



# North Carolina Psychiatric Association

*A District Branch of the American*

*Psychiatric Association*

## Community & Public Psychiatry Committee Proposal

### **Clinical Home: Assessment and Stabilization Service**

02-13-08

*To restore the safety net, each LME needs to have at least one publicly funded safety net clinic or clinical home, depending on the size of the catchment area. This model is designed to permit the clinical home to be operated by the LME or through a contracted provider.*

#### **Problems:**

- Current assessments are often inadequate: when conducted by a provider, they can be geared more to ensuring the provider's services are used than to identifying a patient's comprehensive needs. Assessments can be skimpier than clinically indicated. Psychiatric assessments are often inadequate and do not reflect contemporary standards of diagnosis and evidence-based treatments. Medical assessments are often inadequate, with inadequate integration of psychiatric and medical problems and referral to appropriate medical treatment.
- Provider networks are inadequate to care for some populations (indigent and working poor populations) or to provide some specialized evidence-based treatments.
- The current system, relying as it does on "choice" and marketing, short-changes quality clinical care individualized to a patient's problems, based on evidence, and likely to improve the patient.
- The current system has many gaps of communication and services between disparate providers, with poor communication and care coordination

#### **Populations to be served:**

- All North Carolinians with mental illness or addiction who cannot receive needed services elsewhere, whether because of funding (medically indigent or working poor) or because of complexity and severity of clinical condition.

#### **Functions:**

- Safety Net
- Psychiatric Assessment
  - Comprehensive, multi-disciplinary assessment, one component must be a thorough evaluation by psychiatrist
  - Primary care and Primary care linkage
- Initial proposed treatment plan with recovery-oriented evidence-based interventions for the working diagnosis
  - Stabilize and refer (if necessary, if feasible) to network providers, primary care. etc
  - Guarantee of psychiatric services
    - development and implementation of psychiatric treatment plan
    - consultation (with primary care or other network provider)
    - psychotropic medication management (by the psychiatrist or PCP with consult from psychiatrist)

**Functions, continued:**

- UM – Short-term predictive measures (soon after the patient is referred progress report from the provider would be required to determine if patient has improved, stayed the same or gotten worse. If the latter, patient would be referred back to psychiatrist for reassessment and reevaluation of the treatment plan. If patient has plateaued, provider will be alerted to review the plan.)
- Clinical Oversight
- QM – Continuous Quality Improvement
- 24/7 emergency service for all
  - Until attached to a First-Responder provider
  - As a temporary backup for a failed first responder provider, a failed /inadequate first response or a clinical resource to trouble-shoot solutions with provider about ability to respond in the future

**Necessary Elements:**

Funding

- Market level funding for psychiatrists – in effect, 50% of personnel costs need to be subsidized.
- Adequate nursing, professional, substance abuse, psychotherapy, clerical, staff to support the mission
- Medications – sample availability and Medication Access Review Program
- medical assessment (fear that grants will not be sustainable)
- labs, tests (including psychological testing although may be rarely needed)