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by

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INTRODUCTION

The provision of health care has always been a declared policy of many governments, and every nation in the modern world has a health care system through which its people can get health services. The characteristics of these systems vary greatly with the nation's economic level and political structure.

The United States, a nation of great wealth with a decentralized and relatively permissive political structure, has an especially complex health care system. Its operation involves many separate and largely autonomous components and it is sometimes called a nonsystem.[1]

The complex health care system in the United States has heightened public and professional interest in primary health care in recent years. Widespread disenchantment with conventional health care systems that have become increasingly complex and costly have lead other countries to seek alternate approaches to health care. Even some of the most affluent countries have come to realize the disparity between the high care costs and low health benefits of their conventional systems. The gap between the health "haves" in the affluent countries and the health "have-nots" in developing countries is widening. This gap is also evident within individual countries, regardless of level of development.

In September 1978, at the International Conference of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) at Alma Ata, USSR, the member states declared primary health care as the global strategy for attaining "Health For All by Year 2000."

Primary health care is perceived as the key to achieving an acceptable level of health throughout the world in the foreseeable future. It will also enhance social development and social justice throughout the world. It is equally valid for all countries, from the most to the least developed, although the form it takes will vary according to political, economic, social, and cultural patterns.[2]

PRIMARY HEALTH CARE: WHO-UNICEF MODEL

The Alma Ata report described primary health care as a practical approach to making essential health care accessible universally. The report stated that health care should be provided in the community, by a means acceptable to individuals, and at a cost that the community and the country can afford.[3]

The main objective of primary health care is to provide the population with essential health care coverage, through a continuous and organized supply of services that are geographically, financially, culturally, and functionally accessible to the entire community.

Essential health care includes an array of personal and public health services that are promotive, preventive, curative, and rehabilitative and should include at least the following:

- Promotion of proper nutrition and an adequate supply of safe water;
- Basic sanitation;

- Maternal and child care, including family planning;
- Immunization against the major infectious diseases;
- Prevention and control of locally endemic diseases;
- Education concerning prevailing health problems and the methods of preventing and controlling them;
- Appropriate treatment for common diseases and injuries, and
- Provision of essential drugs.[4]

The community, rather than the individual, is the focal point of the health care system. The community is made up of people who live together and share in varying degrees, political, economic, social, and cultural characteristics; interests; and aspirations, including primary health care. The community is not a mere recipient of care but it actively participates in the solution of its health problems. Individuals and families assume responsibility for their health and welfare and for others in the community by sharing in the identification, assessment, planning, implemention, and evaluation of their care. Such participation is best mobilized through appropriate education, which enables individuals to deal with their real health problems in the most suitable ways.

This approach to health care means much more than providing essential health services. This model evolved from years of experience in basic health services in many countries; has social and developmental dimensions; and, if properly applied, contributes to national advancement by improving the health status of the population and by stimulating action and organization in support of the development process. This approach supports the hypothesis that healthy people contribute more to their social and economic development and, thus, provide the resources and social energy for facilitating the development of health care.

In developing countries especially, where most people have no access to a permanent form of health care, primary health care is a necessity. National programs, such as economic development, antipoverty measures, food production, safe drinking water, sanitation, adequate housing, environmental protection, and education, all contribute to health and have the same goal of human development. Therefore, primary health care should be an integral part of the health care system and the overall social and economic development of the country.

Developed countries also need to rationalize their health care systems and to restrain rising costs. Mounting evidence suggests that early and continuous access to primary health care can reduce the use of hospitals, principally by prevention and early treatment of disorders to halt their progress until hospitalization becomes necessary.[5] This approach is obviously beneficial for both health and economy.

While the primary health care approach is universal, there is no universal recipe for primary health care programs, each being a specific endeavor of the country. What succeeds in one country may not necessarily have the same

results elsewhere. Nevertheless, certain factors emerge from national experiences which can guide others, so international cooperation in this area is likely to be fruitful.

Although the term primary health care is used widely, the concept is not new in the United States. In the midsixties, national attention began to focus on primary health care with programs such as the Office of Economic Opportunity's neighborhood health centers, The Children and Youth and Maternal and Infant Care Programs, and the Migrant Health Program. It continued in the seventies with the authorization and growth of the National Health Service Corps and its scholarship program and the emergence of general practice medicine (family practice) as called for in the Millis and Willard reports (published in 1966). Finally, during the seventies the concept of primary health care gained prominence and acceptance as an anchor against the subspecialty drift of the major medical disciplines.[6]

The concept of primary health care is well-known and widely supported, but considerable disagreement exists about the precise meaning of the term. To some it means any health care given outside a hospital, given as a rule by general practitioners or family medicine specialists. To others it means health care for simple illnesses, regardless of the agent involved in the delivery of care. Finally, others refer to primary health care as early treatment at home, frequently provided by a nonprofessional in a continuous fashion to a defined population. In the British literature, for example, primary health care tends to be equated with the practice of general medicine.[7]

Much of the confusion, I believe, arises from the interchangeable use of primary health care with primary medical care. Laypersons and physicians especially support the view that primary health care is part of the progressive flow of medical care.[8] Moreover, the literature has not been very clear in the differentiation of care from cure and of health from medicine. Yet, many health planners, administrators, and authorities admit that primary health care involves the services of a variety of health professionals, including physicians, nurses, dentists, pharmacists, sanitarians, epidemiologists, workers, therapists, dieticians, and health educators.[9, 10, 11]

The most widely accepted definition of primary health care was developed by the Institute of Medicine in 1977, based on scope, character, and integration of services provided.[12] The report described primary health care as "accessible, comprehensive, coordinated, and continual care provided by accountable providers of health services." It is characterized as part of the personal health care system, rather than a form of community or public health care system. Primary health care is generally recognized as first contact health care, focusing on the total needs of individuals and families entering the system. Primary care may be furnished by a practitioner, a group practice clinic, or a health maintenance organization. Physicians, nurses, and physician's assistants are responsible for providing primary health care.

Despite the extensive effort made by the Institute of Medicine (IOM) to describe primary health care, the definition addressed directly only the characteristics of services and not those of practitioners or clients. The

IOM committee pointed out that their data may not provide a complete picture of primary health care. The committee also acknowledged that despite the emergence of new health practitioners, such as nurse practitioners and physician's assistants, physicians still play a central role in the delivery of primary health care in the country.

In the United States, primary health care is usually characterized by an individual identifying a personal medical problem and seeking help from a primary health care provider, usually a general medical practitioner, or a medical specialist. Health care is often patient initiated and episodic.[13]

Primary health care is provided in the following settings:

- Maternity and Infant Care and Child and Youth Projects, sponsored by federal MCH funds through the state.

- Federally sponsored community health centers which are funded under Public Law 95-626, Section 330. These programs are designed to serve urban and rural communities that are medically underserved and critically short of physicians.

- Health maintenance organizations which are both privately and federally funded.

- Group practices that are multispecialty, family practice, and single practices of family physicians, internists, and pediatricians.

- Family medicine group practices which are hospital or university sponsored.

- University outpatient clinics, ambulatory outpatient clinics, and emergency rooms of private and public hospitals.

- Migrant health programs.

DeTornyay states in her article "Primary Health Care in a Pluralistic Society: Impediments to Health Care Delivery" that primary health care will continue to be a neglected area unless health care planners and workers and the general public accept the following assumptions:

- Primary health care is more than medical care and it is essential to focus on broader services, many of which are not readily available;

- Individuals must have a voice in decisions that affect their well-being; and

- Structural changes must take place in the health care delivery system to focus on groups of people rather than on individuals.[15]

The emphasis on individual rather than group primary health care and preventive medicine is the result of rapid advances in medical technology and tertiary health care throughout the United States. Preventive health

services, such as well-baby care, may not fall under the category of essential health care as would sick-baby care, yet, the high cost of neonatal intensive care could be reduced if more preventive care were available.[16]

Wildavsky estimates that the medical system affects only about 10 percent of the usual indices for measuring health and the remaining 90 percent are determined by factors such as lifestyle, income, and physical environment.[17] The sustained effort to improve and augment primary health care services and to acknowledge the increasingly active role of patients and community members in the management of their health problems has resulted in a new approach to health care delivery known as Community-Oriented Primary Care (COPC).

Community-Oriented Primary Care, according to its proponents Drs. Kark and Abramson, is a strategy whereby primary health care services are organized based on the health needs of a defined population or community, rather than just the needs of individuals who enter the health care system.[18]

The essential features of COPC include the following:

- Definition of the population for which the service feels responsible;
- Complementary use of clinical and epidemiologic skills when assessing the needs of clients, families, subgroups, and the community;
- Defined programs to deal with the health problems of the community or its subgroups, within the framework of primary health care (IOM definition, 1977) and based on epidemiologic findings;
- Involvement of the community in the promotion of its health; and
- Accessibility, the absence of geographic, fiscal, social, cultural, communication, and other barriers to health care.[19]

In 1982, the IOM showed that COPC was not a revolutionary concept in the United States. Elements of COPC have existed in many public and private programs, such as the Office of Economic Opportunity's neighborhood health centers, the federally funded Community Health Center Program, a variety of health maintenance organizations, family practices, the National Health Service Corps, and the Indian Health Service.[20]

Realizing the potential for such a system, in 1983 the IOM conducted a study to assemble information about COPC as it is currently practiced in the United States.[21] The study showed that although COPC is not the prevailing mode of primary health care in the United States, there are practices that regularly perform some of the COPC functions, such as assuming responsibility for the health of a population which is defined more broadly than just patients who present for treatment. The report also stated that there is general consensus among the members of the committee that COPC promises to be more responsive than current primary health care practices in meeting the health needs of people in the community. They also recommended further research and additional demonstration projects using this type of health care delivery.

IMPORTANCE OF THE STUDY

Primary health care will remain a major area of interest in the health care delivery system in the United States and the world. According to John Millis, primary health care is the foundation stone of the entire health care system and its effectiveness, efficiency, availability, and accessibility determine the quality of that system.[22]

Interest in primary health care in the United States is tremendous as evidenced by the growing volume of literature on the subject. DeTornyay reported that primary health care as a major subject heading was first used in cataloging at the Cummulative Index Medicus in 1974.[23] Yet, in just 3 years (1974-77), a MEDLARS search yielded a printout that was two centimeters thick and contained 250 listings from a variety of health publications.

Investigations in primary health care are being encouraged by the federal government through the National Center for Health Services Research and Health Care Technology Assessment because of the significance of some health policy questions. For instance, practitioners are accepting the view that health resources are limited and that they have an obligation to distinguish adequate from extravagant care. Patients seem more willing to ask questions about medical procedures and to accept greater responsibility for their health. Each year, many primary health care providers graduate from training programs in medical, nursing, and allied health schools.[24]

Primary health care is an appropriate area for study because it could be integrated into the present health care system in the Philippines. Despite the differences in national conditions, it is useful for me to examine the primary health care system of another country.

PURPOSE AND DESIGN

The purpose of this study is to describe the following:

- The pattern of primary health care as practiced in Omaha;
- The important characteristics of primary health care as it is practiced in Omaha; and
- The aspects of primary health care in Omaha that might be applicable in a developing city such as Manila, Philippines.

Case studies of nine community-based primary health care centers located throughout Omaha are presented. The nine primary health care centers were selected based on a 1981 study entitled Assessment of the Primary Health Care Needs of North and South Omaha.[25] Initially, I wanted to limit my study to primary health care services for the indigent and elderly, but I found that these centers provide a variety of services to all age and income groups.

I used a set of guide questions and a checklist developed by the Institute of Medicine (Appendices A and B) to obtain information about the primary health care centers. I visited each of these centers; interviewed the nurse, physician, and staff; and observed their activities. Pamphlets and brochures about the center were also used as a source of information.

LOCATION

Omaha is located on the eastern edge of Nebraska, a midwestern state of the United States. Omaha got its name from the Indians who migrated from the Appalachian Mountains during the fifteenth century after a drought and established a large village on the western bank of the Missouri River.[26]

The history of Omaha has been well-knit into that of Nebraska, but somehow the city enjoys its own prominence, not only as the first territorial capital but as a city that planned and carved its own history and its own destiny as America's gateway to the West.[27]

The city of Omaha is politically located within the jurisdiction of Douglas County, the county being the major political subdivision of the state. Douglas County and the city of Omaha have a very close working relationship and they work together in many areas.

Until June 1984, health services in Omaha were a joint responsibility of the city and the county. Since then, health care has become a county service, but the city collaborates closely with the county to ensure the most effective delivery of services.[28]

Omaha occupies a land area of 90.9 square miles, about one-third of Douglas County's 333 square miles. The city is built on rolling terrain according to a plan started in the mid-nineteenth century. Over the years, a network of infrastructures developed that characterize the present day city.[29] Except for the downtown area, abundant greeneries and landscaped spaces blend with roads, pavements, and other infrastructures.

The 1980 census placed Omaha's population at 314,267, about 20 percent of the state's 1.5 million and 79 percent of Douglas County's 397,038 people. The population density was 3,457 persons per square mile. Whites constitute 85.6 percent of Omaha's population, blacks 12.1 percent, and other minorities (American Indians, Eskimos, Aleutians, Asian and Pacific Islanders, and Hispanics) 2.3 percent. The median age in 1980 was 29.3 years. Children under age 10 constituted 14 percent of the population, while the elderly (65 years and older) accounted for 12.2 percent. About 74 percent of Omahans who were 25 years of age and older graduated from high school and about 11 percent graduated from college.[30]

In November 1984, the unemployment rate in Omaha was 4.4 percent. Of its more than 118,000 households, about 30 percent have an annual income below $10,000, another 30 percent earned from $10,000 to $20,000, 12 percent from $20,000 to $30,000, 10.9 percent from $30,000 to $40,000, 4 percent $40,000 to $50,000, and another 4 percent over $50,000. The median income of Omaha households is approximately $16,000, while some 8.2 percent of the households, or about 35,000 individuals, earn below poverty level income.[31] The 1983 Federal Poverty Guidelines set $10,178 as the poverty income level for a family of four.[32]

The birth rate in Omaha did not change significantly from 1980 to 1984. It remained slightly higher than that of Nebraska and the United States, which declined during this period. The death rate showed a similar trend

(figure 1). The infant death rate increased from 11.8 per 1,000 live births in 1982 to 14.6 in 1984, although the overall trend has been declining since 1980 (table 1). Neonatal deaths accounted for most of these deaths during this period. The most common cause of neonatal death was low birth weight, while infant deaths were mainly due to congenital anomalies.[33]

The primary causes of death for all ages have remained the same since 1982 (table 2). They are, in rank order: heart disease, cancer, cerebrovascular disease, accidents, pneumonia, chronic lung disease, atherosclerosis, diabetes mellitus, suicide, and congenital anomalies.[34]

From 1980 to 1984, accidents were the leading cause of death of infants, children, and adults under age 45, while heart disease, cancer, and cerebrovascular disease accounted for the deaths of most persons who were 45 years of age and older. Motor vehicle accidents accounted for the highest percentage of accidental deaths, while the most common sites of cancer were the bronchus and lungs and the large intestine.[35]

In 1986, 13 hospitals (Bergan Mercy, Clarkson, Childrens, Methodist, Douglas County General, Immanuel, Lutheran, Methodist-Midtown, Nebraska Psychiatric, Richard Young Memorial, St. Joseph, University of Nebraska, and Veterans Administration) serve Omaha and the Douglas County area (figure 2). These hospitals provide 4,345 beds or 13.82 beds per 1,000 individuals.[36] Besides inpatient, acute care services these hospitals provide primary health care services in their outpatient clinics and emergency rooms. Some hospitals also have satellite primary care clinics located throughout the community.

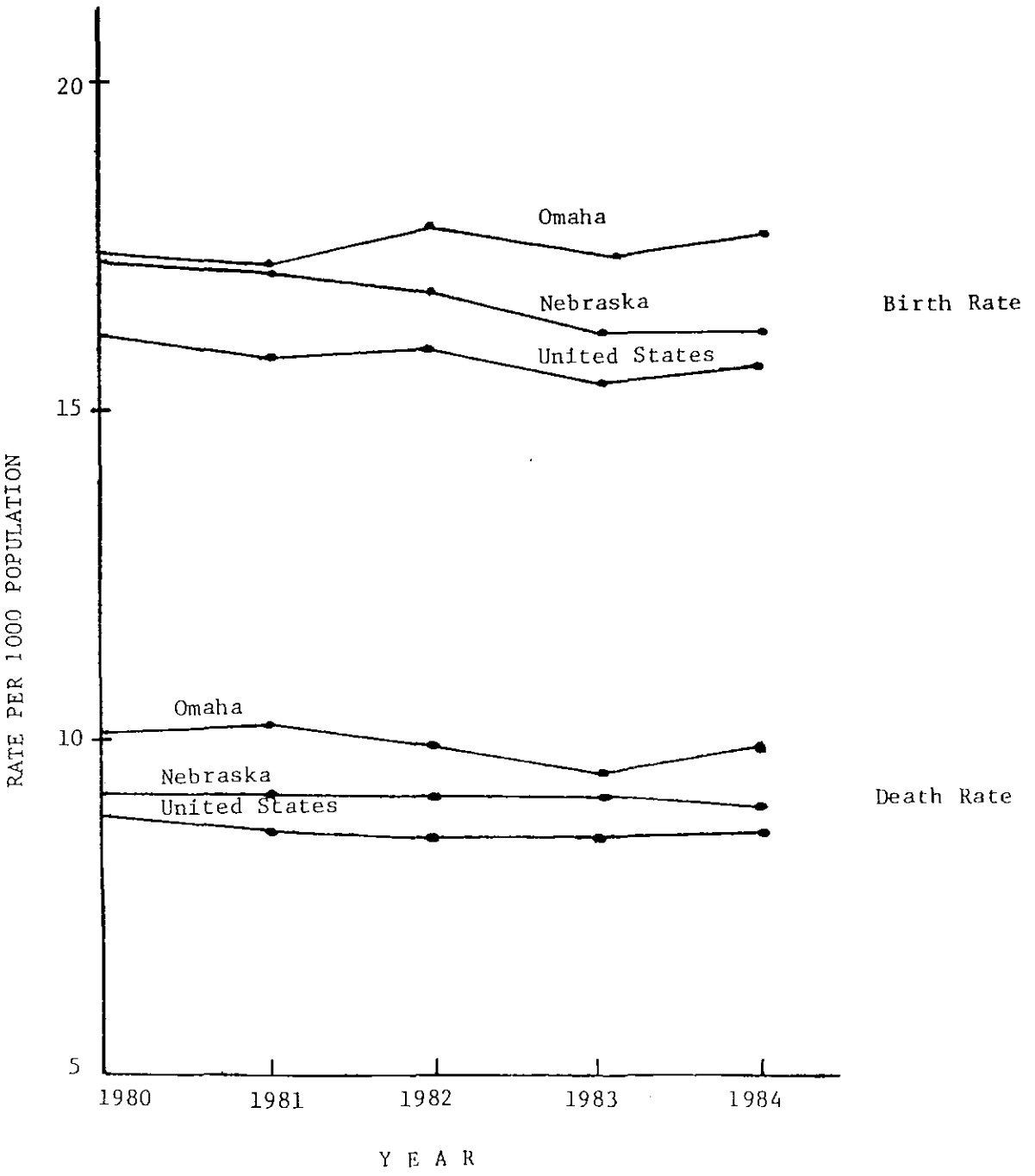
The 1985 telephone directory listed 798 advertisements for physicians and surgeons, yielding a physician to population ratio of 2.5 per 1,000.[37] The Omaha Medical Society estimated that there are about 1,100 physicians, including interns, residents, medical researchers, and faculty members in medical schools in Omaha. These physicians provide primary health care service to patients in individual clinics, group clinics, and hospital outpatient clinics.

The other providers of primary health care are nurse practitioners, chiropractors, naturopaths, and podiatrists. In 1985, there were 42 chiropractors, 20 podiatrists, and 1 naturopath who advertised their services in the telephone directory.

In addition to the aforementioned sources of primary health care, 147 government and private agencies and organizations provide a variety of public health and social services. These programs include alcohol control; blood pressure screening; venereal disease control; environmental safety; family planning; individual, family, and group counseling; hearing, vision, and speech rehabilitation; home care service; health information; physical fitness; senior citizens' assistance; day and night care; shelter programs, self-help; and other services to the residents of Omaha.[38]

Figure 1

Comparison of the Trend in Birth and Death Rates
in Omaha, Nebraska, and the United States, 1980-84



Source: Statistical Report of the Bureau of Vital Statistics, State Department of Health, Lincoln, Nebraska, 1980, 1981, 1982, 1983, and 1984.

Table 1

Infant, Neonatal, and Fetal Death Rates in Omaha, Nebraska, 1980-84

Type of Death	1980	1981	1982	1983	1984
	Rate per 1,000 live births				
Infant	16.4	12	11.8	11	14.6
Neonatal	10.7	6.8	7.3	5.7	9.2
Fetal	10.5	10.5	11.1	7.8	8.5

Source: Statistical Report of the Bureau of Vital Statistics, State Department of Health, Lincoln, Nebraska, 1980, 1981, 1982, 1983, and 1984.

Table 2

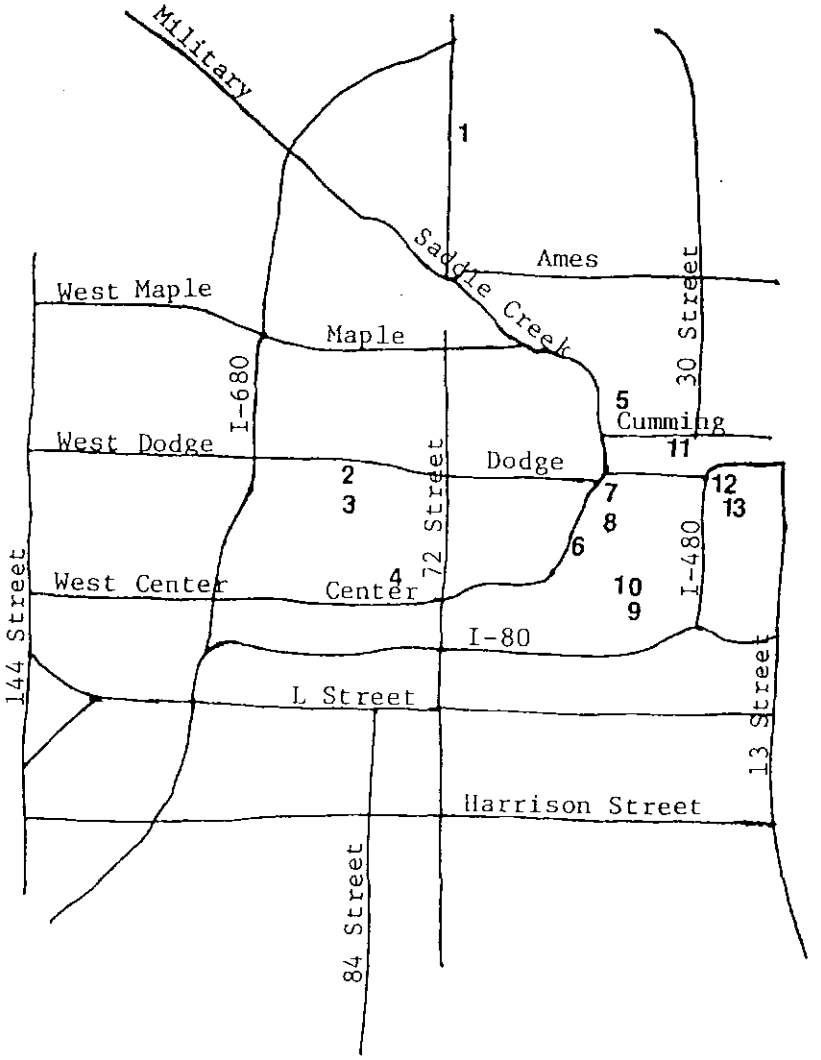
Rates for Six Leading Causes of Death in Omaha, Nebraska, 1980-84

Cause of Death	1980	1981	1982	1983	1984
	Rate per 1,000 population				
Heart disease	379.2	398.3	368.8	350.7	367.1
Cancer	216.6	222.4	227.4	221.2	223.1
Cerebrovascular disease	94.0	88.7	83.8	73.4	73.2
Accidents	42.4	43.7	42.2	35.6	38.3
Pneumonia	24.4	34.8	26.5	30.7	37.7
Chronic lung disease	-	-	29.4	23.2	25.7

Source: Statistical Report of the Bureau of Vital Statistics, State Department of Health, Lincoln, Nebraska, 1980, 1981, 1982, 1983, and 1984.

Figure 2

Location of Hospitals in Omaha, Nebraska, 1986



Legend:

1. Immanuel Hospital
2. Childrens Hospital
3. Methodist Hospital
4. Bergan Mercy Hospital
5. Methodist-Midtown Hospital
6. Nebraska Psychiatric Institute
7. Clarkson Hospital
8. University of Nebraska Medical Center
9. Veterans Hospital
10. Douglas County Hospital
11. St. Joseph Hospital
12. Lutheran Hospital
13. Richard Young Memorial Hospital

CASE STUDIES

The following primary care centers in Omaha were visited. Staff members were interviewed to determine the types of services provided, facilities available, and populations served.

Indian Chicano Health Center

The Indian Chicano Health Center opened in spring 1970, through the combined efforts of the Gethsemane Lutheran Church, students from Creighton University, Luthern Metropolitan Ministries, and representatives of the Indian and Hispanic communities. The center was established to take care of the health needs of minority families who were affected when the major meatpacking plants moved out of South Omaha in the late 1960s. The center was housed in the ramshackled former parsonage of Gethsemane Lutheran Church. In 1979, Lutheran Metropolitan Ministries purchased their current building at 2702 South 20th Street. The building was completely renovated through volunteer help.[39]

The center provides poor Indian-American and Hispanic families with access to comprehensive health care screening, physical examinations, minor medical and dental management and counseling, including a referral system to augment the total health approach. It also provides training for future health care professionals on the cross-cultural variables that affect health care delivery and the use of the multidisciplinary approach to help consumers control their health care services. Through volunteer work, students from minority groups are recruited into the health care profession.

The center has a full-time director who is Hispanic and three part-time outreach workers who are of Hispanic and Indian descent. Medical, dental, and nursing services are provided by volunteers who are health care professionals and students from Creighton University, the University of Nebraska Medical Center, and Clarkson Hospital School of Nursing.

The center operates clinics twice weekly, every Monday and Wednesday after 6:30 p.m. The clinic serves primarily Indians and Chicanos but will help anyone in need. Patients come to the clinic as walk-in clients or with an appointment for a medical problem. They are interviewed by the staff and then referred to the nurse and the physician for examination, diagnostic screening (such as diabetes, pregnancy, and pap tests) and other simple procedures. Simple health problems are managed in the clinic. Patients requiring additional evaluation and management are referred to the hospital.

Indigent patients are referred to the Douglas County Primary Health Care Network and if they are of American Indian descent they are referred to the Winnebago Public Health Service. Patients who do not qualify for these agencies but who need some form of assistance are referred to other social service agencies for specific needs, such as medicine, food, shelter, and home care.

The post-consultation conference is usually provided by the nurse. Patients who do not return for follow-up care are visited at home by outreach workers or by student nurses. All services are free. The center also provides free medicine, clothing, food, and transportion (for referral only)

to poor Indian and Chicano families. Allied services, such as language translation, advocacy, home and hospital visitation, transportation, counseling, and other nonhealth related social services, are arranged by the center for minority families.

The United Way of the Midlands supplies over 80 percent of the financial support to operate the center. Church groups, service organizations, private companies, and individuals also provide cash or in-kind donations.

The center's building looks old but inside it is spacious, bright, and clean. The waiting room, which is about 5 by 10 meters, is carpeted and has comfortable sofas and stacking fiberglass chairs for extra seating. The room can easily accommodate 30 people. The walls are beige and the furnishings and decorations are orange and brown. One corner contains a table, chairs, and toys for children. Signs are written in English and Spanish. There are a variety of magazines and pamphlets, in both English and Spanish, on child health, alcoholism, pregnancy, cancer, tuberculosis, and other topics. Beyond the waiting area are three examining rooms, a treatment room, a dental room that can accommodate two clients at once, a pharmacy, three offices, a conference room, and two bathrooms. The basement, which has a separate entrance, houses the food pantry and donated clothing and goods.

An average of 20-25 clients visit the clinic each day it is open. The average waiting time is 15-20 minutes. The staff members are friendly and helpful and most of them speak Spanish fluently.

The nurse who has been working at the center for several years noted a high incidence of diabetes mellitus type II, hypertension, and alcoholism among Indians. However, no epidemiologic studies have been conducted and control measures are limited to individual clients. The nurse also visits clients in need of follow-up care at their homes.

One constraint at the center is the lack of volunteer health care professionals. Participation by members of the Indian and Chicano communities is limited to performing menial tasks, such as general housekeeping, custodial, and repair work.

Douglas County Primary Health Care Network Clinic

The Douglas County Primary Health Care Network (PHCN) Clinic was established in July 1982, to provide outpatient medical care to low-income county residents who are not covered by other public medical assistance programs, who are uninsured, and who meet specific poverty criteria. Table 3 lists the Douglas County income guidelines for eligibility for PHCN.[40]

The clinic is located on the ground floor of the Douglas County Hospital at the corner of Woolworth Avenue and 42nd Street. It is staffed by two physicians who rotate duty, a nurse, and a receptionist. Services are subcontracted from Creighton University (physicians) and the Douglas County Hospital (nurse and receptionist). The clinic is open Monday through Friday, from 8:00 a.m. to 5:00 p.m. All patients are given verbal and written instructions on what to do and where to go after hours or in case of an emergency.

Table 3

Income Guidelines Used to Determine Eligibility for the Douglas County Medical Assistance Program[41]

Family Size	Annual Income
1	$3,400-$ 4,680
2	4,500-- 6,220
3	4,500-- 7,760
4	6,300-- 9,300
5	7,200- 10,640
6	8,100- 12,180

Patients come to the clinic as walk-in clients or by appointment. Most patients have appointments for follow-up consultations. Patients are first registered and then interviewed by clerks to determine if they are eligible for medical assistance. Patients are also asked to fill out an information sheet which they must return on their follow-up visit. All patients are given free medical consultation pending acceptance into the program. The nurse assesses each patient to determine the medical problem and discusses the findings with the physician who determines if the patient needs medical evaluation. On the first visit, patients are usually seen by the physician, but on follow-up consultations they are seen by the nurse and referred to the physician only when necessary. Telephone consultations are also provided by the clinic. The nurse provides most of the health instructions for patients. Waiting time for medical consultations is 30-60 minutes.

The clinic admits only adult patients with medical problems. Pediatric patients (infants and children under age 18) and patients requiring psychiatric help are referred to other Douglas County health programs, such as general pediatric clinics, childhood immunization clinics, pediatric dental clinics, venereal disease clinics, psychiatric services, and general assistance programs. These services are available to county residents regardless of income but serve predominantly the medically indigent and the medically needy.

Patients who require hospitalization are referred to the Douglas County Hospital for general and routine care and to contracted area hospitals (Bergan Mercy, Clarkson, Lutheran, Immanuel, Childrens, and Methodist) for specialized and complex care. The contracted hospitals require a written referral slip from the PHCN physician prior to hospitalization.

The staff aims to provide comprehensive care, including free service, and free medicine. Individuals who are awaiting acceptance into the program receive a month's supply of free medicine. If they need other social services, such as rent, housing, clothing, transportion, food, or personal items, they are referred to the county's general assistance program. The nurse and the receptionist arrange referrals to various agencies.

The PHCN clinic is financed entirely by Douglas County. The clinic is situated along a corridor that houses outpatient clinics for the hospital and the Douglas County Health Department. A few fiberglass chairs and benches along the walls of the corridor serve as the waiting room. Although well lighted, it looks shabby and untidy. The clinic consists of three adjoining rooms, two examining rooms and one office. The examining rooms are spacious, clean, and well-equipped for minor surgery, but the office is small and rather crowded. Other procedures, such as casting, X-ray examinations, and laboratory tests, are performed in the hospital's casting, X-ray, and laboratory facilities.

An average of 376 patients visit the clinic each month. According to the nurse, the common illnesses of patients are diabetes mellitus, hypertension and arthritis. Health education is provided on an individual basis; no home visits are made. The nurse and the physician are unaware of any epidemiologic studies concerning the clinic's patients.

Douglas County Health Department, South Omaha Clinic

The South Omaha Clinic was established to provide comprehensive health care services for children of low-income families living within the county. The clinic promotes health and provides medical and dental care, including preventive services, diagnosis, treatment, correction of defects, and follow-up care.[42] The clinic is located on the second floor of the South Omaha City Hall Building at the corner of 24th and O Streets.

The clinic is staffed by two physicians who rotate duty, two nurses, and a clerk. The physicians are private practitioners whose services are contracted by the Douglas County Health Department, while the nurses are from the Visiting Nurse Association (VNA) of Omaha.

The clients are infants and children up to 18 years of age. Usually, they come to the clinic for medical problems or routine immunizations. Although the clinic was intended to provide well-baby care, the nurse reports that most of the care provided is curative rather than preventive. Immunizations are administered by the public health nurse every Friday from 9:00 a.m. to 11:00 a.m. The Child Health Clinic, for healthy and sick children, is held on Monday and Thursday from 8:00 a.m. to 5:00 p.m.

Patients may schedule appointments or walk-in. They are assessed by the nurse, the nurse discusses the findings with the physician, and the physician assesses the patient and recommends a therapeutic plan. All patients with new problems are examined by the physician. Both the physician and the nurse provide counseling and health education, but the nurse provides most of this service. The waiting time for consultation is 15-30 minutes. Simple laboratory examinations, such as urine, glucose, hematocrit, hemoglobin, and lead testing, are performed by the nurse at the clinic. Specimens for more complex examinations, such as bacteriologic and blood chemistry studies, are obtained at the clinic and sent to the Douglas County Hospital for analysis. The results are sent back to the clinic and recorded on the patient's chart. Free medicine is given to patients who cannot afford to buy it. Medicine may come from clinic stock (samples from drug companies) or it may be obtained from the Douglas County Health Department if the patient is eligible for medical assistance.

The clinic is rather small but clean and orderly; the walls are freshly painted in light pink. The rectangular waiting room is about 2 by 6 meters and contains 12 vinyl chairs and a table and chairs for children. Signs are written in Spanish. Beyond the waiting area is a narrow passageway that leads to three small examining rooms, a laboratory, a doctor's office, a small clerk's office, and two bathrooms.

According to the public health nurse supervisor, more public health and immunization education campaigns are needed, but the nursing staff is inadequate to carry out these tasks. Most of the nurse's time is taken up with clinical work. Home visits are made to priority patients or they are referred to the VNA.

The staff are unaware of any epidemiologic studies concerning their target population. They noted, however, that otitis media and upper respiratory infection are common disorders among their clients. Health education is provided individually.

The clinic attends to 16-18 patients per day. Patients who need care that is not provided by the clinic are referred to other agencies. The staff arranges all referrals. Usually, a written referral accompanies the patient. Patients who are eligible for county medical assistance are referred to the PHCN.

Douglas County Clark Street Clinic

The Clark Street Clinic was established with the same objective as the South Omaha Clinic, to provide comprehensive child health service to low-income county residents. The clinic is located on the ground floor of the Logan Fontenelle Housing Units at the corner of 22nd and Clark Streets.

The clinic is staffed by a physician, a public health nurse, a clinical assistant, and a clerk. As is true of all Douglas County clinics, the staff is contracted to perform services. The clinic provides general pediatric services Monday through Thursday from 8:30 a.m. to 11:00 a.m. and from 1:00 p.m. to 4:00 p.m. The immunization clinic is held every Wednesday from 2:00 p.m. to 4:00 p.m. However, immunizations are administered during regular hours if the children are fit for immunization.

Most of the clients are low-income black families who reside in north Omaha. Although the clinic serves primarily indigent families, any county resident can use the free services of the clinic.

Clients usually come to the clinic to consult on a medical problem. They may walk-in or schedule appointments. When patients arrive, they register with the clerk and obtain general information about the clinic. The clinical assistant fills out the patient's record and then the nurse determines the patient's problem. The nurse discusses the findings with the physician who then assesses the patient and recommends a therapeutic plan. The physician also provides health counseling, but the nurse provides most health education.

Simple laboratory examinations, such as glucose, hematocrit, hemoglobin, and lead testing, are done by the nurse at the clinic. Other examinations, such as bacteriologic and blood chemistry studies, require drawing the

specimens at the clinic and sending them to the central clinic for evaluation. The results of the tests are sent to the clinic and attached to the patient's record. Free medicine is also given to patients. It may come from the clinic's stock (samples donated by drug companies) or the county assistance program (if the client is eligible). Clients who are eligible for federal aid may get their prescriptions from any drugstore.

Referrals to other agencies or the hospital are arranged by the clinic's staff. Usually a written referral slip accompanies the patient. Clients who are eligible for county medical assistance are referred to the PHCN.

The building which houses the clinic looks old and shabby. Inside, it is orderly and clean but in need of repainting. The waiting room can accommodate 15 people. In one corner is a child's table and 3 chairs; at one end of the waiting room is a screened area for the clerk's office and record room. Beyond the waiting room is a large room for physicians' tables, cabinets, and supplies. The clinic also has 3 examining rooms, a nurse's office, a laboratory, and a bathroom.

About 12 patients visit the clinic each day. The waiting time for consultation is 15-30 minutes. The staff are friendly and accommodating. The staff are unaware of any epidemiologic studies concerning their clients.

The public health nurse who supervises all of the clinics in Douglas County feels that more emphasis should be directed toward preventive care for children in the community. She hopes to reach the children before they become ill. This can be accomplished through home visits by the public health nurse, in coordination with the VNA which operates a child health clinic in the area. Their efforts are constrained, however, by the limited number of public health nurses who are contracted by Douglas County.

The nurse stated that another problem is the lack of continuity of care. Indigent patients use a variety of clinics based on what is convenient at the time the medical problem arises. Frequently, the individuals fail to notify their previous physicians of their new health problems. On several occasions when patients were referred back to their primary physicians they thought the clinic was refusing to attend to their needs.

University of Nebraska Medical Center South Omaha Family Health Center

The University of Nebraska Medical Center South Omaha Family Health Center was opened 15 years ago as a training facility of medical students and medical residents of the University of Nebraska in the field of family practice--a medical specialty which provides health care to all family members at one location. The center occupies half of the lower level of the South Omaha Neighborhood Association (SONA) Building at the corner of 31st and Q Streets. The SONA building is a large, two-story, modern brick structure. Ample parking is provided free of charge at 31st and Q Streets and in the south lot at 31st and R Streets. The SONA building houses a variety of nonprofit community services and is conveniently located near public transportation.

The center is managed by the Department of Family Practice, University of Nebraska Medical Center (UNMC). The director is a consultant in family

practice. Eleven resident physicians specializing in family practice rotate duty at the center. The other members of the staff include a nurse, an X-ray technician, a clinical technician, and a receptionist. In addition, two medical social workers, a psychologist, and a nutritionist from the UNMC are available for referrals. The center is open from 8:00 a.m. to 4:30 p.m., Monday through Friday.

The Family Health Center provides care to any family member who comes to the clinic to consult about a health problem. The clients are strongly advised to make appointments for their clinic visits so that they can be scheduled on the day their family physicians are working, a very important aspect in family practice. To achieve continuous and holistic care, one physician cares for all family members.

All patients register with the clerk at the front window. Returning patients must present their registration and health insurance cards during each visit. Health records are filed by family and are updated each time a member comes for consultation or treatment. The clerk prepares the records for new patients and retrieves the records of returning patients and presents them to the nurse. The nurse assesses the patient to determine the problem. She then discusses her findings with the physician and prepares the patient for examination or treatment by the family physician. The physician counsels clients but leaves most of the health teaching to the nurse.

The family center provides a range of medical services to children, mothers, adults, and elderly individuals, including psychiatric care and alcohol and drug rehabilitation. The center is equipped to provide a variety of diagnostic examinations, including X-rays, minor surgery, and occasionally precipitate labor is performed at the clinic.

The center is spacious and the interior is modern. The waiting room is large, carpeted, and has comfortable sofas and chairs. It can accommodate 20 persons, and contains a child's table and chairs. Beyond the waiting room, separated by a glass window, is a circular passage leading to a medical record room, 7 examining rooms, a supply room, a laboratory, an X-ray room with an adjoining dark room, a minor surgery room, a pharmacy, a nurse's office, and 4 bathrooms. At the center of the hall is a semicircular desk that serves as the nurses' station, and behind that is the doctor's office, which has some wall cabinets for storing supplies.

The family center is supported financially by UNMC revenues from patient fees. The patients receive two bills--one covers expenses at the clinic and staff salaries and the other covers the doctors' fees. The two bills total almost the same amount as fees charged by doctors in the community. The center accepts Medicare, Medicaid, and all other health insurance plans. Patients who are uninsured and who cannot afford to pay their bills but need medical assistance get a free initial consultation. They are then referred to a social worker for assistance and referral to appropriate agencies. Free medicine (samples donated by companies) is also given to indigent patients, provided it is part of their prescription. According to the nurse, approximately 45 percent of their patients are on welfare and about 20 percent of these patients cannot afford to buy medicine. About 600-700 patients come to the center for consultation and treatment each month.

Patients receive health instruction individually when they come for consultations. The staff do not make house visits, however, if home care is needed the center arranges for a house call by the family physician or the VNA.

Patients who require hospitalization are referred to UNMC and placed under the care of their family physicians. Patients are instructed to always notify their family physicians when any member of the family is hospitalized or needs emergency treatment. Another physician cares for the family during the absence of the family physician. The Department of Family Practice also provides a hotline for its clients; physicians provide advice to clients for problems that arise when the health center is closed.

Although a well-organized neighborhood association (SONA) exists in the community, it does not participate in the operation of the clinic. The building is managed by SONA and the family health center merely leases the space for the clinic.

Creighton University Family Practice Clinic

The Creighton Family Practice Clinic was established 10 years ago as an avenue for training medical students and medical residents in the specialty of family medicine. The clinic is located in the western wing of Baker's Shopping Center, a sprawling, single-story, shopping complex that houses a Baker's Supermarket and several small stores. A sign on the glass entrance door indicates the location of the clinic. The clinic is located along a bus route and there is ample space for parking in front of the shopping center.

The clinic is managed by the Department of Family Practice of Creighton University Medical School. Five resident physicians specializing in family practice, three nurses, and a social worker staff the clinic.

The care is family oriented. Appointments are arranged for return visits so that patients are seen by their family physicians. Walk-in clients are accommodated, but they are instructed to make appointments for subsequent visits. Clients come to the clinic to consult about medical problems or to seek follow-up care for chronic problems. As they arrive at the clinic, they register with the nurse at the front desk. She screens the patients and determines the kinds of services the patients need. She also prepares the charts and directs patients to the clinic nurse for further assessment of their problems. The clinic nurse then discusses her findings with the physician, who in turn assesses the patient before developing a therapeutic plan. The physician consults with patients, but the nurse provides most of the health instruction during post-consultation conferences. Laboratory examinations of the blood, stool, urine, and smears, and noncontrast media X-ray studies are conducted at the clinic by the nurse or the physician.

The clinic caters to the medical, minor surgical, and psychiatric needs of the whole family. Most of their clients are expectant mothers, children, and elderly individuals. Several nearby housing apartments for the elderly allow patients to drop by the clinic after shopping. House calls are made by the nurse or the physician when necessary. Consultations by telphone are also provided, especially for older clients.

Patients who are hospitalized are placed under the care of their family physician. If the condition requires the services of a specialist, the family physician coordinates with other health professionals in caring for the patient. Individuals are told to notify their family physicians immediately when a family member is hospitalized.

The clinic sees 400-650 clients each month. About 300 clients are members of the AMI-Health Maintenance Organization. The waiting time for each visit is about 15-30 minutes.

The clinic is quite small and narrow because of its rectangular shape. The waiting room, which is about 3 by 4 meters, can accommodate only 7 chairs. The room is clean, carpeted, and well furnished. Behind the waiting room is a glass partitioned room that serves as the receptionist's and records room. Further inside are 7 small examining rooms, an X-ray room, a doctors' lounge, a supply/treatment/lab room, and a bathroom. The staff are friendly and, perhaps because space is limited, a spirit of comradery exists among them.

The clinic does not cater to indigent patients. Being a privately funded agency, clients are screened to determine their paying capacity. Walk-in patients who are indigent and whose problems are not serious are referred to the Douglas County clinics. Each patient is billed, and new patients must pay cash for their first three visits. Payments through private health insurance, Medicare, or Medicaid are also accepted. Patients who have difficulty paying their bills are referred to a social worker for assistance.

Patients who need services that are not available at the clinic are referred to appropriate hospitals or agencies, usually they are referred to St. Joseph Hospital. Referrals are arranged by the staff, including transportation when necessary. Each patient is accompanied by a referral slip. The nurse keeps a record of referrals to facilitate follow-up care.

Group health instruction is given to clients with common health problems. For example, a program on dietary advice to diabetics was held one evening for several clients. Some studies on hypertension and diabetes mellitus were performed on clients but no specific preventive programs evolved from these studies. Preventive health instruction is given to clients individually when they come for consultations or follow-up visits.

University of Nebraska Medical Center North Clinics

The University of Nebraska Medical Center North Clinics were established under a federal grant to provide low-cost care to mothers and children residing in the area. Two clinics run by two departments of UNMC are located on the ground floor of the Ames Plaza Building on Ames Street.

One clinic provides maternal and infant (M&I) and family planning services. M&I is a program that provides intensive prenatal and postnatal care and counseling to expectant mothers and infants up to one year of age. This clinic is operated by the Department of Obstetrics of UNMC.

The other clinic provides pediatric care under the Child and Youth Program (C&Y). C&Y provides health care to children from 1-19 years of age. The clinic is operated by the Department of Pediatrics of UNMC.

Each clinic is staffed by 1-2 physicians, 3-5 nurses, 1-2 nutritionists, and 3 social workers. Some of them work full-time with the program, while others work part-time. The main clinics of the M&I and C&Y programs are located at the University Hospital Outpatient Clinic.

The C&Y Clinic is open every Monday from 1:00 p.m. to 3:00 p.m. and every Thursday from 1:00 p.m. to 4:00 p.m. Services are available by appointment and parents must accompany children to the clinic.

Patients come to the clinic to consult about medical problems. They are first assessed by the nurse, then by the physician. The approach to therapy is multidisciplinary. The nurse coordinates with all the other health professionals who are involved with the care of patients. The nurse said that a lot of time is spent on preventive health instruction for parents and older children. The staff also works closely with the Women, Infants, and Children Program (WIC), a supplemental food program, and coordinates activities with the staff of the M&I and Family Planning Clinic.

Patients fees are based on a sliding scale. Payments through private insurance companies and Medicaid are accepted. Most of the clinics clients are members of low-income families and reside east of 60th Street. The clinic is subsidized by federal funds; if this funding stops, and it may, the clinic will cease to operate.

Simple laboratory examinations, such as urine testing, hematocrit determination, and blood sugar testing, are performed by the nurse at the clinic. Specimens for other diagnostic examinations are sent to UNMC or patients are sent there for more complex examinations and tests. Telephone consultations are provided and patients are instructed about what to do and where to go for help when the clinic is closed.

The C&Y Clinic has a reception area that can accommodate about 13 patients. It has no chairs or tables for children although it is a pediatric clinic. The room is plain and functional but clean. Beyond the reception area is a passageway that leads to 4 examining rooms, a laboratory, 3 offices, 2 bathrooms, and a work area. The staff appear friendly and helpful. A large bare hall separates the C&Y and the M&I Clinics. The clinics function independently of one another.

The Ames Plaza Building, where the clinics are located, looks old and deserted. It was a shopping complex but closed when business slackened because of competition from nearby stores. The building is located conveniently along a bus route and parking space is available around the building.

Creighton Gerontology Medical Clinic

The Creighton Gerontology Medical Clinic opened in August 1983, for the purpose of providing complete primary health care to persons over 60 years of age. The clinic's services include physical examinations, health maintenance care and counseling, treatment of acute and chronic illnesses, and geriatric assessment. It also serves as a training facility for medical, nursing, and allied health profession students of geriatric care.

The clinic is located in the north wing of the Omaha Housing Authority Building at the corner of 21st and Burt Streets. Just behind the clinic is Burt Tower, a high-rise apartment building for the elderly. Another clinic is located on the ground floor of the Park Tower South Building, also a high-rise apartment building for the elderly.

The clinic is managed jointly by the university's Departments of Gerontology and Family Practice. It is staffed by physicians who specialize in gerontology and family practice, a nurse practitioner, a part-time pharmacy assistant, and two part-time clerks. The Burt Street Clinic is open on Tuesdays and Thursdays from 9:00 a.m. to 4:30 p.m., while the Park Tower Clinic is open on Wednesdays and Fridays from 8:00 a.m. to 4:30 p.m.

The clients at the Burt Street Clinic are residents of Burt Tower and surrounding apartments. Generally, individuals who are 65 years old and older are admitted to the clinic, although individuals 50 years old and older are treated, especially if they are disabled or suffering from a chronic medical problem.

Patients come to the clinic by appointment, but walk-in patients are accommodated when possible. Most patients come to the clinic because of medical problems. A preliminary assessment is conducted by the nurse to determine the patient's problem and the kind of help needed. The nurse refers the patient to the physician for further evaluation and treatment. New patients are assessed by the nurse and the physician, while returning patients who come for follow-up treatment or advice may need the help of the nurse only. Group and individual counseling to families with elderly members is also provided at the clinic. The nurse or the physician make house calls to patients who cannot come to the clinic because of illnesses or physical limitations. The nurse coordinates with various community agencies so that patients have access to services such as transportation, food, recreation, physical therapy, and health education. Laboratory examinations, such as EKG, X-ray, blood count and chemistry, and urine testing are available at the clinic.

Eight to ten patients are scheduled for assessment each day. The waiting time may be 30-60 minutes. About 2 hours is spent making an initial assessment of each new patient. Patients are told to make appointments for their visits to reduce the waiting time. Returning patients only take about 30 minutes for consultation. About 80 percent of the nurse's activities relate to health counseling. Telephone consultations are provided after hours and patients can get advice through a hotline provided by the clinic.

The clinic is funded by Creighton University, the Health Futures Foundation, and Douglas County through the Eastern Nebraska Office on Aging (ENDA). Patients fees are based on a sliding scale based on income. Payments through Medicare and private insurance companies are also accepted. Patients with no Medicare or private insurance are subsidized by ENDA. These patients are treated free of charge. Currently, 8 to 10 patients are treated at no cost.

The clinic is located along a bus line. Parking spaces are available around the building. The entrance to the clinic is through an electronically locked glass door. The lock was installed to prevent trespassers from

entering the clinic. The reception area is clean, carpeted, and comfortably furnished; it can accommodate 10 people. A small table contains a variety of magazines. The clerk's office has a glass wall that enables her to see patients in the reception area and at the door (she controls the door lock). Next to the reception area is a corridor that leads to 4 examining rooms, the medical director's office, a laboratory, a big conference room, a pharmacy with a walk-in safe for storing medicine, a nurse's room, a surgical room (minor surgery), and two bathrooms.

The nurse observed that most of the medical problems of the elderly are diabetes mellitus, hypertension, and arthritis. The nurse emphasizes the preventive aspects of care to patients. She is involved in the training of student nurses who work at the clinic, therefore, she coordinates with the school of nursing to implement health education programs, such as osteoporosis prevention and home safety. She hopes to involve students from the allied health professions, such as pharmacy and social work, in the care of the elderly. A computerized data base provides ready access to information about patients and she expects that epidemiologic studies may be carried out in the near future. The clinic coordinates closely with Creighton Home Health Care and the Visiting Nurse Association to provide home care to their patients.

Visiting Nurse Association of Omaha Health Maintenance Sites

The Visiting Nurse Association (VNA) of Omaha was organized in 1896 as a voluntary nonprofit agency providing community health services to residents of Douglas and Sarpy Counties. The agency provides a variety of programs utilizing approximately 16 different funding sources. The VNA employs approximately 250 full-time and hourly employees.

Preventive health services are provided through contractual agreements with the Douglas County Health Department and the Sarpy County Commissioners. Services include a variety of pediatric and adult clinics; home visitation for guidance and assessment; epidemiologic follow-up for communicable diseases; and school health services for parochial, suburban, and rural schools. The VNA also receives funding for selected maternal and child health visits from area Maternal and Infant (M&I) and Children and Youth (C&Y) Programs conducted by two university hospitals. VNA also serves as the coordinating agency for the state's Sudden Infant Death Syndrome project under a contract with the Nebraska Department of Health.

The VNA is a certified home health agency that makes approximately 70,000 visits annually. It is the only home health agency in the Omaha area that is accredited by the National League for Nursing and the American Public Health Association. Fees for home health visits are reimbursed by Medicare, Medicaid, the Veterans' Administration, Champus/VA, private insurance, and direct charges to clients. A sliding formula for fees is supplemented by United Way funds. State contracts for crippled children provide physical therapy services to handicapped children in their homes or schools. In addition to providing health programs, the agency serves over 100,000 meals annually.[43] Figure 3 shows the organization of various services performed by the VNA.

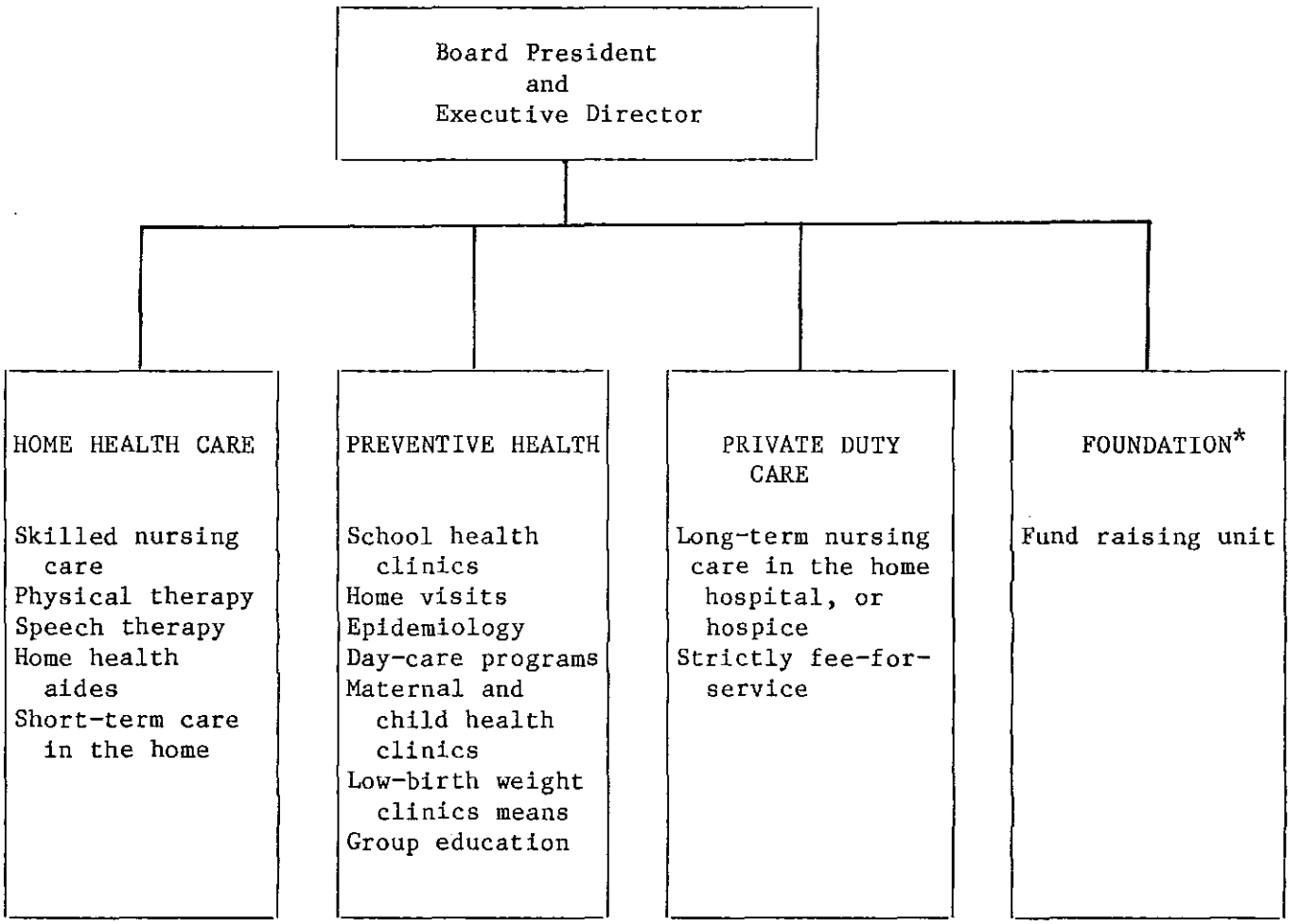
The VNA Nurse-Managed Center for Health Maintenance provides services to adult residents of Douglas and Sarpy Counties to help them stay healthy,

manage their problems, and prolong independent living within the community. Thirty health maintenance sites are located in community centers, churches, homes, and city buildings throughout Douglas and Sarpy Counties.

Their clients consist of individuals who are 60 years old and older who may or may not have medical problems. Because the center emphasizes health promotion and the prevention of illnesses and disabilities, the clients need not wait for a health problem to occur before coming to the center. Clients are assisted in developing and maintaining the abilities needed for optimum functioning. Each client undergoes periodic health tests for vision and hearing, when necessary, to identify health risks and to anticipate possible health problems. Help is given in areas such as recognizing and correcting

Figure 3

Functional Division of the Visiting Nurse Association of Omaha



* = Not operational yet.

Source: Ms. Delanne Simmons, Executive Director, Visiting Nurse Association of Omaha.

deficiencies and developing and maintaining personal care and hygiene. Patients with medical problems are advised to see their primary physicians and are assisted with physician-ordered treatments and medications. Health promotion activities consist mainly of individual or group instruction and counseling about diet and nutrition, activity and exercise, hygiene and skin care, medications, safety, sleep and relaxation, sexuality, and coping with illness.

Patients are referred to community resources for transportation; meals; medical, dental, and podiatric care; shelter; clothing; home care; and other services. The nurse is also available for telephone consultations to respond to patients' health concerns when the center is closed or between visits to the center.

The health maintenance site at the Paxton Manor, a high-rise apartment hotel for the elderly, was established to provide preventive health care for the residents. A room on the second floor of the building is used as the clinic. The nurse from VNA comes Monday through Thursday from 9:00 a.m. to 12:00 p.m. and Friday from 9:00 a.m. to 11:00 a.m. The center is funded by Douglas County through the Eastern Nebraska Office on Aging.

Services are available by appointment to reduce the waiting time for clients. The nurse schedules an average of 4 clients per hour or about 1 client every 15 minutes. Walk-in clients who need immediate help are also accommodated, depending on the problem. This practice is not encouraged, however, because of the limited capacity of the center for immediate and emergency care. If the problem is serious, the client is referred to a physician or a hospital. All medications, injections, and dressings must be ordered by the client's physician.

Most clients visit the nurse for regular assessment of their blood pressure, pulse rate, weight, eyes and ears, feet, and just to verbalize their worries and anxieties. The clients come from Paxton Manor and other neighboring apartment houses for the elderly. The nurse records the outcome of each client's visit, and also arranges referrals to other agencies.

The nurse coordinates with the Downtown Omaha Center for Senior (DOCS), a social service agency administered by the Eastern Nebraska Office on Aging. The DOCS is based in Paxton Manor and provides social and recreational activities to the elderly. The nurse arranges for group health instruction for the elderly with DOCS. For example, since November 1985, they have organized several wellness classes for the elderly. The classes are held every Monday at 10:00 a.m., and 20 to 30 individuals usually attend. The nurse also organizes physical fitness sessions at a health maintenance site in Jackson Tower. The nurse prepares teaching aids and brochures on topics such as insulin shock, diabetic coma, cholesterol, coronary artery disease, and hypertension. Pamphlets and posters are also prepared on topics such as meal planning, exercise, skin care, and self-examinations.

The health maintenance site consists of a sparsely furnished but comfortable room with two tables, three chairs, a filing cabinet, and glass cabinets. Informational pamphlets are displayed on one table and the corridor outside the room serves as the reception area.

A record is maintained of the assessment of each patient's visits (for example, blood pressure, weight, and pulse rate), laboratory examination results, medications, and clinic appointments. The nurse fills out the card each time the patient visits the clinic, and the patient presents the card to the nurse or the physician during each visit.

Table 4 summarizes the characteristics of nine primary care centers in Omaha.

FINDINGS

The purpose of this study was to describe primary health care in the city of Omaha. The findings of the study suggest the following:

- Characteristics of primary care centers:

  -- All of the primary care centers included in the study are community-based. They are located within the community being served, in contrast to hospital-based (located within a hospital) primary care centers. Four of the primary care centers are satellite clinics of two university hospitals.

  -- Five primary care centers are found in South Omaha, while four are located in North Omaha. Figure 4 shows the location of the nine primary care centers.

  -- Three primary care centers cater to clients from all age groups, three centers cater to children and adolescents, two centers provide services exclusively to the elderly, and one center provides services to adults and a few elderly clients.

  -- Four primary care centers provide service primarily to indigent families whose payment for services is subsidized by the county; three centers offer a sliding scale for fees (based on the client's income) and two centers are exclusively fee for service.

  -- Three primary care centers are funded by Douglas County, one center is funded through a federal grant, three centers are funded by private agencies, and two centers are funded by Douglas County and a nonprofit private agency.

  -- Eight of the primary care centers have a core staff consisting of a physician, a nurse, and an ancillary health worker. In these centers the physician acts as the head of the clinic. Only one center is managed and staffed by a nurse.

- Characteristics of service at primary health care centers:

  -- There is very little distinction between primary health care and primary medical care. Whether hospital-based or community-based, primary care centers provide primary care to patients during each episode of illness.

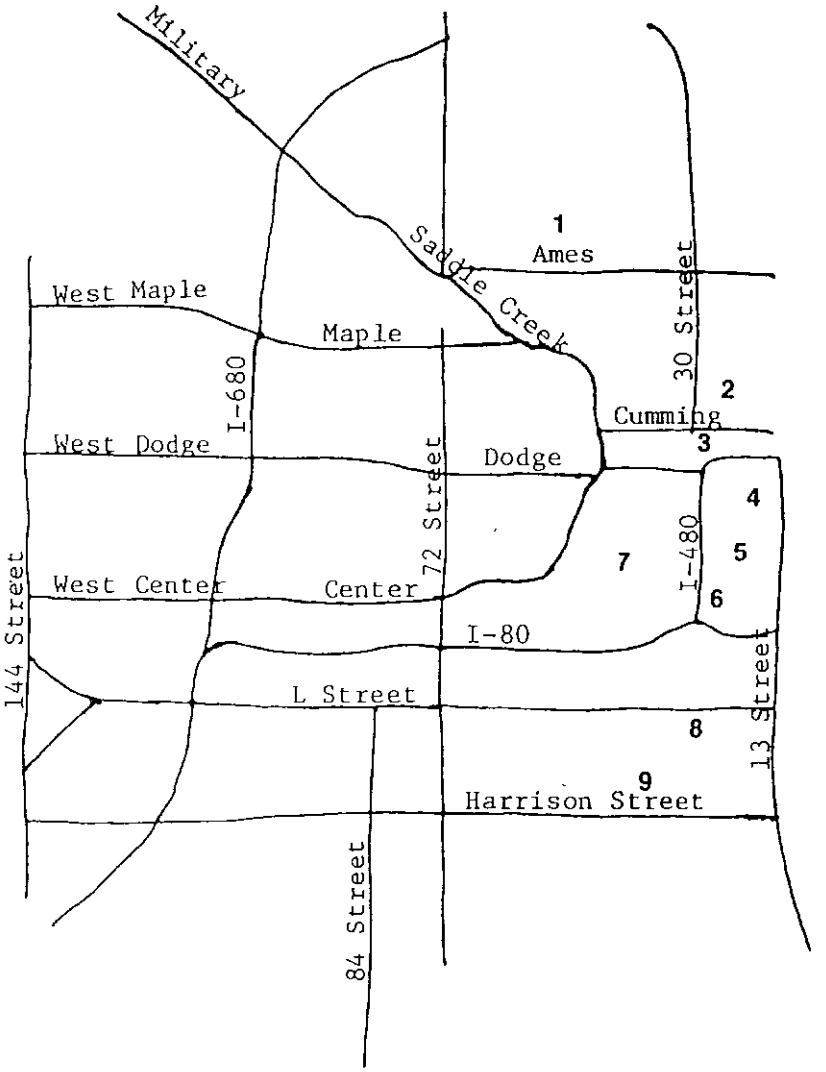
  -- The patient initiates entry into the health care system and this frequently happens during an illness.

Table 4
Characteristics of Nine Primary Care Centers in
Omaha, Nebraska, 1986

Name	Location	Age of clients	Payment of service	Source of funding	Core staff
Indian Chicano Health Center	South Omaha	All	Free	Private and non-profit organizations	Physician, dentist, nurse, and outreach worker
Douglas County Primary Health Care Network Clinic	South Omaha	Adults and elderly	Free	Douglas County	Physician, nurse, and clerk
Douglas County Health Department, South Omaha Clinic	South Omaha	Children up to 18 years	Free	Douglas County	Physician, nurse, and clerk
Douglas County Clark Street Clinic	North Omaha	Children up to 18 years	Free	Douglas County	Physician, nurse, and clerk
University of Nebraska Medical Center South Omaha Family Health Center	South Omaha	All	Public and private insurance, federal aid, and out of pocket	UNMC and patient fees	Physician, nurse, clerk, and social worker
Creighton University Family Practice Clinic	South Omaha	All	Public and private insurance, and out of pocket	Creighton University and patient fees	Physician, nurse, and social worker
University of Nebraska Medical Center North Clinic	North Omaha	Children up to 18 years	Sliding scale for fees, private insurance, and Medicaid	C&Y federal grant	Physician, nurse, and social worker
Creighton Gerontology Medical Center	North Omaha	Elderly	Medicare, private insurance, out of pocket, and sliding scale for fees	Creighton University, Health Futures Foundation, and Douglas County	Physician, nurse practitioner, clerk, and pharmacy assistant
Visiting Nurse Association of Omaha, Health Maintenance Sites	South Omaha	Elderly	Free	Douglas County	Nurse

Figure 4

Location of the Nine Primary-Care Centers
Included in the Study, Omaha, Nebraska, 1986



Legend:

1. University of Nebraska Medical Center C&Y Clinic
2. Douglas County Clark Street Clinic
3. Creighton Medical Gerontology Clinic
4. VNA Health Maintenance Site (Paxton Manor)
5. Indian-Chicano Health Center
6. Douglas County South Clinic
7. Douglas County Primary Health Care Network Clinic
8. Creighton Family Practice Clinic
9. University of Nebraska Medical Center SONA Family Clinic

-- Primary care revolves around the patient's medical problem. The other aspects of care, such as meeting the psychosocial and spiritual needs, become corollary to the main goal of treating the patient's illness. Primary health care stops when the patient recovers from the illness or stops coming to the center.

-- Primary health care delivery in eight of the primary care centers fits the description of primary health care in the Institute of Medicine study in 1978, which defined primary health care as accessible, comprehensive, coordinated, and continuous first-level personal health care provided by accountable health care practitioners. Using the IOM checklist (see Appendix B) to determine whether health care centers were delivering primary health care as defined, the services of each primary care center were evaluated. The findings show the following:

- Access to primary health care services at the nine centers is scheduled through clinic visits or by telephone. Eight centers maintain a 24-hour telephone counseling service. The centers can be reached easily by public or private transportation. The staff are able to minimize the waiting time for consultations to 15-30 minutes by scheduling appointments. Office hours at seven of the centers may not be convenient for working mothers who must accompany their children. Hispanic families might encounter communication barriers at one center because of a lack of full-time staff who speak Spanish.

- Nine primary care centers provide comprehensive diagnosis and treatment of illnesses. Only one center does not manage patients with illnesses. Patients are referred to other agencies for services that are not available at the clinics. These services are usually health related, such as the acquisition of medicine; food; home care, if necessary; shelter for indigent families; and dental care. Referrals are made mainly by telphone; follow-up of these referrals has not been efficient. Usually, the clinics receive feedback information when patients return to the clinic. The exchange of information between health agencies, unless it is between a satellite clinic and the hospital, is difficult and time consuming. Follow-up visits in homes are made by only a few centers for acutely ill patients.

- Continuity of service is maintained during each episode of illness; there is no contact between the patient and the center's staff when the patient is well.

- Accountability for health practices rests primarily with the physician and the nurse and it is maintained within the legal scope of the professions. The physician is mainly responsible for the treatment plans for patients, and the decisions and actions of the other health professionals revolve around that plan. Practice audits are conducted rarely in most of these centers. Disclosure of information about the patient's condition is the responsibility of the physician.

-- Among the nine primary care centers studied, only the VNA Health Maintenance Sites possess some of the elements of community-oriented primary care (COPC) based on the following characteristics:

- It has a defined population for which the service feels responsible. The population served consists of adults who are 65 years old and over and residents of the high-rise apartment where the center is located.

- A complementary use of clinical and epidemiologic skills are used to assess the needs of clients and the community. Although no formal community diagnosis or epidemiologic study was conducted, a system for obtaining information about the problems of the population being served provides the basis for planning health programs. Information is collected through personal observations, referrals to the clinic, and informal inquiries with staff at the apartment building, clients of the clinic, residents of the apartment building and the Downtown Omaha Center for Seniors (DOCS), a social service center based in the same building.

- Individual health screening and counseling is provided to clients of the center. Programs were also developed to meet the needs of individuals who do not come to the clinic. These programs include wellness classes, held every Monday morning, and education and information campaigns on common health problems, such as diabetes mellitus, hypertension, coronary artery disease, cholesterolemia, smoking, and drug use. Information is disseminated through leaflets, posters, and bulletin board announcements.

- The nurse encourages community involvement in health promotion. The residents help in the upkeep and maintenance of the center. The feelings and concerns of clients are taken into account and they are consulted about major programs that the center plans to implement.

- Because the center is located in the apartment building, it is physically and functionally

accessible to the population being served. The consultation schedule does not pose problems because most of the clients are retired from regular employment. The clients refer to the center and the nurse as "our center" and "our nurse," a sign of their acceptance of the center.

- The main strength of the health maintenance site is that its services are organized around health promotion and prevention. In the true sense of the word, it is providing primary health care--care is focused on health, not on cure or illness as in the case of primary medical care.

- The center strives to reach as many clients as possible while they are healthy. Because there is no urgency for clients, the nurse can schedule lengthy appointments and introduce innovative health care programs for clients.

  -- The family centered approach, as seen in family practice clinics, seems to be a more holistic and coordinated system of delivering primary-care than the patient-centered approach. The family physician acts as the central authority who is responsible and accountable for the family's care. The family physician interacts with each member of the family and develops an in-depth understanding of the problems of the family. The only limitation to this approach is that contact is established with the physician only when a member is ill.

  -- The city of Omaha enjoys the advantages of an affluent society. There are facilities for acute, long-term, chronic, and primary-care throughout the city. Health support and welfare services include an array of public health, social, and environmental health programs that are provided by many agencies. However, the agencies that provide services for groups are separated from the primary-care centers that provide services to individuals. Consequently, primary-care practitioners become concerned with the health-illness spectrum of the patients' problems and refer them to various agencies for other health-related needs. Because these agencies have little or no accountability to one another or to a central authority, this system of health delivery leads to limited relationships and a lack of coordination between the agencies; the lack of responsibility by any agency for the overall health of individuals, families, and communities; fragmented care; and additional costs for duplication of services.

IMPLICATIONS AND CONCLUSIONS

The complexity and rising cost of health care have forced many countries to look for alternative, cost-effective, health-care technology. Primary health care gained universal recognition in 1978 when members of the World Health Organization (WHO) and the United Nations Children's Fund declared it a universal goal by the year 2000.

Primary health care as conceived by WHO is a strategy for making essential health services geographically, culturally, financially, and functionally accessible to individuals, families, and communities. Essential health services, a combination of personal, social, and public health services, are provided to everyone. Primary health care encompasses preventive, curative, and rehabilitative care and should address at least the following elements: nutrition, environmental and sanitary conditions, maternal and child care, immunization, prevention and control of endemic diseases, health education, treatment of diseases, and provision of essential drugs and medications.

Primary health care implies more than an extension of essential health care in developing countries. Improvements in nutrition, sanitation, and health will motivate individuals to work for social, economic, and political development. The adoption of primary health care may require a major restructuring of the health care delivery system. It requires the commitment and support of the government and all sectors of society through a national policy that promotes community development for health and related programs.

In the United States, primary health care started as a level of medical care. Eventually, it became an anchor against the drift toward medical specialization. In the 1960's training programs were developed to prepare physicians to deliver comprehensive and continuous primary care. The programs reflected the belief that socially oriented care, responding to a range of patients' problems, complement the increasing use of highly specialized medical services and technological procedures.[44]

Currently, health care professionals differ in their opinions of the nature of primary health care. Generally, primary health care is characterized as the first level of personal care, largely preventive, curative, and holistic (care for the complete person rather than just the illness).

Primary health care in eight of the nine primary care centers studied showed dependence on physicians, medical problem solving, predominance of low-risk cases, and an orientation toward the treatment of illnesses. Despite the efforts of nurses and other members of the health team to provide holistic care with respect and dignity for the patient, emphasis is still placed on traditional medical services.

The primary health care approach is more than just medical care. It is useful in developed and developing countries, regardless of differences in social, physical, economic, and political conditions. The nature and causes of health problems are different, but sickness and disability continue to plague the world. Primary health care in developing countries is directed toward controlling poverty, malnutrition, ignorance, unsanitary conditions, and the inequitable distribution of health care services. Primary health care in developed countries should focus on prevention of morbidity, such as automobile accidents, drug and alcohol abuse, environmental hazards, obesity, and smoking and promotion of health by helping individuals identify and cope with the stresses of daily living. In addition, personal health services must be provided for self-limiting illnesses, minor disabilities, chronic stable conditions, and diseases for which no cure is known.[45]

Because basic or essential health care has never been defined in any U.S. public policy, primary health care is difficult to define. Tonkin pointed out that the word primary means first, as in a series, and also implies basic, as in fundamental elements of a whole.[46] In this context, primary health care must include and stress basic services.

In "Can Essential Services Be Defined?" Friedman claims that reaching a consensus about what is considered essential health services is difficult and fraught with moral, ethical, and political risks.[47] Whether essential health services are defined as the minimum level of health care below which no one should fall or the peak of care beyond which no one should rise, is like a choice between the floor and the ceiling, and often one man's floor is another man's ceiling.

Some argument against setting a national standard in health care is focused on who will benefit from it. Perhaps those whose health care has already exceeded the standard will be in danger of slipping back to the minimum. Hospital administrators suggest that the decision should be left to individuals and their physicians and, to the least extent possible, to the government.

Should preventive care be considered an essential service? Prevention is the way to reduce the need for curative care, which is expensive and inefficient. Preventive health services include screenings, case findings, health education, and community work and activities to ensure a healthier environment. Unfortunately, the effects of preventive work are difficult to measure, and conclusive reports can be expected only after a long period of observation. Nevertheless, a significant amount of evidence has been accumulated concerning the cost-effectiveness of preventive care. More importantly, however, and contrary to curative care, patients can not complain when preventive services are removed. Thus, whenever politicians are looking for savings, the preventive services are in danger of budget cuts, even if costs are relatively small compared with the costs of curative care.

In the United States, people pay for illness care. They rarely pay for health care. In fact, they buy sickness insurance, although it is called health insurance. Can people be influenced to believe that health is a valuable commodity, something that is economically valuable to them, their families, and their society? And, are they willing to buy prevention insurance as well as curative insurance?

Although discussions about the future financing of a health delivery system include cost control and hopes for improvement in the access and quality of health care, physicians remain in control of the delivery of health care, and are largely responsible for determining the costs and places where care will be delivered. As long as this system exits, primary health care will always remain in the shadow of medical care.

Yet, consumers and policymakers are beginning to question the merits of this model of health care delivery. Despite the escalating expense of health care and research; the profusion of clinics, hospitals, and medical centers; and the multitude of medical specialists and practitioners the expected returns from investments are not proportionate. Research shows that health

maintenance organizations, whose focus is on prevention rather than cure, have fewer members hospitalized and, therefore, significantly reduced their health expenditures.[48]

Another way of reducing the cost while enhancing the quality of care is to encourage more paramedical professionals, such as nurses and social workers, to enter primary health care. The Institute of Medicine report on primary health care disclosed that new health practitioners (nurse practitioners and physician's assistants) enhance the delivery of primary care by educating individuals about ways to lead more healthful lives.[49] The availability of a sufficient supply of new health practitioners could ensure that primary care services are available. Health practitioners, by communicating with patients, might help patients adhere more closely to prescribed regimens. Individuals will assume increased responsibility for their health and may face illnesses and other important events more resourcefully. The committee also believes that if nurse practitioners and physician's assistants are utilized properly the cost of health care can be reduced. Lewis indicates that nurse practitioners and physician's assistants can provide a range of medical services at a level comparable in quality to that of physicians.[50]

What aspects of primary health care as practiced in Omaha may be applicable to a developing city like Manila, Philippines? Not many, but certain experiences in Omaha may help strengthen the primary health care program in Manila.

- A city with limited resources, such as Manila, would do well to avoid the highly pluralistic and free enterprise approach to health care delivery that is practiced in Omaha. Manila should retain the more holistic and integrated approach, similar to the WHO model. Because the government is the main health care provider, it should provide leadership and direction to the program.

- Strengthen community action and particpation at the neighborhood level (barangay in the Philippines). People should accept more responsibility for their health, while government agencies should provide the support services to help people achieve this goal.

- Controls should be built into the health care delivery system to prevent one health profession from dominating the system. Health should not be equated with medical care alone.

- Nurse-managed health maintenance centers provide a cost-effective means for delivering health care. Other categories of health workers, even nonprofessionals, can be trained to provide primary health care when nurses are not available.

- Data gathering systems should be improved because they will serve as the basis for more research in primary health care.

- Primary health care is inhibited in the United States and other countries, such as Denmark, by expanding hospital systems.[51] Regulations should be instituted to balance various levels of health delivery with the needs and resources of Manila.

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APPENDIX A

Guide Questions Used in Assessing Primary Health Care Services

1. Explain briefly the history of the center.
2. What is the philosophy and/or objective(s) of the center?
3. How is the center organized and staffed?
4. What is the target population of the center? Who are its clients? How are they identified and/or reached?
5. What are the various services and health programs of the center?
6. What are the clinic hours of the center?
7. How do clients enter into the health care system?
8. How are referrals conducted?
9. What are the sources of funding for the center?
10. Describe the physical facilities of the center.
11. In what way do the staff identify the problem(s) of the population/community? Has there been any community diagnosis or epidemiologic investigation conducted in the community?
12. Does the community participate in its health care?
13. What are some of the most significant problems encountered by the staff in providing care to the community?

APPENDIX B

A Primary Care Checklist

A list of activities or indicators was prepared to introduce as much specificity as possible into the definition of primary care. These activities provide evidence of the achievement or presence of these attributes in a unit.

These indicators are not of equal importance or value. They have been listed in order; essential indicators have been separated from important indicators. The unit must have an essential indicator for it to be considered as having achieved the attribute under which the indicator is listed.

This checklist could have many uses. Among the most important is its use as a self-evaluative instrument for a clinic or practice unit. The checklist could also be used by outside agencies as a measure of the quality of a teaching clinic's primary care experience for trainees. Other indicators might have equal or greater value, and other researchers may want to validate these indicators or use another format.

In the list below, those items that are considered essential are marked by an asterisk before the number or letter in the left hand column, while those that are important but not essential are unmarked.

APPENDIX B
A Primary Care Checklist

Item	Indian-Chicano Clinic	HHCN Clinic	Douglas Co. South Clinic	Douglas Co. Clark Clinic	UNMC Family Practice Clinic	Creighton Family Practice Clinic	UNMC C&Y Clinic	Creighton Gerontology Clinic	VNA Health Maintenanc Site
A. Are Services Accessible?									
1. Are services available to patients?									
* a. Is access to primary care services provided 24 hours a day, 7 days a week?	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
* b. Is there an opportunity for a patient to schedule an appointment?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
c. Are scheduled office hours compatible with the work and way of life of most of the patients?	No	Yes	No	No	No	No	No	Yes	Yes
d. Can most (90 percent) medically urgent cases be seen within an hour?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
e. Can most patients (90 percent) with acute but not urgent problems be seen within 1 day?	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
f. Can most (90 percent) appropriate requests for routine appointments, such as preventive examinations, be met within 1 week?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Are services convenient to patients?									
a. Is the practice unit conveniently located so that most patients can reach it by public or private transportation?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
b. Is the practice unit so designed that handicapped or elderly patients are not inconvenienced?	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes

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c. Does the practice unit accept patients who have a means of payment regardless of source (Medicare, Medicaid)?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3. Are services acceptable to patients?									
* a. Is the waiting time for most (90 percent) of the scheduled appointments less than a half hour?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
* b. If a substantial minority (25 percent) of patients have a special language or other language or other communication barrier, does the office staff include people who can deal with this problem?	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
c. Are waiting accommodations comfortable and uncrowded?	Yes	No	Yes	No	Yes	No	Yes	Yes	No
* d. Does the practice staff consistently demonstrate an interest in and appreciation of the culture, background, socioeconomic status, work environment, and living circumstances of patients?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
* e. Is simple, understandable information provided to patients about fees, billing procedures, scheduling of appointments, contacting the unit after hours, and grievance procedures?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
f. Are patients encouraged to ask questions about their illnesses and their care, to discuss their health problems freely, and to review their records, if desired?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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* g. Does the practice unit accept patients without regard to race, religion, or ethnic origin?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
B. Are Services Comprehensive?									
* 1. Within the patient population served, and realizing that this might be restricted to a certain age (pediatrics) or sex (obstetrics and gynecology), is the practice unit willing to handle, without referral, the great majority (over 90 percent) of the problems arising in this population (for example, general complaints such as fever or fatigue, minor trauma, sore throat, cough, and chest pain)?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Not Applicable
* 2. Are appropriate primary and secondary preventive measures used for those people at risk (for example: immunizations for tetanus, polio; early detection of hypertension; control of risk factors for coronary disease)?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
* 3. Are practitioners in the unit willing, if appropriate, to admit and care for patients in hosptials?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
* 4. Are the practitioners in the unit willing to admit and care for patients in nursing or convalescent homes?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
* 5. Are the practitioners in the unit willing, if appropriate, to visit patients at home?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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A Primary Care Checklist

Item	Indian-Chicano Clinic	HHCN Clinic	Douglas Co. South Clinic	Douglas Co. Clark Clinic	UNMC Family Practice Clinic	Creighton Family Practice Clinic	UNMC C&Y Clinic	Creighton Gerontology Clinic	VNA Health Maintenance Site
* 6. Are the patients encouraged and assisted in providing for their own care and participation as allies in their own health care plan (for example: through instruction in nutrition, diet, exercise, and accident prevention)?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7. Do the practitioners in the unit provide support to those agencies and organizations promoting community health (for example: health education programs, health, and emergency training)?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
C. Are Services Coordinated?									
* 1. Do the practitioners in the unit furnish pertinent information to other providers serving the patient, actively seek relevant feedback from consultants and other providers, and serve as the patient's ombudsman in contacts with other providers?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
* 2. Is a summary or abstract of the patient's record provided to other physicians when needed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
* 3. Do the practitioners in the unit develop a treatment plan with the patient that reflects consideration of the patient's understanding? Do the practitioners use a variety of tactics to ensure that the patient will cooperate in the treatment? Does the plan of treatment reflect the patient's physical, emotional, and financial ability to carry it out?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4. Is another source of care recommended when a patient moves to another geographic area?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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APPENDIX B
A Primary Care Checklist

Item	Indian-Chicano Clinic	HHCN Clinic	Douglas Co. South Clinic	Douglas Co. Clark Clinic	UNMC Family Practice Clinic	Creighton Family Practice Clinic	UNMC C&Y Clinic	Creighton Gerontology Clinic	VNA Health Maintenance Site
D. Are Services Continuous?									
* 1. Can a patient who desires to do so make subsequent appointments with the same provider?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
* 2. Are complete records maintained in a form that is easily retrievable and accessible?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
* 3. Are relevant items or problems in the patient's record highlighted, regularly reviewed, and used in planning care?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4. Is each patient reminded of his or her next appointment?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
E. Is The Unit Accountable?									
* 1. Do the practitioners in the unit assume responsibility for alerting proper authorities if a patient's problem reveals a health hazard that may affect others in the community (for example: discovery of esposure to toxic chemicals in an industrial plant; discovery of a communicable disease)?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Is there a patient-disease and age-sex registry maintained that can provide the basis for a practice unit?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3. Is there a system for regular review of the quality of the process of medical care (for example, reviews for completeness of therapeutic programs and follow-up of acute illnesses)?	Not Sure	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Not Applicable

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A Primary Care Checklist

Item	Indian-Chicano Clinic	HHCN Clinic	Douglas Co. South Clinic	Douglas Co. Clark Clinic	UNMC Family Practice Clinic	Creighton Family Practice Clinic	UNMC C&Y Clinic	Creighton Gerontology Clinic	VNA Health Maintenance Site
4. Is there a system for regular assessment of the outcomes of the care offered (for example, review of the outcome of treatment of a specific illness, review of level of satisfaction of patients with the services provided, review of compliance with recommendations)?	Not Sure	Yes	Not sure	Not sure	Yes	Yes	Yes	Yes	Yes
5. Is there evidence that the unit regularly assesses the capability of the staff and provides opportunity for continuing education?	Not Sure	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6. Are the patients appropriately informed about the nature of their conditions, the benefits and risks of available treatments, and the expected outcomes? Are they provided the opportunity to ask questions and discuss their medical records?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7. If unexpected or undesired outcomes occur, are they made known and adequately explained to patients, and is a method established for responding to any expressed dissatisfaction (such as conferences, counseling, arbitration, adjustment of billing, or referral)?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8. Does the provider maintain financial accountability by keeping accurate records and adequate professional liability coverage?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Source: Institute of Medicine. A Manpower Policy for Primary Health Care. IOM Publication:Washington, DC, 1978.