An Update from the Health Quality and Cost Council's Telemedicine Task Force

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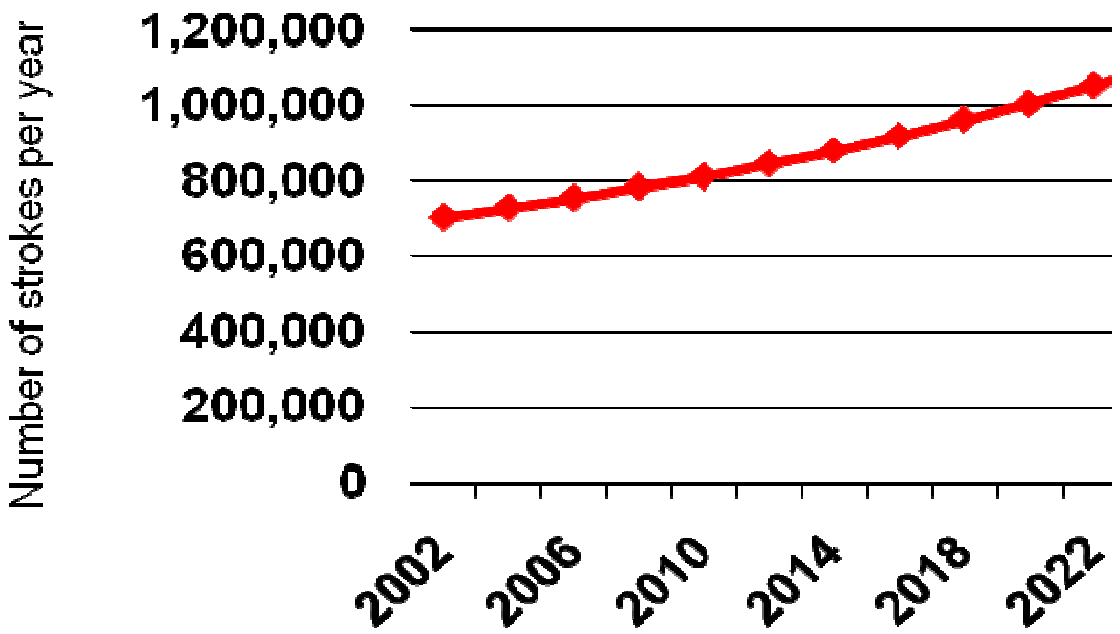
Maryland Telemedicine Task Force

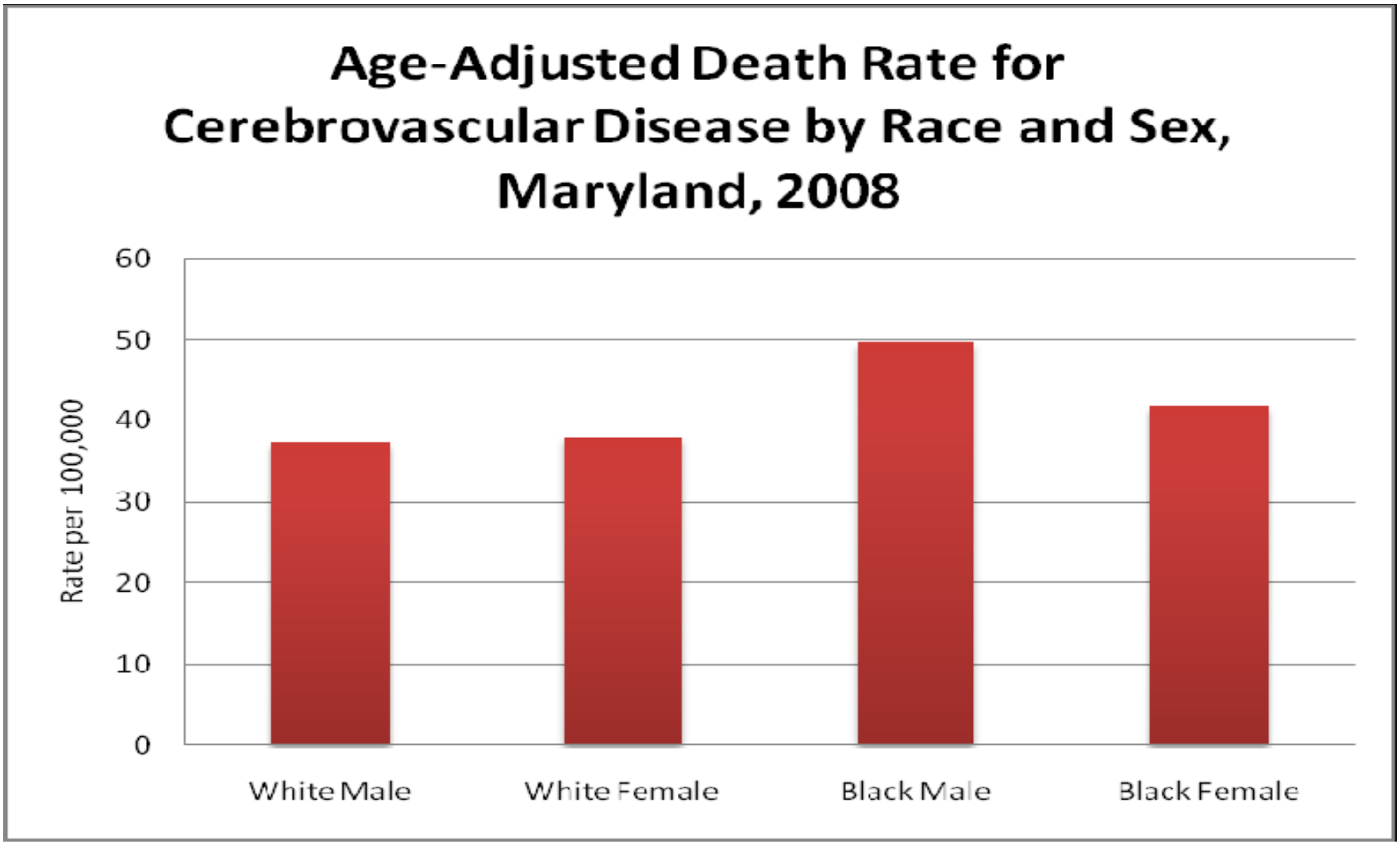
- Established June 2010 by the Maryland Health Quality and Cost Council chaired by Lt. Governor Anthony G. Brown and DHMH Secretary John Colmers
- Tasked with developing a plan for statewide telemedicine system in response to challenges with acute stroke care
- Membership: DHMH, Maryland Advisory Council on Heart Disease and Stroke, MHA, Maryland ACEP, MHCC, AHA/ASA, MIEMSS and hospital representatives

Acute Stroke

- Third most common cause of death
- Leading cause of disability
- Affects everyone, regardless of race, sex or socioeconomic status
- According to the HSCRC there were over 40,000 discharges from Maryland Hospitals of patients who had suffered a stroke resulting in $803,135,583 in total charges. HSCRC also reported in 2008 outpatient stroke related costs were $30,005,637.
- In US, the projected number of strokes per year will increase from 700,000 per year in 2002 to 1,136,000 per year in 2025, an increase of over 60 percent.



Projected Number of Strokes in the United States, 2002 - 2025
(from Broderick J., Stroke, 2004)

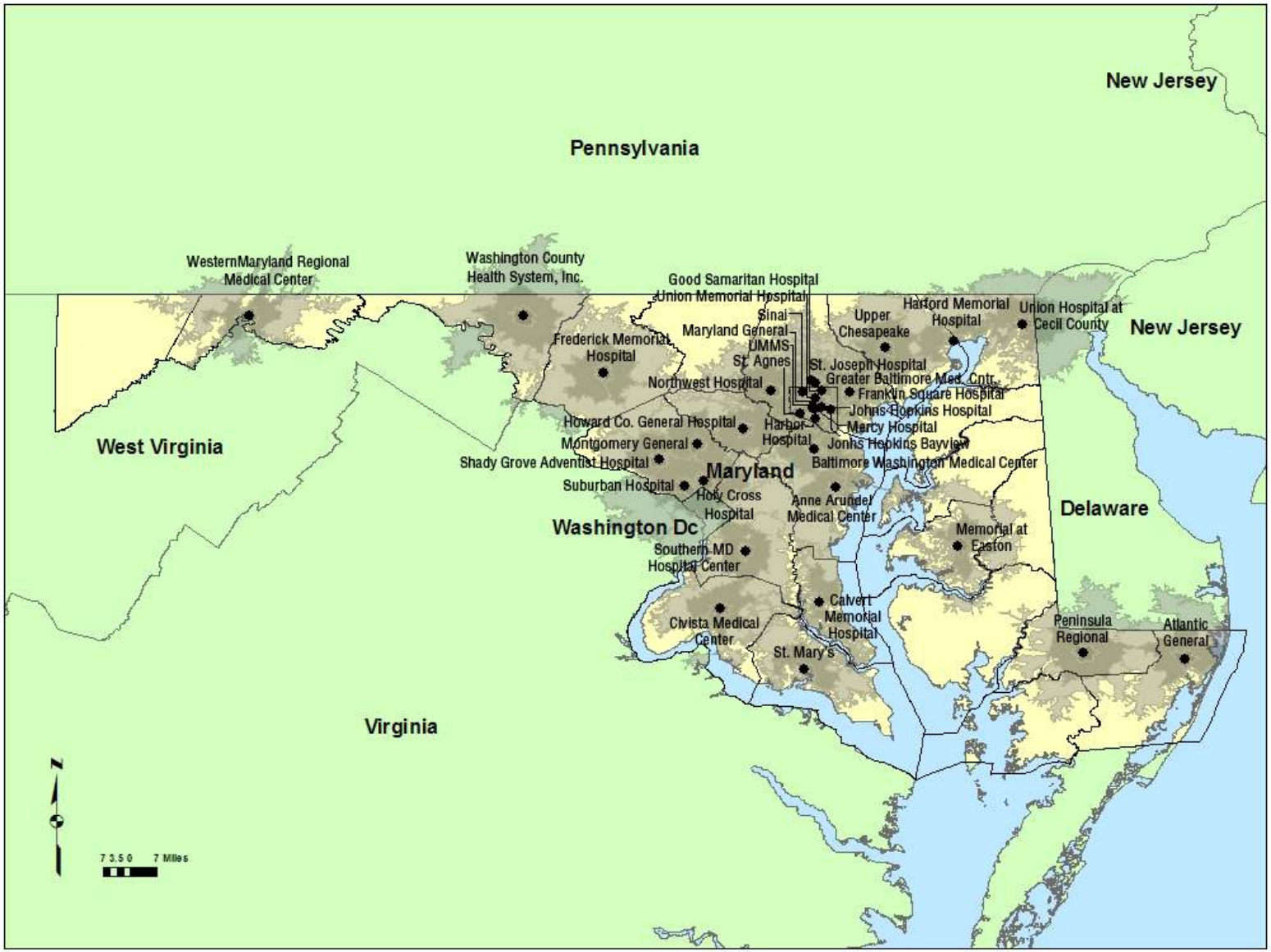

Age-Adjusted Death Rate for Cerebrovascular Disease by Race and Sex, Maryland, 2008
Rate per 100,000
60
50
40
30
20
10
0
White Male
White Female
Black Male
Black Female

Acute Stroke Care in Maryland

- 1996 FDA approves t-PA for the treatment of acute ischemic stroke
- 1999 AHA/ASA Operation Stroke
- 2002 Maryland State Advisory Council on Heart Disease and Stroke (DHMH)
- 2003 MIEMSS develops acute stroke protocol for EMS providers
- 2005 Maryland State Stroke System Plan drafted and approved
- 2006 MIEMSS publishes regulations for designation of Primary Stoke Centers (PSCs)
- 2007 MIEMSS designates PSCs

Maryland State Stroke System

- Statewide with a regional approach
- Includes EMS protocols for recognition and triage of acute stroke patients, standards with verification and designation of PSCs, system data/PI, and interfacility transfer guidelines
- By 2010, 34 of the states 43 eligible hospitals have been designated as PSCs


New Jersey
Pennsylvania
WesternMaryland Regional Medical Center
Washington County Health System, Inc.
Good Samaritan Hospital
Union Memorial Hospital
Sinai
Maryland General
UMMS
St. Agnes
Frederick Memorial Hospital
Northwest Hospital
Howard Co. General Hospital
Montgomery General
Shady Grove Adventist Hospital
Suburban Hospital
Holy Cross Hospital
Harbor Hospital
Upper Chesapeake
Harford Memorial Hospital
Union Hospital at Cecil County
New Jersey
St. Joseph Hospital
Greater Baltimore Med. Cntr.
Franklin Square Hospital
Johns Hopkins Hospital
Mercy Hospital
Johns Hopkins Bayview
Baltimore Washington Medical Center
West Virginia
Maryland
Anne Arundel Medical Center
Delaware
Washington Dc
Memorial at Easton
Southern MD Hospital Center
Calvert Memorial Hospital
Civista Medical Center
St. Mary's
Peninsula Regional
Atlantic General
Virginia
N
7 3.5 0 7 Miles

Challenges

- Vulnerabilities of the State Stroke System include:
  - Limited number of neurologists and neurosurgeons to take emergency consultation call.
  - Increasing demands on tertiary stroke centers with limited communication capabilities.
  - Limited bed availability in tertiary centers.
- These vulnerabilities could be mitigated with by telemedicine.

Response to Challenges

- 2007 and 2009 Advisory Council cites need for statewide telemedicine for acute stroke care
- 2010 DHMH “white paper” presented to and supported by the advisory council
- 2010 Maryland Health Quality and Cost Council establishes Telemedicine Task Force

Issues Identified

- **Broad based need beyond acute stroke (ACEP survey in rank order)**
  - **Stroke**
  - **Dermatology**
  - **Neurology services**
  - **Radiology services**
  - **Wound care**
  - **Burn care**
  - **Cardiology services**
  - **Pathology**
  - **Orthopedic services**
  - **Pediatrics**
  - **Psychiatric services**
  - **Rehab services**
  - **ENT services**
  - **Perinatal services**
  - **Plastic surgery**
  - **Trauma care**
  - **Neonatal services**
  - **Obstetrics**

Issues Identified

- Regulatory and legal barriers
  - Credentialling requirements at both centers
  - Licensing requirements across state borders
- Costs
  - Start up and ongoing
  - Vendor or home grown?
  - Reimbursement
    - Third party payers do not currently cover
    - Medicare – covers only professional component and only in rural underserved areas

Telemedicine Task Force Recommendations

- Create the Maryland Telemedicine Network (MTN)
- Public – Private partnership
- Commission or other such official body to develop criteria for the MTN as well as the design requirements of the IT infrastructure
- Sustainable funding sources for both development and maintenance of the network
- Identify an IT provider that can meet the design requirements

Telemedicine Task Force Recommendations

- Administrative infrastructure, ongoing quality improvement etc.
- Address legal and regulatory issues
- Allow hospitals in neighboring states and DC to participate
- Synergistic with the Maryland Health Information Exchange

Future for Telemedicine Task Force

- MHCC and MIEMSS, together direct a telemedicine initiative to address an interoperable approach to the many disease categories of concern in Maryland.
- Development of Advisory Groups to replace the Telemedicine Taskforce.
- 4 Advisory Groups identified:
  1. **Clinical Advisory Group:** to include physicians with particular disease area expertise, Chief Medical Officers, Med Chi, and MHA.
  2. **Technical solutions and Standards Advisory Group:** to include hospital CIOs, Department of Information Technology, CRISP, and Exchange representatives.
  3. **Financial and Business Model Advisory Group**: to include Payers, and hospital CFOs
  4. **Regulatory/Licensure/Credentialing Advisory Group**
- Ongoing group work to take place during 2011.

Questions/Comments?