgia 30307

Dr. T. O. Vinson, Director
DeKalb County Health Department
440 Winn Way
Decatur, Georgia 30033

Mr. Lyndon A. Wade, Executive Dir.
Atlanta Urban League
239 Auburn Avenue, N. E.
Room 400
Atlanta, Georgia 30303

Dr. Robert E. Wells,
1938 Peachtree Road, N. W.
Atlanta, Georgia 30309

Joseph A. Wilbur, M. D.
615 Peachtree Street, N. E.
Atlanta, Georgia 30308

Mrs. Daisy Bigsby
585 Gibbons Drive
Scottdale, Georgia

MEMBERS OF EXECUTIVE COMMITTEE
OF
COMMUNITY INVOLVEMENT STEERING COMMITTEE
FOR
AREAWIDE COMPREHENSIVE HEALTH PLANNING

NAME	AFFILIATION	VIEWPOINT
Hon. Howard Atherton	Mayor of Marietta	municipalities
Mr. Linwood Beck	Director, Georgia Heart Assoc.	voluntary agencies
Hon. Thomas Callaway	Commissioner, DeKalb County	Maclog
Mr. Drew Fuller	Chmn. Health Committee, Atl. C. of C.	commerce
Mr. Fred Gunter	Administrator, So. Fulton Hospital	hospitals
Hon. Walter Mitchell	Chmn., Fulton County Commission	county govts.
Mr. A. B. Padgett	Chmn, CHP Steering Committee	Community Council
Dr. Oscar Vinson	Director, DeKalb Board of Health	Public Health
Mr. Lyndon Wade	Director, Atlanta Urban League	consumers
Dr. Robert Wells	Chmn. Fulton County Med. Soc. Board	medical professions