
Successfully working within the known Bureau of Primary
Care Scope of Services Rules in creating direct access to
specialty care in an **FQHC** :

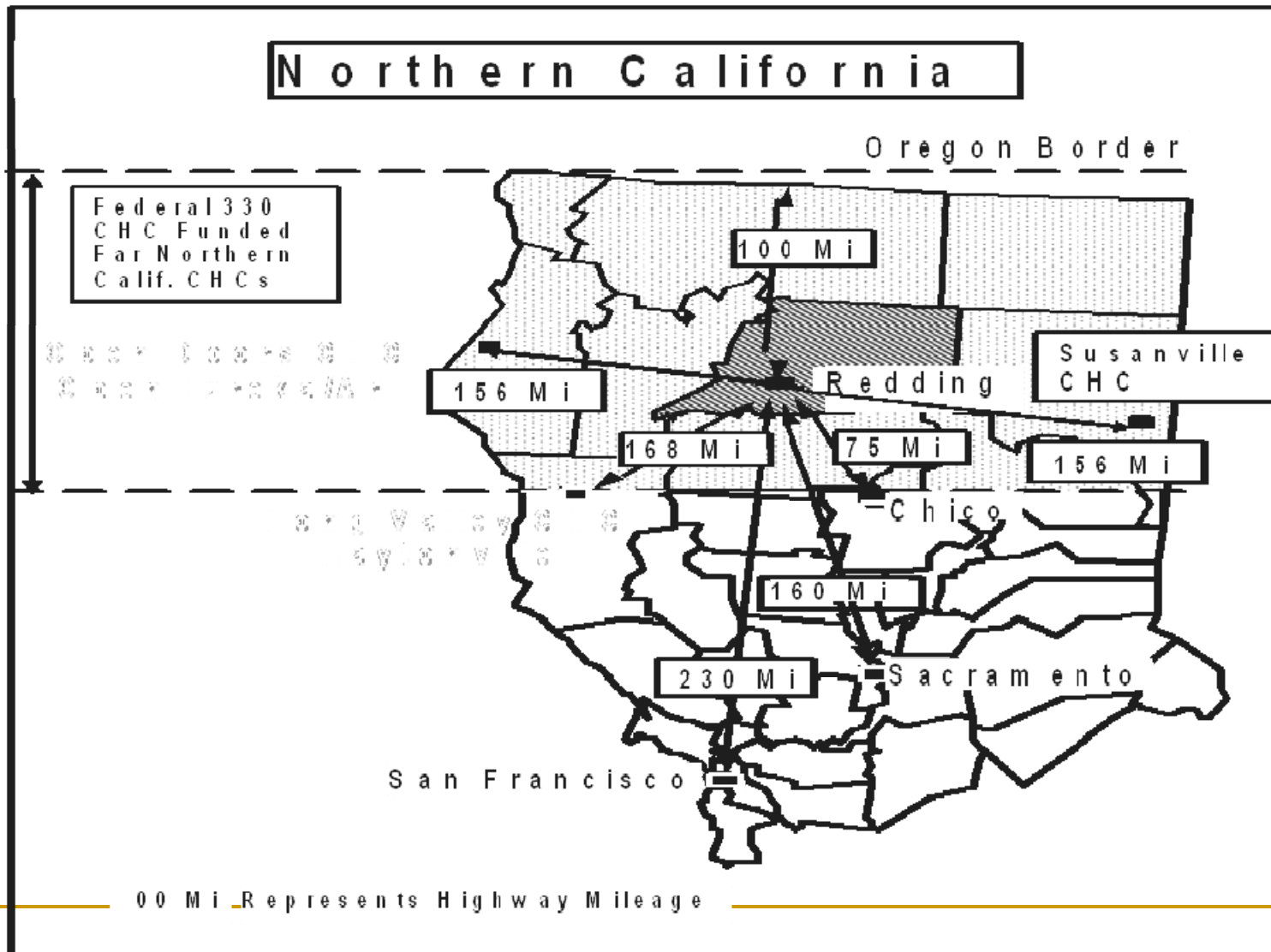
Shasta Community Health Center's Story!

Presentation by:

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Shasta Community Health Center

Shasta CHC & Other 330's in Far Northern California



Shasta Community Health Center

Happy Valley



Redding Dental



Main Redding Clinic



City of Shasta Lake



Why would a CHC create specialty care access?

- CHCs are focused on primary care so undertaking specialty care has not been a typical CHC pursuit.
 - To not create access when little or none exists is not only hard on our patients it is also very hard on our primary care clinicians.
 - Recruitment and retention can be enhanced by creating better access to specialty care for our primary care medical staff.
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Things to consider

- Do you have space capacity?
 - Specialist availability can make scheduling a challenge.
 - Personality differences: primary care clinicians are typically very different than specialist physicians.
 - Billing issues – i.e. watch out for global billing arrangements!
 - Telemedicine is providing some alternative options in specialty care although reimbursement continues to be an issue.
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Staff and Operating Impacts

- Shasta CHC has had an active specialty care program since its inception in 1988.
 - Today, Shasta CHC has over twenty-five specialists undertaking clinics within its four walls as little as 4 hours a month for some, and as many as two days a week for others.
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Typical Specialty Care Mix at Shasta CHC

- Neurology
 - ENT
 - Plastics
 - Endocrinology
 - Gynecology
 - Plastic Surgery
 - G.I.
 - Podiatry
 - Urology
 - Telemedicine-Psychiatry
 - Infectious diseases
 - General-Vascular Surgery
 - Pediatric Cardiology
 - Dermatology (Pediatric and Adult)
 - Pulmonary
 - Rheumatology
 - Telemedicine-
Endocrinology/Pedia-tric
Neurology/Child Psychiatry
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Why do Specialists Contract with CHCs

- A way to help them with their hospital call follow-up arrangements (i.e. picking up low income and special needs patients while covering the ER or hospital call).
 - A way to give something back in a defined and controlled way without burdening their offices.
 - Specialists do not tend to want to be the patient's doctor forever, it is reassuring to them to know that can effectively hand that patient back to the primary care clinician at the end of their involvement.
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Why do specialists want to contract with a CHC

- Reimbursements through the FQHC or RHC can be somewhat better than FFS Medi-Cal. This is certainly true of the uninsured!
 - Remember, getting the specialist to see the patient the very first time is the critical step to access.
 - Be careful of giving away your FQHC reimbursement! It will cost money for you to deliver the specialty care services (and save money for the specialist). Also, don't create unintended consequences (i.e. be seen as the Medicaid fiscal agent!).
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Staff and Operating Impacts

- Nursing resources to support specialty care programs run at a ratio of 2-3 hours per every hour of specialty clinic.
 - You have less control over specialists, beware of their offices wanting you to host their specialist on their “on-call” day.
 - Some specialties see patients quickly and efficiently (e.g. 3-4/hr.- ENT) while others are expectedly slower (e.g. Neurology 1-2 per hr.).
 - It is best to host a specialty care group rather than one specialists in order to spread the work and reduce burn-out potential.
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Contracting vs. Volunteering

- Shasta CHC pays its specialists. This allows us to have a performance contract.
 - We pay most of its specialist a rate per patient, making no distinction between payor classes.
 - We pay them once per month and submit to them the billing information giving patient specific information.
 - We do not pay specialists for undertaking tests and services in their offices or their outpatient or hospital inpatient facilities. They bill FFS Medi-Cal.
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Staff and Operating Impacts

- Credentialing is important: make sure that the specialists is signed up with Medi-Cal and has not been excluded from working with either or both Medicaid and Medicare.
 - For most specialists, FTCA will not cover them for malpractice. They need to be separately covered (i.e. wrap around or extending their own coverage).
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Other Quality Issues

- If a CHC moves into specialty care, take a poll of the medical staff and find out the specialty of greatest need and target it.
 - Assign the same nurses to a specialist. Match nursing staff to the specialist's personality is critical.
 - Assign more Admin time to your CMO in order to work closely with specialists and help them out with their frustrations at the CHC because it is unfamiliar grounds to them.
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Bureau's Issues

- FTCA: Concern that federal malpractice liability exposure will grow with addition of specialty care
 - Reimbursement: Concern that specialists will bypass State FFS arrangements for higher FQHC rates
 - Scope Issues: Short of a clarifying PIN on the subject, is specialty care a legitimate part of one's scope of project?
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FTCA Issues

- Most specialty physicians working part-time at your health center will not likely be covered under FTCA.
 - Insist in their contracts that they must cover themselves for malpractice at your CHC
 - Let the Bureau know that specialists are covering their own malpractice but ensure that this service is part of your scope of project so that you have FTCA coverage for your CHC
 - Better yet, have wrap around coverage!!
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Reimbursement Issues

- Specialty care can be billed within the four walls of the FQHC at your PPS rate.
 - Documentation requirements are the same. Make sure specialists adhere to your billing documentation needs.
 - Shasta CHC reimburses specialists on an encounter basis, ranging from \$45 to \$100 an encounter as we find them more productive (vs. hourly paid) and reimbursement is more clear-cut.
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Scope of Service Issues

- Specialty Care has flown under the radar of the Bureau for years but there have been a push, particularly among California FQHCs to expand specialty care services within the FQHC funding and program framework.
 - Shasta CHC has had a history since 1988 and has consistently included documentation to the Bureau on its Specialty Care program.
 - No clarifying PIN on this subject yet.
 - State has allowed this but only using the “Four Walls” rules.
 - Shasta CHC went through a lengthy BSV justification process to ensure that specialty care was included in our scope (subject to any new PINS)
 - In dealing with the Feds, make sure you make clear that such services are “consultative” in nature – i.e. that you are not doing brain surgery in your four walls!!
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Type of Specialty Care	Description of Services	Documentation of Approval by BPHC
<i>Example: Nephrology</i>	<i>We see a large diabetic population with a Diabetes Registry of 1100 patients as of March 2008. Poor control leads to spilling proteins which leads to kidney failure. Specialist is contracted 4 hours per week to work with diabetic population and primary care providers on this issue</i>	<i>Status in 1996 with funding in 1997ee has included nephrology in Form A since 1994, and this item has been approved every year through the status in 1996 with funding in 1997. OR something to the effect of “We requested a change in scope to add nephrology in 2005, and this was approved in NGA dated Feb 2, 2005. Please see attached”</i>
Breast Surgery Consultation	Services are focused almost exclusively on women (and the occasional man) who have mammogram reports indicating cancer and the surgical treatment/follow-up of breast cancer. Service provided 4 hours per month.	Services provided since 1995. SCHC obtained 330 status in 1996 with funding in 1997.
Cardiology (Peds)	Services provided for children who have heart defects or other cardiology issues (usually genetic). Service provided 8 hours per month. Because this is a sub-specialty and only available through a “visiting” arrangement with pediatric cardiologists based in Sacramento, California (160 miles away) this is a major access issue for low-income young children who would otherwise likely not be diagnosed, treated and followed by this sub-specialty if they had to regularly go to Sacramento for care.	Services provided since 1988. SCHC obtained 330 status in 1996 with funding in 1997.
Endocrinology	Services are almost exclusively for the diabetic population (SCHC has almost 3000 diabetics in the practice) and focused on the more complex patients who have complications or are difficult to manage. Service provided 4 hours per month. This endocrinologists is the only one in the far region of Northern region of California. A pediatric endocrinology clinic is also undertaken 4 hours per month through the use of Telemedicine with a specialists based in Los	Status in 1996 with funding in 1997ee has included this service prior to and since the original 330 status in 1996 with funding in 1997 award; with original implementation of service in 1995.

Potential Red Flags

- Specialty Care makes up less than 7% of total SCHC visits; be careful with stand alone specialty care clinics under FQHC, at least not without a clarifying PIN and/or specific federal approval.
 - Be careful to not give the impression that your interest in providing specialty care has anything to do with paying your specialists more money and/or trying to undermine the FFS system but rather, it is primarily about access for your patients who would otherwise go without.
 - Don't underestimate the effort and cost of managing specialists in your primary care practice.
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Benefits

- Meeting a community need.
 - Engaging the specialty care community who will better understand you.
 - More hospital support “Curb-side consults” extend your primary care clinicians’ knowledge-base.
 - A sense of pride with your staff.
 - It is a resource that must be nurtured, supported and monitored. Go in with your eyes open!
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