ATLANTA METROPOLITAN AREA

COMPREHENSIVE HEALTH PLANNING

PROPOSAL

VOLUME III

TASK FORCE REPORTS

Submitted by

METROPOLITAN ATLANTA COUNCIL OF LOCAL GOVERNMENTS

20 June 1969

This is an incomplete edition of VOLUME III,

PROPOSAL FOR COMPREHENSIVE
HEALTH PLANNING

Other work is in process of completion.

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FOREWORD TO VOLUME III

The descriptive reports in this volume represent the efforts of some 27 "task forces" organized to assist the comprehensive health planning staff in identifying the Atlanta area's health problems in sufficient detail to project the scope of the first year of effort by the permanent planning staff. Several hundreds of area citizens, both health providers and health consumers contibuted their time, expertise, and insights in the preparation of these reports. Although in many cases, the task force reports were quite detailed and voluminous, all have been condensed for inclusion in this volume. The points of view expressed in these reports are those of the task forces themselves, and their recommendations deal with the specific problem areas, rather than with the total community health situation. As input to the total planning process, these are valuable documents, and the staff expresses great appreciation to the task force chairmen and members.

Manpower Shortage in Allied Health Professions

SUMMARY:
EXISTING VACANCIES WILL INCREASE ALARMINGLY WITH POPULATION GROWTH UNLESS MORE INDIVIDUALS ARE ATTRACTED AND RETAINED. THESE PROFESSIONS SHOULD BE UPGRADED AND PUBLICIZED; EDUCATIONAL OPPORTUNITIES SHOULD BE DEVELOPED, AND TRAINING PROGRAMS COULD USE FINANCIAL SUPPORT. SYSTEMATIC EVALUATION OF EXISTING AND FUTURE NEEDS AND RESOURCES SHOULD BE DETERMINED AND UTILIZED AS THE BASIS FOR A COMPREHENSIVE EFFORT TO CORRECT THESE DEFICIENCIES.

Problem:

Demand grows faster than supply. Why?

- --While existing vacancies are distressing,
- --Population increases create new needs;
- --Public and professional awareness of these professions is minimum;
- --Required education (B.A. or corresponding degree) is not within the financial reach of many;
- --Professional dedication is exacting;

Y E T

VOCATIONAL BENEFITS,
CAREER OPPORTUNITIES AND
PRESTIGE are inadequate.

- --Training programs are still in the development stage in Georgia;
- --Communication and coordination needed to unite all related health care groups behind a study and solution of this problem is lacking;
- --Funds to develop programs, sponsor students; for research and patient care are not available.
- --Accurate assessment of all needs - present and future, has not been made.

Resources:

There are clinical, medical, rehabilitation facilities which provide practical training, and while the number is increasing, further expansion will be necessary.

One graduate and two undergraduate programs in Allied Health Professions are presently under development, but these will require time to grow and graduate trained individuals. Even these, however, cannot fulfill the number or variety of available positions.

Solutions:

Undertake systematic analysis of the entire problem to serve as a realistic basis for planning and corrective action.

Provide financial support, develop career incentives, arouse public/professional interest in and for these professions.

Develop transportation and communication networks in all areas: patients, employers, health professionals, institutional, organizations and associations, public and private agencies.

Empahsize broad health service rather than: crisis oriented care.

Improve and expand hospital and rehabilitation facilities to assist in training and improve use of present personnel.

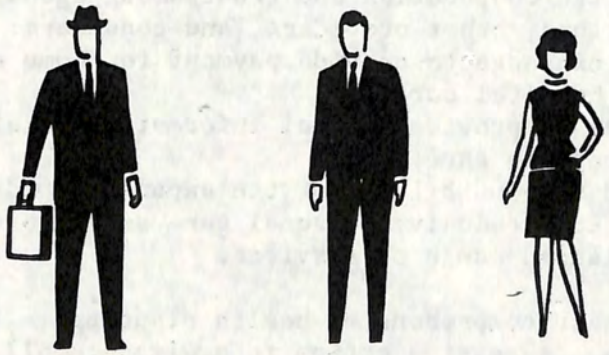
Mount an aggressive campaign to recruit and retain - even recall - existing personnel.

NUMBER OF REGISTERED ALLIED PROFESSIONAL PERSONNEL IN GEORGIA AND IN THE ATLANTA METROPOLITAN AREA

Georgia		Metropolitan Area
4,000,000	Population	1,300,000
135	Physical Therapists	75
9,092 (3,267)☆	Nurses	3,865 (1,477)☆
40	Occupational Therapists	19
1,000	Social Service	500
(100 students included)		
175★	Speech Pathologists	75★

☆ (inactive)

★ (public schools included)



Home Health Care

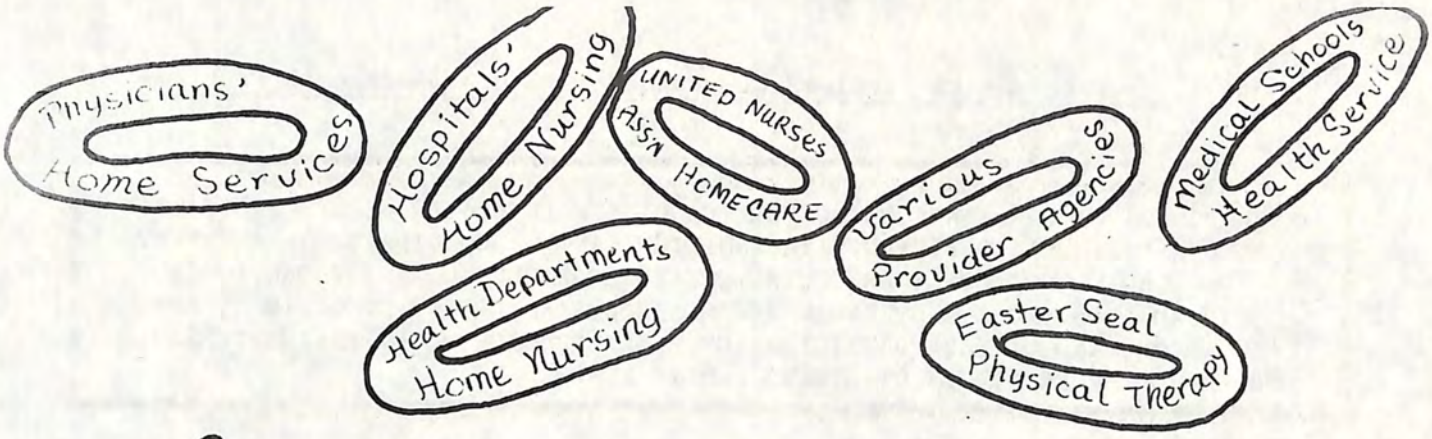
SUMMARY:
THE PAUCITY OF HOME HEALTH SERVICES IN THE ATLANTA AREA LEAVES MANY PATIENTS WITHOUT NEEDED CARE, CREATES SERIOUS BOTTLENECKS IN INSTITUTIONS, AND LIMITS PHYSICIANS IN THEIR CHOICES OF SETTINGS WHERE PATIENTS CAN RECEIVE ADEQUATE CARE. THE ANSWER LIES IN THE AMALGAMATION OF ALL PROVIDER AGENCIES.

Text Outline:

- We DO have:
  - duplication, fragmentation, and threats of further proliferation;
  - increasing service needs due to upward trends in population growth, longevity, institutional costs and manpower shortages;
  - seven agencies serving fewer than half of the patients who need services;
  - obvious gaps in services to the sick and disabled at home;
  - fairly adequate services for protecting the general community health; and
  - interest and concern for better coordination, primarily due to activity under special projects over the past three years.

- We DO NOT have:
  - a central coordinating and research unit;
  - the most efficient, economical, and effective utilization of our limited supply of personnel;
  - whole-hearted cooperation and trust among agencies, institutions, other providers, and consumers;
  - insurance exchange to provide payment for home care in lieu of hospital care;
  - a structure to provide central information, liaison, and easy access to care;
  - designated responsibility for the expansion and development of comprehensive personal care services at home; and
  - a well balanced range of services.

- Specific charge to comprehensive health planning:
  - Long Range: agressive action to amalgamate all agency providers of home health services; and
  - Immediate: central coordination and establishment of research and education programs in home health services.



Separate Links – no matter how strong – DO NOT MAKE A CHAIN!

The ATLANTA AREA needs a <u>chain</u> of home health services

Meeting Health Problems Compounded with Socio-Economic Problems

SUMMARY:
THE POOR AND DISADVANTAGED SUFFER INEQUITIES IN HEALTH LEVELS AND CARE UNDER EXISTING INSUFFICIENT, INCONSISTENT AND UNCOORDINATED ARRANGEMENTS WHICH ALSO DO NOT CONSIDER THE ALMOST INSEPARABLE SOCIAL, ECONOMIC AND CULTURAL PROBLEMS. A SYSTEM BASED ON IMPROVING LIVING CONDITIONS, HEALTH EDUCATION, AND CITIZEN PARTICIPATION WOULD PRODUCE MORE PERMANENT RESULTS WHILE MORE EFFECTIVELY UTILIZING PUBLIC FUNDS.

Problem:

Poor sanitation, inadequate and improper diet invite and perpetuate health problems.

The under and improper use of health services and resources lend to the seriousness and aggravation of health services and problems.

Quality of housing and overcrowding are related to certain diseases, accidents, and mental disorders.

All of these primary social and physical conditions are characteristic of the economic poor.

Health care tends to be piecemeal, poorly supervised, and uncoordinated.

Current Resources:

Public Health Department programs, services, facilities
Federal outlays of $465,453,901 in 1968 (HEW, HUD, OEO)
Charity hospital with more than one thousand beds
Local and State Government contributions
Over twenty health-centered voluntary agencies

Solution:

A health centered approach to these problems should:

* plan together with other social institutions, programs, and movements to develop adequate and safe living conditions in the areas of homelife, housing and neighborhood, transportation, health and general education, business and industry, legal arrangements, health resources, etc.; and

* encourage the development and improvement of medical resources and programs to meet technological, organizational, cultural, geographical, numerical considerations of what our society needs.

Trends:

Indications are that as things go, "the sick get poorer and the poor get sicker." In turn, it is their voice which is seldom heard and frequently not interpreted into programs designed for them.

PROBLEMS IDENTIFIED FOR COMPREHENSIVE HEALTH PLANNING BY A SAMPLE OF LOW-INCOME RESIDENTS

Problem	Meeting	1	2	3	4	6	7	8	9	10	TOTAL
	County	G	F	G	F	F	F	F	F	F	
	Present	24	15	10	5	8	18	6	8	6	102
HEALTH											
Knowledge of Services		□		□	□	☆					4
Trash, litter, refuse		□	□			☆			□		4
Emergency Care			□	□							2
Discrimination at Hospital				□							1
Insufficient Personnel				□		☆					2
Inadequate Services				□				☆		□	3
Sewage					□	☆				□	3
Garbage and Rats				□							1
Limitation of Charity Care							☆	☆		□	3
Special Envioronmental Need		□	□						□		3
Health Problems Total											26
HEALTH RELATED											
Finances		□			□						2
Transportation		□	□	□		☆		☆			5
Garbage Service		□	☆	□		☆					4
Code Enforcement				□		☆			□		3
Housing				□		☆			□		3
Street Lighting						☆					1
Fire Hydrants		□									1
Housekeeping										□	1
Mental Releasee Employment							□				1
Health Related Problems Total											21
All Problems Total											47

G=Gwinnett County
F=Fulton County

□ =mild concern
☆ =high concern

Problem Indicators:

ATLANTA (SMSA), 1960:

Overall:	
Families with income under $3,001	21%
Unsound housing units	19%
In Depressed areas:	
Families with income under $3,001	52%
Persons per residential acre	58
Non-white:	
Percent of total population	23%
Median income	$3,033.00
Median years of education	7.6

Title: Better Mental Health for the Atlanta Area

SUMMARY:
MENTAL HEALTH PROBLEMS GENERALLY ARE CAUSED BY STRESSES AND STRAINS ON PERSONS AND ARE DUE TO ENVIRONMENTAL, PHYSICAL, SOCIAL, ECONOMIC, EDUCATIONAL AND OTHER FACTORS. ONE OUT OF TEN PERSONS COULD BENEFIT BY RECEIVING SOME FORM OF MENTAL HEALTH SERVICES. BUSINESS AND INDUSTRY SUFFER HEAVY LOSSES FROM THE IMPACT OF MENTAL ILLNESS ON EMPLOYEES AND THEIR FAMILIES. SURVIVAL OF OUR DEMOCRATIC INSTITUTIONS IN THIS HIGH ENERGY NUCLEAR AGE MAY WELL DEPEND ON MOBILIZING THE RESOURCES OF EVERY COMMUNITY TO FIGHT AND PREVENT MENTAL DISORDERS AND TO PROMOTE POSITIVE MENTAL HEALTH.

Problem:

130,000 inhabitants of the metropolitan area (10% of population) could lead happier more effective lives if they had the benefit of modern mental health services.

Ten percent of school children have handicapping emotional and psychological problems. These children need help towards self-realization.

Heavy loss by business and industry in the metropolitan area due to impact of emotional and psychological disturbance on worker and family, can be drastically reduced by a comprehensive system of modern mental health services.

Greater involvement of general hospitals, physicians, and psychiatrists is essential to proper development of mental health programs.

Insurance coverage not yet adequate.

More MANPOWER must be made available; better use should be made of present personnel and new sources of manpower explored.

Mental health services must be brought to the people rather than administered for the convenience of the "establishment".

Full development of comprehensive community mental health centers in the ATLANTA AREA is a TOP PRIORITY.

Total resources of every community should be mobilized to treat and rehabilitate victims of mental illness, to PREVENT mental disorders, and to produce a climate conducive to better mental health for all.

Physicians could and should be first line of defense against mental illness, but their medical training has not prepared them for this role. The outpatient clinics, as a rule, are severely understaffed.

A crucial barrier to the developing mental health program is lack of trained personnel.

Current Status:

No general hospital in the Atlanta Area accepts patients who are mentally ill. Exceptions: Emory University operates a psychiatric unit of twenty beds for patients selected for teaching purposes; and Grady Memorial Hospital has a psychiatric unit of thirty-six beds for emergency short-term patients.

The public schools' staff, while improving in number and qualifications, is still inadequate.

The State Retardation Center is under construction.

Psychiatric units as components of comprehensive community mental health centers are under construction, as follows: Clayton County Hospital (25 beds); DeKalb General Hospital (44 beds); and Northside Hospital, Fulton County (25 beds).

There are four private psychiatric hospitals in the Atlanta Area (SMSA).

The State Regional Hospital (Atlanta) has been constructed and is being activated to serve fourteen counties.

The State of Georgia has built the Georgia Mental Health Institute for the primary purpose of "training and research".

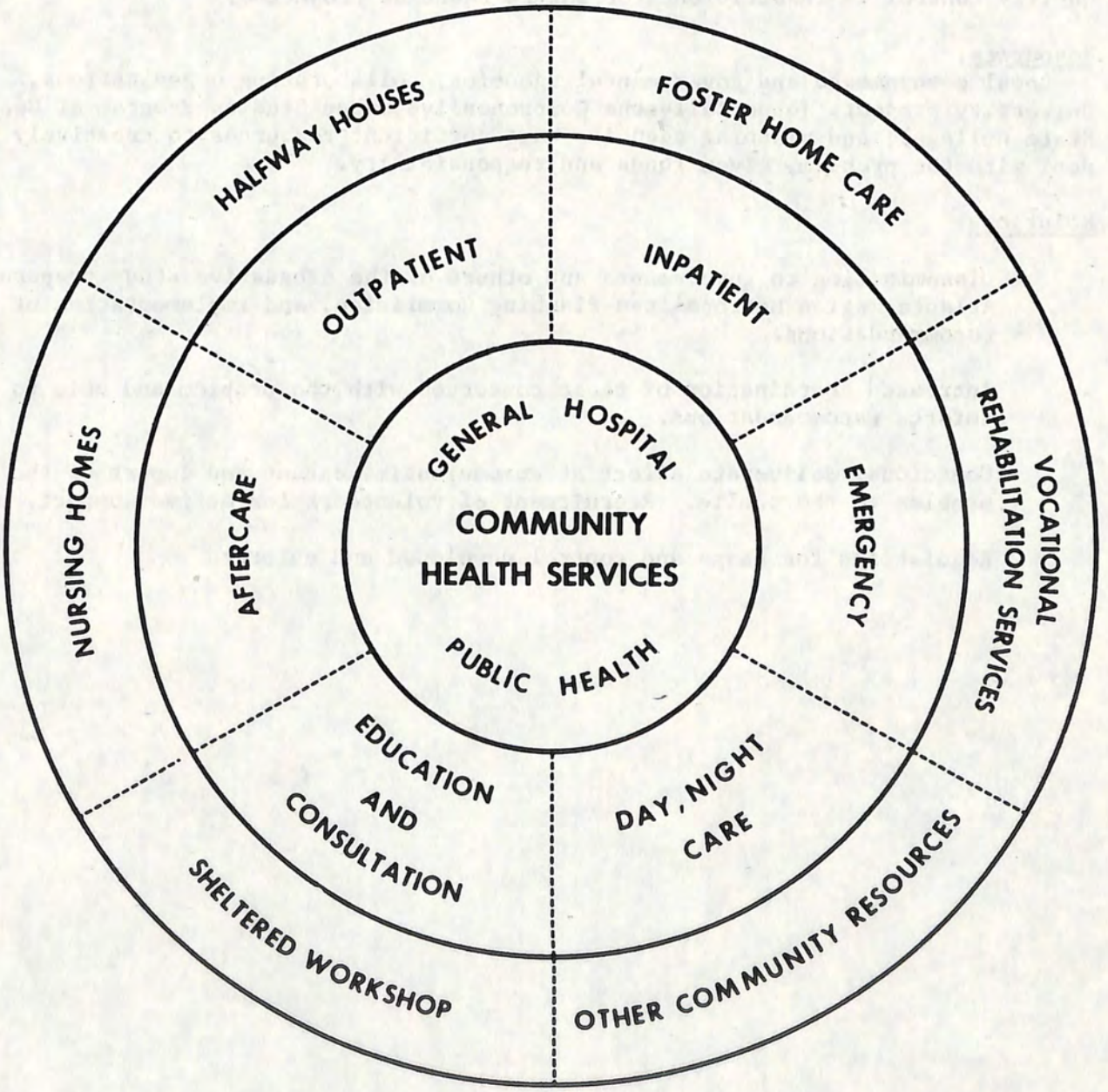
Possible Solutions:

The full development of at least ten proposed comprehensive community mental health centers in the Atlanta Area will alleviate for the present many of the problems when they become operational.

More MANPOWER must be made available, better use should be made of present personnel and new sources of manpower should be explored.

Total reliance must not be placed on hospitals, clinics, or mental health professionals to do the "job" of dealing with mental health problems; but rather every resource in the community, such as the schools, the churches, the courts, the health and welfare agencies, etc., should be fused with and oriented in basic principles of mental health, that each will be a positive force that will help create a climate conducive to better mental health for all.

COMPREHENSIVE
COMMUNITY MENTAL HEALTH PROGRAM



Control of air, water pollution and waste disposal vital to Atlanta Area future.

SUMMARY:
THE CONSERVATION OF ENVIRONMENTAL RESOURCES OF AIR AND WATER AND THE RELATED CONTROL OF WASTE DISPOSAL ARE FUNDAMENTAL CONTRIBUTORS TO HEALTHFUL LIVING. IN THE ATLANTA METROPOLITAN AREA THE CRITICAL PROBLEM IS ONE OF AREAWIDE PLANNING AND IMPLEMENTATION IN TERMS OF PRESENT AND PROJECTED POPULATION NEEDS.

Problem:

Present water resources will be adequate for future needs only if handled properly on a planned basis. Waste water, solid waste, and air pollution are compounding problems as a result of lack of overall planning and coordination among governmental bodies. Pollution of rivers and streams threatens health, recreation and wildlife. Automobile graveyards, rodent-infested litter and dump areas illustrate to the observer an increasing solid waste problem, Air quality control is insufficient for future needs as projected.

Resources:

Local governments and governmental agencies, collaborating organizations, University projects (especially the Comprehensive Urban Studies Program of Georgia State College), and planning agencies have sufficient resources to creatively deal with the problem, given funds and responsibility.

Solutions:

Dissemination to governments and others of the exhaustive study prepared for Atlanta Region Metropolitan Planning Commission, and implementation of its recommendations.

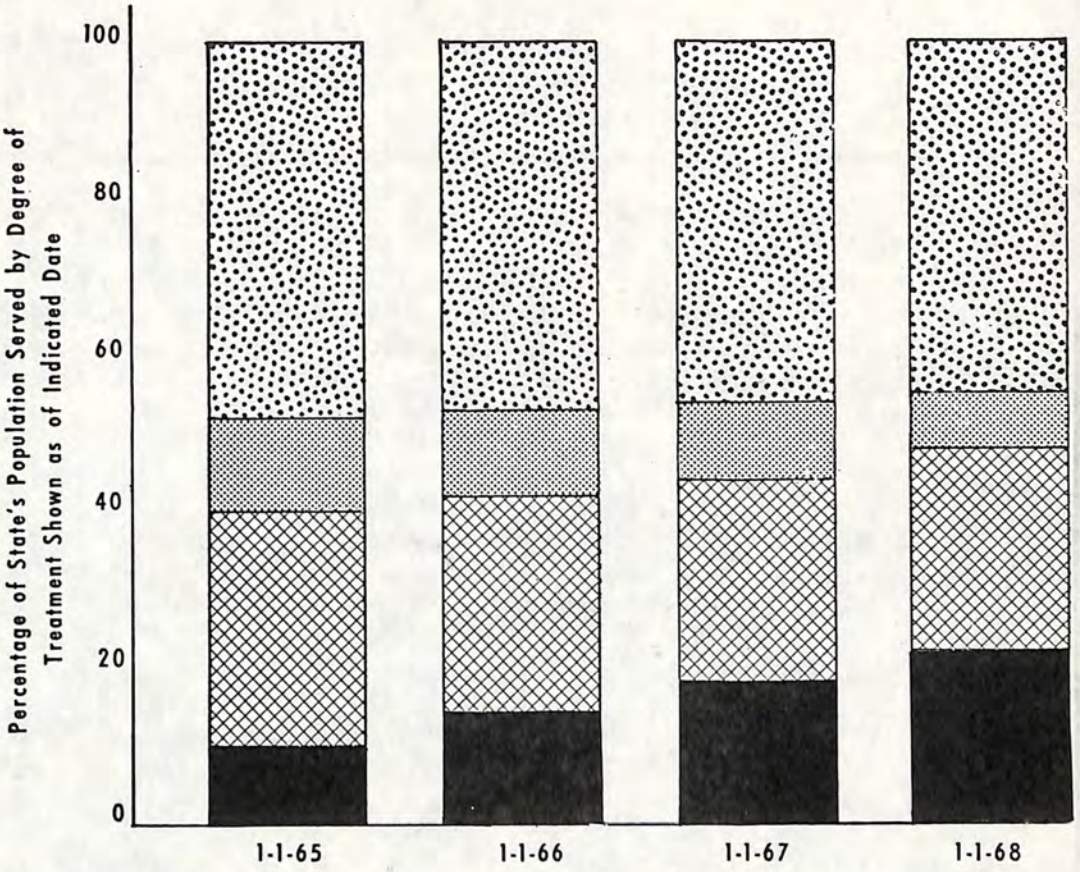
Increased coordination of those concerned with the problem and able to enforce recommendations.

Conscious, deliberate effort at communicating extent and import of the problem to the public. Recruitment of volunteers for active support.

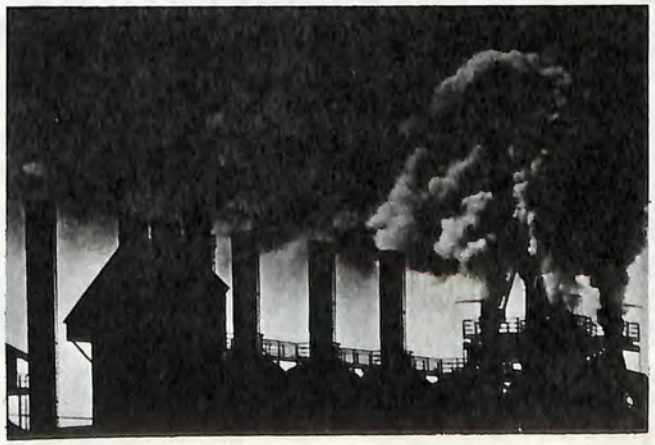
Regulations for usage and control developed and enforced.

PROGRESS TOWARD PROVISION OF ADEQUATE SEWAGE TREATMENT IN GEORGIA

POLLUTED STREAMS



POLLUTED AIR



Proctor Creek - Case Study of a Multiple-Impact Health Hazard

SUMMARY:
PERIODIC FLOODING OF PROCTOR CREEK, A HIGHLY POLLUTED WATERWAY IN SUBURBAN ATLANTA, RESULTS IN CONTAMINATION, DROWNINGS, INCREASE IN NUMBER OF PESTS, DESTRUCTION AND LOSS OF PROPERTY. REDUCTION IN POLLUTION AND FLOOD LEVELS MUST BE SOUGHT TO IMPROVE OVERALL CONDITIONS IN THE NEIGHBORHOOD.

Problem:

An area involving 1200 residences and 6000 families encounters the following problems as direct result of pollution and flooding of the creek:

Seven drownings in six years.

Illnesses directly related to pollution.

Sewage backup and overflow conditions in homes.

Uninhabitable basements resulting from constant sewage backup.

Severe, oppressive odors.

Proliferation of pests, insects, rats.

Property erosion, damaged building foundations, loss of large articles in floods.

Fire hazard from oil and other flammable materials in creek.

Current Resources:

Georgia Water Quality Control Board, Public Works Department of Atlanta, the Corps of Engineers, and area industrial plants.

Solutions:

Alternative plans and detailed study of cost alternatives and benefits will be necessary for improvements of the creek and adjacent areas. Possibilities include:

Channel improvements, floodwalls, enclosure, zoning restrictions.

Controlled access to prevent drownings.

Clean stream beds and banks of unsightly and hazardous objects that block stream flow.

Separation of sanitary and storm sewers.

Make area adjoining stream part of a lineroe regional park.

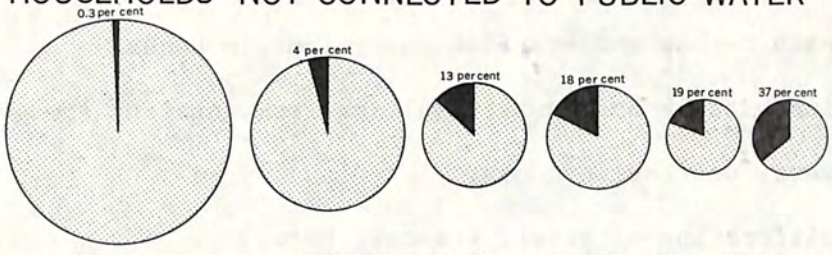
Evacuate residents and fill creek.

Indict companies contributing to pollution.

Park site demolition

SOLID WASTE

HOUSEHOLDS NOT CONNECTED TO PUBLIC WATER

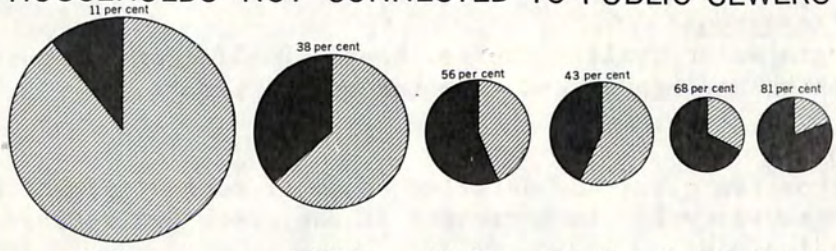


	Atlanta	DeKalb Co. outside Atlanta	Cobb Co.	Fulton Co. outside Atlanta	Clayton Co.	Gwinnett Co
Connected	153,696	60,523	28,702	26,124	10,415	7,974
Not Connected	441	2,518	4,425	6,194	2,449	4,770

SEWAGE

AIR POLLUTION

HOUSEHOLDS NOT CONNECTED TO PUBLIC SEWERS



	Atlanta	DeKalb Co. outside Atlanta	Cobb Co.	Fulton Co. outside Atlanta	Clayton Co.	Gwinnett Co
Connected	137,182	39,223	14,587	18,332	4,116	2,384
Not Connected	16,955	23,818	18,540	13,986	8,748	10,360

OPEN SEWERS

PROBLEMS OF PROCTOR CREEK

ODOR PROBLEM

SOLID WASTE DISPOSAL

SOIL EROSION

DROWNING

FLOOD PROBLEM

Public Health, Budgets, Boundaries and Personnel

SUMMARY:
THE NUMBER OF PERSONS TREATED WITHIN PUBLIC HEALTH SERVICES, ALMOST WITHOUT EXCEPTION, IS DIRECTLY RELATED TO THE COUNT OF MANPOWER, FACILITIES, AND POPULATION OF A GEOGRAPHICAL AREA RATHER THAN TO COMMUNITY HEALTH. OF COURSE, THIS IS A CONVENIENT ARRANGEMENT OF OUR MARKET ECONOMY AND JURISDICTIONAL SUBDIVISIONS. IF SERVICES WERE BASED ON MORE EXTENSIVE INVESTIGATION AND DOCUMENTATION OF HEALTH NEEDS RATHER THAN A CAPACITY TO PROVIDE SERVICES, PRESENT RESOURCES AND EFFORTS COULD BE MORE EFFECTIVE.

Problem:

Programs in Public Health are dependent upon both county and state funds and budgeting policies.

While these policies do take into account health needs and demands, they are directly affected by grant-in-aid formula.

As grant-in-aid monies are received on a local level, local directors are required to decide on where local (matching) money, furnished by the county governments, will be spent.

A thorough analysis of community consumer needs has not been developed.

It is patently impossible for the same individual to both operate and objectively evaluate program areas.

Confining program operations along county lines has adversely affected certain state health programs.

Reciprocity is provided for and is even discouraged by budgets.

A planning agency could:

Broaden the voice of decision in programs to include lay, governmental, and professional consumers as well as providers.

Share the burden of public health officials in allocation decisions.

Extend planning and establish communication across county lines in such programs as water and air control, industrial hygiene, sanitation, etc.

Title: Emergency Health Services - The Systems Approach

SUMMARY:
PRESENT EMERGENCY HEALTH SERVICES DEPEND UPON DECISIONS OF MANY INDEPENDENT LOCAL AUTHORITIES. LACK OF COORDINATION AND COMMUNICATION, AS WELL AS LACK OF INFORMATION ON WHAT CARE IS AVAILABLE AND HOW TO UTILIZE IT RESULT IN OMISSIONS, DUPLICATIONS AND DISSERVICE TO THE PUBLIC.

Problem:

There is much adequate emergency health care being planned and provided (especially for disaster and mass casualty) but uncoordinated efforts are resulting in dynamic deficiencies:

NEEDS	Unfulfilled	in some vital areas
STAFFING	Inadequate	numbers quality
FACILITIES		distribution
SERVICES	Incomplete Restricted Part-time	and often tardy to some classes death follows no clock
INFORMATION	Fragmented	in-service and to the public who often most need to know
TRAINING	Insufficient	for public self-help or service personnel needs
TRANSPORTATION	Dangerous	clogged urban corridors delay help/cause accidents
FINANCING	Marginal	and less in urban areas
COMMUNICATION	Infrequent	between the private and public power structures most involved in health services
PLANNING	Duplications & Omissions Unimaginative	uncoordinated efforts of all 6-county area groups; emergency health programs; reluctant public and professional acceptance of new methods

Needed:

One comprehensive system administered by one community-wide representative agency.

Solution:

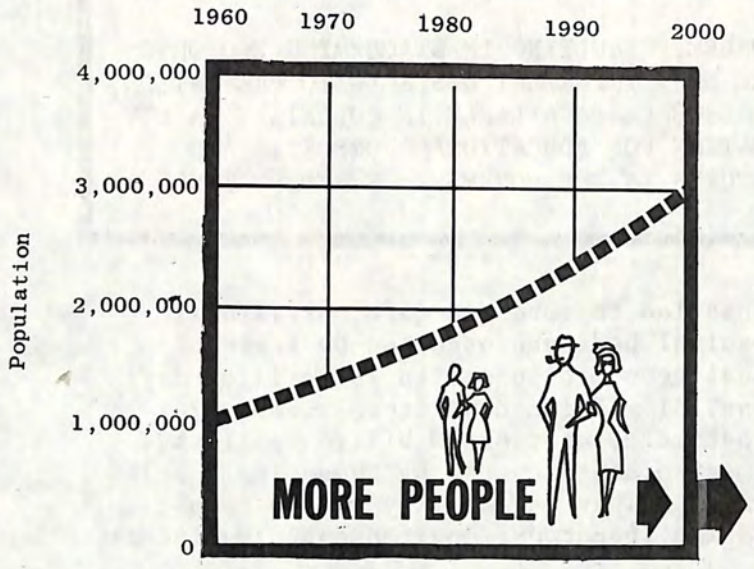
The Systems Approach: The involvement of all health-concerned institutions, organizations -- including governmental units and officials, both legislative and executive under the experienced guidance of health professionals.

The Goal: One central agency, one overall plan, to provide total, adequate emergency health services and care throughout the community.

Objectives:

- Increase staffing and facilities
- Provide adequate ambulance service
- Train the public in first-aid and medical self-help
- Establish hospital affiliated neighborhood health care centers
- Initiate two-way radio communication between hospitals, fire, police, hospitals, and other emergency care units
- Hold actual disaster and mass casualty exercises

EMERGENCY SERVICES



Total Population; Atlanta Five-County Source: Atlanta Region Metropolitan Planning Commission

Emergency Health Services in the Atlanta Area???

Health care is divided into a number of categories. One of the most important of these is emergency health care. The following:

- Hospital emergency room care
- Emergency care in physicians' offices
- Emergency care in neighborhood health centers
- Emergency care in industrial situations
- First aid training of the public
- Accident prevention
- Ambulance services
- Marking of evacuation routes
- Helicopter evacuation and landing facilities
- Emergency psychiatric and acute alcoholic care
- Poison control and poison control centers
- Blood banks
- Communications between institutions and organizations providing emergency health care
- Public information on sources of emergency health care
- Education and continuing education of personnel providing emergency health care
- Disaster and mass casualty reception

are not emphasized and organized in the Atlanta area.

Prevention of Accidents Can Significantly Reduce Area Toll of Deaths and Injuries

SUMMARY:
ACCIDENTS CONSTITUTE A MAJOR HEALTH PROBLEM, RESULTING IN STAGGERING ECONOMIC AND MANPOWER LOSSES. PUBLIC APATHY, THE MOST IMPORTANT OBSTACLE TO PREVENTION, MAY BE OVERCOME BY WELL PLANNED USE OF RESOURCES AVAILABLE IN VOLUNTARY SAFETY CONTROL, LEGISLATION, IMPROVED COMMUNICATION FOR EDUCATIONAL PURPOSES, AND PLANNING FOR BETTER SAFETY PHYSICAL FEATURES IN THE MOVEMENT OF PEDESTRIANS AND VEHICLES.

Problem:

An ever-increasing flow of traffic has led to more and more collisions, injuries, and deaths. Nearly 50% of hospital beds are occupied by accident victims. National figures indicate annual economic losses in 132 million days bed-disability, 94 million days work loss, 11 million days school loss, 22 million hospital bed days, and a total estimated cost of 12 billion dollars. Home, traffic, and other accidents are most often incurred by those least able financially and socially to bear the burden. This may chiefly be the result of compounded difficulties -- poor education, hazardous environment, low income.

Current Status:

Mortality statistics indicate the problem has reached epidemic proportions. Accidents are the leading cause of death to persons under the age of 44, and rank fourth as cause of death in all ages, following heart disease, cancer, and stroke.

Obstacles:

A major challenge is that of changing the viewpoint of those who still think of accidents as uncontrollable events. Public apathy exists, in this more than any major area, largely as a result of ineffective communication between experts and lay people. Indicative of this is fear of loss of personal freedom when strict preventive legislation is proposed.

Solutions:

1. Increased cooperation between safety councils, legislators, and mass media for planning and communication.

2. Increased use and standardization of drivers education in schools and defensive drivers courses in adult organization.

3. Increased financial support for safety-involved organizations.

4. Research into human behavior aspects of safety/accident problems.

5. Better street and highway design in the Atlanta Area.

6. Elimination of unnecessary roads and streets in order to provide for better pedestrian and vehicle movement.

7. Planned program of railroad, street and pedestrian "grade separation" in the Atlanta area.

8. Institution of a streetlighting program.

MAJOR FACTS ABOUT ACCIDENTAL INJURIES AND DEATHS-1968
(Statistics provided by: Epidemiology and Surveillance Branch Division of Accident Prevention,State of Georgia)

Following are estimates of the annual toll of accidents for the United States:

Persons killed	112 thousand
Persons killed motor vehicle	53 thousand
Persons injured	52 million
Persons injured,moving motor vehicle	over 3 million
Persons bed-disabled by injury	11 million
Persons receiving medical care for injuries	45 million
Persons hospitalized by injuries	2 million
Days of restricted activity	512 million
Days of bed-disability	132 million
Days of work loss	90 million
Days of school loss	11 million
Hospital bed-days	22 million
Hospital beds required for treatment	65 thousand
Hospital personnel required for treatment	88 thousand
Annual cost of accidents	$16 billion
Annual cost of accidental injuries	$10 billion

It is estimated that the prevalence of physical impairments caused by injuries in the non-institutionalized population of the United States is over 11 million.

Medical and Dental Service/Information and Referral

SUMMARY:

INFORMATION ON THE HEALTH SERVICE NETWORK IN THIS AREA IS FRAGMENTED AND UNCOORDINATED. REFERRAL PROCEDURES LACK STANDARDIZATION. CHANGING POPULATION AND INDUSTRIAL CHARACTERISTICS SUGGEST RE-APPRAISAL OF CURRENT AREAS OF CARE CONCENTRATION AND COORDINATION. MANY OF THE CAUSAL FACTORS ARE BEYOND THE CONTROL OR EVEN THE PURVIEW OF THE PRACTITIONER.

A CENTRAL PLANNING AGENCY COULD GATHER, MAINTAIN AND DISSEMINATE THE INFORMATION BOTH CARE PROVIDERS AND USERS NEED.

Problem:

Direct health care involves doctors, dentists, other health workers, hospitals, health centers, associations, programs and community organizations. The patient enters the system at any point, in highly varied states of health, wealth, intelligence and experience. Both parties suffer strain and are inefficiently serviced due, in part, to incomplete, haphazard information and referral systems.

Atlanta Has:

Health characteristics that are frequently below National par, consistently below those of Northeast metropolitan areas, but that rate favorably with other parts of the South.

Population increases and related rising health service demands that are offsetting past numerical gains in medical personnel, facilities and agencies.

Aggravated problems of age, youth and working women arising from rapid urbanization and industrial growth.

Complex administrative, educational and personnel procedures resulting from complicated Federal programs and financing.

One large hospital supplying quality care to a vast but limited number of indigent sick of two counties. Patients needing some types of care cannot be adequately treated, and even normal sicknesses exceed the plant's capacity.

Medical societies and voluntary agencies making outstanding efforts in community health planning and implementation for several but incomplete areas.

Atlanta Needs:

Formal communication between demands and provisions of services. Increased and more efficient use of existing personnel and facilities.

Broader and more intense coverage of community health problems.

SELECTED CHARACTERISTICS OF METRO ATLANTA WHICH AFFECT MEDICAL SERVICES

Characteristic	Primary effect on Medical Care Services
More older persons	Domicillary and extended care, treatment for special diseases and impairments, third-party payment
More younger persons	Treatment for infectious diseases, including venereal disease, accidents, impairments, handicaps, maternal and child care.
Urbanization and industrialization	
Special groups	Special deliveries of care (migrants, veterans, etc.)
Affluence	Greater quantity and quality of care.
Poverty	Public provision of care.
Congestion	Epidemiological control.
Suburbanization	Geographical redistribution.
Formal groups	Special interests.
Mobility	Fragmented care.
Work shifts	Full time availability.
Working females	Convenience, special diseases.
Organization and Bureaucratization	Third-party payment, insurance, prepayment
Federalization	Public programs and financing
Medical centers, schools special institutions	Personnel demands
Technological advancement	Development of medical science Greater expectations from public mediums of broader communication

Title: Alcohol and Drug Abuse - Causes Human Suffering

SUMMARY:
RECOGNIZED AS THIRD LARGEST HEALTH PROBLEM, BUT CHARACTERIZED BY NEGLECT, STIGMA AND REJECTION. PUNITIVE REACTION TO PROBLEM MUST YIELD TO A CONSTRUCTIVE APPROACH OF ASSISTING THE PERSON TO RECOUP AND REGROUP HIS PSYCHOLOGICAL RESOURCES FOR A MORE ADEQUATE RESPONSE TO LIFE'S RESPONSIBILITIES AND OPPORTUNITIES.

Problem:

Atlanta area (SMSA) leads nation in rate of arrests for public intoxication.

Largest market in world for bootleg whiskey.

Area has estimated 50,000 victims of alcoholism.

$5 million expended annually for local care of victims of alcoholism and their families.

$12 million annual loss to local industry due to alcoholism; absenteeism, accidents, lowered efficiency, etc.

Human suffering due to alcoholism cannot be estimated.

General Hospitals of area reluctant to accept victims of alcoholism as patients. Ditto doctors.

No facilities for treatment of drug addicts.

Current Resources:

Are limited in scope. The Georgian Clinic division of the Georgia Mental Health Institute and limited private programs, serve the entire state population. This service is incidental to the institute's research and training mission. The Emory University Vocational Rehabilitation Alcohol project which has served the chronic court offender alcoholic will probably be discontinued due to expiration of a three-year federal grant program. The Georgia Division of Vocational Rehabilitation provides limited rehabilitation services for alcoholics. A start has been made in the Atlanta Region (SMSA) toward preventing alcohol drug abuses through integrating services for individuals with the plans for comprehensive community mental health programs.

Treatment, care and rehabilitation of victims of alcoholism and persons addicted to drugs must be incorporated in the services of the proposed comprehensive mental health centers of the area, including some adjacent counties.

Additional reliable data is needed on the extent, nature and scope of the local problems of alcohol and drug abuse on a basis upon which to plan effective and innovative programs for prevention, control, treatment and rehabilitation of alcohol and drug abuse.

★ Changing attitudes and concerns of communities by information, education and consultation.

★ More effective enforcement of drug laws and regulation of drugs.

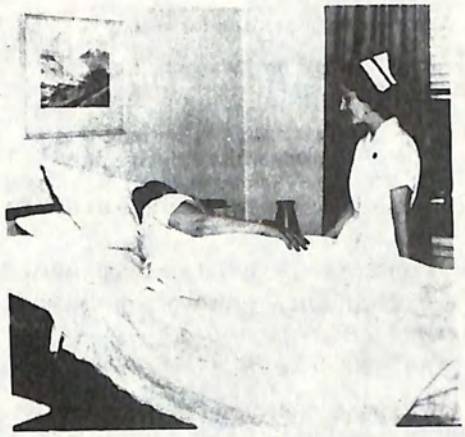
Trends:

Since most authorities and federal officials embrace the view that alcohol and drug addiction is a problem of living and probably symptomatic of an emotional illness that should be treated (a non-criminal circumstance) it logically appears that newly developing programs associated with community mental health centers will evolve as well as a thrust toward improving conditions in deprived neighborhoods where addiction is most common.

Goals and Objectives:

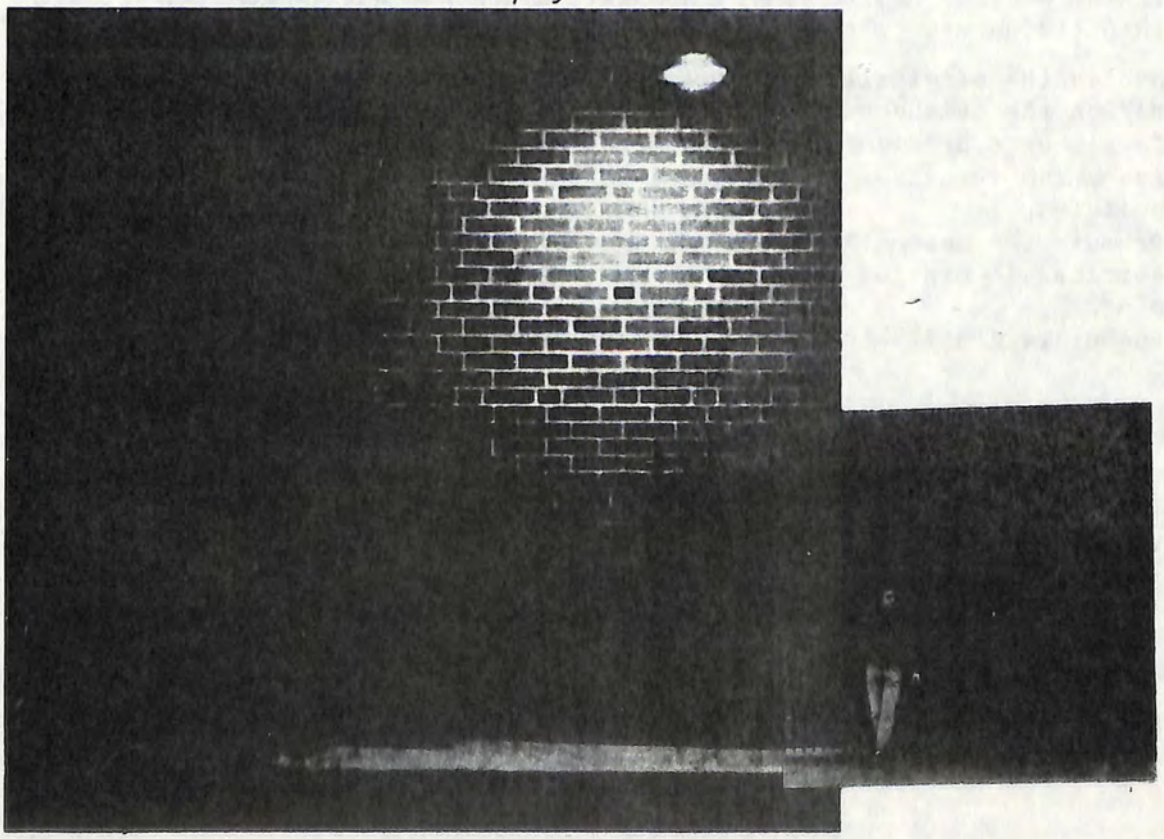
The Georgia Legislature has expressly recognized alcoholism as a disease and declared it to be a public health problem with administrative responsibility for alcoholic rehabilitation given directly to the Division of Mental Health of the State Department of Public Health and indirectly to the County Boards of Health and Public Health Departments. Comprehensive programs for alcohol and drug abusers can be developed in conjunction with or as an integral part of comprehensive mental health programs. The range of services that will be provided by the community mental health programs are very nearly the range of services required for dealing with alcohol and drug problems. The goals of these programs and services will be: (1) improved health and prevention of disease; (2) separation of the alcohol and drug abuser from alcohol and drugs; (3) repairing the physical and emotional damage and preventing further damage; (4) changing community institutions, programs and services to meet the special needs of the alcohol and drug abuser. While federal funds will be helpful in launching programs, state and local governments cannot presently rely upon federal funds for long-range support, although such continued federal support may well represent the only hope for programs for the alcohol and drug abuser in Georgia.

DRUNKS DON'T BELONG IN JAIL



By Henry Jackson

DRUG ABUSE: The Empty Life



Balancing the Costs of Health Care

SUMMARY:

THE COSTS OF MEDICAL CARE ARE RISING SHARPLY, EVEN MORE THAN THE COST OF LIVING. ILLNESS, DISABILITY AND PREMATURE DEATHS CREATE DISPARATE COSTS - BOTH DIRECT AND INDIRECT - TO FAMILIES ACCORDING TO CIRCUMSTANCES WHICH THEY CANNOT APPRECIABLY CONTROL: INCOME AND OCCUPATION, TYPE OF DISEASE AND TREATMENT.

Problem:

The costs of health make it prohibitive to some families and ultimately contributes to poorer health and additional costs to the community.

Current Status:

1. Federal assistance is directed to special groups of persons: Aged, maternal and infant, indigent, etc.
2. Federal programs are developed around certain diseases and disabilities: Crippled children, tuberculosis, blindness, cancer, venereal disease, etc.
3. Middle-income groups use physicians' services at a lower annual rate than other income groups.
4. Certain businesses and industries promote health and coverage from debilitating health expenses.
5. The costs of health insurance rises with the cost of medical care, especially hospital rates.

Possible Solutions:

The rising cost of health may be stabilized and the entire community brought into its purview within an area plan which can:

1. Review the eligibility requirements of tax-supported health services.
2. Reduce the demand on rare skills by providing information and referral services to providers and consumers.
3. Recommend the wider inclusion of extra-hospital services in insurance policies.
4. Promote the assembling of complex equipment, professional skills and services to provide for extensive, continuous, non-domicilary treatment.
5. Encourage architectural and organizational modernization in hospitals.

THE COSTS OF BEING UNHEALTHY

NUMBER OF DISABILITY DAYS* PER PERSON PER YEAR BY FAMILY INCOME, TYPE OF DISABILITY AND AGE

In the United States, July 1966-June 1967

	All Incomes**	Under $3,000	$3,000-4,999	$5,000-6,999	$7,000-9,999	$10,000 and over
RESTRICTED ACTIVITY						
All ages	15.4	27.6	16.3	13.7	12.3	11.9
Under 17 years	9.6	9.2	9.1	9.9	9.7	10.1
17 - 24 years	9.6	12.8	9.8	9.0	9.3	7.9
25 - 44 years	13.8	24.8	17.0	14.1	11.9	11.3
45 - 64 years	21.4	43.5	25.5	18.0	15.9	14.8
65 years and over	35.2	39.8	29.2	36.2	34.8	29.0
BED DISABILITY						
All ages	5.6	9.7	5.9	5.3	4.4	4.5
Under 17 years	4.3	5.1	4.2	4.6	4.0	4.2
17 - 24 years	4.1	4.5	4.4	4.0	4.5	3.5
25 - 44 years	4.8	9.0	6.5	4.6	4.1	3.9
45 - 64 years	6.9	14.3	7.5	6.3	4.6	4.8
65 years and over	11.9	13.2	9.2	12.9	10.7	12.5
WORK-LOSS DAYS AMONG CURRENTLY EMPLOYED* **						
All ages	5.4	7.9	6.7	5.8	4.4	4.6
Under 17 years	—	—	—	—	—	—
17 - 24 years	3.9	4.7	4.5	4.3	4.2	2.7
25 - 44 years	4.8	8.1	6.6	5.3	3.7	4.2
45 - 64 years	6.6	10.3	7.9	7.3	5.5	5.7
65 years and over	6.3	7.0	7.9	5.0	****	6.7

*Refers to disability because of acute and/or chronic conditions.

**Includes unknown income.

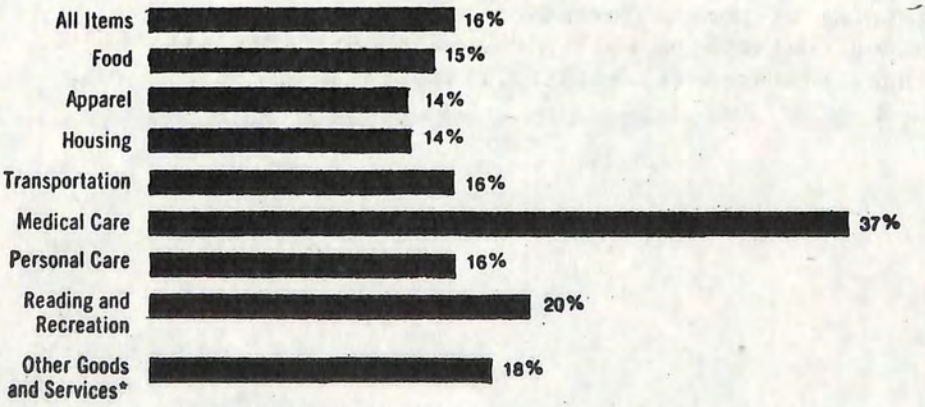
***Based on currently employed population 17+ years of age.

****Figure does not meet standards of reliability or precision.

Source: United States National Health Survey, United States Department of Health, Education and Welfare.

INCREASES IN MEDICAL CARE AND OTHER MAJOR GROUPS IN THE CONSUMER PRICE INDEX

In the United States, 1957-59 — 1967



*Comprises tobacco, alcoholic beverages, legal services, burial services, banking fees, etc.

Source: U.S. Department of Labor, Bureau of Labor Statistics.

THE COSTS OF BEING HEALTHY

Coordination of Planners

SUMMARY:
A COMMUNITY-WIDE HEALTH PLAN CANNOT SUCCEED WITHOUT STRONG COORDINATION OF ALL INTERNAL AND EXTERNAL SPECIALIZED PLANNERS. THE VARIETY AND INTERDEPENDENCY OF MODERN PLANNING AGENCIES REQUIRE A CAREFULLY CONSIDERED LONG-TERM BASIS FOR BENEFICIAL INTERACTION AND EXCHANGE WITHOUT LOSS OF CREATIVE AUTONOMY. PRESENT SHORT-RANGE, INFORMAL, INCOMPLETE COORDINATION, WHICH CAN RESULT IN DUPLICATIONS AND OMISSIONS, SHOULD BE STRENGTHENED BY A COMPREHENSIVE, CONSENSUAL LONG-RANGE PLANNING FRAMEWORK.

Text Outline:

- Reasons for coordination:
  - The informal, unstructured coordination among local planners are inadequate to the pace of change in the modern community.
    - Present planning coalitions are arranged around limited groups and mainly for short range goals.
    - While there are 60 agencies listed as serving the physically disabled, the gaps and overlaps are only suggested, the interrelationships are not well established.
  - Cities are receiving increasing amounts of federal aid and attention yet no projective framework for land-use, transportation, services, health care, etc., has been adopted by relevant providers.
    Physical and population rearrangements are widespread and require accompanying service rearrangements.

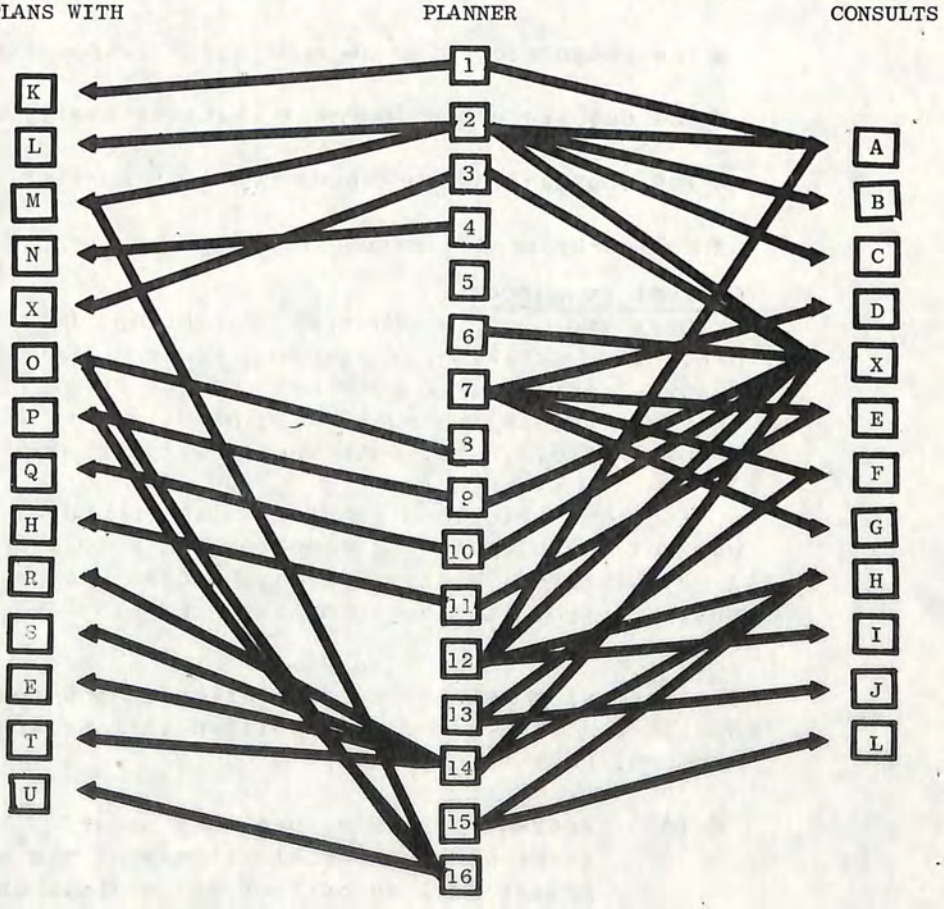
- How coordination could be achieved:
  - Provision of channels of communication and programs of active cooperation by:
    - exchanging of skills and controls (personnel, data, funds, etc.);
    - use of computer based techniques;
    - interlocking decision-making arrangements;
    - overlapping of common jurisdictions;
    - organized contacts on multiple levels of staff; and
    - meetings, conferences, mailing lists.

PROFILE OF HEALTH AND HEALTH RELATED PLANNING AGENCIES

Agency (Coded) — Characteristic (Yes = ■)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
■	■	■	■	■		■	■	■	■	■		■	■	■	■	Permanent
		■	■		■	■	■		■		■					Official
■		■		■		■	■	■			■	■	■	■	■	Serves more than 1 county
■	■	■		■	■		■	■	■	■	■		■	■	■	Directly related to health
■		■	■		■			■	■	■		■	■		■	Advisory function
■	■	■	■	■	■		■			■	■	■	■	■	■	Implementing function
	■							■			■		■	■		Direct evaluation procedure
■	■	■		■	■	■		■	■	■	■		■		■	Collects health data
						■									■	Reports published (health)
■	■	■			■	■		■	■	■	■	■	■	■		Uses outside consultations
■			■		■	■	■	■	■	■	■		■			Reports on request
■	■	■	■		■	■		■	■	■	■	■	■	■		Immediate future plans
■	■	■	■				■	■	■	■			■	■	■	Formal interagency relations
■		■	■					■	■		■		■	■	■	Finance interagency coord.
■	■						■	■	■	■			■			Formal planning structure

EXTENT AND DIRECTION OF INTERCHANGE AMONG A SELECTED GROUP OF PLANNERS



Note: Numbers and letters are coded for names of agencies. A decoded listing may be found in the Appendix.

Suicide Prevention - Crisis Intervention

SUMMARY:
THE MAGNITUDE, URGENCY AND COMPLEXITY OF SUICIDAL AND PSYCHIATRIC CRISES MAKE THEM PUBLIC HEALTH PROBLEMS. THE TRAGEDY, CHRONIC RECURRENCE AND OFTEN LENGTHY HOSPITALIZATION CONNECTED WITH THESE EMERGENCIES CAN BE AVERTED OR ALLEVIATED BY CONSISTENT PREVENTIVE CARE. THE PROPOSED COMMUNITY COMPREHENSIVE MENTAL HEALTH CENTERS COULD EFFICIENTLY PROVIDE THESE NEEDED MULTI-DISCIPLINE SERVICES.

Problem:

Past reluctance of the general lay and medical public to openly become involved in the recognition, research, cooperation and sympathetic treatment these crises demand.

Suicide nationally, ranks among the top ten causes of death; is fourth in cause for all male deaths between 20-45, and is second highest cause among college fatalities.

In the Atlanta Metropolitan Area, the suicide rate exceeds the National average by about 25%.

For each actual death by suicide, 8-10 serious attempts occur.

Psychiatric crises--that often end in suicide or physical violence to others, can often be foreseen by trained personnel in the complex web of social, economic, cultural and health problems that aggravate mental instability.

- The essence of time demands quick responsive help.
- The desperate bewilderment requires easily available aid.
- The constant danger needs constant service, on a 24 hour basis.
- Follow-up of all cases is basic.

Current Resources:

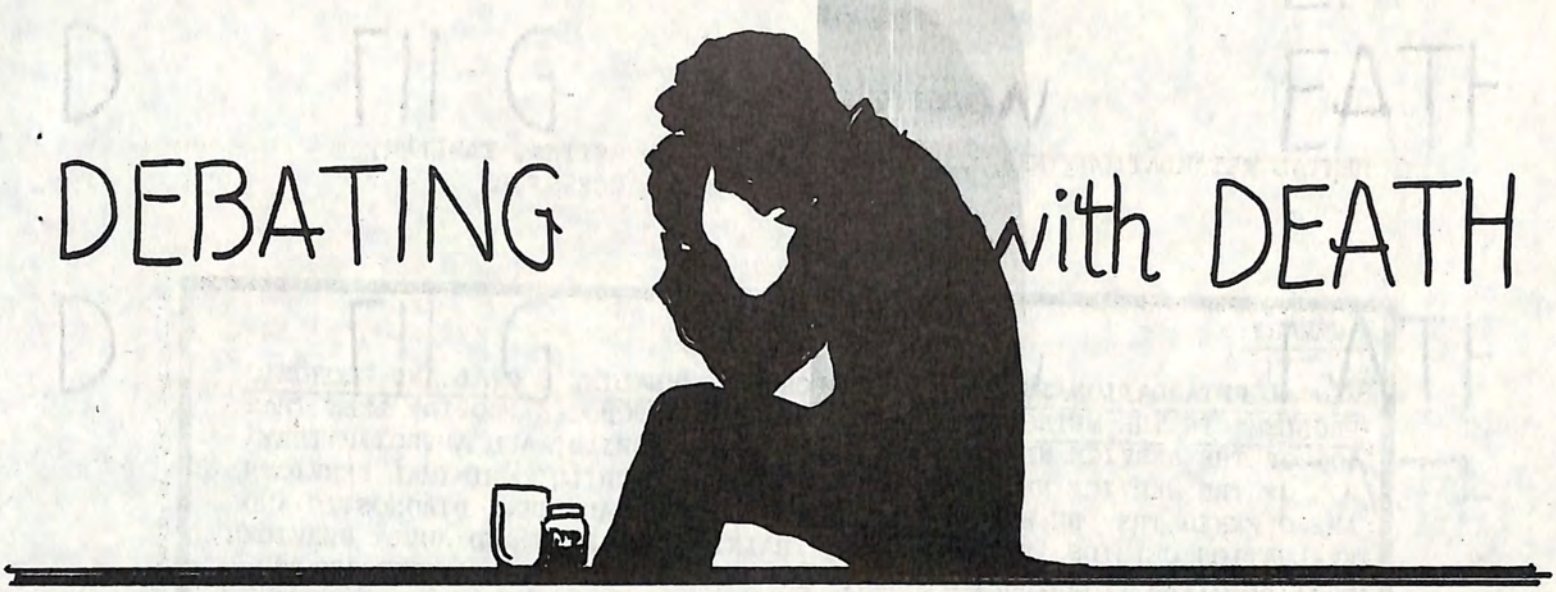
Only two Georgia counties, Fulton and DeKalb, are served by a suicide-prevention, crisis-intervention center. Coordinated with Grady Memorial Hospital psychiatric services and the respective County Health Departments, the program has two multi-discipline crisis teams available 24 hours a day. A total of 4,375 patients were treated in 1968.

A unique telephone service, also manned 24 hours a day, 7 days a week, was set up to cover ten counties, on a toll-free basis. The "staff" includes a psychiatrict, a clinical psychologist, a psychiatric nurse, three public health nurses, two sociologists, and six "lay counselors."

Solution:

The fastest possible implementation of the ten proposed Community Mental Health Centers in the Metropolitan Atlanta Area, with the backup of Georgia Regional Hospital-Atlanta.

- To: Prevent crises before they occur.
  Eradicate the social stigmas of the problems.
  Enlist full support of all medical and political units.
  Make effective use of current knowledge and resources.



FULTON-DeKALB EMERGENCY MENTAL HEALTH SERVICE
CASES BY COUNTY - FIRST 18 MONTHS

Fulton.....	1530	44.1%	Gwinnett.....	45	1.3%
DeKalb.....	622	17.9%	Douglas	10	.3%
Cobb	130	3.7%	Other	57	1.6%
Clayton.....	70	2.0%	Unknown	1009	29.1%

PSYCHIATRIC SERVICES - GRADY MEMORIAL HOSPITAL
January - December, 1968

I	Emergency Patients	4375
II	Inpatients	1912
III	Outpatients	4022
IV	Consultations:	
	A. Medical Inpatient Service	356
	B. Pediatrics	166
	C. Obstetrics	757
V.	Drug Clinic Opening July, 1968-December, 1968	803
VI.	Crisis Service Opening August 19, 1968-December, 1968	421
VII.	Psychiatric Day Center Opening November 4, 1968-December, 1968	36

MENTAL RETARDATION (MR) PROGRAM NEEDS: MORE, BETTER, EARLIER, MORE ACCESSIBLE

SUMMARY:

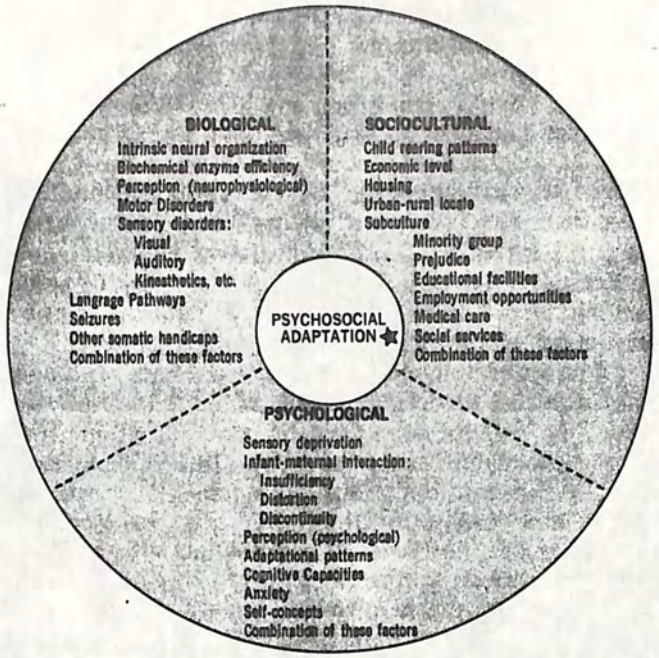
MENTAL RETARDATION IS ONE OF THE FOREMOST HEALTH, SOCIAL AND ECONOMIC PROBLEMS IN THE METRO ATLANTA AREA. PUBLIC SCHOOLS PROVIDE LESS THAN 50% OF THE SERVICE NEEDS OF THE EDUCABLE MR CHILD, AND APPROXIMATELY 50% OF THE SERVICE NEEDS OF THE TRAINABLE MR CHILD. MINIMAL SERVICES ARE OFFERED THE PRE-SCHOOL AND POST SCHOOL RETARDATE. DIAGNOSTIC AND EVALUATION CLINICS, EDUCATION AND TRAINING PROGRAMS AND ADULT SERVICES MUST BE GIVEN PLANNING EMPHASIS. SERVICES ARE WASTED HOWEVER UNLESS PLANS ARE MADE TO INSURE DELIVERY OF THESE SERVICES TO THE CONSUMER. A TRANSPORTATION PLAN MUST THEREFORE BE A VITAL PART OF PROGRAM DESIGN.

The Problem: The MR person is one who, from childhood, experiences unusual difficulty in learning, and is relatively ineffective in applying what he has learned to the problems of life. He needs special training and guidance to make the most of his capacities.

Current Status: In Metro Atlanta, there are an estimated 42,647 retarded persons. At the present time, only 6,804 individuals by our survey are receiving education and training, residential services, vocational rehabilitation or other adult services from appropriate community agencies.

Needs: While all the metropolitan area school systems offer some services for mentally retarded children, many are not served. Private residential facilities serve only non-ambulatory neurologically impaired children. Vocational Rehabilitation works with retardates enrolled in public school special education programs, and with a limited number of MR from the community at large. Expansion of all these programs is needed. Day training facilities for the severe and moderate pre-school, severe school age, and severe and moderate adults should be established.

Structure of Planning Organization: The responsibility for area wide mental retardation planning should rest in a 6 county planning body made up of representatives from the 6 local health districts. Each district would appoint 6 representatives, drawn from vocational rehabilitation, the health department, family and children's service, public schools, associations for retarded children, and recreation departments. An MR specialist should be employed.



Estimated Number of MR Persons in the 5 County Area★★

Level of Retardation	Chronological Age Range			
	0 - 5	6 - 17	18+	Total
Mild	5409	9554	24506	39469
Moderate	305	537	1375	2217
Severe	108	191	493	792
Profound	22	42	105	169
			Grand Total	42,647

Existing Services in the 5 County Area★★

Public Schools		Private Schools		Residential		Voc.	Adult
EMR	TMR	EMR	TMR	Private	Public	Rehab.	Act.
5151	377	40	225	106	120	703	82

Organizational Chart★★

Comprehensive Health Planning

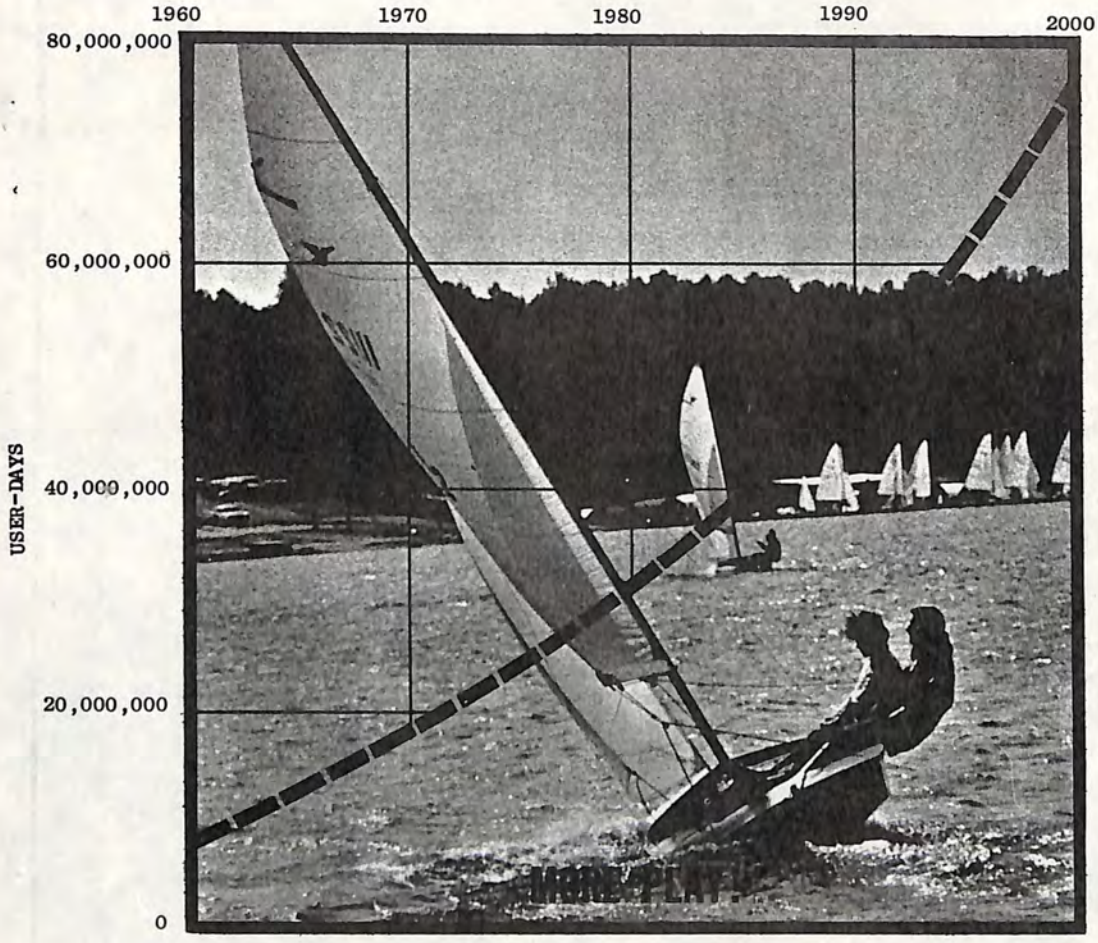
Metro Atlanta MR Planning Committee

DEKALB	FULTON	COBB	GWINNETT	CLAYTON
	One Representative from each field			
Voc. Rehab.	Voc. Rehab.	Voc. Rehab.	Voc. Rehab.	Voc. Rehab.
Health Dept.	Health Dept.	Health Dept.	Health Dept.	Health Dept.
FACS	FACS	FACS	FACS	FACS
Schools	Schools	Schools	Schools	Schools
ARC	ARC	ARC	ARC	ARC
Recreation	Recreation	Recreation	Recreation	Recreation

MR Specialist
Secretarial Staff

★ 1. Conceptual Visual Aid: Interaction of Multiple Factors. (From Richmond, J. B., and Lustman, S. L., J Med Educ 29:23 (May) 1954).

★★ Douglas County not included in the above 5 county tables and charts.



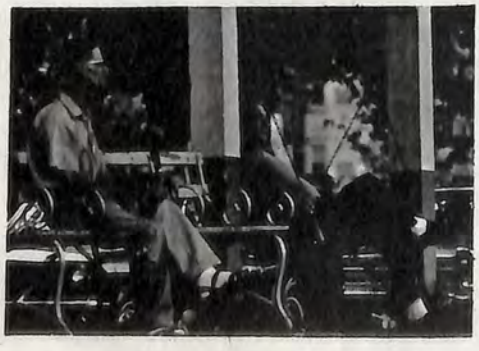
NUMBER OF USER DAYS PER YEAR FOR NON-URBAN OUTDOOR RECREATION FACILITIES, ATLANTA FIVE-COUNTY REGION.

Sources: U. S. Study Commission/Southeast River Basins; Atlanta Region Metropolitan Planning Commission. (1960 figure is based on annual 8 user-days per person, and 2000 figure is based on annual 26 user-days per person.)

CURRENT STATUS:

THE LAST PUBLISHED INVENTORY OF PARKS SHOWED 2,405 ACRES OF PUBLIC PARK LAND. THIS INCLUDED 67 PARKS AND 98 GREEN SPACES. THE FOLLOWING TABLE SHOWS THE DETAILS OF SIZE AND NUMBER.

SIZE	NUMBER	TOTAL ACREAGE PER CATEGORY	PERCENTAGE OF TOTAL ACREAGE
OVER 100 A	7	1233 A	51%
30-100 A	8	472 A	20%
15-30 A	9	156 A	6%
LESS THAN 15 A	43	390 A	16%
GREEN SPACES	98	155 A	7%
TOTAL	165	2405 A	100%



BY NATIONAL STANDARDS, PARK SYSTEM HAS GREAT INADEQUACIES. THESE STANDARDS ARE BASED ON YEARS OF EXPERIENCE IN PROVIDING RECREATION UNDER A VARIETY OF CONDITIONS. ON THE MOST GENERAL LEVEL, THEY CALL FOR A TOTAL OF 10 ACRES OF PARK LAND PER 1000 POPULATION; ATLANTA AREA SMSA, CURRENTLY HAS ABOUT 4.6 ACRES PER 1000 POPULATION. STANDARDS PROPOSED IN THIS REPORT WOULD INCREASE THE OVERALL CITY AVERAGE TO 7.2 ACRES PER 1000 POPULATION BY 1983 AND TO 10 ACRES PER 1000, IF FLOOD HAZARD AREAS ARE ADDED TO THE SYSTEM AS PROPOSED.

Title: Parks' and Recreation's Lag in Facilities, Services and Manpower.

SUMMARY:
GREATER RECOGNITION, FINANCIAL SUPPORT AND PARK/RECREATION PLANNING SHOULD BE GIVEN THE GROWING DEMANDS FOR RECREATION AND PARK FACILITIES, PROGRAMS AND SERVICES THROUGHOUT THE ATLANTA AREA, (SMSA). IT BEHOOVES LEGISLATOR, RECREATION AND PARK EXECUTIVES TO OBSERVE AND CORRECT THE PRESENT LAG OF FACILITIES SERVICES AND PROFESSIONAL MANPOWER NEEDS IN THE FASTEST GROWING CITY IN THE SOUTHEAST.

Problem:

Unfortunately, Atlanta does not have the park system and recreation program it needs and deserves. There is:

- lack of good public relations
- lack of public and city support
- inadequate local financing
- rising cost of land
- insufficient maintenance
- insufficient acreage
- staff personnel occupying position without proper training
- absence of public information on parks and recreation
- past segregation and apathy of current integration
- lack of a comprehensive plan to guide park and recreation development
- lack of standards at the state and local level.

Possible Solution:

To provide recreation programs and facilities in all neighborhoods of the city.

To encourage housing project and apartment owners to include recreation facilities.

To insure close supervision of staff and a good in-service training program for staff members that are not professionally trained.

To recruit professionally trained personnel for staff position.

To provide a well-balanced program for all ages, with a wide variety of interests.

To involve residents in planning and operation of public recreation.

To provide minimum standards for all recreations programs.

Trends:

These are not theoretical standards. A survey done in 1965 showed that 49 out of 189 cities met the acreage standards. As part of this study, comparisons were attempted with other cities the same size as Atlanta. Overlapping governmental jurisdiction made these comparisons difficult, but it appeared that out of 20 similar cities, 15 to 7 had more park acreage per population than Atlanta. About one-half met the acreage standards.

Inadequate open space.

Inadequate Planning.

Lack of interest at the Board of Aldermen level.

Diverted funds.