A proposal for the development of a primary health care delivery system in White County, Georgia

William A. Murphy

ATLANTA UNIVERSITY

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A PROPOSAL FOR THE DEVELOPMENT OF A
PRIMARY HEALTH CARE DELIVERY SYSTEM
IN WHITE COUNTY, GEORGIA

A THESIS
SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR
THE DEGREE OF MASTER OF PUBLIC ADMINISTRATION

BY
WILLIAM A. MURPHY

DEPARTMENT OF PUBLIC ADMINISTRATION

ATLANTA, GEORGIA
MAY 1979
ABSTRACT
PUBLIC ADMINISTRATION

Murphy, William A. B.A., Fayetteville State University 1975, Political Science

A Proposal for the Development of a Primary Health Care Delivery System in White County, Georgia

Advisor: Ms. Mary Nell Morgan
Thesis Dated April 1979
Degree Conferred: May 1979

The primary purpose of this paper is to identify and recommend a workable solution to White County's problem of access to adequate basic medical care and basic health care services.

White County's problem is twofold. The first is the absence of an adequate number of health care providers. The second is the absence of a health care facility to treat the county's people.

This study looks at the conditions that are necessary for any county to have and maintain a doctor. After a comparative analysis of the optimum conditions as opposed to the present conditions that exist in White County is made; it can be concluded that White County cannot maintain enough doctors to serve its population.

The possible solutions to White County's problem are suggested. That solution is the setting up of a primary health care center.
This study then makes recommendations for the short range and the long range direction for the health system of White County, Georgia.
ACKNOWLEDGMENTS

I would like to thank my family, Ms. Valerie Fisher, and the staff of the Appalachian Primary Health Care Unit for their faith, confidence, understanding, and assistance in the completion of this document.
# TABLE OF CONTENTS

I. Introduction ......................................................... 1

II. Problem Identification .......................................... 4
   A. Identification of Problem
   B. Determinants of the Problem
   C. Methodology

III. Primary Health Care and the Models Used ............... 11
   A. Definition
   B. Health Care Delivery Models
      1. Hospital Based Center
      2. Health Department Based Center
      3. Community Based Center

IV. Conclusions .......................................................... 15

V. Recommendations ..................................................... 19

VI. Appendices .......................................................... 24

VII. Bibliography .......................................................... 46
**LIST OF TABLES**

<table>
<thead>
<tr>
<th>Chart A</th>
<th>25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chart B</td>
<td>27</td>
</tr>
<tr>
<td>Hierarchial Structure of a Community Health Care Center</td>
<td>28</td>
</tr>
<tr>
<td>Budget Information</td>
<td>29</td>
</tr>
<tr>
<td>Preoperational Workplan</td>
<td>30-42</td>
</tr>
<tr>
<td>Letters of Support</td>
<td>43</td>
</tr>
</tbody>
</table>
I. Introduction

The demands for medical services by the nation's two hundred million people are enormous. Some thirty-two million patients each year are admitted to hospitals as bed patients. The cost of providing this care is clearly a national crisis. In Georgia these concerns are even more pressing for the health problems of Georgia are among the greatest in the nation. In many areas of the state, the people do not have access to day-to-day health services and the medical care necessary to maintain their physical well-being.\(^1\) The disease patterns currently identified in Georgia emphasize a need for programs of accessible continuing primary health care to identify the health problems early and avoid health crises. With the present distribution of health manpower and resources in the Appalachian region of Georgia many of its residents are totally dependent on crisis or emergency care provided at a sight some distance from their home communities. White County has such a problem.

It is the purpose of this study to address and recommend a solution to White County's problem. The dependence on crisis or emergency care coupled with the growing number of closed

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\(^1\)Statewide Joint Practice Committee Between Medicine and Nursing, The Continuing Role of Nursing in Georgia, 1978, page 17.
practices of primary care providers, and the dwindling number of physicians taking Medicaid/Medicare patients have precipitated the creation of the Appalachian Primary Health Care Unit (APHCU).

The Appalachian Primary Health Care Unit's purpose is to establish a rural health system that joins local, regional and state providers together at a primary level of health care. Primary health care is defined as health care which is first received when a patient seeks help in resolution or prevention of health problems.

The APHCU will develop primary health care services in rural and growing population areas where the traditional family physician, who is the sole provider of primary health care is no longer available; and, other care is inaccessible or inadequate. The models for the delivery of these health services will utilize a registered nurse who has acquired advanced knowledge and clinical skills in nursing through the successful completion of a graduate nursing program to provide health care with only limited supervision from a physician. This nurse is called a nurse practitioner. The APHCU places emphasis on integrating primary health care services with existing services and with public or private providers.

The primary care provider is a scarce commodity in rural areas. It is even a scarcer commodity for those most in need and least able to afford primary medical services. In 1978, the Appalachian Georgia region had an areawide ratio of 1 primary care physician to 2,771 people. This ranged from 1
per 1,633 to 1 per 9,150 in White County. This maldistribution of physicians became apparent to me during my internship with the Appalachian Primary Health Care Unit. It was my responsibility to collect and collate the statistical data on the Appalachian counties to determine the counties' eligibility for primary health care centers.

The nurse practitioner based model for treatment under medical protocol and an understanding with local physicians and hospitals, commits the counties, hospitals and private providers and public health agencies to a system of basic medical and health care that is not currently present within the state. This study will show that this commitment will change the present health status and alleviate the deficiencies that White County has in the areas of health care providers and a health care facility.

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3Protocol is defined as the steps or diagnostic work-up and courses of treatment written and agreed upon between the nurse practitioner and back-up physician.
II. Problem Identification

White County is about fifty-nine (59) miles from the city of Atlanta and about sixty-three (63) miles from Athens. This puts White County within the Appalachian foothills region of Georgia. The county has a population of 9,150 residents.\(^4\) The population size expands to about ten to twelve thousand people on weekends and holidays because of the resort nature of the county. The average weekly income of its residents is about $132.62 and the effective tax rate is about $7.46 per $1,000.00.\(^5\) The county's per capita income for the year 1975 was $3,202.00.\(^6\)

White County has only two major thoroughfares; they are state highways 75,115 and federal highway 192. The maximum safe speed on either of these highways is about forty (40) miles per hour. This county has no public transportation and the traveling time from one end of the county to the other can vary from fifty minutes to one hour. This variance in traveling time is dependent upon weather conditions. If the weather conditions are good, then the best time can be made. If the weather conditions are poor, as in the case of a winter storm, traveling time can be very bad.

\(^4\)Bureau of Industry and Trade, Economic Development Profile of White County, Atlanta, Ga., 1978, page 2.
\(^5\)Ibid., p. 3.
\(^6\)See appendix for Chart A.
Hospital facilities in White County are non-existent. The nearest hospital is about thirty (30) miles from White County. This facility is located in Gainesville, Georgia. The only public health facility that is located in the county is the local health department. Herein lies the health care problem that this study will focus upon. The health problem is due to an inadequate number of doctors and an absence of a hospital facility to serve the citizens of the county.

The methodology for this study included an analysis of certain demographic data on White County. The data analyzed was related to economic and health care conditions. The economic and health care conditions in White County were juxtaposed with analysis of studies which are similar to this study. The data findings in White County were compared with national and regional averages. To supplement the finding of the data analysis, several key persons were interviewed. The persons interviewed were: Ms. Dorothy N. Payne, Public Health Nurse, White County Department of Public Health; Ms. Gen Hunter, Health Educator with the Appalachian Primary Health Care Unit; Ms. T. Irene Sanders, Nurse Practitioner, also with the Appalachian Primary Health Care Unit.

In addition, public hearings were conducted to facilitate citizen participation in the development of a proposal to establish a community based primary health care center in White County. This hearing was conducted June 16, 1978 at the Helen Town Meeting Hall in White County. At this hearing were approximately twenty-five to thirty of White County's community
leaders, the local health official and the representative from APHCU. Due to the number and importance of the people attending, and the factors discussed, the APHCU judged the meeting to be a success.

There are three key factors that must be viewed in relationship to White County's problem:

(1) The absence of a hospital facility.
(2) There is only one doctor to serve nine to twelve thousand residents and tourists.
(3) The roadways are limited, meandering, and often impassible in inclement weather.

The solution to White County's problem is directly related to the resolution of the second factor. Once the physician population is increased, then it is expected that the hospital facility problem will be eliminated. The reasoning here is based on the belief that when enough doctors are present to meet the needs of the county, these doctors will apply enough pressure on local authorities to build a hospital.

The question to be asked now is what were the factors resulting in only one doctor in the county? The best way to answer this question is from the standpoint of what is necessary for White County or any county to have adequate medical providers to meet its needs. It must be noted at this time that there is a direct relationship between the community environment and the type of medical care a community has or will have. For an area to retain or attract a medical practice a community must have a highly technological, sophisticated hospital. This can either be in an urban or suburban setting.
There must be some medical peer present with the same philosophy of practice. A community must be able to support an income net in the area of $50,000.00 within a two year period. There also must be an availability of group practice within the area. Physicians want and must have an exceptionally high quality of life, sufficient leisure time and leisure activities. A referral mechanism of some type must be present. A comparison of the local conditions that are necessary to attract and maintain a physician, and the conditions that are present in White County can now be made.

The area to be discussed is the availability of a highly technological, sophisticated hospital. As indicated, (by Chart A in the Appendix) there is no hospital facility within the confines of the county's limits. The nearest facility is about thirty (30) miles away and has only a fifty (50) bed capacity. This hospital size does not foster the provision of highly technological, sophisticated services. The county's average weekly income is only $132.00. This, coupled with the size of the base population, could not support an additional income in the range of $50,000.00 over an extended period of time.

The availability of group practices in the county is non-existent. The only physician in the county will be retiring soon and would not welcome the increased patient load that at some point in time would result from a group practice. It would

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7 Primary Care Development Project, Prescription for Primary Health Care: A Community Guidebook, 1976, page 25.
be safe to assume that White County's present doctor practices there because it is his home.

The social and leisure activities are entirely limited to outdoor activities. There is a void in the areas of concerts, plays and other cultural activities.

Given these facts it is evident that White County is not able to maintain and retain, in the traditional manner, more than one physician. This means White County has a solo practice, with the physician at the top of the health care pyramid (Appendix B). We can now assume that: (1) the population of White County will go on being underserved in the areas of basic health care delivery; or (2) an alternative form of basic health care delivery must be found.

The new health outlook for the state of Georgia and the United States would not allow for this continued deficit in basic health care delivery. The only workable solution based on two assumptions is to find an alternative form of basic health care delivery.

In choosing an alternative form of basic health care delivery several factors must be considered. These factors are: (1) the type of health care delivery system to be initiated must meet the people's needs and at the same time must be retainable and maintainable by the people of White County; (2) the alternative form must be one that can achieve the maximum acceptance and integration in the community and any other existing health care delivery system within the county, region and the state; (3) the system must
offer the easiest possible access and a minimum amount of expense.

These criteria emphasize several key points. All of which direct themselves to a primary care delivery system as the possible solution to the basic health care problem in White County.

There are several key factors that must be analyzed before a decision can be made on the suitability of a primary care delivery system in White County. These factors are: (1) the identification of the absence of an adequate medical care facility within the county; (2) the absence of an adequate number of medical care providers; (3) the desires of the people of White County to have a health care system that they want; and, (4) the level of cooperation between the existing health care delivery agent and the new health care delivery system.

A comparative analysis is necessary in examining the first two factors that would influence the choices of a health care delivery system. In examining factors three and four an interview was necessary.

In White County there is no hospital facility present. There is only one doctor located in the county, and he is not far from retirement. Comparing these facts with the ideal conditions, which are: (1) the availability of a highly technological, sophisticated hospital; (2) the availability of medical peers for definition (these are doctors with the same philosophy of practice); (3) the availability of a
group practice; and, (4) the availability of sufficient leisure time and leisure activities. These facts demonstrate a need and a deficiency in the areas of medical personnel and a medical care facility.

The desires of the people of White County to have an adequate medical system to meet their immediate needs was voiced in their town meeting. At this meeting it was the consensus of opinion that there should be some type of health care delivery system present that was affordable and controlled by the citizens of White County. This system should be one where Medicaid/Medicare, and indigent persons would be allowed to benefit from the services.\(^8\)

The cooperation of the local health officials was received at the same meeting.\(^9\) These local officials and the sole health provider gave their verbal consent to the new system's purpose. The latter sent letters of support and pledging of their cooperation (Appendix F).

Based on the desires of the people of White County and the opinions of the local health providers primary care delivery would be the best possible solution for the county's health care delivery problems.

\(^8\)Taken from the minutes of the White County Town Meeting on Health Care, White County, Georgia, June 16, 1978.

\(^9\)Ibid.
III. Primary Health Care and the Models Used

Primary health care delivery is a new system to the state of Georgia. The present contextual framework used by the state for primary care is:

(a) An initial and continuing relationship between patients in need of care and the providers of that care;

(b) A continuity of care for the patient population of all ages and in all states of health and illness;

(c) A responsibility by the providers; for a continuum of comprehensive care which includes the maintenance and promotion of health evaluation and management of disease, and restoration of good health (this refers to the willingness and ability of the primary care team to handle a great majority of the health problems arising in the population it serves);

(d) Accessibility which is defined as attainable services that are available on a 24 hour basis (this refers to the responsibility of the provider team to assist the patient or the potential patient to overcome temporal, spatial, economic, and psychologic barriers to health care); and

(e) Primary care which is acceptable to patients.

Furthermore, the patients should understand the services they receive, the reason for those services and the patients' own role in the health care system.\(^\text{10}\)

This contextual framework is good, but it does not give us a definition of primary health care. For the sake of understanding primary health care, it is the care that is

initiated by clients or providers in a variety of settings and which consists of a broad range of personal health care services. Among these services are the basic health care delivery during acute and chronic phases of illness, the promotion and maintenance of good health, the prevention of illness and disability, the guidance and counseling of individuals and families, and referrals to other health care providers.  

Primary health care is the entry level of a three tier health care delivery system. The other levels are secondary and tertiary. Secondary health care delivery is care which physicians and hospitals can provide. This level is usually based in a hospital. The services rendered would include:

(1) medical and surgical diagnosis and care for both acute and chronic illness,  
(2) major surgery and care for major medical emergencies,  
(3) special care for dental, ophthalmology and obstetrics and others, and  
(4) special emergency care such as hospitalization and nursing home care.

The tertiary level of health care takes place in large teaching hospitals. The services given here are usually of highly specialized diagnostic and therapeutic nature. The medical care is normally for the uncommon and complicated problems, consequently the service is specialized and often

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12 See Chart B in the Appendix.
involves extremely complicated surgery.\textsuperscript{13}

Primary health care can be delivered in a variety of models. The three basic ones are: hospital based, health department based, and community based models. The specific type of model used is dependent upon the type of sponsoring organization, the involvement and roles of private and public health care organizations and the general attitude of the community desirous of that service.

The hospital based model comes about as a result of communities that have a hospital desirous of attracting primary care professionals. In this model the hospital expands its organized outpatient departments, or converts a specific time period each day in the emergency room for primary care treatment. In some cases a large teaching hospital offers sponsorship and other assistance to affiliated or free standing satellite clinics which provide primary health care treatment.

The health department based model is usually supported by the local county and state health departments. This involvement by these health departments is in a direction away from the traditional orientation of a health department in health care. The health department based model serves as a financial, managerial and technical resource to community groups interested in opening rural health care clinics. The health department based model directly delivers comprehensive primary care from a health department facility. This model consolidates and

\textsuperscript{13}Georgia Department of Human Resources, Division of Physical Health, Community Based Center: A Primary Health Care Model, 1978, page 2-4.
integrates categorical programs and incorporates these within a primary care framework. This model also adds primary care capabilities to existing categorical delivery projects.  

The last model to be explained is the community based model. In this model primary health care services are delivered from a facility that was constructed or renovated for the sole purpose of primary health care delivery. This model is usually located in small communities. The community serves as a governing body in the formation and selection of staff personnel for the center.

This model, unlike the others, can be started with the minimum staff. As in the case of the previous two models, the staff composition for a community based center should be as follows: a family nurse practitioner with assistance from a physician who is available by telephone when needed, a registered nurse, clerk/bookkeeper, and two registered nurses to allow for the continuous availability of services at the center.

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IV. Conclusions

There are several key factors that must be examined before a reasonable conclusion can be drawn as to the exact solution to White County's problem. A review of the pertinent facts is now in order. The basic problems identified are: (1) the absence of an adequate medical care facility within the county, and (2) the absence of an adequate number of medical care providers.

The second area to be examined is the possible causes of the problems mentioned. These causes are: (1) the absence of an adequate technologically advanced hospital, (2) the absence of adequate peer group definition, (3) the unavailability of an adequate number of providers to form a group practice, and (4) the absence of a variety of leisure and cultural activities.

All of these factors relate to a community maintaining a physician. If a community can maintain a physician, it is also quite possible that it will be able to attract other physicians. If a community can attract physicians to their area, then through the amassing of a large number of physicians, a community will be pressured to construct a facility to treat the patient seen by the doctors. This facility will in most instances be some type of hospital. In the instance of White County, this area is unable to attract physicians, so it is not pressured by its citizens to build a hospital facility. At this stage it is evident that
hospital for White County is just a goal not an objective. A hospital is the ultimate goal in the resolution of White County's health care problems. The purpose of any program of health delivery that White County would start now would be directed to the elimination of their immediate health care problem and achieving of their ultimate goal. To bypass the objective and proceed directly to the goal would not be possible. A hospital at this point in time would not eliminate the basic health care problems that this county has. A hospital in most instances would only be possible when enough physicians are present to operate it. White County does not have enough doctors nor does it have a need presently for a hospital facility.

In the future this need might possibly change; but at present, the needs of White County are for the basic health care services.

The area that is being looked upon as a possible solution to the health care problems of White County is primary health care. The ways in which primary health care can be delivered are: (1) through a hospital based model, with the hospital authority maintaining control; (2) through a health department based model, with the county or state maintaining control over the facility; and, (3) through a community based model with a board composed of community members controlling the center.

Primary health care is the solution; the choice now rests on which model will best suit the needs of White County. To
this writer it seems the health department based model would be the most reasonable alternative. This is due primarily to the fact that a health department is already located in the county and the expense of extending or building an additional unit would be minimal.

The most reasonable alternative is not, in some cases, the best choice for the community involved. It is true that the expense of building or extending an additional unit on the present health department to enable it to deliver primary health care would be minimal. The key factors here are: (1) retention of control, and, (2) the present role of White County's health department. In order for the health care system to work we must foster some type of acceptability by the community it is supposed to serve. The best possible way to foster this is to allow people in the community to have control over its health system.

The health department's present role is away from services which might appear to compete with the private sectors medical or dental care. The health department's head nurse voiced the opinion that to expand the health department would not give her the needed aid or allow her to expand her role as a public nurse. For this reason, the idea met with general opposition from Ms. Dorothy Payne, the public nurse.

At this point the decision about a variation in the health center should begin. The variation in the health center

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involves the way it is financed, by Medicaid/Medicare. The center would be totally funded by the funds received from seeing Medicaid/Medicare patients. This type of system has several inborn faults. These faults are: (1) the federal oversight on a center would be such that control would technically be in the community's hands, but with the tremendous oversight the federal agencies would be directing the center; (2) the initial cash base for starting a total Medicaid/Medicare center must be larger than for any model that has Medicaid as a supplement; (3) the difficulty and complexity involved in filling out the Medicaid/Medicare forms would put an additional burden on the bookkeeper/secretary; the increased work load would necessitate the addition of a person to deal strictly with the Medicaid/Medicare forms; and, (4) the reluctance of most physicians to participate in Medicaid/Medicare program. The reluctance is precipitated on factors one, three and the ever present threat of an investigation by the Medicaid/Medicare agency.16

This opposition from the public health nurse, the desire of the community to keep the decision making in their hands, and the impracticality of a complete Medicaid/Medicare practice makes the best possible alternative the community based model.

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16 Interview with Gen Hunter, Health Educator and Irene Sanders, Nurse Practitioner, Appalachian Primary Health Care Unit, March 28, 1979.
V. Recommendations

Based on the conclusions, the recommendations for the alleviation of health care problems that White County has is the construction of a community based primary health care center. The establishment of a community based center would aid in the prevention of illness and the maintenance of good health through the intervention at the earliest possible time in the prevention of disease.

The recommendations which follow are taken from the proposal which was developed by the APHCU for White County, Georgia. At the end of March, 1979, the implementation of the proposal was at the point of approximately 65 per cent completion. It is projected that a community based primary health care center will be available for service in White County by September 1, 1979.

The planning and implementation that the community should follow in the development of the primary health care center is as follows:

1. The organizational phase: The community board chosen must seek support from local and state health agencies and the local medical societies and health providers where possible.

2. The community must get clarification as to the exact nature of the health problem in its service area (the county). There should then be a setting of priorities as to the order in which these needs will be addressed. The goals and objectives should be established for the center with a review process during the first six months after establishment and thereafter on a yearly basis to review evidence of effectiveness and attainability of goals and objectives.
(3) A plan should be developed by the community to identify the programs it wants to meet its needs, the exact way the center is to be financed, by Medicaid or Medicare, sliding fee for service or by the federal, state or some local civic agency.

(4) The exact cost of the community center must be determined in relationship to the needs of the community. Such costs as start-up for support services, and space costs are just examples.

Before the actual delivery of primary health care can begin on a day-to-day basis, the following steps must be completed:

(1) The organizational structure must be fully developed.

(2) The policies and procedures for the day-to-day activities must be made, e.g., admittance, duties and responsibilities of staff members.

(3) The recruitment of staff, e.g., nurse practitioner, physicians and the support staff.

(4) The acquisition of local, state and federal certificates and licenses for operation of a health program.17

The staff makeup of the primary health care center will consist of a physician who is on call. He or she will give assistance to the nurse practitioner. There should be a nurse's assistant and a secretary/bookkeeper. The function of each is as follows:

Physician on call - acts as a consultant in matters of medical care and patient diagnosis, gives protocol to the nurse practitioner.

17For exact detail of implementation plan, see Appendix for pre-operational time table and plan.
Nurse practitioner - sees, diagnoses, and treats patients with aid from the physician on call and the nurse's assistant.

Nurse's assistant - assists the nurse practitioner in seeing and treating patients.

Secretary/bookkeeper - has the receptionist and bookkeeping duties.

These job descriptions have been general, because the Community Board, along with the physician who will be on call, has the responsibility of writing job descriptions (Appendix C).

How the program is to be financed is crucial to the success of White County's program. This community based program will need start-up funds and on-going operation funds.

Sources to consider:

(1) Medicaid/Medicare. The "Rural Health Clinic Service Bill", Public Law 95-210 provides that rural health services are eligible for reimbursement under Medicaid and Medicare, providing that the clinic meets the Department of Health, Education and Welfare's guidelines.

(2) Sliding scale fee for services is based on income level and number of family members. Some patients would pay the full fee and others would pay a reduced fee. Those unable to pay could still receive services. For further assistance in developing a sliding scale contact the Georgia Department of Human Resources and the local or area medical societies.

(3) Federal government funds are available by submission of application for specific grant programs.

(4) State and local governments: the local legislators and local officials may be able to secure financial assistance and they should be included in the original planning phases. Revenue sharing and community development funds are available to the local counties.
(5) Philanthropic foundations: the local ones are more likely to provide funds due to their close proximity.

(6) Local businesses and industries: might possibly provide start-up funds, equipment, loaned personnel, volunteer help and could contract with the center for health services for their employees. Include representatives from business and industries in planning phases.

(7) Lending institutions could provide loans for start-up costs and should be included in the planning phases.

(8) Community-wide fund drives, community events and other local fund-raising efforts are often very good sources of funds.

(9) Church groups and civic organizations can also provide start-up funds or sponsor on-going services.

(10) Insurance and other third party payments are available and efforts should be made to utilize them. 

The program's cost may be determined by considering the on-going operational expenses of providing basic primary care services. The minimal operating cost is approximately $50,000.00 to $60,000.00 (See Budget Information in the Appendix). The start-up cost will exceed normal operating cost by approximately 25%. The budget will be at a lower figure the following years.

If this guide is followed, White County will have a primary health care center.

The long term changes in the community based model could be one of adding the services of a National Health Service.

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18 The Primary Care Development Project, page 18-21.
Corps doctor to the center once the patient load increases.\textsuperscript{19} This might facilitate the community's goal to attract more doctors.

\textsuperscript{19}National Health Service Corps - A scholarship fund whereby the federal government pays the doctor's tuition; in return the doctors must serve a minimum of two years wherever he is assigned by the corps.
APPENDIX A

WHITE COUNTY

Population 8,647 1978
9,400 1980

Size 155,500 acres
243 square miles

Terrain Level low rolling hills - mountainous

Highways Federal #129
State #115,75
Interstate - none If none, distance
          to nearest interchange
          38 miles, I-85.

Rail Lines serving - none

Bus Line None

Public Transportation None

Weekly Manufacturing Wage 1975 $132.62 per person

County Per Capita Income 1974 $3,202.00

Property Tax Structure - is based on the total tax liability
per $1,000.00 of fair market value
and apply to real and personal property

County $7.46 per $1,000.00

Health Facilities
Number of Hospitals in County 0
Number of Beds 0

Nearest Facility 30 miles
Location Gainesville
APPENDIX A CONTINUED

Other Facilities – County Health Department
Huntington Nursing Home

Number of Medical Personnel – Medical Doctors: 1
Dentist: 3

Information obtained from Bureau of Industry and Trade, Economic Profile of White County, Atlanta, Ga., 1978.

Appalachian Primary Health Care Unit, Appalachian County Inventory Sheet, 1978.
APPENDIX B

LEVELS OF MEDICAL CARE

APPENDIX C
APPENDIX C

HIERARCHICAL STRUCTURE OF A COMMUNITY HEALTH CARE CENTER

COMMUNITY BOARD

DOCTOR ON CALL

NURSE PRACTITIONER

NURSE'S ASSISTANT

SECRETARY/BOOKKEEPER
APPENDIX D
## APPENDIX D

### BUDGET INFORMATION

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<td>Other*</td>
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**$51,660**

* This includes utilities, audit, phone, rent/lease, insurance, maintenance, postage, etc.
### APPENDIX E

**PreOperational Workplan**

<table>
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<th>Community Name</th>
<th>Date Workplan Prepared</th>
<th>Date Practice Will Open</th>
<th>Task</th>
<th>Lead Time Required</th>
<th>Actual Deadline Date/Person Resp.</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.</td>
<td>Planning Practice Policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>a.</td>
<td>Incorporate the sponsoring group/Community Board</td>
<td>At time of application</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b.</td>
<td>Organize the Community into committees</td>
<td>As soon as Board of Doctors is selected</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>c.</td>
<td>Develop a schedule of regular Board meetings</td>
<td>90-120 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>d.</td>
<td>Sign the Memorandum of Agreement</td>
<td>30 days after grant approval is given</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>e.</td>
<td>Draft the Personnel Policies and Procedures</td>
<td>90 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>f.</td>
<td>If applicable, develop signed protocols with back-up physician and nurse practitioner</td>
<td>Before the center begins operation and before survey of Rural Health Clinic Certification</td>
<td></td>
</tr>
</tbody>
</table>

*Source: National Health Service Corps*
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<tbody>
<tr>
<td>1. (Continued)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>g. Draft the community version of the Principles of Practice</td>
<td>Develop with the primary care provider(s) after he/she is hired</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Develop Principles of Practice with primary care provider(s)</td>
<td>Completed within first 60 days of employment of primary care provider(s)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: National Health Service Corps*
APPENDIX E CONTINUED

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</thead>
<tbody>
<tr>
<td>2. PLANNING THE PROSPECTIVE BUDGET</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Prepare the estimated annual expense budget</td>
<td>At the time of application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Determine start-up funds required</td>
<td>At the time of application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Determine the annual cash requirement</td>
<td>90 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Complete the initial pre-operational worksheet</td>
<td>At the time of application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Prepare final annual expense budget</td>
<td>90 days</td>
<td></td>
<td></td>
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<tbody>
<tr>
<td>3. PLANNING THE MEDICAL FACILITY, EQUIPMENT AND SUPPLIES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Facility -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Decide the type of facility needed</td>
<td>At the time of application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Decide whether to renovate, lease or build</td>
<td>At the time of application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Determine where the facility will be located</td>
<td>At the time of application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Plan the interior design of:</td>
<td>200 days&lt;br&gt;120 days&lt;br&gt;90 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- building&lt;br&gt;- renovating&lt;br&gt;- leasing</td>
<td>200 days&lt;br&gt;120 days&lt;br&gt;90 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Design a maintenance schedule</td>
<td>30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Erect an outdoor sign</td>
<td>15 days</td>
<td></td>
<td></td>
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</tbody>
</table>

* Source: National Health Service Corps
### APPENDIX E CONTINUED

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</thead>
<tbody>
<tr>
<td>1. (Continued) Equipment and Supplies -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Decide equipment selection based on the services to be provided:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- medical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- dental</td>
<td>120 days</td>
<td>150 days</td>
<td></td>
</tr>
<tr>
<td>b. Develop a purchasing procedure</td>
<td></td>
<td></td>
<td>140 days</td>
</tr>
<tr>
<td>c. Order the equipment:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- medical</td>
<td></td>
<td></td>
<td>90 days</td>
</tr>
<tr>
<td>- dental</td>
<td></td>
<td></td>
<td>120 days</td>
</tr>
<tr>
<td>d. Order the medical/dental supplies</td>
<td></td>
<td></td>
<td>30 days</td>
</tr>
<tr>
<td>e. Make office equipment selections including the type of Accounts Receivable and Disbursement Systems desired</td>
<td></td>
<td></td>
<td>60 days</td>
</tr>
<tr>
<td>f. Order the office equipment including the Accounts Receivable and Disbursement Systems</td>
<td></td>
<td></td>
<td>60 days</td>
</tr>
<tr>
<td>g. Order the office supplies</td>
<td></td>
<td></td>
<td>30 days</td>
</tr>
<tr>
<td>* Source: National Health Service Corps</td>
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APPENDIX E CONTINUED

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</thead>
<tbody>
<tr>
<td>4. PLANNING THE SELECTION AND MANAGEMENT OF THE STAFF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selection -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Community Board and Primary Care Provider(s) design a staffing pattern</td>
<td>Immediately following hiring of Primary Care Provider(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Formulate job descriptions</td>
<td>90 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Develop and implement a staff recruitment program</td>
<td>90 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. The Community Board and, when possible, Primary Care Provider(s), select and hire the:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- nursing staff</td>
<td>30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- non-nursing staff</td>
<td>30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. The Community Board and Primary Care Provider(s) finalize the written personnel policies and procedures</td>
<td>60 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Design a staff orientation session</td>
<td>60 days</td>
<td></td>
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</tbody>
</table>

* Source: National Health Service Corps
4. (Continued) - Management

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>c. Implement the staff orientation session and invite personnel from Health Insurance companies including Medicaid and Medicare to instruct staff in procedures for submitting claims forms</td>
<td>15 days prior to practice opening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Design a system for Board members to oversee the management of the staff</td>
<td>90 days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Source: National Health Service Corps
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<th>ACTUAL DEADLINE DATE/PERSON RESP.</th>
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</thead>
<tbody>
<tr>
<td>5. <strong>THE FRONT DESK</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Select an appointment system</td>
<td>30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Design the patient flow through the practice</td>
<td>60 days prior to designing interior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Develop, in concert with the Primary Care Provider(s), referral information for the receptionist</td>
<td>60 days after assignee arrives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Design a registration form</td>
<td>30 days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| e. Community Board determines and commits to writing practice policies in the following areas:  
- credit policy  
- billing policy | 30 days | 30 days | |
| f. Community Board and Provider jointly determine and commit to writing practice policies for the receptionist use:  
- office hours  
- coverage scheduling  
- fee schedule  
- emergency visit procedure | 30 days | 30 days after assignee arrives | 30 days | |

*Source: National Health Service Corps*
### APPENDIX E CONTINUED

<table>
<thead>
<tr>
<th>TASK</th>
<th>LEAD TIME REQUIRED</th>
<th>ACTUAL DEADLINE DATE/PERS.</th>
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<tbody>
<tr>
<td>c. (Continued)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Grievance procedure for patient complaints</td>
<td>30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Select the type of telephone system to be installed</td>
<td>45 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Install the telephone</td>
<td>15 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Select an answering service system</td>
<td>45 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Submit application for Bureau of Narcotics and Dangerous Drugs Dispensing Number</td>
<td>60 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Open a bank account in the practice name</td>
<td>30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Acquire a bond for the Collection Officer/Receptionist</td>
<td>30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Purchase additional insurance for non-NHSC salaried personnel (casualty, fire, theft, malpractice)</td>
<td>30 days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td>6. PLANNING THE MEDICAL RECORD SYSTEM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Provider selects medical record jacket</td>
<td>90 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Order medical record jacket</td>
<td>60 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Provider decides forms to be used in medical record</td>
<td>90 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Order medical record forms</td>
<td>60 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Select a medical record identification system</td>
<td>90 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Select medical record storage cabinets</td>
<td>90 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Order medical record storage cabinets</td>
<td>45 days</td>
<td></td>
<td></td>
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<tbody>
<tr>
<td>7. DEVELOP PROCEDURES FOR THIRD PARTY INSURANCE BILLING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Request a physician or clinic identification number/code from Medicaid, Medicare and other third party payors</td>
<td>Immediately following commitment of provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Request Medicare and Medicaid personnel to come to community to train business staff members of the practice at staff orientation session</td>
<td>15 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Obtain all available manuals and guidebooks published by third-party payors for instruction or billing procedures, schedule of reimbursement amounts, and procedure codes</td>
<td>45 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Design follow-up tracking system to monitor reimbursements from third-party payors</td>
<td>30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. If N.P. model, apply for certification as rural health clinic with State Standards and Licensure Section</td>
<td>120 days prior to anticipated opening date</td>
<td></td>
<td></td>
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<tr>
<td>7. (Continued)</td>
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</tr>
<tr>
<td>f. If N.P. model, complete Survey for rural health certification</td>
<td>Before clinic operations, but after N.P. is hired and protocols are written and signed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Signed and postmark Provider agreement with the Department of Medical Assistance for medicaid reimbursement</td>
<td>Before center begins operation</td>
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APPENDIX E CONTINUED

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<tbody>
<tr>
<td>8. INTRODUCING THE PROVIDER TO THE COMMUNITY AND PLANNING THE MEDICAL FACILITY INFORMATION BOOKLET</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Arrange for the provider to meet civic leaders and community residents</td>
<td>1. During provider interview visit 2. After permanent arrival in community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Plan a social gathering for the provider to meet other health professionals</td>
<td>1. During provider interview visit 2. After permanent arrival in community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Assist provider in obtaining hospital privileges if applicable or establishing relationship with back-up physicians</td>
<td>90 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Develop, print and distribute a Medical Facility Information Brochure</td>
<td>60 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Notify local newspaper of practice opening date</td>
<td>15 days</td>
<td></td>
<td>* Source: National Health Service Corps</td>
</tr>
</tbody>
</table>
APPENDIX F
January 2, 1979

Mr. Cliff Hood
City Manager
Box 146
Helen, Ga. 30545

RE: Village Primary Health Care Clinic

Dear Mr. Hood:

This is to certify that I am in support of the Village Primary Health Care Clinic. I will be making referrals to and receiving referrals from them.

Sincerely,

[Signature]

Dorothy M. Payne
Public Health Nurse

Cc: North Health District
APPENDIX F CONTINUED

Mr. Cliff Hood, Manager  
City of Helen  
Helen, Georgia 30646  

Dear Mr. Hood:

As Director of White County Department of Family and Children Services, I am acutely aware of the limitations of our present health care system. Many of the clients served by our agency reside in the upper end of White County and must travel a number of miles to receive health care. Our agency struggles to provide transportation to out of county health care providers.

I am very supportive of the idea of a primary health care facility within our county. Please be assured that our agency will refer clients as appropriate.

Sincerely,

KENNETH L. CURTIS, Director  

WHITE COUNTY DEPARTMENT OF FAMILY  
AND CHILDREN SERVICES  

KLC/44
TO WHOM IT MAY CONCERN:

I am presently practicing general medicine in White County and feel there is a need for increasing the availability of primary care in this area.

Sincerely,

Myron O. Eberhardt, M.D.
Bibliography


Georgia Department of Human Resources. A Definition of Primary Health Care, 11-28-78.


Georgia Department of Physical Health. Primary Health Care: A Perspective, undated.


Bibliography


The Statewide Joint Practice Committee Between Medicine and Nursing. The Continuing Role of Nursing in Georgia, 1976.