CHAPTER 4: DISCUSSION OF EXISTING RURAL HEALTHCARE SERVICE DELIVERY MODELS

In the next several chapters of this report, we discuss different models of rural healthcare delivery and various initiatives used by different states to improve their rural healthcare systems. We then recommend a framework for how Wyoming should organize and prioritize rural healthcare services and strategies for developing and implementing initiatives to address rural healthcare needs.

Overview of Chapter

In this chapter we introduce and discuss the advantages and disadvantages of three models that have been used to organize rural healthcare service delivery:[88]

- New Community Project
- Hub and spoke healthcare delivery model
- Integrated rural healthcare networks

Although these models are often referred to or described interchangeably as network development, cooperation, collaboration and consolidation, all depend on the idea that rural healthcare providers can accomplish more by working together to coordinate service delivery than each can individually.

New Community Project

Dr. James Satterlee, professor emeritus of rural sociology at the South Dakota State University and director of the New Community Project, advocates a multi-county regional approach to providing local services.[89] This model is part of a larger community development plan to address the out-migration of people from rural areas by providing health, education and government services on a regional rather than community or county level. Out-migration from rural communities has negative effects on local economies, as evidenced by vacant store fronts, closed churches, deteriorating roads and abandoned houses and schools. The basic assumption of the model is that if services are available to people who reside in rural areas, they are more likely to stay in the area and contribute to the viability of the rural community.

[88] Although we discuss these models in the context of rural healthcare service delivery, these models have also been used for organizing other activities, including rural economic development.

[89] James Satterlee, "The New Community." Available online: http://sdrurallife.sdstate.edu/newcommunity/introduction.pdf.

Dr. Satterlee recognizes that economic development may be separate from, or even at odds with, community development. As an example, he notes that the trend of farms and ranches becoming larger and fewer in number is a sign of a prosperous farm economy. However, consolidation of farms only contributes to the dwindling population. Although economic development is essential to a thriving community, the concept of community development recognizes that there are other institutions in the community that should not be sacrificed for economic growth.

The model provides a strategy for health, government and educational organizations to come together to bring services and stability to areas with low population density. In the New Community Project each region designates a center for services in a convenient geographic location or in a population center. The center then provides services via satellite offices and outreach to more remote areas. In this model, counties consolidate to form a "new community" to provide the basic infrastructure necessary for service delivery, including health services. Counties retain their social autonomy but depend on the new community for infrastructure. The counties that comprise these "new communities" depend on factors such as population and geography. Dr. Satterlee sees this consolidation as essential to the continued economic development and survival of rural areas.

In terms of health service delivery, Dr. Satterlee envisions a regional medical center that provides outreach services to satellite health service centers staffed by midlevel providers in rural areas. Telemedicine and mobile services are central to providing these services.

Figure 4.1, on the following page, illustrates the New Community concept.

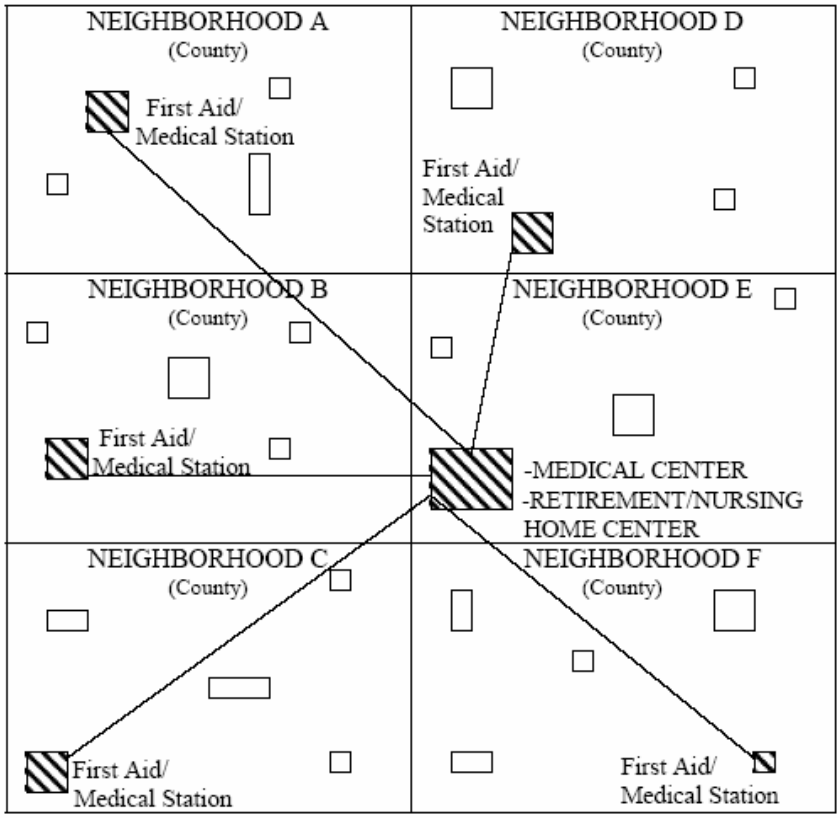
Although Dr. Satterlee does not characterize his model as a hub and spoke approach (described below), it is similar in that it also designates a regional hub in a population center that is large enough to provide services and outreach to satellite, or "spoke" clinics staffed by mid-level providers.

Hub and Spoke Healthcare Delivery Model

The "hub and spoke"[90] approach to healthcare service delivery attempts to promote the development of primary care resources on a local basis, where possible, and the development of specialty and other institutional services on a regional basis to improve access to healthcare services. This type of integrated delivery approach can provide more efficient and effective delivery of rural healthcare services.

[90] Hunter Health, "Better Rural Health Plan," (December 2002). Available online: http://www.hunter.health.nsw.gov.au/hunterstrategy.

Figure 4.1: The New Community, Medical Services/Healthcare[91]



In a hub and spoke system, the level and complexity of care increases from the community setting (the spokes), to the secondary hubs, to the primary hub. This arrangement allows patients to receive primary care services in or near their communities, while necessitating travel to the hub for specialty care services, inpatient admissions and complex radiological procedures. Under this model, capacity is developed first in the hubs and then access is developed in more remote areas where it may not be feasible to locate physicians. Access can be provided by transporting people to services, via improved non-emergency transportation or by bringing services to people through telemedicine or provider outreach — providers periodically visit a community to provide healthcare services.

A range of primary care, emergency and specialist services can be provided on an outreach basis from regional hubs. For example, in rural Pennsylvania, Geisinger Medical Center provides specialty services to rural communities via physician outreach. In Montana, the St. Luke Community Healthcare Network has implemented a similar model. The network receives Federal grant funding from the Health Resources and Services Administration's

[91] James Satterlee, "The New Community." Available online: http://sdrurallife.sdstate.edu/newcommunity/introduction.pdf.

Office of Rural Health Policy[92] to establish a sustainable, integrated system linking rural primary care physicians and their local hospitals with consulting or visiting specialists. Although this network does not call its delivery system a hub and spoke model, it is similar to Geisinger's hub and spoke model in Pennsylvania in that it uses a network to provide specialty care to rural communities on an outreach basis. In this "concentric sphere" delivery system, the primary care provider is the center of care in the rural community, while specialists provide regular scheduled outreach clinics to rural communities. These specialists are required to work with the local primary care physician in developing treatment options and to educate the primary care physician and other providers, such as physician assistants and nurse practitioners, about recent developments in their specialty.[93,94]

The Veterans Health Administration's medical system uses a hub and spoke service delivery model to organize its services with the goal of providing services as close as possible to the veteran's community.[95] This model has also been used to organize emergency psychiatric services,[96] oncology,[97] rural healthcare for the homeless[98] and rural primary care.[99] In addition, countries such as Australia, which have rural populations spread over large geographic distances, use the hub and spoke rural healthcare model to reach people in remote locations.[100]

Telemedicine and the Hub and Spoke Model

The hub and spoke concept is used extensively across the United States to connect telemedicine networks. Telemedicine networks generally contain at least one hub and one spoke, but may contain several of each as well as secondary hubs in smaller towns. The hub site is typically a regional hospital or medical center in an urban area that provides specialty services, via a telecommunications link to small, rural, remote sites at clinics, schools or other community locations. These specialty services would most likely be unavailable to these areas without this link.

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[92] Health Resources and Services Administration, Office of Rural Health Policy, "Rural Health Outreach Program." Available online: http://ruralhealth.hrsa.gov/funding/outreach.htm.
[93] St. Luke Community Healthcare Network, "Grant Will Enhance Rural Healthcare." Available online: http://www.stlukehealthnet.orghdln74.htm.
[94] Karen Cromwell, Monida Healthcare Network, Interview, (December 20, 2004).
[95] VA Palo Alto Health Care System, "Overview: Integrated Delivery System." Available online: http://www.palo-alto.med.va.gov/StrategicPlan/integrated.htm.
[96] Warren Tih-Shuh Lee, et al, "An Emergency Treatment Hub and Spoke Model for Psychiatric Emergency Services," *Psychiatric Services*, (December 2003). Available online: http://ps.psychiatryonline.org.
[97] Barbara Ann Karmanos Cancer Institute, "Affiliate Program." Available online: http://www.karmanos.org.
[98] Patricia A. Post, "Hard to Reach: Rural Homelessness and Healthcare," (January 2002).
[99] Robert Wood Johnson Foundation, "National Program Project Report, Arkansas Practice Sites." Available online: http://www.rwjf.org/reports/grr/022256.htm.
[100] Hunter Health, "Better Rural Health Plan", (December 2002). Available online: http://www.hunter.health.nsw.gov.au/hunterstrategy.

For purposes of obtaining federal grant funding, the hub site will develop a network with rural clinics, hospitals and other sites to apply for a grant as a consortium. The hub then uses the funding to build a telemedicine network that connects the hub to the spoke sites.[101]

Montana's Partners in Health Telemedicine Network uses a hub and spoke network model that is designed to address the problems related to rural healthcare while supporting primary care providers in its service area.[102] The hub, and principle organizer of the network, is a regional referral center located in Billings — the largest city in a 500 mile radius. The secondary hubs and spokes were selected based on need for services, interest in the project and their ability to obtain the necessary telecommunications network connections.

Health Education/Training and the Hub and Spoke Model

Rural health education and training programs have also used hub and spoke network models to improve the availability of primary care providers in underserved areas and encourage students' interest in rural health. Typically, health science education occurs in the larger communities designated as hubs, while clinical training takes place in hospitals and clinics in small communities and rural areas.[103]

The University of Nebraska Medical Center's Rural Health Education Network (RHEN) is an example of a hub and spoke training model that is used to change how and where health science students are educated.[104] RHEN was formed after discussions with local communities and the state's Rural Health Task Force. This task force identified five regions of the state and invited all rural communities within the regions to join the network. Education takes place at the hub sites, while clinical training occurs in rural areas. One of RHEN's major goals is to involve community healthcare providers, students and faculty in developing a model for rural healthcare delivery.

The University of Washington School of Medicine's WWAMI program, which is a partnership between the School of Medicine and the states of Washington, Wyoming, Alaska, Montana and Idaho, also uses a hub and spoke approach in graduate medical education. In the Regional Residency Rotation, residents participating in accredited programs at the University of Washington also participate in four to eight week rotations at remote site within the WWAMI region during their course of study.

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[101] Office for the Advancement of Telehealth, "Letter to the FCC: Solutions to the Third Party Payment Issue," (May 19, 1999). Available online: http://telehealth.hrsa.gov/pubs/fccfil2.htm.
[102] John Zauher, "Telehealth in Montana." Available online: http://mansfieldfdn.org/programs/program_pdfs/zauher2.pdf.
[103] University of Nebraska, "Rural Health Initiatives." Available online: http://www.unmc.edu/alliedhealth/rural.htm.
[104] University of Nebraska, "Rural Health Initiatives." Available online: http://www.unmc.edu/alliedhealth/rural.htm.

Wyoming's Trauma Care Program - A Local Example of a Regional Approach

Wyoming's Trauma Program is an example of an existing healthcare delivery system in Wyoming that has characteristics similar to those of the New Community Project and hub and spoke network model. This program defines multi-county regions and specifies the relationships among hospitals. As part of the trauma program, Wyoming has designated five regions of the State. The existing regions are based around hospitals and thus represent an opportunity to develop a model for delivery of other healthcare services. The system relies on clear and consistent transfer and referral processes to ensure that patients receive the appropriate level of care.

Wyoming legislation requires that all hospitals have trauma care certification and participate in the trauma care system.[105] Wyoming's system was modeled on the trauma designations from the American College of Surgeons; however, Wyoming-specific modifications were required. Wyoming does not have any Level I Trauma Centers, which are generally university-based teaching hospitals.[106] In addition, Wyoming has added a Level V designation to account for smaller facilities, such as Critical Access Hospitals.

Wyoming's trauma care facilities, their designations and the services provided by each facility are listed in Exhibit 4.1 on the following page.

Integrated Rural Healthcare Networks

Rural healthcare networks provide a means by which rural communities can strategically plan and coordinate healthcare services. The purpose of such networks is to organize healthcare resources to bring new capabilities to the community. An integrated rural healthcare network is defined as a "formal organizational arrangement among rural healthcare providers that uses the resources of more than one existing organization and specifies the objectives and methods by which various collaborative functions will be achieved."[107] Through these networks, partners can share administrative and management functions, as well as potentially reduce costs through volume discounts through shared purchasing arrangements and shared service usage. Some of the hub and spoke networks discussed in the previous section are characterized as integrated service delivery models. There are similarities between some integrated rural health networks and the hub and spoke model, however not all rural healthcare network organizes their activities in a "hub and spoke" fashion.

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[105] Office of Emergency Medical Services, "Annual Progress Report 2003 of the Wyoming Trauma Program," (November 17, 2003). Available online: http://www.wdh.state.wy.us/ems.

[106] U.S. Department of Health and Human Services, "Model Trauma Care System Plan" (Health Resources and Services Administration, September 30, 1992).

[107] Ira Moscovice, et al, "Understanding Integrated Rural Health Networks," *The Millbank Quarterly* (1997).

Exhibit 4.1: Wyoming Trauma Care Program[x]

Trauma Designation	Hospitals	Services Provided and Referral Patterns for Each Designation
Regional Trauma Center (Level II)	• United Medical Center, Cheyenne • Wyoming Medical Center, Casper	Provide the highest level of care. These facilities have the resources to provide advanced care to trauma patients. Regional trauma centers must have a neurosurgeon on staff.
Area Trauma Center (Level III)	• Campbell County Memorial Hospital, Gillette • Memorial Hospital of Sheridan County, Sheridan • Lander Valley Medical Center, Lander • Ivinson Memorial Hospital, Laramie • West Park Hospital, Cody • Sweetwater County Memorial, Rock Springs	Provide care to a majority of trauma patients. These facilities are able to provide initial care to trauma patients in less populated areas; however, they may not be able to provide emergency surgical treatment. Provide 24-hour access to an on-duty trauma physician or nurse.
Community Trauma Hospital (Level IV)	• Evanston Regional Hospital, Evanston • Community Hospital, Torrington • Washakie Medical Center, Worland • Platte County Memorial Hospital, Wheatland • Powell Valley Healthcare, Powell • Riverton Memorial Hospital, Riverton • Hot Springs County Memorial Hospital, Thermopolis • Memorial Hospital of Carbon County, Rawlins • Memorial Hospital of Converse County, Douglas • Star Valley Medical Center, Afton • Johnson Memorial Hospital, Buffalo • St. John's Hospital, Jackson • South Lincoln Medical Center, Kemmerer	Provide lower level of care. These facilities do not typically have a 24-hour emergency department and may only have one surgeon on staff.
Trauma Receiving Facility (Level V)	• Weston County Medical Services, Newcastle • North Big Horn Hospital, Lovell • Crook County Memorial Hospital, Sundance • South Big Horn County CAH, Basin	Provide stabilization and resuscitation before transferring patients to a higher level facility.

[x] Source: Wyoming Trauma Care, "Trauma Rules." Available online: http://wdhfs.state.wy.us/ems/ trauma.htm.

The network development process generally involves local community leaders who establish goals for the initiative. Integrated networks include a variety of healthcare providers (e.g. hospitals, physicians, rural health centers), who integrate functions and activities to provide a coordinated continuum of services; however, networks can also include interested parties who are not direct service providers, including universities and professional societies. Networks can be entirely rural, or they can include partnerships with providers and hospitals in more urban communities.

There is no single model of a network as each has been developed in response to specific local circumstances. However, other states, communities and organizations have implemented programs and policies that could be reproduced in Wyoming to encourage network development.[108] For example:

- Oregon Community Health Improvement Partnership uses a state-facilitated community decision-making process supported by state-provided community data and a needs assessment to assist communities in the redesign of their health systems. The goals of this partnership are to better meet residents' needs and enhance rural healthcare access.[109,110]

- Heartland Health Alliance is a network of 35 rural and urban Nebraska and Kansas hospitals dedicated to enhancing the delivery of rural healthcare. The Alliance has identified and undertaken innovative programs in emergency transport and service delivery. For example, through the Chest Pain Initiative, hospital staff and physicians conducted an assessment of local emergency medical service and emergency room processes and provided training for hospital staff, emergency medical service personnel and primary care services providers with deficiencies.[111]

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[108] Academy Health's Networking for Rural Health Initiative provides a number of resources for parties that are interested in forming rural healthcare networks. See their website at http://www.academyhealth.org/ruralhealth/index.htm for information and a list of publications.

[109] Oregon provides state matching funds for a community representative to provide ongoing support. [Source: State of Nevada, Department of Human Services, "Strategic Plan for Rural Health Care in Nevada," (October 2002). Available online: http://www.hr.state.nv.us/shcp/documents/RuralHealth_Documents/NVReportAppendix/NV-Report-FINAL.pdf.]

[110] Office of Rural Health, "Community Health Improvement Partnership." Available online: http://www.ohsu.edu/oregonruralhealth/whatsneworh.html.

[111] The critical access hospitals in the Alliance formed a network to apply for state Medicare Flexible Hospital Program grant funds for automatic defibrillators and an electronic BLS/ACLS training system to be rotated among the facilities. The original funding for the alliance was a health system (Bryan LGH Health System). [Source: State of Nevada, Department of Human Services, "Strategic Plan for Rural Health Care in Nevada," (October 2002). Available online: http://www.hr.state.nv.us/shcp/documents/RuralHealth_Documents/NVReportAppendix/NV-Report-FINAL.pdf.]

- BlueCross BlueShield of North Dakota has a Rural Health Grant Program to implement innovative ideas for improving healthcare delivery in rural communities. Communities address healthcare challenges through health promotion and wellness, pediatric emergency care, parish nursing, diabetes, case management, home health and staff education. A 2004 grant was awarded to a faith-based coalition that included eight churches and community healthcare providers that established a network of parish nurses and trained volunteers to provide holistic healthcare services for individuals through home-based services.[112]

- North Carolina Center for Nursing, through a grant from the Robert Wood Johnson Foundation, sponsors nine nurse workforce planning groups distributed throughout the state. These groups bring nurse employers, educators and practitioners together to develop creative solutions to local nursing workforce problems.[113]

Georgia's Integrated Rural Healthcare Networks

The State of Georgia has significant experience with state-facilitated integrated network development. Georgia implemented a campaign to transform the delivery of healthcare in rural areas through network development. Since 1996, Georgia has facilitated the development of 19 regional rural health networks covering 74 of its 117 rural counties.[114] The state's strategy encourages development of sustainable regional integrated networks using existing community assets. Each network is expected to provide relevant services, achieve financial viability, improve quality and coordination of care, expand access to care for the uninsured and improve health status.

The state-funded network development grants give communities a great deal of freedom in deciding how to use their resources, as long as the networks address the five outcomes described above. The specific strategies vary with local needs and interests.

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[112] The critical access hospitals in the Alliance formed a network to apply for state Medicare Flexible Hospital Program grant funds for automatic defibrillators and an electronic BLS/ACLS training system to be rotated among the facilities. The original funding for the alliance was a health system (Bryan LGH Health System). [Source: State of Nevada, Department of Human Services, "Strategic Plan for Rural Health Care in Nevada," (October 2002). Available online: http://www.hr.state.nv.us/shcp/documents/RuralHealth_Documents/NVReportAppendix/NV-Report-FINAL.pdf.]

[113] Ibid.

[114] Karen J Minyard, et al, "Transforming the Delivery of Rural Health Care in Georgia: State Partnership Strategy for Developing Rural Health Networks," *Journal of Rural Health*, (2003), Vol. 19, No. S.

After six years of experience with this model, Georgia reports several key elements to its success, including:

- State leadership and effective policy; a clear vision and mission are essential
- Partnerships involving state agencies, academia, and philanthropic organizations; these partnerships help leverage resources
- Technical assistance, which provides a critical support system to young networks

Wyoming's Rural and Healthcare Networks

Wyoming currently has several networks in place. Some of these networks are specific to healthcare, while others focus on economic development. In building new networks, it may be helpful to build upon existing relationships.

Wyoming Health Resources Network

The Wyoming Health Resources Network (WHRN) is a public/private partnership and is composed of the State's leaders in healthcare. This organization organizes and supports efforts to recruit and retain healthcare providers in Wyoming, while encouraging healthy communities. Developed in 1993, WHRN was created through collaboration between the Wyoming Department of Health, Wyoming Hospital Association, Wyoming Nurses Association, and the Wyoming Medical Society. WHRN has been successful in recruiting 77 permanent healthcare providers to the state since 1996. WHRN has also expanded their services to include a clearinghouse for grants that provide state funding to community health initiatives.[115]

Wyoming Primary Care Association

The Wyoming Primary Care Association, established in 1996, is a membership-based organization of ambulatory primary healthcare providers, plus other interested organizations and individuals. This organization focuses on issues related to healthcare access and its mission is to provide a coordinating structure for public and private nonprofit primary healthcare programs that serve medically indigent and underserved people of Wyoming. This organization operates, in part, through a grant from the Health Resources and Services Administration's Bureau of Primary Health Care.[116]

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[115] Wyoming Health Resources Network, "Welcome to WHRN." Available online: http://www.whrn.org/.
[116] Wyoming Primary Care Association, "What is the Wyoming Primary Care Association," and "WPCA Mission Statement." Available online: http://www.wypca.org/mission.shtml.

Frontier Mental Health Services Resource Network

The Frontier Mental Health Services Network is a part of the Western Interstate Commission for Higher Education (WICHE) and is a consortium of nine university-based, state/local government-based and independent experts from a variety of mental health/substance abuse related fields. The mission of this network is the collection, analysis, and synthesis of knowledge regarding needs for and delivery of mental health services in rural communities.[117]

Wyoming Rural Development Council

The Wyoming Rural Development Council's (WRDC) mission is to create partnerships that result in effective, efficient and timely efforts to enhance the viability of Wyoming. This is a voluntary council that brings together partner groups consisting of local/regional, state, Federal and tribal governments, non-profit organizations and private sector individuals and organizations.[118] The WRDC:

- Assists rural communities in visioning and strategic planning
- Serves as a resource for assisting communities in finding and acquiring grants for rural projects
- Serves as a neutral forum for identification and resolution of multi-jurisdictional issues
- Promotes, through education, the understanding of the needs, values, and contributions of rural communities

The council, through its affiliation with the Wyoming Community Network,[119] also performs community assessments to determine the resources that exist in individual Wyoming communities and asks the community to identify its major assets and challenges. These assessments may prove useful in identifying how communities perceive their need for and access to primary care and other core and specialty healthcare services.

[117] Frontier Mental Health Services Resource Network, "About the Network." Available online: http://www.wiche.edu/MentalHealth/Frontier/frontier.asp#About.
[118] Wyoming Rural Development Council, "About Us," "Our Mission" and "Our Goals." Available online: http://www.wyomingrural.org/default.htm.
[119] Wyoming Community Network. Available online: http://www.wyomingcommunitynetwork.com/.

Advantages and Disadvantages of Existing Rural Healthcare Service Delivery Models

Each of the models discussed above has advantages and disadvantages for rural healthcare delivery in Wyoming.

New Community Project and the Hub and Spoke Healthcare Delivery Model

Although the models have common characteristics, there are differences between the Hub and Spoke and New Community models. The New Community is a much broader community development concept that was developed specifically for addressing the issues faced by rural communities. The New Community provides a plan for distributing government services in addition to healthcare. Hub and Spoke models focus on one service and do not typically take into account broader community needs outside of the hub and spoke network.

There are several advantages of a hub and spoke system for healthcare delivery in Wyoming and other rural states. Developing resources based on hub or spoke status helps to attract specialists to hubs, where there is sufficient population to support their services. The system allocates resources efficiently, while providing access to primary health services in remote areas that cannot support a full-time provider. There is also potential to reduce professional and clinical isolation through encouraging collaboration and improved communication among providers.

However, there are substantial drawbacks and barriers to implementing a hub and spoke system in Wyoming. The hub and spoke model is often used in centrally planned health systems, such as Australia and England, where the government has control over the distribution of healthcare resources. In the United States' pluralistic healthcare system where most providers are private, it is not realistic to assume that the government or any one entity can control the distribution of healthcare resources. There is no mechanism for the government to force redistribution of existing private providers to fit them into a particular model. However, the State can use its funding for new service and infrastructure development as the lever to promote hub and spoke network development.

In addition, the perceptions of local communities must be considered. The very term "hub and spoke" may have pejorative connotations to rural communities. There are tensions between rural and urban providers that might be intensified by a hub and spoke system. There may be a perception that rural communities feed the regional centers with patient referrals, but receive few benefits in return. Rural communities may fear losing local control over healthcare resources and may be highly protective of local delivery systems. Rural communities also may view local healthcare services as central to the local economy and view encroachment by larger health systems as a threat to local economic development. The patient incurs costs to travel to a hub, while the community loses the money that would have been spent on local health services. As a result, these communities might resist their

designation as "spokes" and not be receptive to attempts to organize them into a larger system.

Similar difficulties apply to the New Community model; the State cannot redistribute existing providers or ration existing services to fit the model and rural communities may resent what they view as a heavy-handed, top-down approach. It would also be difficult for counties that may not have a history of working together to coordinate and consolidate their resources.

Integrated Rural Healthcare Networks

Although many rural health networks have been very successful and rural health networking has been effective in organizing rural health service delivery, it is not an easy task:

> "Rural health networking is a collaborative strategy. It requires individual actors to come together voluntarily, agree on a course of action, and take action cooperatively. Because the individual goals of the actors may differ, it is not always easy to agree on common goals, let alone a common strategy for achieving goals. Rural health networking is not easy; it requires time, trust, will, and skills. Network members must have the ability to separate their individual goals from the common goals of the network and the vision to see the potential benefits of joint action."[120]

The underlying trust that is required to create effective rural health networks makes it difficult for parties who have never worked collaboratively before to come together to address such a politically and personally charged topic as health services delivery. Building a network for health services delivery takes a substantial investment of time and resources. For example, implementation of the Wyoming Trauma Program has been in progress for over eight years. Thus, if Wyoming wants to promote rural health networking to ensure integrated healthcare service delivery, as a first step, it may be useful to build on already established networks.

Summary

In this chapter, we have discussed three models for rural health services delivery and their advantages and disadvantages. Key to this discussion is the concept of defining priorities to address the trade offs between cost and access. A rural healthcare initiative for the State of Wyoming should integrate these different models to provide solutions to Wyoming's specific rural healthcare needs, while building on existing resources.

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[120] Gregory Bonk, "Principles of Rural Health Network Development and Management," (January 2000), p. 1. Available online: http://www.academyhealth.org/ruralhealth/bonk.pdf.

The discussion of the advantages and disadvantages of these different models highlights the need for integration of different approaches to ensure participation from local providers. Only with their support will it be possible to ensure an efficient rural healthcare system that organizes services in a way that assures adequate local access to primary care and specialty services on a regional basis.