Rural Telemental Health Delivery Models: Opportunities and Challenges

Muskie School of Public Service

John Gale

Co-authors: David Lambert, Zach Croll, David Hartley, Anush Hansen

NOSORH Region A Meeting
Providence, RI
June 19, 2012

RHRC Rural Health Research & Policy Centers

Maine Rural Health Research Center

Contact Information

John Gale, MS
Maine Rural Health Research Center
Muskie School of Public Service
University of Southern Maine

Email: jgale@Usm.maine.edu
Phone: 207-228-8246

RHRC Rural Health Research & Policy Centers

Maine Rural Health Research Center

Overview

- Background
- Terminology and reimbursement issues
- Description of study
- Initial findings
- Examples of telemental health programs by region
- Opportunities
- Challenges

Terminology and Reimbursement Issues

- Originating site: where patient is located and "seen"
  - Physician offices, CAHs, hospitals, skilled nursing facilities, community mental health centers, Federally Qualified Health Centers, Rural Health Clinics
- Distant (presenting) site: Where provider of service is located
  - Provider can include physicians/psychiatrists, clinical psychologists, clinical nurse specialists, or clinical social workers
- Medicare reimbursement issues
  - Beneficiary must reside or use telemedicine system in a rural HPSA
  - Involves a "face to face" encounter in real time using technology
  - Provider at distant site can bill for service using appropriate codes
  - Originating site can bill a telehealth facility fee ($24.10)
- Medicaid reimbursement depends on state policies
- Commercial reimbursement driven by company policies

What We Know

- Telemental health is offered as a solution to overcome long mental health access issues in rural areas
- One of the most commonly used telehealth applications
- Technology is less of a limiting issue than in the past
  - Costs are declining
  - Units are more portable – PC-based units are available
  - Connectivity is improving
- Examples of successful programs are well known
- Yet, rural telemental health programs have not grown as quickly as advocates have expected

What We Don't Know

- Why growth in telemental health programs has not met expectations
- The issues related to scope and viability of telemental health programs in a changing health care environment
- How many telemental health programs and what services and functions they provide
- Which models are successful and sustainable and which are not

Study Description

- Snowball sample with short on-line survey of telemental health programs: organizational context, services, and staffing patterns
- 150 programs identified through review of ORHP and HRSA grants; web searches, and referrals from regional telehealth resource centers
- 60 programs responded with 52 reporting that they are involved with telemental health services
- Telephone survey with 25 programs to understand clinical, business and reimbursement environments, and program sustainability
- National advisory group recruited to assist in design and interpretation of survey and interview

Organizational Settings

Organizational Setting	Percent
Academic medical centers	28%
Community mental health centers	9%
Acute care hospitals	8%
Consulting firms/vendors	8%
Federally Qualified Health Centers	6%
Rural Health Clinics	6%

Services Provided

Service	Percent
Direct patient care	94%
Professional to professional consultation	72%
Care management or coordination	46%
Professional supervision of clinical staff	36%
Quality improvement activities	32%

Types of Direct Care Services

Direct care service	Percent
Medication management	82%
Initial diagnostic evaluation	80%
Psychotherapy	62%
Crisis stabilization	44%
Assessment for involuntary commitments	28%
Substance abuse treatment	26%
Case management	26%

Program Staffing

Clinician	Percent
Psychiatrists	88%
Clinical psychologists	44%
Clinical social workers	38%
Psychiatric nurse practitioners	30%

Example: Community Mental Health Center (CMHC)

- Telehealth used to sustain rural network by planning, coordinating, and referring services among its members
- Settings: 2 nursing homes, 5 hospitals, and a county jail
- Staff include masters-level clinicians from the main office and a contracted psychiatrist from another state
- Key learning points:
  - Enables provision of services that otherwise wouldn't be available
  - Requires psychiatrists who can adapt treatment to modality
  - Available "tech" help is key
  - Capital investment is substantial but "doable"
  - Service reimbursement must be at least equal to direct care

Muskie School of Public Service | Maine Rural Health Research Center

Example: Regional Health System

- Nearest MH services 80 miles away
- Regional health system includes a CAH, 3 RHCs, 2 long term care (LTC) facilities, a day care center, and a wellness center
- Settings: LTC and RHCs (½ day/month-4 patients seen per day)
- Services: diagnostic evaluation, individual psychotherapy, medication management, and crisis management
- Used for medical staff education 1-2 times per month
- Key learning points:
  - Self sustaining with 3rd party and patient billings
  - Reduce costs using therapist to provide education and training
  - Some costs absorbed by hospital as "overhead"
  - Use to supplement onsite services (not viewed as a standalone service)

Muskie School of Public Service | Maine Rural Health Research Center

Example: Crisis Services in Critical Access Hospitals

- Problems with MH patients clogging EDs
- Hub & spoke model: CMHC provides crisis services to 6 CAHs
- Services are provided CMHC's 24/7 access center using LCSW/LMH staff and psychiatrist
- Standardized protocols/algorithms used to assess patients
- CMHC "sees" patient using telehealth technology and prepares consultation report and disposition plan
- ED LOS reduced from 16-18 hours to 240 minutes
- Hospital pays $125 per consult to CMHC
- Learning points:
  - Substantial savings (lower ED LOS), fewer unnecessary hospitalizations
  - Standardized protocols and 24/7 access key

Muskie School of Public Service | Maine Rural Health Research Center

Example: Small FQHC

- Child psychiatry services provided by a psychiatric hospital
- Services began at request of a clinic nurse whose daughter needed services and nearest specialist was a 90 minute drive
- An additional client came on board based on staff referral
- Hospital provided clinician, billing service, and technical support
- Service ended when the psychiatrist and technical staff resigned
- Learning points:
  - Viability of service depends on willingness of staff to participate
  - Technical support needed
  - Well liked by two patients and family – staff champion needed

Muskie School of Public Service | Maine Rural Health Research Center

Example: Public Hospital District/RHC

- Island based originating site
- Developed as a result of a HRSA planning grant
- Contract with mainland psychiatrist to provide services – went through multiple contracts with different providers
- Psychiatrist billed fee for service – if service denied, RHC paid the psychiatrist for services rendered
- First psychiatrist refused commercial coverage, second refused Medicaid – RHC absorbed more and more of cost of services
- Volume ranged from 15-20 patients to 2-3 patients at the end
- Learning points:
  - Service dependent on time and willingness of psychiatrist
  - More and more risk absorbed by practice

Muskie School of Public Service | Maine Rural Health Research Center

Example: Public Hospital District/RHC

- Upper North West – Island based originating site
- Developed as a result of a HRSA planning grant
- Contract with mainland psychiatrist to provide services – went through multiple contracts with different providers
- Psychiatrist billed fee for service – if service denied, RHC paid the psychiatrist for services rendered
- First psychiatrist refused commercial coverage, second refused Medicaid – RHC absorbed more and more of cost of services
- Volume ranged from 15-20 patients to 2-3 patients at the end
- Learning points:
  - Service dependent on time and willingness of psychiatrist
  - More and more risk absorbed by practice

Muskie School of Public Service | Maine Rural Health Research Center

Example: Tribal Health System

- Native government regional consortium
- Started 5 years ago with a HRSA grant
- 20 clinicians provide telemental health services to children, adult, and seniors living in native communities
- Some push back from providers who prefer face-to-face encounters at start of treatment – difficult due to travel distances
- Not thought to be sustainable without grant
- Reimbursement covers provider time but not technology infrastructure costs
- Learning points:
  - Adequate reimbursement needed to cover provider and technology costs
  - Affective use of technology to serve patients in remote areas

Muskie School of Public Service | Maine Rural Health Research Center

Example: Statewide Telehealth System

- Founded in 2004 upon sale of BC/BS to Anthem – Anthem required to develop and fund telehealth program for 3 years
- At the end of 3 years, assets turned over to 501c3
- Brokerage model that connecting originating and presenting sites
- Operates statewide with 250 partners – partners pay monthly fee
- Fees cover scheduling services, electronic health record, and network of providers. Provider handle their own billing.
- Legislation mandates coverage of telehealth by all 3rd party payers
- Learning points:
  - Reduces burden of arranging service on small providers
  - Membership fees ensure sustainability

Muskie School of Public Service | Maine Rural Health Research Center

Example: Managed Behavioral Health Network

- Funded by State Health Department since 1996
- Managed behavioral health system contracts with community-based agencies
- Serves persons with SMI in a 62,000 SM rural area
- Capitated model simplified delivery of services as technology can be used to provide services without concern for FFS payment
- Systems are not required to itemize services
- Learning points:
  - Capitation allows services to be provided on a rational basis
  - Allows providers/systems to deploy effectively deploy limited resources to serve covered populations

Muskie School of Public Service | Maine Rural Health Research Center

Example: Private Telemental Health Vendor

- Marketed nationally
- Service employs a cadre of psychiatrists to provide services
- Seeks to contract with local providers for a set rate –typically on an hourly or daily basis
- Local provider responsible for enrolling psychiatrists in 3rd party provider networks, billing, no-shows, scheduling, and collections
- Vendor provides some technical assistance to support providers
- Learning points:
  - Local providers must bear the risk of developing and sustaining service
  - Doesn't fit the RHC program as RHCs cannot bill for the services of a psychiatrist provided through telehealth technology

Muskie School of Public Service | Maine Rural Health Research Center

Example: Rural Community Mental Health Center

- Use telemental health to sustain rural network of planning, coordination and referral relationships
- Provides direct care to patients in nursing homes, local corrections facility, and at five hospitals
- Uses employed staff and an out-of-state contracted psychiatrist
- Medicaid and some private insurance are major payers
- Fees charged to sites to cover technology support costs
- Increased access with high provider and consumer satisfaction
- Learning points:
  - Some sites can recoup site fees while others cannot
  - CMHC unsure of potential growth

Muskie School of Public Service | Maine Rural Health Research Center

Example: Academic Medical Center

- Established in 1995, was a member of the State's Telehealth Commission which led to the development of the formal telemental health program in 2008-2009
- Provides 8 to 10 "half days" of services to rural mental health providers around the state
- 1/4th of state's rural MH providers use telehealth technology
- Draws on clinical/academic resources to develop infrastructure
- Despite the growth of service, major service gaps remain
- Learning points:
  - Not sufficient to address all service needs
  - Supplements existing services, not at a solution to access issues

Muskie School of Public Service | Maine Rural Health Research Center

Example: Academic Medical Center

- Service began in 2000 with a contract to provide MH services to prison populations in an adjoining state
- Provided foundation to expanding services (through an OAT grant) to 41 community mental health centers statewide
- Provides 26.5 hours/week of telepsychiatry services to state MH centers under contract with Department of Behavioral Health
- Program doesn't bill third party payers for services rendered
- Learning points:
  - Sustainability dependent on state contract
  - Allows effective use of resources to serve rural areas

Example: Academic Medical Centers

- Primarily serves adults incarcerated in state correctional system
- State contracts with two academic medical centers in the state
- One serves western half of state; the other serves the eastern half
- 90% of counties served are very rural
- Capitated contract with the Department of Corrections
- Learning points:
  - Capitation (rather than fee for service) allows best deployment of scarce resources
  - Base created by contracts allows the technology to serve other populations

Example: Rural CMHC Network

- Umbrella health organization includes 5 CMHCs and 7 CAHs
- Started 4 years ago with Rural Health Outreach funding
- Primarily funded through Medicaid and 3rd party billing
- Grant funding to secure more equipment
- Substantial inroads in using telemental to increase access and shore up the network
- Concerns about sustainability under developing Medicaid managed care program
- Dealing with a number of credentialing related challenges
- Learning points:
  - Reimbursement doesn't cover technology acquisition
  - Potential Medicaid reimbursement changes threaten sustainability

Example: Academic Medical Center

- Serves persons of all ages -2,500 encounters/year through a network of 85 partner sites
- Started in 1993 serving rural mountainous area
- Children /adolescents are the largest group served
- Medicaid is the major payer for mental health services
- Program bills local community service boards $150.00/hour
- Community service boards can use the time as they wish
- Facing growing competition private telehealth vendors
- Learning points:
  - Community service boards absorb the risk of no shows and uninsured patients and are responsible for seeking reimbursement from Medicaid and other payers

Muskie School of Public Service | Maine Rural Health Research Center

Example: Private Counseling Service

- Founded in 1995 to fill service gaps faced by children, adolescents, and their families
- Provides services in 22 counties through 40 end points from which services can be initiated (presenting site) or received (originating site)
- Serves 31 sites (21 in state and 10 in an adjoining state)
- Eleven psychiatrists are used; only some reside in-state
- Reimbursed by private insurance, self pay, Medicaid payments, contracts, and grants
- Learning points:
  - 50% no-show rates undermine viability of serving particular sites

Muskie School of Public Service | Maine Rural Health Research Center

Example: State Mental Health Authority

- State MH authority contracts with statewide network of 160 sites including CMHCs, FQHCs, substance abuse providers, hospitals, clinics, VA centers, courts, and IHs facilities
- Served 40,000 residents last year
- Funded through user fees and occasional grant funding
- State MH authority charges a monthly fee for fixed endpoints (currently $125/month-- considering increase to $200) and a network maintenance fee for MOVI usage
- Most service funding comes through the Medicaid program
- Learning points:
  - Gaining Medicaid funding was politically difficult
  - Ongoing technology training is an ongoing challenge

Muskie School of Public Service | Maine Rural Health Research Center

Example: State Mental Health Authority

- State MH authority contracts with statewide network of 160 sites including CMHCs, FQHCs, substance abuse providers, hospitals, clinics, VA centers, courts, and IHs facilities
- Served 40,000 residents last year
- Funded through user fees and occasional grant funding
- State MH authority charges a monthly fee for fixed endpoints (currently $125/month-- considering increase to $200) and a network maintenance fee for MOVI usage
- Most service funding comes through the Medicaid program
- Learning points:
  - Gaining Medicaid funding was politically difficult
  - Ongoing technology training is an ongoing challenge

Muskie School of Public Service | Maine Rural Health Research Center

Example: Rural Health Network

- Serves 18 rural, underserved counties
- Started in the 2008 as a partnership of an academic medical center and 14 CMHCs (the points of access into MH system)
- 198 children and 155 adults served in past year
- Predominantly treats Medicaid populations
- In January 2012, Medicaid covered telemental health services although simultaneous cuts in Medicaid funding have jeopardized reimbursement rates
- Learning points:
  - Still grant dependent
  - CMHCs dependent on Medicaid funding and do not have a base o other patients whose coverage (Medicare and commercial) cover telehealth

Muskie School of Public Service | Maine Rural Health Research Center

Example: Multi-Specialty Group Practice

- 779 physicians (80 medical specialties and subspecialties) practicing in 54 locations
- Technology used to enhance efficiency within a well organized and resourced system seeing a large rural area
- 45-50 patients serviced per month
- 2 psychiatrists, 1 social worker and 8 clinical psychologists
- RN at each site serves as telehealth coordinator.
- Most payers reimburse for service although Medicaid rate does not cover actual costs
- Learning points:
  - Biggest challenge is the lack of sufficient mental health workforce
  - Adequacy of Medicaid reimbursement is an issue

Muskie School of Public Service | Maine Rural Health Research Center

Conclusions

- Telemental health is growing but still not met expectations to resolve rural access issues
- Many programs are still dependent on grant funding
- Adequate 3rd party reimbursement and diverse payer mix are key
- Solves transportation and workforce distribution issues - does not solve other challenges of developing rural MH vices services
- Difficult to create “virtual” mental health practices in rural areas
- Many programs do not achieve economies of scale
- Small practices may not be able to absorb administrative and financial risk of sub-contracts with private and academic venders
- Works very well to deploy personnel resources in capitated or closed systems