



Healthcare in Very Rural and Frontier Communities: Balancing Equity, Effectiveness and Efficiency

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National Center for Frontier Communities (NCFC)

- Founded in 1997 to provide national leadership and build collaboration on issues important to frontier communities.
- The only national organization solely dedicated to the smallest and most geographically isolated communities in the United States.
- Provides a voice for Frontier to be recognized as a vital and significant part of America and equitably reflected in policy, programs and environment.
- Involved for the past 25 years in supporting the frontier movement.



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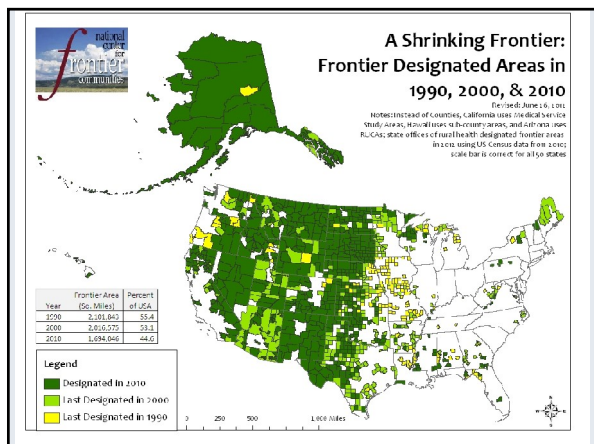
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Urban-Rural Disparities Including Remote Rural Disparities

	Urban	Rural	Remote Rural
Uninsured	15.3%	17.8%	21.2%
Have a personal health care provider	81%	79.4%	78.7%
Deferred care due to cost	13.1%	15.1%	16.2%
Adults who have received annual dental cleaning	88.8%	82.1%	78.8%



- ### Rural Health Care Systems of the Future
- Essential services determined by the community.
 - Services integrated into care coordination approaches.
 - Rural health care delivery systems must be efficient and show health outcomes;
 - Dependent on new or adapted technology.
 - Provider organizations must be fiscally accountable, show cost-savings and be sustainable.
 - Primary health services are integrated with oral, behavioral and public health services.
 - Coordinated with other community-based organizations to address social determinants of health such as poverty, food insecurity, housing and employment.
 - Primary health care providers will take a more central role in rural communities. Hospitals will remain a source of rural health care leadership, but are no longer the primary focal point for patient care.

2012 Activities

Priorities and Strategies

Based on 2011 Frontier Assets and Gaps Analysis

Strategy #1: Develop, implement and sustain model programs that address the unique needs of frontier communities.

Strategy #2: Develop systems and structures that promote and support more community-based health care.

Strategy #3: Increase advocacy for frontier health.

Strategy #4: Research on frontier health costs and outcomes, factors impacting both of these areas and how frontier outcomes compare to rural and urban.

Frontier Evidence-based and Promising Programs

1. Care Coordination using Community Health Workers
2. Frontier Extended Stay Clinic [FESC]
3. Frontier Community Health Integration Project [FCHIP]
4. Behavioral Health Aide
5. Dental Therapists



Community Health Care Worker (CHW) Model for Care Coordination

- ❖ Addresses health professional shortages common in frontier.
- ❖ Many frontier states currently recognize and use CHWs (17 state CHW org, 3 national org).
- ❖ Growing research health outcomes.
- ❖ Care coordination as part of PCMH and ACA -- getting much attention.
- ❖ States are beginning to recognize CHWs and/or care coordination as a billable service.



Findings

- No consensus on CHW core functions and scope of practice.
- 5 states have CHW training systems and credentialing regulations (AK, MN, OH, TX, NY.) At least six rural/frontier states are in the process of formalizing CHW workforce development.
- Growing interest among rural and frontier states to define and develop the care coordination function of CHWs.
- No standard definition for care coordination.
- CHW roles and functions not recognized as falling within the realm of clinical care coordination. CHW care coordination scope and functions need to be defined.

Findings (Con't)

- ACA and other policies provide a promising environment for development and implementation of CHWs in care coordination models.
- Four states provide Medicaid/ Medicare reimbursement if under supervision of a licensed provider. (AK, MN, OH, NM-(BH).Most depend on grant or state funding.
- Some Medicaid/Medicare MCOs contract for care coordination functions, including services performed by CHWs.

CHW Model for Care Coordination Issues

- Workforce Issues: Training Requirements and Scope**
- Certificates vs. certification vs. credentialing
 - Standardized competencies and training
- Funding Mechanisms for Sustainability**
- Innovative Medicaid funding models exist and more are emerging that could better accommodate care coordination services with existing state funds.
- Regulatory Barriers to Care Coordination**
- State requirements for care coordination (e.g. by Medicaid, PCMHs, etc.) with no or varying standards.
 - States struggle with whether or not to regulate CHWs who perform care coordination functions
- Cost Effectiveness and Quality of Care**
- Inconclusive research on effectiveness and cost effectiveness of this model. More research is needed.

Recommendations

- Clarify CHW core functions and scope of practice.
- Care coordination functions, roles and responsibilities of all team members need further clarification and integration.
- New financing models that are flexible and focus on patient health outcomes, rather than fee-for-service, is needed.
- Care coordination needs to be valued and supported by private insurance and managed care organizations, in addition to public payers.

Recommendations (Con't)

- Training programs for CHWs and medical providers need to include the role, function and value of CHWs in the care coordination process.
- Quality assurance and supervision of CHWs in providing care coordination services must be structured into workforce development initiatives.
- Further research to include application in frontier areas. Common metrics for the CHW model of care coordination should be developed.
- Integration of CHWs into the healthcare team will require building trust, collaboration and referral systems within clinics that have CHWs and between clinics and non-clinical CHW providers.

Frontier Extended Stay Clinic (FESC)



FESC Services

The clinic maintains observation beds for:

- the care of patients needing overnight care without the clinical necessity for transfer to a hospital,
- when weather or other conditions do not permit the safe transfer of patients needing hospital care.

- No more than 6 observation beds
- Average length of stay less than 48 hours (with exceptions)
- Medical backup through telemedicine

FESC Requirements

Location

- must be in Frontier area
- At least 75 miles from closest hospital
- Closest hospital is not accessible by public

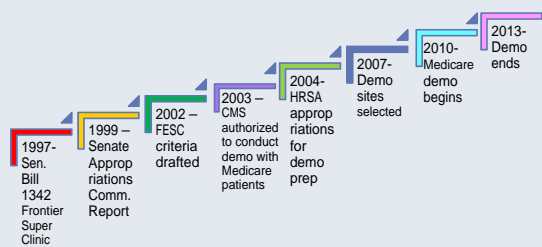
Organizational Structure

- Must be a public or private, non-profit, tax-exempt corporation

Staffing and Staff Responsibilities

- A MD/DO, NP, PA, or certified nurse-midwife available, directly or on-call, at all times the clinic operates
- A MD/DO, NP, PA, RN, CNS, LPN, Certified Alaska Community Health Aide, Alaska Community Health practitioner, or EMT is on duty whenever the clinic has one or more observation patients

Timeline



What we are learning?

- > Univ. of AK and Institute of Social and Economic Research evaluations (2012)
- > RUPRI Center at the Univ. of Iowa Evaluation (2012)
- > CMS/Mathematica Final Evaluation (2014)

Findings:

- Cost savings due to avoided transfer costs
- positive impact on clinical quality
- improved their emergency response capacity
- Patient and family experiences improved
- Frontier community support

Recommendations NRHA Policy Brief

- > Recognize the FESC as a new and permanent CMS provider type.
- > Adjust the current FESC authorizing language and CMS Conditions of Participation to allow more frontier communities to benefit from this model
 - Allow an expanded role for EMTs and paramedics in observation and monitoring at all FESCs
 - Amend FESC location requirement from 75 miles from nearest hospital to 35 miles
 - Allow FESCs to bill for all emergency care services
 - Provide start-up and operating costs



Frontier Community Health Integration Project (FCHIP)

PURPOSE:

Develop and test new frontier models to increase access to, and improve the adequacy of, payments for acute care, extended care, and essential health care services provided under Medicare and Medicaid.

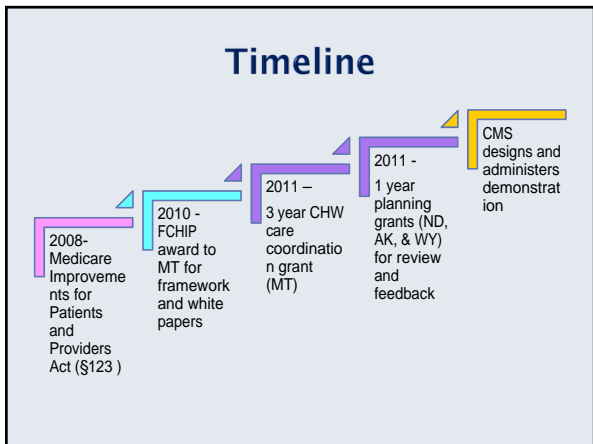
Eligibility

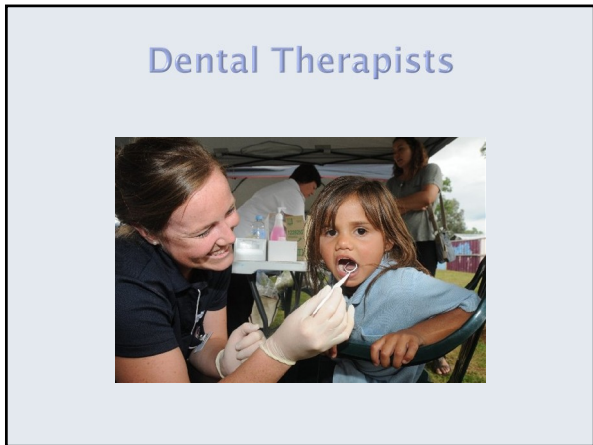
Rural Hospital Flexibility Program in Alaska, Montana, North Dakota, and Wyoming selecting eligible counties with:

- o 6 people or fewer per square mile
- o A CAH furnishing home health or hospice
- o Senior nursing facility services through CAH swing beds or local nursing home.
- o A CAH with a daily acute-care census of 5 patients or less

Montana Proposed Model

- Local, integrated health care organization serving as a medical home.
- Access to basic emergency, hospital, primary care, outpatient, care transitions, and long-term care services in isolated frontier areas.
- Improve quality and care transitions.
 - o Shared savings component
 - o Networks of 10 or fewer local systems
- Network approach to care transitions using community health workers





Dental Therapist profession has existed internationally for over 50 years
however,
it is a newly emerging profession in the U.S.

Emerging models currently operating in Alaska and Minnesota

Alaska Dental Health Aide Therapists (DHAT)

- o Based on New Zealand's dental nurse model
- o First DHATs were certified in 2004
- o Several levels and scope, ranging from dental health aides to DHATs
- o 2 year DENTEX training program DENTEX (partnership between Univ of WA Physician's Asst and Alaska Native Tribal Health Consortium)
- o DHATs closely tied to their supervising dentists through telemedicine and phone consultations.
- o Services are billable to Medicaid

Minnesota Dental Therapist, Oral Health Care Practitioner and Advanced Dental Therapist Models

- o Minnesota DT Legislation passed in 2009
- o Created two levels of DT: the dental therapist (DTs) and the advanced dental therapist (ADTs)
- o DTs and OHCPs work with an on-site dentist under direct or indirect supervision. Advanced DTs will be able to do some work under general supervision.
- o Scope of practice for DT and ADT models developed by the University of Minnesota School of Dentistry, oral health advocates, and state lawmakers
- o DTs are reimbursed for the services they provide to Minnesota Health Care Plan enrollees . State is working with CMS for Medicaid reimbursement.

Recommendations for DT Program Development

- Facilitate cooperation between dentists, advocates and policymakers;
- Create policy and regulations to integrate DTs into the oral health system (e.g. scope and role of various players).
- In 2011 the Commission on Dental Accreditation (CODA) taskforce formed to develop accreditation standards for DT education standards.
- Provide incentives and regulations to ensure DTs serve the underserved;
- Explore the use of telehealth for training, supervision and quality assurance
- Reimbursement policies that support DTs and dental practices;
- Conduct additional research on DT patient outcomes in U.S.

Behavioral Health Aids



Emerging BHA Models

- BHAs as Care Coordinators and Case Managers
- BHAs as support workers
- Mental Health First Aid certified laypeople
- Peer Counselors and Peer Specialists
- *Promotoras* with behavioral health training
- Alaska's BHA Model
- Behavioral Health Practitioners

Findings

- There is little published research on most BHA models and their use in rural and frontier areas.
- Exchanging information is difficult; no national organizations or networks for most types of BHA.
- There are no nationally recognized core competencies for most types of BHA.
- Many BHA programs lack a stable source of funding.

Recommendations

- Develop nationally recognized core competencies to standardize terminology used by various BHA models.
- Conduct additional research on effectiveness, training and licensing of models and cost.
- Create national platform for exchange of expertise, information, models, etc.
- Investigate new funding options
- Explore of telehealth for training, supervision and quality assurance.

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