

CSHCS Strategic Planning: Community-Based Services Work Group
Wednesday, May 27, 2009
MEETING NOTES

Participants: Gretchen Backer, Chris Buczek (phone), Bonnie Campbell (phone), Cheryl Celestin, Mary Cushman, Lisa Hahn, Arlene Gorelick, Carole Keefe, Tiffany Kostelec, Dennis Lyne, Mary Marin, Karla McCandless, Gwen Moore (phone), Matt Richardson, Kathy Stiffler, Maria Thomas (phone), Jane Turner, Pam Whitten

The Community-Based Services Group was assigned the strategic planning objective that includes: “Implement health communications technology including the statewide utilization of telemedicine...”

The work group asked Dr. Pamela Whitten, MSU Professor of Communication Arts and Sciences, to discuss telemedicine in Michigan and to help the group explore opportunities for CSHCS to take advantage of this growing area of technology.

Dr. Whitten provided some background information and an overview of telemedicine. She noted that there is an Office for the Advancement of Telehealth (OAT) funded through HRSA. The web page is <http://www.hrsa.gov/telehealth/>

Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies used in telehealth typically are: videoconferencing, the Internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications. While new applications are increasingly found for using these technologies, significant barriers remain to making these technologies an integral part of daily health care practice.

Dr. Whitten noted that telehealth, telemedicine, and e-health are terms used interchangeably, and they are simply about using communications technology to do health related activities.

Telehealth is used by many different medical specialty providers (psychiatry is a big user), and it is used by different delivery systems such as hub to spoke specialty services, home health, hospice, school-based services, nursing homes, prisons (Michigan prisons have a statewide system), community mental health, etc. It is also used within integrated systems such as military telemedicine, veteran’s hospitals, managed care (Kaiser Permanente), and by socialized health care systems (Norway).

In Michigan, Marquette General Hospital or the Marquette General Health System supports the Upper Peninsula Telehealth Network, which has 42 networked sites.

<http://www.mgh.org/telehealth/>

Other locales in Michigan use telemedicine for a variety of applications. Munson Health Care <http://www.munsonhealthcare.org/> uses telemonitoring, The Michigan Stroke Network <http://www.michiganstrokenetwork.com/> was cited as a user. Bronson Hospital in Kalamazoo uses BRAD, Bronson’s Robot Assisted Doctor. BRAD helps emergency medicine physicians

consult with the Bronson neuroscience team for patient stroke evaluation. The specialists can consult from virtually anywhere with just a laptop and internet access.

The State also has videoconferencing technology available at Michigan State University, the University of Michigan, Wayne State University, Spectrum Health in Grand Rapids, and many Community Mental Health Centers.

Telemedicine can be used in real time (synchronous) as in a face to face consultation or for remote monitoring (asynchronous) for such conditions as congestive heart failure, dementia, or diabetes.

After Dr. Whitten's presentation, the discussion turned to applications of telemedicine to serve CSHCS families. Questions posed included: What are the needs in Michigan? Where/how can the needs be met? Are there easy opportunities or low hanging fruit to focus on for a start?

Numerous questions arose. Is the intent to make sub specialists available to families closer to home so that there is less travel for families? Do we start by looking at certain diagnoses? How would we approach implementation as there are key buy-ins needed by specialty providers, by providers in the community, by families.

It was suggested that perhaps we need to start with existing relationships. For example, a hematologist from MSU regularly travels to Marquette for a clinic. Sometimes weather does not permit the flight. Telemedicine might be used to provide the consultation from MSU. In that instance, the pieces are in place except for use of the technology.

Another use might be for follow-up visits with specialists. There will be a need for face to face meetings, but follow-up checks might be an opportunity to use technology.

There was some mention of the Children's Health Initiative in the Mid Michigan area. One of the goals is to address the need for sub specialists in mid Michigan. Perhaps the services of the sub specialists recruited could be shared with other areas via telehealth.

It was suggested that a contact be made with the Michigan Primary Care Association. Perhaps FQHCs could be used as the location for the telemedicine visit, or they could be the primary care medical home for some children and links to subspecialty providers could be made using telemedicine.

What are the outcomes we are trying to achieve? Reduce travel time ("keep families off I - 75"), reduce hospitalizations, and provide patient education.

How much new equipment would physician offices need? Could you use what they currently have in the way of computers and connections? You can't use public internet sites because of privacy issues.

How do we get started and are there opportunities to capture stimulus funds or collaborate with projects already being designed?

It was suggested that our best opportunity is to look at existing relationships between providers and referral centers and Children's Hospitals. We need to talk to families and learn from them as to how this technology might address some of their needs.

It was noted that research has shown that the largest barrier to implementing telemedicine tends to be provider acceptance. They need to understand how it will help them do their work better and that they can afford to do it.

Kathy Stiffler volunteered to call the Michigan Primary Care Association and talk about possible collaborations with FQHCs in upper lower Michigan. She will also follow-up with Mary Cushion in Mount Pleasant about what interest is there and how to involve resources at Central Michigan University.

Staff work needs to be done relative to the geographic distribution of children enrolled in CSHCS. We need to understand needs identified by families. We can explore resources and activities at the Children's Hospitals and referral centers across the state. We can gather information about on-going activities that might lead to opportunities for collaborations.