HEALTH CARE FOR RURAL UNDERSERVED AREAS

I. Background

The most pressing and the most difficult problem facing the health care system in the United States is that of providing access to medical care in underserved urban inner city and rural areas.

These areas share the same basic problems - poverty of residents and adverse living conditions for professional workers. However, solutions for the two areas are not likely to be identical, because of differences in characteristics of both people and conditions.

The urban ghetto is characterized by crowding, and by the potential threats posed by street crimes among adolescents and young adults. The rural community is characterized by wide dispersal of older people, with boredom the chief threat to the young professional. While a neighborhood health center might serve the needs of a crowded city, it would not serve the rural area.

North Carolina is still a rural state. Even in the industrialized Piedmont Plateau, the industrial towns and cities are surrounded by rural countrysides containing scores of hamlets, once relatively prosperous, but now losing all young people to a more secure life in the cities. These towns are inhabited by those unable to make the grade in the city, those too old to change their pattern of life, or those who are somehow tied to land or homes. These are generally in an older age group, and as a result of the out-migration of their sons and daughters, they are left without the support of younger generations in times of medical need.

A health care system designed to serve such a rural area must consider several desirable objectives. First, the services should be widely dispersed, to conform to the dispersal of the people. Second, the services should be highly personal and supportive. Third, the services should be relatively. economical, not duplicating complex, specialized services available in existing community hospitals located within a reasonable driving distance.

Such a health care system must also recognize the fact that highly trained professional workers are not likely to settle in rural areas. Physicians, nurses, physician's assistants, and all other skilled professionals are likely to prefer larger towns and cities.

The desired characteristics of the services to be provided, plus the low probability of obtaining full physician or other professional coverage leads logically to a system based on health care workers recruited from the community to be served. These workers must be incorporated into a framework in which supervision, backup and continuous support are provided for the community worker and the patient.

A system meeting the above criteria has been established on a pilot basis in the Bragtown and Rougemont-Bahama districts, all within Durham County. The first of these is a semiurban area, composed of black residents almost surrounded by white housing areas. It is basically a dispersed neighborhood, containing on one border a recently built urban housing project for limited income families. The second is a widely dispersed rural area, comprising most of the upper half of Durham County, and containing two towns - Rougemont and Bahama.

These communities are served by health care systems having a common design. The neighborhood residents in each area, through their community councils, have been asked to select housewives, who have then been trained as community health workers. Two have been selected in Bragtown, and two in the Rougemont-Bahama area, all serving on a half-time basis.

These workers have two levels of immediately available consultation, plus the more remote backup of the entire medical community in Durham County. First, a physician's assistant is assigned to the four workers. This person is available to consult with the worker, to go to a patient's home, to examine the patient, and to transmit findings to physicians. Two part-time physicians cover two "clinics" in the area at regular intervals, for consultation and for treatment of cases scheduled through the community health worker.

Several problems have developed. First, there is no available public

transportation, and taxi service is beyond the means of most patients. Second, there is a need for more community worker time and more physician coverage. Third, there is a need for a mobile "clinic" which can be moved from place to place to better meet patient needs in this scattered area.

II. Objectives

A. To establish an effective fiscally feasible health care delivery system for one rural and one semiurban area of Durham County. This system will be a prototype for other areas of the state, and will include preventive, emergency, referral and followup services.

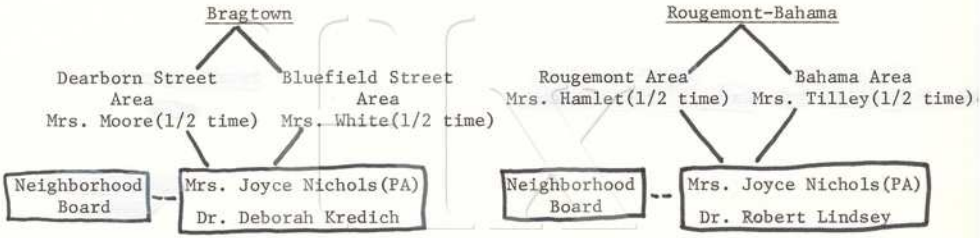
B. To provide accurate information regarding acute and chronic illness in rural areas, and the response of patients to these illnesses.

C. To provide data regarding the total cost of medical care in such areas, and its effect on the utilization of care.

D. To evaluate the effectiveness of the system in meeting health care needs.

III. Plan

The existing structure is as follows:



The neighborhood resident who is ill may call the community health worker at any time. She responds as she deems appropriate, but the responses may include the following types. She might immediately arrange medical care through the emergency room of the patient's choice. If no other transportation were available, she could use her own automobile for such a trip. She might consult the physician's assistant, who might arrange a home visit for data collection and for lab studies the following day with later contact of the physician designated by the patient. She might ask the patient to come to the next scheduled clinic in the neighborhood. She might, in response to simple problems, provide first aid type services herself. She might provide councilling in appropriate cases, etc., etc.

The entire team maintains an awareness of community problems, and even seeks out problems of a public health variety, which are studied and acted upon in various ways. In this task, they are advised by a neighborhood health board, chosen by the neighborhood council.

The "clinics" which currently exist are in fixed locations, and consist of an examining area plus first aid supplies and starter medications. One (Bluefield area, Bragtown) is in a community center building, and the other (Rougemont-Bahama) is in a church building.

Because of the nature of the area, and the location of the clinics, those in the immediate area are served best, and those in more remote areas might not be served at all.

There are also individuals who, because of illness or lack of transportation, cannot come to a clinic at all. Some roads are impossible except with special vehicles.

The plan is to (A) expand the availability of health worker coverage, by providing full-time salaries for these individuals, (B) expand the physician coverage by providing a full-time salaried physician who can coordinate care and work with existing part-time physicians, (C) to provide a mobile clinic which can be regularly staffed by a combination nursing-clerical staff, and which can be moved from place to place on a regular schedule to provide more even coverage over the area, (D) to provide a suitable vehicle for home visits by the physician's assistant, which could also be used to transport patients to clinics or to hospitals if necessary.

These persons and these facilities would be used in a manner similar to that described above. Regular meetings with the community board will provide feedback regarding the acceptance of services by the people, and will point out areas in which assistance is needed.

Routine well clinic exams have and will continue to be done. Emergencies will be handled in the most expedient manner possible. If a private ambulance is the best solution, this will be called. If a trip by the project transportation vehicle is needed, this too will be provided.

Referrals and appointments will be processed, and followup services will be provided. Rehabilitation services will be provided under consultation and supervision of Durham County Health Department and Medical Center personnel.