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ABSTRACT

The distribution of health professionals, particularly physicians and dentists, has been especially critical for rural America. An effective lasting solution will depend not only on economic incentives but on the development of a health care delivery system that links providers to hospitals, decreases professional isolation, and utilizes physician extender personnel in isolated areas. Before building a health system, the community must consider four basic issues: (1) need--are there enough people to require the services of one or more physicians? (2) feasibility--is the community able to financially support health care personnel and facilities? (3) existing health care sources--where does the population currently obtain health care? and (4) linkages--are major health resources accessible and available in the larger region for required backup services? The health system should address the population's needs for all three levels of care--primary, secondary, and tertiary. Emergency medical service should be an essential component at all levels. Consideration should also be given to linkages with medical schools and health departments, transportation, and community and financial support. Seven models of the rural primary care center depicting various levels of organizational arrangements are described. (NQ)

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Building A Rural Health System

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U.S. Department of Health, Education, and Welfare
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Building A Rural Health System

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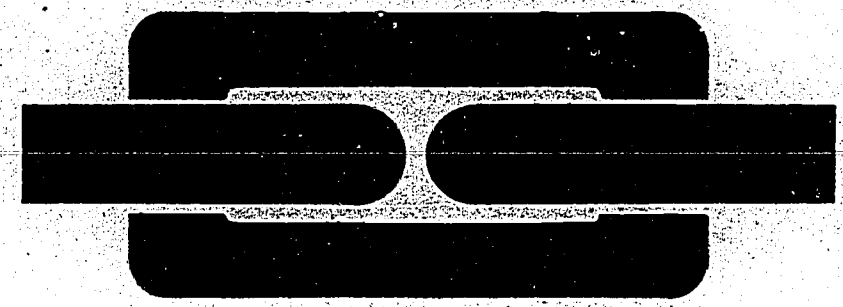
Contents



THE FEDERAL INITIATIVE IN RURAL HEALTH

It has long been recognized that community health planning can prevent waste of money and fragmentation and duplication of services. There is a need for more efficient use of available health manpower and resources. Nowhere is the need greater than in rural America.

The recently enacted National Health Planning and Resources Development Act (Public Law 93-641) creates a network of health planning and resource development agencies at the regional and State levels. Not less than 25 percent of the allotments to the States for medical facilities projects may be used for outpatient facilities to serve medically underserved people and half the allotments must be expended in medically underserved rural areas.

Public Law 91-419, the Rural Development Act of 1972, requires that goals be established for the rural development of employment, income, population, housing, quality of community services and facilities. This legislation will have a decided impact on the health and quality of life or rural people who are seriously affected by the prevalence of disease and chronic conditions resulting from inadequate shelter, poor water supplies, substandard sewage systems, and occupational and work-related illnesses.

The new priority requires strengthening the rural health system in primary and preventive care through integration of services. By pulling manpower, supporting services, facilities, and technical assistance together at the local level, an independent and self-sustaining capability in health care can

be created. This local effort should be designed to use local and State resources to an increasing degree.

The Bureau of Community Health Services, Health Services Administration, is integrating the activities of four of its component parts—the Community Health Centers Program, the Migrant Health Program, the Appalachian Health Program and the National Health Services Corps—to develop county/community and multicounty/community primary care systems in areas with critical health manpower shortages. Forty-seven of these integrated efforts—Rural Health Initiatives—were in operation by the summer of 1975.

Approximately 21 percent of the 127 centers supported by the Community Health Centers Program that provide health care to more than 1.4 million people are rural projects. Many others serve rural populations as part of their service areas and 17 of the 20 family health centers are located in rural areas.

The Migrant Health Program is responsible for the health care of approximately 3 million farmworkers and their dependents in 100 agricultural counties throughout the United States and Puerto Rico.

The Appalachian Health Program administers over 300 health planning and operating grants in the 13 Appalachian States region. It coordinates health activities with the overall development program of the Appalachian Regional Commission.

The development of ambulatory care systems has been an increasing priority of the Public Health Service. The National Health Service Corps (NHSC) has been strengthened and expanded to meet its primary mission of developing health care practices in areas with critical shortages of primary care providers. The NHSC has placed more than 325 physicians, 80 dentists, and 141 physician extenders in 270 areas in 46 States and Territories, 85 percent of them in rural areas.

Other PHS efforts with impact on rural health include the Indian Health Service (IHS), which operates 51 hospitals, 83 health centers, and 300 health stations and satellites, providing medical and community health services to 500,000 Indians and Alaskan Natives. Because of the unique Federal responsibility for the Native American population, the IHS is usually not considered a rural health program, although it serves an overwhelmingly rural population and these services represent a significant Federal contribution to rural health needs.

The Emergency Medical Services Systems Act is especially important to many rural communities that have been unable to develop adequate emergency care. Most of the grants awarded in this program have been for feasibility studies and planning in rural areas. These plans are reviewed to insure that adjacent rural communities are not excluded from any proposed emergency medical service system.

Forty-three percent of the 256 community mental health centers, funded by the National Institutes of Mental Health serve one or more predominantly rural counties. Although these rural centers have small catchment area populations, they must bring services to people scattered over areas as large as 10,000 square miles.

The distribution of health professionals, particularly physicians and dentists, has been especially critical for rural America. An effective lasting solution will depend not only on economic incentives but on the development of a health care delivery system in rural America that links providers to hospitals, that decreases professional isolation, and that utilizes physician extender personnel in isolated areas. The development of rural health care systems must be linked with the development of schools for health professionals in non-metropolitan communities and of measures and incentives to move the residency training of more physicians out of metropolitan areas.

The National Health Planning and Resources Development Act should be a major force in directing the use of Federal resources throughout the country. The Act should insure that the service programs will offer more effective communitywide solutions. It reflects the positive trend of placing more reliance on States and localities to develop and deliver health services.

In addition, there is a need to move expeditiously and thoughtfully toward a rational system of health care financing that provides for the distribution of the costs of care over a broader population and gives effective incentives for cost control and quality assurance. It will be most important to develop this system so that it can accommodate increases in services that the American people may expect in the future.

Historically, Federal approaches to health problems have been categorical; most programs have focused on individual groups or populations with specific problems or diseases or special beneficiary status. It is necessary to reconsider this approach, especially in the growing number of rural areas with critical health manpower shortages and/or significant resource shortage.

Implementation of a more effective Federal initiative in rural health will require closer ties among local, State, and Federal activities, those conducted by consumer and professional groups and those being supported through foundation and other funding. Some State medical associations are designing mechanisms to supply health services to rural areas and are developing modifications of delivery and financing systems at the county and multicounty level. Even with federally-funded projects from a number of departments, success appears to be related to the active participation of the local community, especially health professional groups and organizations.

BUILDING A RURAL HEALTH SYSTEM

Because of today's transportation modes, it is not necessary to have a physician in every town. Health resources can be organized into larger and more efficient systems where rural and small urban communities form a population base large enough to support a full range of quality health services and facilities.

The newer hospitals or additions often contain office space for physicians so that the laboratory, X-ray, and emergency room services can be used for ambulatory patients as well as inpatients. In large towns, physicians' offices are often located close to the community hospital. In rural areas, it might be more practical to staff small satellite health centers with physician extenders residing in the community.

The community must consider four basic issues before building a health system:

1. Need: Are there enough people to require the services of one or more physicians?
2. Feasibility: Is the community able to financially support health care personnel and facilities?
3. Existing health care sources: Where does the population currently obtain health care?
4. Linkages: Are major health resources accessible and available in the larger region for required backup services?

COMPONENTS OF A HEALTH SYSTEM

A health system should attempt to meet the health needs of all people. It has become increasingly apparent that basic (primary) health care can be provided on an ambulatory or walk-in basis within reasonable distance of the people being served. Some patients may need specialty care and hospitalization (secondary), therefore primary ambulatory care should be linked to secondary levels of care. Others may need the more specialized diagnostic services or treatment available in the large medical centers (tertiary). For a health system to be complete, it must provide access to a tertiary care facility where highly developed diagnostic skills are available and unusual procedures such as heart surgery or organ transplants can be performed.

No one rural community will have the totality of health care needed by its population. But each community can have access to basic primary care and be linked through formal arrangements to higher levels of care in the same or another com-

munity, at the State level, or even in another State. A rural health system should address the needs of the population for all three levels of care.

Primary Care

A primary care facility should be no more than 30 minutes driving time from the majority of the people to be served. A local community health center, physician's office, or health department can be organized to deliver primary care services to ambulatory patients.

Primary (ambulatory) care represents 80 percent of the care that people need and includes the diagnosis and treatment of uncomplicated illnesses and disease, preventive services, case finding services, home care services, minor surgery, emergency care for problems not requiring specialized personnel and equipment, and preventive, diagnostic, and restorative dentistry.

Traditional primary care services should relate closely to other sources of primary care which include:

Health departments offer many preventive services and may arrange for family planning, immunizations, communicable disease control, crippled children's vocational rehabilitation, home nursing, health education, dental care, and screening procedures. Health departments usually offer environmental health services.

Schools sometimes provide health services that include nursing, vision and hearing testing, other screening procedures, and health education.

Mental health services are available through community mental health centers which sometimes provide consultant services.

Voluntary health agencies (heart, cancer, lung, mental health associations) usually operate on a regional basis in rural areas and have local committees. They may be sources of service in education, nutrition, anti-smoking, and obesity control.

Agricultural extension services may also offer health education, nutritional counseling, or other services.

Primary care is usually provided by physicians, physician's assistants, nurse practitioners, nurses (including LPNs), dentists, dental hygienists, and dental assistants. It utilizes health and related assistants for laboratory work, outreach, and other services using specially trained personnel.

Under the direct supervision of a physician, physician extenders may provide diagnosis and treatment. The physician may not always be present at the center, but he is always avail-

able by telephone for consultation and patients who require a physician's attention are referred to him.

The primary care team has the capability of providing or arranging for laboratory and X-ray procedures. The administrative aspects of the practice are usually managed by someone familiar with that work.

Primary Care Personnel—Population Ratios

An option for staffing primary health care centers is based on the following assumptions:

A physician and his backup personnel (receptionist, nurse) are able to provide primary care services to a patient population of 1,500 to 2,000 persons.

Physician extenders such as nurse practitioners are estimated to be capable of handling a patient load of 1,000 to 1,500 persons. Physician extenders and support staff appear to be economically viable at this level.

The National Health Service Corps Program approves and staffs sites at:

A physician to population ratio of 1 to 4,000.

A physician extender to physician ratio of about 1 to 2 or 3 where feasible.

Sample health personnel-population ratios for primary care centers which would need to be adjusted to the specific site are:

10,000 population or above	5 or more physicians 2 or more physician extenders An administrator and backup personnel
5,000 to 9,000 population	2-4 physicians 1-2 physician extenders A bookkeeper-manager and backup personnel
2,000 to 4,000 population	1-2 physicians 1 physician extender Backup personnel
1,500 population or less	1 physician extender with backup by physician(s) and bookkeeper-manager Backup personnel

Secondary Care

Secondary care offers inpatient or diagnostic care, both acute or chronic, and includes medical or surgical diagnosis and care for complicated problems (including dental). Any hospitalization, nursing home care, or emergency medical service requiring specialized attention is secondary care. Consultation by medical specialists in areas such as ophthalmology, obstetrics, and surgery also represent secondary care.

A secondary care site usually should not be more than 60 minutes driving time from the primary care facility.

Health problems which are inherent to the area, such as black lung disease, may require the addition of physician specialists to the secondary health care team. Arrangements should be made to insure (1) the linkage of primary care sites to secondary care sites so that all referred patients will be seen by the appropriate specialist; (2) that patient records are made available to the specialists for quality care; and (3) that reports from the specialist flow back to the center to insure adequate followup. In some instances it may be necessary to provide and make special arrangements for specialty services to communities some distance from the primary care site.

Primary ambulatory care centers need formal arrangements with hospitals which meet the conditions of participation under Medicare, including licensure by the State and accreditation by the Joint Commission on Accreditation of Hospitals.

Tertiary Care

Tertiary care is normally available in large teaching hospitals or university medical centers. It is exemplified by a medical school complex or a teaching hospital center where diversified types of functions (diagnostic workups, heart surgery, neurosurgery, and renal dialysis) are brought together for the common purposes of medical care, medical education, and research.

Tertiary care ideally should be no more than two to three hours driving time from primary care sites. Helicopters and other aircraft may be used to link rural areas to tertiary care centers.

Emergency Medical Service

Emergency medical service is an essential component at all three health care levels. At the primary level it calls for physician or physician extender care 24 hours a day, seven days a week, and emergency transportation services staffed by trained attendants capable of on-site and/or in-transit care.

A Stratified Health System

TERTIARY MEDICAL CARE AND HEALTH SERVICES: FOR A STATE OR MULTIPLE COUNTY REGION

(Provided in a Medical Center of a University Teaching Center)

Quality specialty care in a personalized fashion:

1. Specialized medical, diagnostic, and therapeutic services for unusual and complicated cases.
2. Specialized surgical care for unusual and complicated cases (neurosurgery, organ transplants, etc.)
3. Specialized dental care for unusual and complicated oral disease and surgery.
4. Emergency medical care.
5. Part of a comprehensive health care system.

SECONDARY MEDICAL CARE AND HEALTH SERVICES: FOR A REGION

(Provided in a Regional Hospital or Health Center)

Quality secondary and referral care in an available and personalized fashion:

1. Medical and surgical diagnostic services for complicated problems.
2. Surgical care and medical care for complicated problems.
3. Services for major surgical and medical emergency problems.
4. Specialty dental care—orthodontics, endodontics, periodontics.
5. Emergency medical care.
6. Part of a comprehensive health care system.

PRIMARY MEDICAL CARE AND HEALTH SERVICES: FOR AN AREA

(Provided in an Area Health Ambulatory Center)

Quality primary care and health services in an available, personalized, and continuous fashion:

1. Preventive services, case-finding services, and diagnosis and treatment for usual and uncomplicated illness and disease.
2. Minor surgery and medical care for uncomplicated problems.
3. Home care programs—nursing services.
4. Preventive, diagnostic, and restorative dental services.
5. Part of a comprehensive health care system.
6. (In large Area Health Centers, services for surgical and medical problems not requiring specialized personnel and equipment.)

(Provided in a Community Health Center, usually a satellite to an Area Primary Health Center)

Quality primary medical care and health services in an available, personalized, and continuous fashion:

1. Preventive services, case finding services, and diagnosis and treatment for usual and uncomplicated illness and disease.
2. Supervision of home care health services.
3. Part of the comprehensive health care system.

Source: R.C. Rakal, M.D. (Iowa)

OTHER RESOURCES

Linkages to Medical Schools

Many medical schools are interested in:

- training opportunities in rural areas for students and residents
- providing preceptorships
- staff support
- specialty consultation
- quality review
- continuing education opportunities

Each center should endeavor to negotiate arrangements with medical schools in the above areas. Such relationships should prove useful to a rural health care system for future recruitment of scarce personnel and for filling professional needs.

Health Departments

In many areas, county and district health departments, with major responsibilities and potential for broader preventive, environmental, and educational roles, could serve as important factors in the development of a broad-based effective rural health care system.

Transportation

Rural health system planning must consider the need for emergency and other types of transportation. This is very important to a rural health care system and may be the critical element in making it possible for people to obtain the care they need.

The Administration on Aging, voluntary health agencies, health departments, health programs, and other social programs may offer services or provide payment for transportation. The trend is to integrate transportation services to meet more than one public service need.

Community Support

Substantial community support is a key factor in the success and continuity of a rural primary health care system. All facets of the community—business, political groups, civic organizations, churches, and interested individuals—should be involved in planning and monitoring the center.

Accounting, legal, management, and organizational abilities, as well as other skills, have proved to be indispensable in community development of a health system. The community must be aware of the existence of the center and the quality of care offered, and they must utilize the center.

Financial Support

Fiscal viability is critical in the continuing operation of a primary care center. All sources of potential income must be identified and utilized. Third party insurers (Medicaid, Medicare, and private insurance companies) should be identified, have rates negotiated where required, and be billed for services. County or State governments may be a source of funds for persons who are unable to pay for their own care. Private foundations may also supply financial support.

REPRESENTATIVE MODELS

Organizational arrangements and methods of delivery of rural primary care could include solo practices, group practices, medical foundations, public health clinics, health maintenance organizations, hospital outpatient departments, school health programs, and community health centers.

The following seven models concentrate on descriptions of one approach to the delivery of rural health care—the rural primary care center.

Special emphasis is given to the involvement of hospitals in the development and delivery of primary care services in rural areas. This emphasis is believed appropriate because (1) the community hospital is a logical focal point for the community's health resources and should be an integral component of any community health care system, and (2) a need exists to establish coordinated systems for more effective and efficient utilization of institutions in the delivery of primary health care.

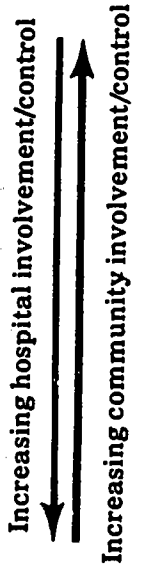
While each model discussed may not describe the relationships at the secondary and tertiary levels, it is understood that these linkages must be established for any of these centers to be considered as part of a delivery system.

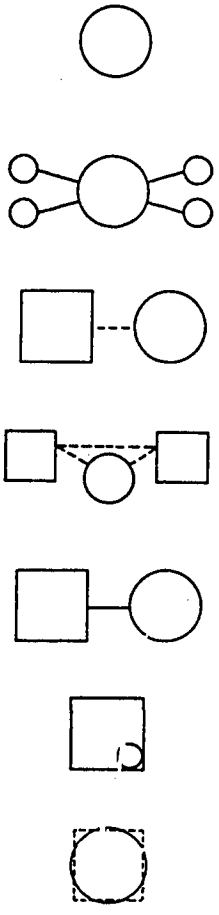
Schematic of Models

The seven models shown in the schematic depict varying levels of organizational arrangements. Hospital involvement/control is the particular organizational relationship that differentiates the models. The degree increases from model No. 1 to Model 7—as shown by the top to bottom scale. The antithesis is one of community involvement/control and increases from model No. 7 to model No. 1.

The schematic depicts only an involvement/control relationship between the center and the hospital. Other relationships, such as contracted services, training affiliations, and hospital admitting privileges for center physicians may exist, but are not shown. In some instances, the center may contract with a hospital for sophisticated laboratory testing or radiological services, but the hospital is not involved in the policy-making and management of the center.

SCHEMATIC OF MODELS

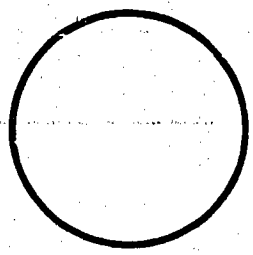




1. Free-standing, community-owned, and operated center
2. Community-based corporation operating satellite centers
3. Community-based center assisted by hospital
4. Hospital-based center jointly developed by two hospitals
5. Hospital-operated satellite center
6. Hospital-based (physically) center
7. Hospital converted to center

Primary Care Center

Hospital



1. The Free-Standing, Community-Owned and Operated Center

This model of a rural primary health care center is characterized by a private, nonprofit, community corporation which owns the facility and has total responsibility for its management and operation. Annual dues may be levied to provide a voting membership in the corporation. The full corporate membership, which is broadly representative of the population of the service area, elects the board of directors. All personnel working in the center, including physicians and dentists, are usually salaried employees of the corporation.

This model requires a substantial and long-range commitment of time, energy, and money by the community. The community accepts the responsibility for the development and operation of its own health care system and the ultimate goal must be to attain and maintain self-sufficiency after outside "start-up" grants, if any, are terminated.

Some basic criteria that might be used for this center are:

a. The service area (1/2 hour's driving time from center) shall contain not less than 3-4,000 persons.

b. A physician-to-patient and dentist-to-patient ratio of at least 1-2,000.

c. At least 50 percent of the service area population must reside approximately 30 minutes driving time from the nearest hospital or health center.

d. The sponsor must be a nonprofit public or private corporation.

e. The community or sponsor must demonstrate strong leadership in developing the project and provide a substantive financial commitment.

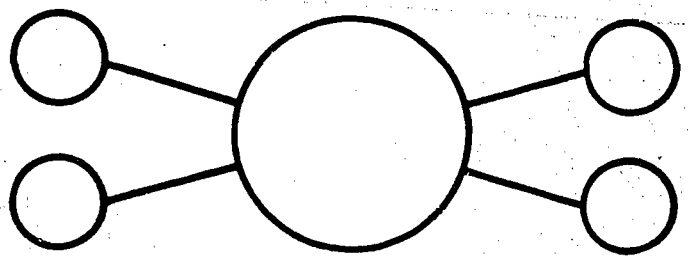
f. All clinical personnel must be salaried employees of the health center.

g. At a minimum, the program must have the equivalent of two full-time primary care physicians and/or physician extenders.

One area for cooperation between a hospital and community-based health center is that of providing hospital staff privileges for physicians employed in the center. Center physicians can admit their patients to hospitals, either as the attending physicians or by referral to other physicians on the hospital staff. The latter method may be more desirable to the center physicians because of travel and time involved in attending their patients in the hospital, especially where the hospital is some distance away.

There will continue to be debate among providers of care about the need for and/or the appropriateness of the community-based center as a source of rural primary health care. To some, it is unnecessary duplication and competition; to others, it is a further inroad for socialized medical care. Nevertheless, this primary care model suggests that local control is often popular with those being served, primary care services have been made more accessible in rural areas, and the model can be reproduced and adapted to the needs and desires of rural communities.

With the necessity of attaining self-sufficiency of major concern, most of the difficulties encountered in the developmental years relate to financing. Most community-based centers must generate sufficient revenue from their services to support their operating costs when grant support is ended. A significant amount of this revenue is derived from third-party payers such as Medicaid, Medicare, and private insurance carriers. Free-standing, community-based centers differ from the usual health care providers with which these insurers usually deal, and center administrators frequently experience difficulties and long waiting periods before obtaining the necessary approval from these service agencies.



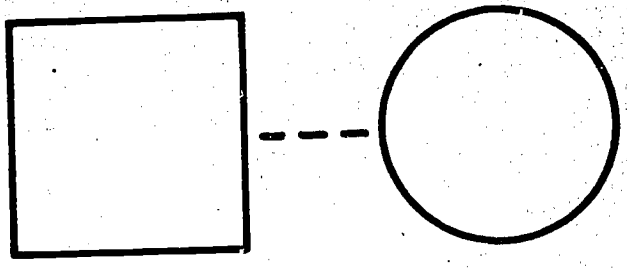
2. The Community-Based Corporation Operating Satellite Centers

This model of rural primary health care delivery is essentially an expanded version of the free-standing, community-operated center. The basic organizational difference is that

centralized administrative services (planning, development, and billing) are provided for operating one or more satellite centers.

All personnel working in the satellite centers are usually salaried employees of the corporation.

Each satellite center usually offers primary medical services, and if feasible, dental care. Transportation may be provided for those who need it. Some basic laboratory services are available, while more extensive tests are sent to a commercial laboratory. Radiology services may or may not be provided at center; patients needing this service can be referred to the primary center or to local hospitals. A small, limited pharmacy may be established. Home nursing services are arranged through the local visiting nurses association, and social service referrals are made to the appropriate agencies. Emergency services are available through a physician on call when the center is closed and at the emergency room of the local hospital. Medical services are provided to nursing and boarding homes in the areas of the centers.



3. The Community-Based Center Assisted by a Hospital

This model combines community control with the technical assistance and administrative resources of a community hospital. Hospital involvement with the development and/or operation of a center goes beyond contracting to provide services or granting medical staff privileges to the physicians working in the center. The hospital is responsible for meeting the community's primary health care needs, but does not control or operate the delivery system. A community corporation retains the decision-making authority for defining, developing, and operating its own health care system. The success of this model depends basically upon a total commitment of time, talent, and money from the community, and a commitment by the hospital to advise and assist, but not to control or manipulate, the community system.

An agreement must be reached between the hospital and the community corporation that defines the intent, purpose, and goals of the relationship between the two organizations, and

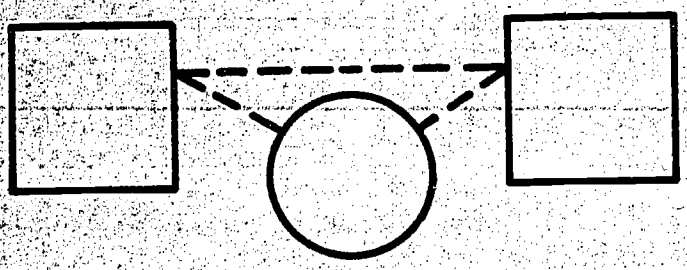
decides on the type of health system that is to evolve. The basic elements of this agreement might be:

1. The community corporation does not plan, develop, and maintain its own primary health care system, although it has the right to determine what services are to be provided.
2. There is a real need for the development of such a health care system in the area.
3. The role of the hospital must not result in a long-term involvement in the operation of the center; other local hospitals should become functional parts of the system.
4. The hospital would operate the system for a stipulated period of time and provide for an orderly transition of control and operation to the community corporation.

The clear intent and mutual understanding of this agreement is to assure the transition of responsibility from the hospital to the community so that the center can become self-sufficient and determine its own destiny. There should be no attempt by the hospital to control the system.

The establishment of this kind of relationship between a community and a hospital is invaluable for successful implementation of this model of rural primary health care delivery and is necessary for developing a comprehensive scope of services. The continuing availability of technical expertise and consultation in administrative and program development, staff recruitment and training, and program evaluation can be a major factor in the success of the program.

Another important component of the relationship between a community corporation and a secondary health care facility is an educational one. A family practice residency program and other educational activities of a hospital may provide academic stimulation for the employees of the center. The family practice program serves as a continuing source of new staff and provides a framework for professional interaction and consultation.

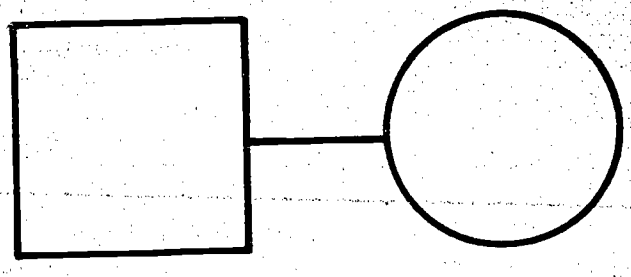


4. The Hospital-Based Center Jointly Developed by Two Centers

This model of developing and delivering primary health care is more complex and involves more hospital input and control than the previous models. Successful implementation depends on open communication, mutual respect and confidence, and a joint commitment of the two hospitals to do what is best for the community.

In many rural areas where there are two hospitals; both may be experiencing financial difficulties and physician shortages, and there is needless duplication of services. Serious consideration could be given to consolidating the two institutions if the respective hospital boards concur. The cooperative establishment of a primary care center by the two hospitals may not only attract and retain physicians, but also serve as a stimulus for continued cooperative consolidation efforts between the two institutions.

All staff in this model are salaried employees. Specialty services are available through contracts with consultants and all ancillary services of the hospitals are provided to the center.



5. The Hospital-Operated Satellite Center

In this model, the hospital extends its outpatient services by establishing a satellite facility. The center is geographically removed from the hospital, but administratively controlled and

operated by it. If a community nonprofit corporation is involved, it is in an advisory capacity. In the absence of a local corporation, a more informal advisory committee is frequently utilized to obtain community input.

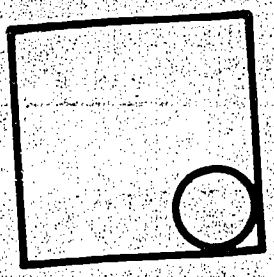
Ultimate decision-making responsibility for the functioning of the center rests with the hospital. The facilities may either be built or leased by the hospital but are frequently located in renovated buildings.

An advantage of this model of delivery is the ready availability of the backup services of the hospital despite the geographic separation, because both facilities have a single administration. The emergency room at the hospital, staffed 24 hours a day, 7 days a week, provides backup service when the clinic is closed. Laboratory and radiology services are performed at the hospital and specialty consultations are available. This model permits the physician to become involved in other hospital activities more easily. Other consultation and/or rehabilitation services may also be arranged with local health and voluntary agencies.

This type of center may provide needed community health services on a sound financial basis with a minimum of capital outlay by the hospital with or without State and/or Federal funding for development. Community control or community input may be limited to advisory only.

A hospital-operated satellite center may include a strong teaching component. It may be a division of the Family and Community Medicine Program of the hospital or medical school program and the center can be staffed with supervising physician(s) and residents assigned on a rotating basis and may function on a group-practice, fee-for-service basis.

Financial self-sufficiency may not be a priority goal of this model as it is with those previously described. This center may be an important education component of the hospital's or medical school's family practice residency program, and as long as a high-quality training experience is provided, deficit financing is secondary. Since the community has no legal or financial responsibility for sustaining the center, there may be a possibility that at some future time, the support of the center may become too burdensome for the hospital.



6. The Hospital-Based (Physically) Center

The primary health care center in this model is physically located in or immediately adjacent to the hospital. Administratively and organizationally, the center operates as one of the departments of the hospital. Physical proximity affords certain advantages over a satellite located at a distance from the hospital. All of the technical/administrative resources of the hospital are immediately available and little or no duplication of sophisticated and expensive radiology, laboratory, and related diagnostic services should be necessary. Many people use the hospital emergency room as their main source of primary care, and locating family health centers in or adjacent to hospitals may serve to shift patients from episodic care to more comprehensive, continuing health supervision. If, however, one of the reasons for establishing a primary care center is to make services more accessible to underserved populations in terms of distance and travel time, locating the center in a hospital may not contribute to this purpose.

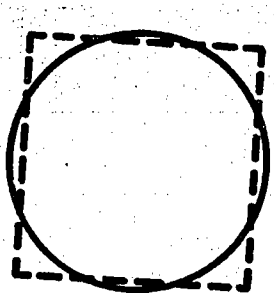
Certain unique problems may be encountered in operating a primary care center in a hospital. It must compete for limited resources with other traditional hospital programs in an environment oriented to specialized inpatient care. As a department for which the hospital board is ultimately responsible, the center may have difficulty in getting effective input from, and responsiveness to, the community even with a community advisory committee.

There is a need to educate the community to the advantages of comprehensive primary care as opposed to episodic emergency care to avoid underutilization of the center.

To increase the accessiblity of services and expand their utilization, the hospital might operate outreach centers in adjacent areas. The hospital leases the space and equips and staffs the center.

Locating the primary care center in a wing of the hospital makes it unnecessary to purchase expensive laboratory and radiology equipment and supplies. The emergency room is available for backup coverage when the center is closed and personnel can be shared among the center, the hospital, and an extended care facility, where one exists.

In some instances the hospital may have established several urban and/or rural backup linkages with other resources in the development of its primary care center. These may provide secondary and tertiary level care.



7. The Hospital Converted to a Center

This model represents the conversion of a rural hospital from an acute care inpatient facility to an ambulatory care center providing primary care.

Many small rural hospitals are confronted with the dilemma of conforming with stringent standards for organization, facilities, equipment, and services while their already limited financial resources are being eroded by increasing costs. As alternatives to bankruptcy and closing, some are entering into shared services arrangements or mergers. Another option may be to change the facility into a primary care center. Whether this is viable for a particular rural hospital depends on the health care needs of the service area population and the availability of primary care services. In areas with enough private practitioners, conversion to a nursing home facility or a specialty hospital may be more appropriate.

Whatever new mission may be decided upon, the decision must be based on a thorough evaluation of area health needs and resources, and a carefully planned transition must be developed to minimize the impact on the community.

If the hospital is to be restructured as an ambulatory care center, it must:

- Emphasize ambulatory care while de-emphasizing acute inpatient care.
- Reduce the number of acute care beds each year that occupancy is below 70 percent.
- Close all inpatient beds at any time if they are financially unprofitable.

or

- Take steps to meet the standards for hospital accreditation.

The inclusion of inpatient beds for limited care for recovery, observation, testing, and minor surgery and illnesses may be justified by the remoteness of the area and frequent difficult climatic conditions. It is not intended that the center should be a "de facto" small hospital.

The professional staff of the center would be employees of the board of directors and would receive either guaranteed salaries and/or a percentage of their net revenue.

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