Challenges of Practice in Rural/ Frontier Areas

ROMAN M. HENDRICKSON, M.D.

CARE CURRENTLY DELIVERED

- Rural Health Clinic Hospital Owned
- Hospital
- Nursing Home
- Assisted living

PRIMARY HEALTH CARE NEEDS-GAPS

- 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

PRIMARY HEALTH CARE NEEDS-GAPS

Continued

- 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

PRIMARY HEALTH CARE NEEDS-GAPS

Continued

- 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