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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?

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Let's Design a Rural Health System

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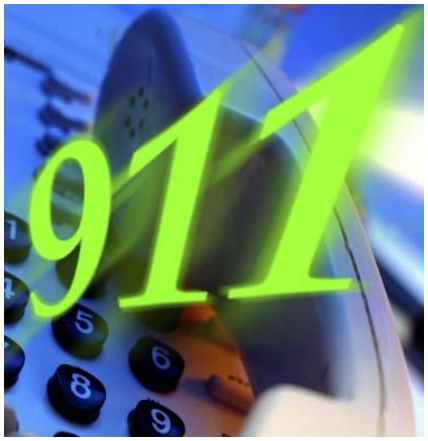
- What is the most important rural health care service?
  - YES! Emergency services.
- What's next most important?
  - YES! Robust primary care.



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Critical *Services* (not necessarily *providers*)

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- 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**

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Form Follows Finance

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- 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!

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The Rural Dilemma

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Six Phases of A Project

Enthusiasm

Disillusionment

Panic

Search for the Guilty

Punishment of the Innocent

Praise and Honors for the Non-Participants

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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.

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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.

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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. PO_2)

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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.

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Major Challenges

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

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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

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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.)

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What Next?

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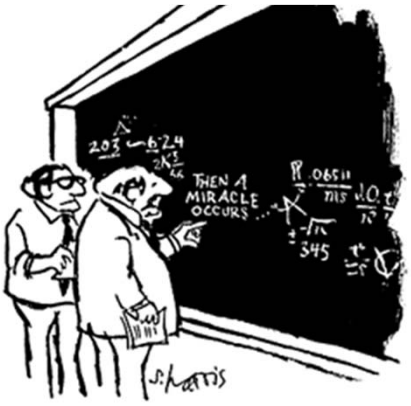
- Do we need different models of rural health care?
- What services should the new models provide?
- How would we finance the new models?
- What are other barriers to new model development?



"I think you should be more explicit here in step two."

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