Patricia Atkinson, MAT
SouthEast Alaska Regional Health Consortium
and
A. Clinton MacKinney, MD, MS
RUPRI Center for Rural Health Policy Analysis

Frontier Extended Stay Clinics: A Sustainable Frontier Community Model

NRHA Annual Rural Health Conference
Louisville, Kentucky
May 8, 2013

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 (eg, 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
Form Follows Finance

- 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.
A. Clinton MacKinney, MD, MS
RUPRI Center for Rural Health Policy Analysis
clint-mackinney@uiowa.edu

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?
Frontier Extended Stay Clinics: A Sustainable Frontier Community

Clint MacKinney  
clint-mackinney@uiowa.edu

Patricia Atkinson  
patat@searhc.org

Patricia Atkinson, MAT  
SouthEast Alaska Regional Health Consortium  
and  
A. Clinton MacKinney, MD, MS  
RUPRI Center for Rural Health Policy Analysis