Shasta Community Health Center
MODEL OF CARE
For
NEUROPSYCHIATRIC SERVICES
December 8, 2004

SUMMARY: We are an FQHC who is integrating neuropsychiatry with primary care medicine. We made this commitment because of our belief that one of the biggest obstacles for patients to climb out of the poverty pit is accessing psychiatric services. It is also our belief that 80-90% of psychiatric disorders can and should be managed by a primary care clinician. This provides a patient with the best possible chance for health and wellness. We believe that for those 10-20% of patients who rightfully require specialty psychiatric services, that we should be able to refer those patients to a psychiatrist for consultation. For this purpose, we have now established a Primary Care Neuropsychiatry Department at Shasta Community Health Center. At this time, we have employed several neuropsychiatry professionals including a Psychiatrist, Physician Assistant, Certified Registered Nurse Psychiatric Specialist and several Licensed Clinical Social Workers. This is stage I of an organized plan to expand our services to the population we serve. This relatively simple addition to our Medical Staff is already allowing us to reach many more thousands of patients.

MISSION STATEMENT: The goal of the Medical Staff at Shasta Community Health Center is to address neuropsychiatric disorders in the population we serve and to treat these disorders within the medical model of care. Our goal is to provide psychiatric resources to our patients in order for them to recover from the poverties of mind, body and spirit that burden them and prevent them from experiencing health and happiness.

STRUCTURE: The Medical Staff is organized into the following departments:

1. Family Practice
2. Specialty Family Medicine
3. Pediatrics
4. **Primary Care Neuropsychiatry (PCN)**
5. Satellites
6. Urgent Care
7. Health Outreach for People Everywhere (HOPE)
8. Dental

PRIMARY CARE NEUROPSYCHIATRY DEPARTMENT

- Location: PCN is nestled within the center of the clinical area so that other patients and staff have physical access to them. Information flow is bidirectional. Clinics not located at the main address access PCN via phone, pager, telemedicine or referral.

- Patient access: access to PCN services is through various mechanisms.
  1. Direct referral from a primary care clinician (PCC). Our goal is to stabilize patients with a limited number of visits and then to refer back to the PCC for on-going care.
  2. Urgent assessment for acute needs on site. (PCN staff is called to help a patient with urgent needs who has presented to SCHC for a continuity or acute medical visit but in actuality the patient has a neuropsychiatric problem which needs urgent attention.)
  3. Curb side consults by PCC's.
  4. Telemedicine with outlying clinics both within and without of SCHC.
  5. A Psychiatric Nurse staffs our homeless outreach program (HOPE) one day per week. Homeless patients may access PCN services through this outreach program.

- Job tasks of PCN.
  1. Direct clinical services. The goal is limited consultation for the majority of patients with a rapid return to the PCC. A few of the seriously impaired will need on-going follow-up care by PCN staff.
  2. **Training and education of PCC's. The plan is to expand the scope of practice for the PCC's so that they can more comfortably care for the more serious and complicated neuropsychiatric disorders.**
  3. In-patient consultation on a limited basis. We are willing to expand our in-patient services once we have reached a critical mass of psychiatrists.
  4. Community service. We assist all other agencies in Shasta County. This includes Social Services, Law Enforcement, Faith based ventures to serve the underserved, etc.
  5. Continued attempts to collaborate with County Mental Health are on-going but this has been difficult because of the long standing bureaucratic barriers that often bind agencies hobbled by poor public policy decisions.
  6. Legislative initiatives. PCN staff will participate in the planning for dispensation of Prop 63 funds to the extent we are able to.
  7. Conducts peer review activities to ensure quality of care across clinicians and across all departments.
  8. Provides neuropsychiatric support to other grant funded programs such as HOPE, telemedicine and EIS (HIV program.)

- Funding of PCN:
  1. Direct billing of patient encounters pays for the majority of the expenses. However, supplemental grants are required to offset the costs of serving the uninsured.

2. Various grant monies are dedicated to PCN. These monies were deliberately written into the grants.
3. Uninsured patients pay on a sliding fee scale, based upon their ability to pay.
4. Some health insurances reimburse for this service. If they do not, the patient is expected to pay cash.
5. Psychiatrists bill Medicaid through medical cpt codes (i.e. 99213, 99244, etc.) (Medicare does reimburse for neuropsychiatry visits but not with parity for other medical conditions.)

- Growth Plan:
  1. We are currently recruiting for an additional psychiatrist and an LCSW. It is essential we reach the critical mass of psychiatrist staff to provide continuous coverage and to make the program independent of the presence of a single physician.
  2. PCN will be developing formal policies and procedures and templates for clinical services that ensure consistency of services. These P&P's can also be shared with other CHC's.
  3. PCN will develop evidence based clinical care guidelines for all PCN staff and PCC's.
  4. PCN will expand our community education initiatives. We will schedule educational events with acute medical hospitals, Mercy Maternity Clinic, private doctor's offices, other community clinics, etc. There will be a community forum meeting in our SCHC auditorium every other month.
  5. PCN will participate in community wide "mental health awareness week" activities.

- Health Outcomes:
  1. **Significant improvements in health outcomes have already been observed. What is most impressive and surprising is that relatively small interventions have resulted in dramatic positive changes/improvements in people's lives. There are also indications that the crime rate has dropped. Some members of law enforcement feel that our outreach to the homeless and those with psychiatric disorders might be responsible for this.**
  2. Outcomes have been measured by patient satisfaction surveys.
  3. Formal outcomes reporting will be available in 2005. Clinicians will be measuring improvement via various tools such as the Global Assessment Functioning Scale (GAF) which measures a patient's level of functioning.

FUNDAMENTALS OF COLLABORATION:

Shasta Community Health Center passionately supports the concept of collaboration. However, after over a decade of intense, continuous, highly motivated attempts to collaborate with other agencies, we have identified a list of criteria which is critical for us to be successful in our CHC mission. These include:

- In all decisions, patient care is the first priority. No financial or operational decisions will be agreed upon by SCHC if there is a corresponding negative impact to quality medical care.
- Shasta Community Health Center declares upfront its belief that no agency has a legitimate advantage or higher authority compared to any of the other participating collaborators; this includes county or community mental health providers.
- All programs, policies and procedures, and assignment of responsibilities will be developed, decided and agree upon between all parties impacted, but especially between the medical staffs of SCMH and SCHC.
- SCHC adamantly declares that it will not participate in any program or initiative which is set up such that non-physicians can override a physician's orders. Final authority will reside with the physician in all matters regarding clinical care. This is an absolute.
- SCHC will not engage in illogical work-arounds whose sole purpose is to comply with the technical aspects of regulations. Any resources we commit must directly improve access and/or quality of care.
- All funds must be equitably distributed. In addition, SCHC must be an active participant from the beginning in the group who makes decisions regarding the distribution of funds.
- Shasta Community Health Center will need to be fully informed regarding all regulatory, limiting or binding factors related to the programs being developed. There must be no withholding of information by individual groups as a strategy to improve that individual group's financial advantage or to avoid the more difficult tasks.
- A major goal of any initiative should be to align incentives so that all partners are motivated by the same rewards.
- Honesty, ethical business behaviors and the commitment to comply with all applicable federal and state laws are valued qualities we look for in our partners. Shasta Community Health Center will extract itself immediately from any collaborative effort if we determine other engaged agencies are not likewise motivated.