Frontier Extended Stay Clinics: A Sustainable Frontier Community Model

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Not Just “Frontier”

- Think of two communities
  - ~5,000 population
  - Community Health Center
  - >2 hours to trauma center
  - ~3,000 population
  - Critical Access Hospital
  - Average daily census <0.5
- What’s the best health care system for these two rural communities?
Let’s Design a Rural Health System

- What is the most important rural health care service?
  - YES! Emergency services.

- What’s next most important?
  - YES! Robust primary care.

Critical Services (not necessarily providers)

- 24/7 access to adequately equipped and well-trained emergency care
- Robust primary care services (patient-centered medical home)
- Moderately sophisticated diagnostic services (e.g., CT, ultrasound, moderate complexity laboratory)
- Rehabilitation services
- Extended stay capacity for patients typically treated in hospital observation units
- Well-developed telemedicine capacity, protocols, and relationships
- Periodic specialist care outreach
- Seamless coordination with tertiary and other services
- Reliable and inexpensive transportation
Health care delivery is predicated on health care finance... or
How we give care depends on how we get paid for care.
There is not financing mechanism to adequately pay for the care our small rural communities need!
Six Phases of A Project

- Enthusiasm
- Disillusionment
- Panic
- Search for the Guilty
- Punishment of the Innocent
- Praise and Honors for the Non-Participants

What is a FESC?

Frontier Extended Stay Clinic:
- At least 75 miles from a hospital (current rules);
- Designed to provide emergency care;
- Also able to provide limited observation services.
FESC-CAH-Clinic Comparison

- Different life-safety code standards: AHCO vs. HCO vs. BO (NFPA 101)
- Similar requirements for equipment, medications, etc.
- No surgeries, inpatients, babies, blood, anesthesia, or deep sedation in the FESC.

FESC-CAH Differences

- FESC limited to 4 patients at a time.
- FESC limited to 48 hour max visit time.
- FESC can use LPN/EMT/P for patient observation.
- Provider onsite within 30 minutes in FESC, 60 in CAH.
- More lab tests required at FESC (e.g. PO2)
Major Accomplishments

- Demonstrated that a clinic can provide:
  - 24/7 emergency services;
  - Robust primary care;
  - Limited monitoring and observation services.
- Saved payers money.
- Premera Blue Cross and Medicaid will continue paying beyond the CMS demonstration.

Major Challenges

- Cost of start-up (from clinic);
- Ongoing operational cost of maintaining 24/7 availability to community;
- Attracting and retaining staff.
What Makes Us Unique?

- Not all that unique, but...
- Large primary care clinic, no hospital nearby
- Focused on provision of primary, preventative, and emergency care
- Scaled-back health care infrastructure overall
- Presence of visionaries

What Needs to Change?

- Frontier clinics must be reimbursed for emergency services.
- Reimbursement rate for observation services must more closely match the cost.
- Current reimbursement mechanism (4-hour blocks) doesn't work well for anyone.
- Financial support for facility upgrades and other start-up costs is essential.
- FESC is a misnomer. (But FECES doesn't work either.)
What Next?

- Do we need different models of rural health care?
- What services should the new models provide?
- How would we finance the new models?
- What are other barriers to new model development?
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