Challenges of Practice in Rural/Frontier Areas

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CARE CURRENTLY DELIVERED

- Rural Health Clinic Hospital Owned
- Hospital
- Nursing Home
- Assisted living
• Transportation- local and distal no public transportation or taxis
• No patient education
• No case management services
• No behavioral health services, consequently increased suicide risk
• No discharge planners
• No local DME/ respiratory suppliers
• No local home health/ Hospice
No weekend after-hours outpatient pharmacy, No in-hospital pharmacy
Physician services not predictably available reliance on PA/NP coverage
No subspecialty care
Limited Imaging and lab services, limited blood bank availability
Indefinite lack of availability of EHR
Lack of access to capital for new or replacement equipment and facilities
- Limited access to ancillary staff professional and non-professional
- Expectation to provide same services at same level as in more urban centers
- Limited tele-medicine services
- Limited ambulance service availability
- All staff and providers where “multiple hats”
- Professional Isolation- decreased access to ongoing education and collaboration
WHAT IS BEING DONE TO ADDRESS GAPS?

- Increased dependence on PAs/NPs
- Search for partners to access capital and administrative resources
- Increased use of helicopters for transfers
- Expanded use of telemedicine for Radiology and Psych services
- Reliance on adjacent hospitals 50+ miles to provide pharmacy services
WHAT IS BEING DONE TO ADDRESS GAPS?

Continued

- Use of distant home health, hospice services, DME, and OT not always available
- Use of volunteer transportation
- Patient education and case management done by provider, nursing, and other ancillary staff as another “add on task—another hat to wear”
- Less frequent use of imaging or sub-specialty care due to “geographic rationing” forces increased primary care responsibility and search for friendly distant specialty collaborators
- Patients frequently just don’t get services they need especially in a timely fashion
WHAT CAN BE DONE IN THE FUTURE?

- Find access to capital for rural health services
- Consider their lack of resources when a rural provider asks for help, treat them as a peer not a subordinate
- Don’t assume a rural provider is incompetent or lazy just because they may ask for help with a problem that is routinely handled by a primary care or ER provider in an urban area who may have a lot more resources
- Find a way to break down professional isolation related problems on a regular basis
- Expand tele-medicine service availability, especially tele-psych in crisis
WHAT CAN BE DONE IN THE FUTURE?

Continued

- Expand shared administrative resources with more urban locations including case management and patient education
- Increase visiting subspecialty services
- Increase regular onsite CME for providers and all hospital staff in rural areas, don’t let us be the last to know anything.
- Find a way to make rural/frontier providers feel like they are an ongoing member of a bigger team
- Improve portable shared diagnostic imaging and other diagnostic services limiting the need to send patients to distant locations
- Expand tele-pharmacy services