The Appalachian Rural Health Project in Chautauqua County, N.Y., 1973–78

SIDNEY FINKELSTEIN, MD
DOROTHEA F. JANCZAK, RN, MS

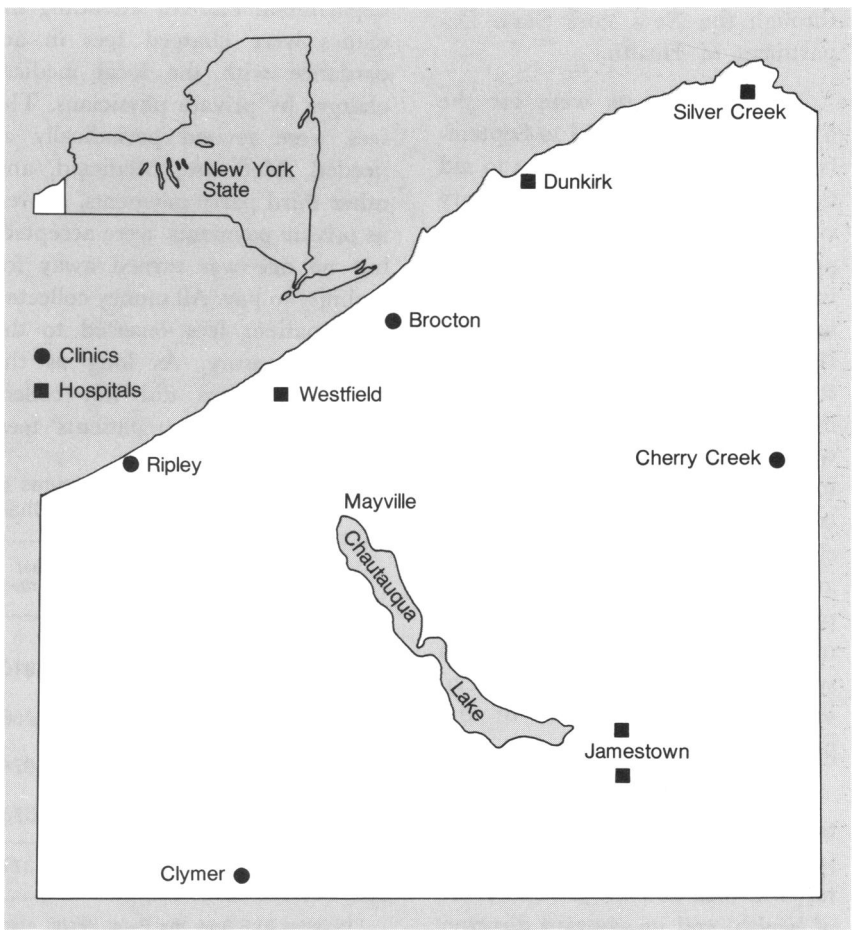
AMONG THE SOLUTIONS to the delivery of health care in rural areas being tried throughout the country are those financed through the Appalachian Regional Development Act of 1965. This act opened the door to a variety of health and social projects in the Appalachian Region. The southern tier of New York's counties including Chautauqua, which forms the southwest corner of the State, is considered part of Appalachia (fig. 1). This paper is a report on a project that came into being because of the act.

The county—1,080 square miles and a total population of 147,305—is primarily rural. The two largest cities are Jamestown, with nearly 40,000 people, and Dunkirk with approximately 16,000. There are five hospitals in the county.

In 1973, the Community Services Research and Development Program of the School of Preventive Medicine, State University of New York at Buffalo, concluded a study of the county. The program's researchers found that 125 physicians were providing patient care in the county in May 1973. These physicians were clustered in or near Jamestown and Dunkirk, and 88 of them reported that their practice was limited to a medical specialty.

Chautauqua County maintained a physician to population ratio which was about half that of the State outside New York City. In

Figure 1. Chautauqua County, N.Y.



Dr. Finkelstein, Commissioner of Health, and Mrs. Janczak, Director of Patient Services, Chautauqua County Department of Health, saw the project described in this paper through to completion in September 1978. The project was launched in 1973 by Lionel L. Richardson, MD, and Dorothy Reardon, RN, MA, who then held the positions of Commissioner of Health and Director of Patient Services. Between 1973 and 1978, the rural health project passed through six changes in county health commissioners, including Arnold B. Mazur, MD, and two interim part-time health commissioners, Lillian V. Ney, MD, and Luis Suarez, MD (Dr. Suarez served at two different periods).

Tearsheet requests to Sidney Finkelstein, MD, Commissioner of Health, Chautauqua County Department of of Health, Health and Social Services Bldg., Mayville, N.Y. 14757.

addition, more than a third of the county's physicians were more than 60 years old, suggesting a need to recruit new physicians to compensate for the normal attrition among older practitioners (*1*).

In 1973, the Chautauqua County Department of Health applied for and was awarded two grants from the Appalachian Regional Commission (ARC). The first grant to be approved, medical outpatient services adapted in children (MOSAIC), was for the age group 0–6 years; funds were received through the New York State Department of Social Services. Because the MOSAIC grant was limited in its scope to providing services only for young children, a second grant, Rural Health, was sought in order to cover services for those aged 7 years and older. The Federal funds for Rural Health were funneled through the New York State Department of Health.

The ARC grants were for the 5 years from April 1973 to September 1978. Their purpose was to aid the county in establishing primary care centers in rural areas without practicing physicians. With the funds, medical clinics were established in Clymer, Cherry Creek, Brocton, and Ripley (fig. 1). In these clinics, health care was delivered by a multidisciplinary staff working in an open system oriented to the patient or client and the community (*2*), rather than a closed, uniprofessional-dominated and controlled system (*3*). The prevention and wellness goals of the multidisciplinary staff in this open system became known as the social development components of the project.

A full-time administrative assistant and a typist were first employed to assist the project's director, who was also the commissioner of health, and its assistant director, who was director of patient services, with the further coordination of the program. Medical and professional advisory panels were formed, and liaison with interested community groups was established.

The Chautauqua County Medical Society endorsed the principle of the Rural Health/MOSAIC project in June 1973. An ad hoc liaison committee, composed of about 10 members of the Chautauqua County medical and dental societies, was formed and met five times in 1973 to review the project and make recommendations in regard to clinic sites, the recruitment of physicians and dentists, and sliding fee schedules for medical and dental services.

All administrative and fiscal matters were centralized in the Mayville office of the county health department. Patients attending the clinics were charged fees in accordance with the local medical charges by private physicians. The fees were revised periodically as needed. Medicare, Medicaid, and other third party payments, as well as private payments, were accepted, but no one was turned away for inability to pay. All money collected from patient fees reverted to the county treasury. As long as the clinic physicians did not collect money directly from patients' fees, the physicians were covered under the county's liability insurance program and they did not need private malpractice insurance.

The grant for the first year totaled $587,903, but because of the difficulty in getting started, the unused grant money was returned to the funding agencies.

Between October 1, 1973, and September 30, 1978, the total grant expenditures were $1,294,377.44. New York State disbursed $817,599.68 in Federal funds. Patient fees amounting to $355,349.01 were collected, and the county appropriation totaled $121,428.75 (table 1).

Goals and Obstacles

The original goal of the project was stated as follows: "To work toward greater availability and accessibility to primary health care services for the residents of Chautauqua County regardless of income. Strong emphasis will be placed on preventing conditions of ill health and on providing an interdisciplinary approach to local primary health care problems."

The two project grants, Rural Health and MOSAIC, originally had their own objectives, which were overlapping and duplicative and totaled more than 20. Because this machinery was cumbersome, the two grants were merged into

Table 1. Summary of expenditures by grant periods, October 1, 1973–September 30, 1978, Chautauqua County, N.Y.

Period	Total expenditures	County expenditures	Patient fees collected	Federal grant
Oct. 1, 1973–Sept. 30, 1975	$ 364,910.98	$ 14,681.43	$ 51,448.06	$316,177.55
Oct. 1, 1975–Sept. 30, 1976	333,258.39	18,384.40	103,291.51	270,146.06
Oct. 1, 1976–Sept. 30, 1977	326,674.39	42,467.82	105,323.79	133,453.65
Oct. 1, 1977–Sept. 30, 1978	269,533.68	45,895.10	93,356.01	97,822.42
Total	$1,294,377.44	$121,428.75	[1] $355,349.01	$817,599.68

[1] Includes $1,929.64, the Rural Health grant's share of proceeds from equipment sale.

Table 2. Patient encounters of the social development staff, by discipline, January 1, 1974—September 30, 1978, Chautauqua County, N.Y.

Service	1974	1975	1976	1977	1978	Total	Discipline and period
Home visits	590	1,442	1,802	543	0	4,377	Health guides 11/74–9/77, nutritionist 1/74–5/76, social worker 9/74–2/76
Transportation	256	896	995	113	0	2,260	Health guides, bus driver 4/74–3/76
Screenings by pediatric nurse	400	512	547	665	0	2,124	Began 1/74, pediatric nurse practitioner transferred to health department 1/78
Examinations by pediatric nurse	400	500	575	357	0	1,832	
Dental hygiene screenings	3,695	388	5,389	6,140	4,314	19,926	Dental hygienists 9/74–9/78
Dental hygiene prophylaxis			932	1,681	3,597	6,210	
Total	5,341	3,738	10,240	9,499	7,911	36,729	

one package, and the objectives were consolidated. By October 1975, the objectives and methodology for measurement, as stated in the request for the Appalachian Rural Health continuation grant, were as follows:

Objective 1. To utilize a variety of medical and paramedical professionals in an interrelated delivery pattern to maximize the contribution of each team member to individual wellness and community health.

How met. A staff of many disciplines was hired: one social worker, one nutritionist, one bus driver, four health guides who were outreach workers, two physician assistants, one pediatric nurse practitioner, one dentist, two dental hygienists, one podiatrist, one child development coordinator (table 2).

Obstacles and attempts to overcome them. Convincing documentation of the financial viability of the social development components of the project was lacking. These components did not generate revenue and were the main targets of criticism by the Chautauqua County Medical Society as being "too costly."

A public hearing was held on March 28, 1976, regarding this criticism of the medical society and the project's outcome. It was pointed out that the total clinic attendance between 1974 and 1975 had improved by 300 percent (table 3). Community groups overwhelmingly supported continuance of the project's medical components. However, a compromise was reached to reduce the budget by discontinuing most of the social development components. The clinics remained open. Objective 1 was eventually dropped.

Objective 2. To inform the community of the availability of clinic services through outreach workers,

Table 3. Patient visits for primary care, 1974–78, Chautauqua County, N.Y.

Locus of care	1974	1975	1976	1977	8 months of 1978	Total	Month opened	Final status
Brocton clinic	....	979	2,641	3,724	216	7,560	1/75	Private 2/78
Cherry Creek clinic	955	3,635	3,607	4,133	2,750	15,080	5/74	Private 10/78
Clymer clinic [1]	1,594	3,381	2,195	....	....	7,170	1/74	Private 7/76
Ripley clinic	162	830	2,478	3,113	1,500	8,083	8/74	Closed 9/78
Dental clinic in Mayville	....	195	24	....	....	219	1/75	Closed 1976
Dental clinic in county infirmary	10	300	....	....	....	310	1974	Closed 1975
Home visits by physician	....	79	14	50	5	148	....	....
Hospital visits by physician	....	806	205	273	45	1,329	....	....
Other:								
Dunkirk clinic	120	....	....	....	....	120	1974	Closed 1974
Mayville clinic	....	60	....	....	....	60	1975	Closed 1975
Totals	2,841	10,265	11,164	11,293	4,516	40,079		

[1] Through July 1976, when clinic became private.

mass media communications, presentations to the community, and word of mouth.

How met. Many talks were given to community groups by staff of the social development components. The social worker and health guides worked closely with community organizations to form health committees in each area where a clinic was established.

Obstacles and attempts to overcome them. Awareness that medical services were available at the clinics evolved slowly. Some people reviewed the clinics as "government controlled." The health committees were encouraged to take a more active role in community-related activities and in publishing news notices.

A study of consumer attitudes and selected characteristics of health care, conducted by Fredonia State University's Department of Sociology, confirmed that the communities were in favor of the clinics' services (unpublished papers, "Preliminary Report of the Survey of May, 1975. Patients of the Cherry Creek County Health Clinic," dated November 11, 1975, and "Supplemental Report of the Survey of May 1975. Patients of the Cherry Creek County Health Clinic," dated January 28, 1976). Patterns of clinic attendance, by selected characteristics, summarized in table 4, paralleled the national trend (*4*).

Objective 3. To provide primary health care and its related services to all members of the community who need it in a system that facilitates the use of services.

How met. Clinics were moved out of substandard quarters into larger, modern, renovated buildings that were fully equipped and staffed with nurses, clerks, and cleaners. The pediatric nurse practitioner rotated to the clinics to assist physicians.

Obstacles and attempts to overcome them. The constant turnover in personnel, especially physicians, resulted in a patchwork of physician coverage at the clinics. The logistics of the operation made supervision difficult. The clinics were 20 to 30 miles from the central administrative office, necessitating long journeys to deliver supplies and equipment. Most telephone calls were long distance.

The county's bureaucratic structure necessitated the submission of bids for the purchase of medical equipment and supplies, making it difficult to treat emergency patients. The process of hiring personnel was slowed down because of civil service contractual agreements. Rental leases of clinic sites required approval by the county legislature.

Nevertheless full-time physicians were eventually hired and part-time physicians eliminated. As clinic operations become more autonomous, less supervision was required. Close communications with the county personnel department, central services (purchasing), and the county attorney's office led to efficient services.

Objective 4. To obtain and use the services of specialist consultants in the continuing medical care of patients.

How met. Not met in the project's clinics.

Obstacles and attempts to overcome them. Specialists were too difficult to recruit. Clinic physicians referred patients to specialists outside the clinic. Objective 4 was eventually dropped.

Objective 5. To conduct a dental education program with emphasis on prevention, to test the need for additional dental services through a system of screening and referral, and to provide a backup dental care delivery system.

How met. The project's dentist and dental hygienists visited the schools within the county and implemented an organized prevention program of screening, administer-

Table 4. Comparison of selected characteristics of patients, by clinic, January–June 1976, in percentages

Selected characteristics	Ripley	Brocton	Cherry Creek	Clymer
Age:				
Patients less than 1 year	4.0	1.6	3.4	3.6
Patients less than 5 years	14.7	10.7	9.3	9.1
Patients 65 and over	15.9	19.1	15.6	11.3
Sex:				
Female	57.6	61.6	54.9	53.3
Female over 65	9.7	8.6	10.5	12.5
Diagnosis or reason for visit:				
Examination or checkup	30.9	23.7	29.8	33.6
Infection, parasitic	2.3	2.3	1.4	2.2
Respiratory system	23.8	24.0	21.2	23.1
Circulatory system	12.3	10.1	10.9	7.9
Digestive system	2.5	4.7	3.4	2.1
Patient status: proportion of new patients.	28.0	34.1	24.3	23.8
Payment category:				
Private payment	50.7	68.3	63.4	74.5
Medicare	9.5	11.1	12.1	3.6
Medicaid	36.9	17.5	17.1	16.3

SOURCE: State University of New York at Fredonia, Department of Sociology.

ing sodium fluoride, prophylaxis treatments, and teaching in groups and one-to-one. Children in need of dental care were referred to private dentists (table 2).

The project dentist provided direct patient care at the county infirmary and to mentally retarded children at the Mayville office of the health department, where a dental office was established (table 3).

Obstacles and attempts to overcome them. Strong community awareness and support of dental health for school children did not exist. Schools were unwilling to include a dental hygiene program in their budgets even at the cost of approximately $2 per capita. The program carried out by the dentist was not financially viable or self-supporting, and it was limited in scope. The county dental society withdrew its support of direct patient care.

The county health commissioner sent letters to all school administrators urging them to consider the inclusion of a dental hygiene program in their budgets, but to no avail. The dentist's position was terminated in January 1976; however, he remained in the county and set up a private practice in a rural area. The dental hygienists continued their work until the end of the project in September 1978 when their jobs were terminated.

Objective 6. To utilize all available sources of payment to maximize the income of the clinics without jeopardizing availability of services to all, regardless of income.

How met. The clinics used a fee schedule in accordance with the charges of local physicians. It was adjusted periodically as needed. Billing policies were established and controlled out of the administrative office by the senior account clerk. If patients were unable to pay their complete bill, they were requested to make partial payments at intervals.

Obstacles and attempts to overcome them. Early in the project, many patients looked upon the clinics as government-run, free clinics. Long distances between clinics and the administrative offices made monitoring of collections difficult. Because the project was accountable to two State entities—the New York State Department of Health and the State Department of Social Services—voluminous reports and cumbersome and time-consuming paperwork were required.

To deal with the clinic's identity problem, the clinic physician's name was printed on the bill's heading in place of the project's title. Patients felt that this enhanced their relationship with the physician and helped to remove the image of the clinic being controlled by government.

The problem of distance was handled by having the clerks for each clinic report to the administrative office on a weekly basis to consult with the senior account clerk regarding bills and financial matters.

The two grants, Rural Health and MOSAIC, were merged into one budget in 1976. Each clinic's financial viability gradually increased (table 5).

Objective 7. To use all appropriate hospitals for needed backup services in a pattern that would minimize admissions.

How met. Clinic patients were referred to hospitals for specialized services such as X-rays; how much hospital admissions were reduced was difficult to measure.

Meetings were held with various hospital administrators so that they could consider taking over the project clinics as satellites, but the hospitals had their own financial and viability problems and were uninterested in taking on another program. Objective 7 was not attained and was eventually dropped.

Objective 8 (added in October 1976). To encourage project physi-

Table 5. Costs per patient and clinics' financial viability, by facility, 1976, Chautauqua County, N.Y.

Financial factor	Clinic and number of patient visits			
	Brocton 2,641	Cherry Creek [1] 3,828	Clymer [2] 2,195	Ripley 2,478
	Dollars			
Cost of operating the clinic	$66,916.22	$73,025.79	$36,936.65	$62,047.55
Income	24,198.44	38,946.70	25,152.60	25,538.17
Net cost	42,717.78	34,079.09	11,784.05	36,509.38
Cost per patient	25.33	20.24	16.82	25.03
Net cost per patient	16.06	8.90	5.39	14.73
	Percent			
Self-sufficiency of clinic, Jan. 1, 1976	24.9	47.8	68.1	21.1
Self-sufficiency of clinic, Dec. 1, 1976	36.5	49.4	....	54.8
Growth in self-sufficiency	11.6	1.6	....	33.7

[1] Includes 14 home and 205 hospital visits.
[2] Data for Jan. 1–June 30. Clinic became a private practice on July 1.

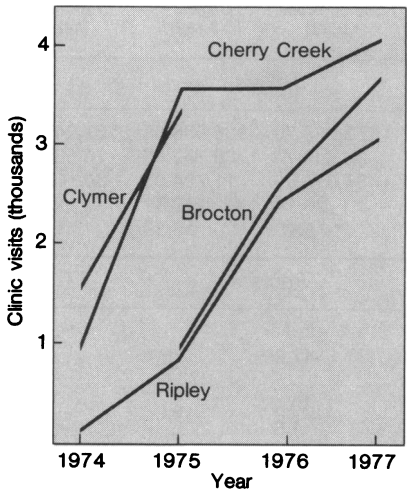
cians to assume the clinics' medical practices on a private basis as the clinics become medically and financially viable.

How met. An intensive effort to recruit physicians was carried out through advertisements in major medical journals. The project paid all travel and lodging expenses for the physician applicants.

The health committees welcomed the physicians and their families and offered assistance in finding housing and in filling other needs. Hospitals granted staff and admitting privileges to the clinic physicians. The Cherry Creek community built a $30,000 medical building on donated land to entice the physician to stay in the community. Patient attendance at clinics increased slowly but steadily (table 3, fig. 2).

Obstacles and attempts to overcome them. Physician recruitment was time-consuming, costly and, more often than not, ended in the applicant's withdrawing his application. The physician's income from his clinic services was not sufficient. The monthly operating cost of each clinic was $6,000. Salaries of clinic personnel under civil service were higher than those paid in private enterprise. It was difficult to change civil service nursing and clerical staff from full-time to part-time and maintain stability of staffing.

Figure 2. Growth in patient visits by clinic site, 1974-77, Chautauqua County, N.Y.



Ripley clinic trailed in patient attendance and financial viability. During the last 3 months of the project, the clinic was forced to move to a church facility because of a badly leaking roof and the landlord's violation of the lease agreement.

To provide the physician more latitude and independence and, as an inducement to private practice, the physicians' positions were removed from civil service status and put on contracts. Physician applicants were offered an annual remuneration of $40,000 plus an additional $5,000 if they applied for and received hospital admitting privileges for clinic patients. Other sources of income for the physicians were sought—positions as school physician, posts at the county infirmary, assisting at surgery in hospitals, and pediatric consultant assignments. (Some clinic physicians were specialists.)

In preparing the clinic physicians for the transition to private medical practice, administrators counseled them regarding the clinic's operation and other financial and business matters. Clymer clinic was taken over on a private basis in July 1976, Brocton in February 1978, and Cherry Creek in September 1978.

Meetings were held with the Ripley Health Committee and the town supervisor to evaluate the clinic's problems, but no concrete solution was found. The Ripley clinic was closed at the end of the project in September 1978. The physician assigned to it did not take it over because it was not viable financially; however, he set up a private medical practice in a more populous community with a hospital 8 miles from Ripley.

Another crisis related to objective 8 occurred a year before the end of the project. On October 1, 1977, 1 year before the completion of the grant program, the funding agency attached a condition that the county or municipality should make plans for supporting the clinics in perpetuity, regardless of their viability or the inappropriateness of location. The agency further claimed that Federal grant money could not be used to subsidize private medical practice. On February 1, 1978, the Brocton clinic's physician had decided to take over the clinic for private practice, a step that was within his contractual option. (The Clymer clinic's physician had already done this in July 1976.) The action concerning the Brocton clinic resulted in the immediate suspension of the grant for 30 days by the Appalachian Regional Commission.

A hearing was held in Albany under the auspices of the New York State Department of State in March 1978. It resulted in a 30-day extension to resolve conflicting objectives. Among those attending were representatives of Region II of the Department of Health, Education, and Welfare and representatives of the Appalachian Regional Commission. Were the clinics to continue to be operated privately at the option of the physician or be run forever by the county? The incumbent Chautauqua County Commissioner of Health made the presentation, and on April 1, 1978, notification was received that the original objective of converting the clinics to private practice was viable and acceptable. The Chautauqua County Medical Society had supported this position with letters and documents written by its president and presented at this hearing. They reemphasized the society's previous

stand that the clinics should be converted to private practice.

Discussion

Although they contributed to the successful completion of the project, objectives 1,4,5, and 7—the multidisciplinary social development components, the specialized medical consultant services, the dental education and direct dental services, and the hospitals for backup services—were never attained and were eventually dropped. Objectives 2,3, 6, and 8 were attained. These objectives were to inform the community of the clinics' services through outreach, to provide primary health care, to use all available resources of payment for clinic services, and to encourage project physicians to operate the clinics in private practice.

Thus, in a roundabout way, the project's grant attained its goal of providing greater availability and accessibility of primary care services for the residents of Chautauqua County living in medically underserved areas.

The crisis that developed when Federal authorities questioned the goal of converting the clinics into private practices was aptly forecast by Watkins, who stated, "a major political dilemma in rural health care centers derives from the short term funding requirements and unpredictable policy changes in funding requirements at the state and federal levels" (*5*).

The early success of the social development components in the multidisciplinary team approach was in creating awareness and paving the way for change in the health care delivery system of Chautauqua County. It seems ironic that the contributions of the social development components within the open system approach (*2*) ultimately led to their demise and to a closed system (*3*) following the outcry of the county medical society.

The ultimate survival of the rural health care center in a complex political and economic arena represents a major dilemma. Funding mechanisms relied on at early stages stress eventual economic self-sufficiency, yet impediments outside the financial arena may be more detrimental to survival than lack of funding. The more comprehensive the program, the greater the risk of underuse of some services, thus threatening the financial solvency of the highly used services (*5*).

Another interesting facet of the project was the important role of the four health committees composed of consumers, established through the efforts of the project's social worker and health guides. The credibility or the affection in which the public health worker is held in any community, the kinds of interpersonal relations he or she is capable of establishing, are crucial factors in effecting change. But equally crucial are the persons in the community who are prepared to establish a relationship with the health worker (*6*).

Community control of the rural health care center creates an environment responsive to change and the needs of the consumer group. The increased demand for participation in and ownership of health care services introduces a significant political dynamic to the rural setting that portends action rather than apathy as a response to crisis (*5*). Indeed the power and response of the core consumer groups at the public hearing saved the rural health project in Chautauqua County from going under. In this respect, the project attained its goals because of the support of the grassroots element.

The withdrawal of support and the unexpected attack of the county medical society caused a great deal of speculation. Although the medical society had endorsed the rural health project in principle when it began in 1973, it was later assumed that this had been done as an appeasement measure in the expectation that the project would eventually "go away." Opposition occurred at the peak of the clinics' growth when it appeared that they were indeed alive and permanent. It can also be assumed that the medical society feared that the project would lead to "socialized medicine." However, as time passed, several members of the medical society became more supportive of the project and assisted by filling in at the clinic sites whenever a physician was needed, especially during the physician recruitment process when a vacancy occurred.

The innovative rural health program in Chautauqua County and the county medical society's "about-face" exemplified conservative reaction to change. Bennis (*7*) and Selzwick (*8*), in discussing organizational change, have noted that leaders of systems who are conservative or reactionary themselves and who wish to maintain or retreat to known forms or organizations will not encourage such deliberate innovation. Nor are proponents of revolution who "know" how things should be organized likely to be hospitable to a new approach that they cannot "own." But those who seek reasoned solutions to specific, identified problems may well be encouraging about change. In any case, the new endeavor and the planning structure that it employs will be subject to the full range of buffeting usually present between innovating complex organizations and their environments.

Conclusion

The experience of this project offers lessons applicable to other groups

interested in rural health. Objectives should be kept within a reasonable, realistic range, be measurable, and be reviewed periodically through formal evaluations of the programs. The project's expected results should be determined and clearly stated at its beginning. The questions that must be asked are—who is to take over the program, and how will this be accomplished when the funding ends? Objectives may need to be adjusted once a problem is recognized.

Staff must be committed to the goals of the program and be adaptable to the day-to-day problems and to rapid, unexpected changes in dealing with community response to the recognized need.

A strong and viable financial accounting system with built-in checks and balances must be developed. Staff should be informed of the program's financial viability and allowed input in improving the system.

Numbers of staff should be adjusted to particular stages in the growth of the program. People who are hired need to understand that the program may end and be psychologically prepared for termination of employment at the end of the project. Budget allowances need to include the payment of the staff's legitimate unemployment claims.

A pioneer grant to establish medical centers should run for at least 5 years. Implementation in the earliest stages is extremely difficult, and it may take at least a year to get off the ground, as did the project in Chautauqua County. Legal services need to be available, especially if space is being leased for medical clinic facilities.

Initial and continued endorsement of the program by the local medical society, with free exchange of ideas and feelings, is essential.

Grassroots support of the community core groups is fundamental to any such project, as the intricate political process inherent in the development of rural health care centers demonstrates. This implies education, active participation, and control by the community in active partnership with health care providers.

Influencing health delivery systems in the 1980s will be the struggle for power within the institutional structure. A major change that will extend this struggle is the direct involvement of consumers in the health planning process (*9*).

References

1. State University of New York at Buffalo, School of Preventive Medicine: Community health information profile for Chautauqua County. Buffalo, 1973.
2. Leininger, M.: An open health care system model. Nurs Outlook 21: 171–172, March 1973.
3. Garfield, S. R.: The delivery of medical care. Sci Am 222: 15–23, April 1970.
4. Ambulatory medical care rendered in physicians' offices, United States 1975. Advance Data from Vital and Health Statistics of the National Center for Health Statistics, No. 12, Oct. 2, 1977.
5. Watkins, J. M., and Watkins, D. A.: Considerations in creating rural health centers. Fam Com Health 1: 85–94, July 1978.
6. DuBois, C.: The public health worker as an agent of socio-cultural change. Health Education Monogr 5: 5–19 (1959).
7. Bennis, W. G.: Changing organizations. McGraw-Hill Book Co., New York, 1966.
8. Selzwick, P.: TVA and the grass roots. Harper and Row Publishers, New York, 1966.
9. Green, B. L.: Rural health delivery systems of the 1980's. Fam Com Health 1: 95–108, July 1978.

SYNOPSIS

FINKELSTEIN, SIDNEY (Chautauqua County Department of Health): and JANCZAK, DOROTHEA: *The Appalachian Rural Health Project in Chautauqua County, N.Y., 1973–78. Public Health Reports, Vol. 95, May–June 1980 pp. 263–270.*

The Appalachian Regional Commission awarded a 5-year grant to the Chautauqua County Department of Health to establish primary health care services to medically underserved rural areas of the county. Four clinics were opened at various stages as the project grew.

What began as an open system multidisciplinary approach to the delivery of primary health care changed abruptly to a closed system in March 1976, when the county medical society members voiced a strong objection to the rural health project. Among other assertions, the medical society claimed that the clinics of the project were "too costly and unnecessary as they now exist." Equally strong voices of community people demanded that the project be allowed to operate. An unprecedented public hearing was held and, as a result, a compromise plan was developed that permitted the medical services of the clinics to be continued, but most of the multidisciplinary components devoted to social development were eventually dropped.

By September 30, 1978, when the project grant ended, three of the four clinics had been taken over on a private basis by physicians who had previously been assigned to the clinics and supported by the project.

The effects of grassroots support and power of the people in a community in determining their health rights and needs were demonstrated and documented in this pioneer program. It is anticipated that the Chautauqua County experience may be a helpful model in planning other projects that attempt to institute change in the health care delivery system in underserved rural areas.