California Health Improvement Project (CHIP)

Developing an Insourcing Strategy for Telepsychiatry Services in a Consortium of Native American Health Centers

Thomas J. Kim, MD, MPH
California Rural Indian Health Board (CRIHB), Sacramento, CA

Problem Statement and Underlying Causes

Barriers to psychiatric and behavioral health services for Native American communities in California are often related to:

- Access due to their rural locations;
- Lack of cultural competence of providers;
- Billing and reimbursement structures; and
- Payer mix of clients that Tribal Health Programs serve

Telepsychiatry has great potential to address many of these issues.

- **Access Limitations**
- **Need for Culturally Competent Providers**
- **High Cost**

Ready access to tribally experienced providers at market competitive rates in a program operated by tribal clinics

Project Description

Create a **consortium-based telepsychiatry provider service** for California Rural Indian Health Board (CRIHB) member clinics. These clinics will independently hire and share culturally fluent psychiatrists and mid-level behavioral health providers to provide excellent care within a particular historical, cultural and social context. By working together as a consortium, they will reduce administrative fees (contracting, medical record sharing, scheduling, billing) and potentially reduce costs for telepsychiatry.

Goal and Objectives

Goal: Provide a CRIHB based telepsychiatry service to rural Native American communities which more effectively achieves Triple Aim goals of providing excellent care and enhanced patient experience due to provider cultural fluency while improving access and promoting financial sustainability to their telehealth programs.

Output-Oriented Objectives:

- By June 2016, create and obtain approval for an alternative billing mechanism as an option for clinics in which CRIHB bills for visits.
- By June 2016, hire one part-time psychiatrist and one part-time mid-level behavioral health practitioner who both fulfill core cultural competencies as defined and approved by the project's tribal advisory committee (community members/leaders and clinic staff).

Outcome-Oriented Objectives:

- Increase the first year aggregate utilization of behavioral health care by 15% compared to prior to baseline by August 2016.
- Improve the aggregate patient experience by 15% compared to prior to project implementation.
- Achieve an hourly operation rate below the median rate for telepsychiatric care in a statewide survey by the California Telehealth Resource Center by August 2016.

Outputs & Outcomes

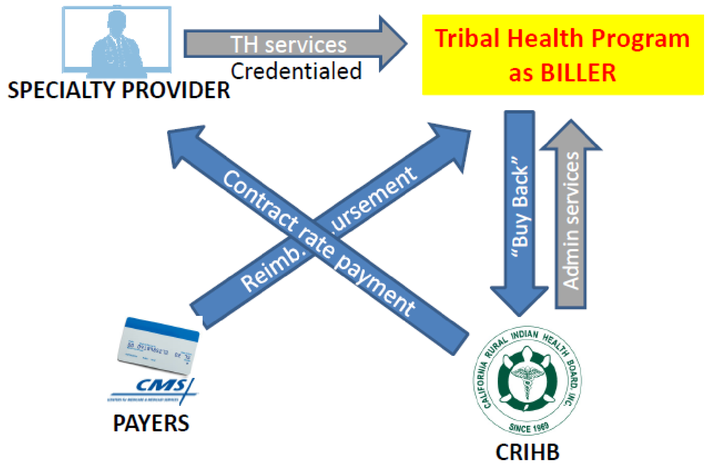
Outputs Achieved

Four of seven full member tribal clinics offer telepsychiatric services (none >10 hours per month) and all four cite high fees as a barrier to access and program expansion.

By August 2016, through a long internal process utilizing feedback from stakeholders, a business model was developed combining two previously used billing and reimbursement models:

1. Direct contracting between a specialty provider and clinic
2. CRIHB retaining a portion of member clinics federal pass-through funds ("buy back") to cover the costs for a provider.

The first exposes clinics to market rates. The second does not create a sustainable funding model nor provide opportunities to maximize reimbursement through the IHS MOA wrap-around rate (similar to FQHC encounter rates). With feedback from tribal clinics, a hybrid version of these two models was developed to ensure access to a protected number of hours per month for their clients, the ability to bill for specialty encounters and guarantee hours and payment to specialty providers.



As of August 2016, we are developing contracts with one part-time psychiatrist and one part-time mid-level behavioral health practitioner. One provider is a California Native while the other will need training to fulfill core cultural competencies.

Outcomes Achieved

- As of August 2016, none of the anticipated outcomes have been achieved. The business model development and approval process went through numerous iterations before accepted.
- CRIHB administration has offered to highly subsidize this program to ensure high clinic participation in order to create a base of utilization for financial stability. We anticipate a program start in October 2016.

Lessons Learned

- Competing financial concerns between a central support association and its members should not be underestimated and can be a significant barrier to which additional research and time needs to be dedicated.
- Creative solutions are possible and the model that we have developed is novel for tribal clinics in California and leverages enhanced reimbursement programs for tribal clinics. We believe this model is attractive to clinic administrators, telehealth specialists and better control for patient experience through ensuring cultural competence.
- While focus on the financial sustainability of this program was needed, our work revealed an equally large concern of tribal community buy-in and demand. We have piloted community outreaches through open-house events at clinics targeted toward community elders. We hope to develop these outreaches as a standard part of this program.

About My Organization

The California Rural Indian Health Board (CRIHB) was founded in 1969 by Native American tribes throughout the state to serve as a primary care association for their Tribal Health Programs and to be a state and national platform for policy research and advocacy. In addition, CRIHB provides technical assistance, public health programming and research, and manages pass-through funding. CRIHB serves twelve Tribal Health Programs which represent 35 tribes in California. Each of these programs are independent and are owned and operated by their Tribes. Collectively, they serve over 85,000 Native American and non-Native rural patients annually at their outpatient facilities.

Contact Me

For more information, contact me::
Thomas J. Kim, MD, MPH
Thomas.kim@crihb.org
916-929-9761

CHCF HEALTH CARE LEADERSHIP PROGRAM