



Nebraska Medicine

Fall 2012 | Volume 11, Number 3

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Utilizing today's
technology in
your practice



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Physicians and Facebook: *Implications of Social Media Usage in the Health Care Industry*

by Tara A. Stingley, J.D. *
Cline Williams Wright Johnson &
Oldfather, L.L.P.

Like it or not, social media websites such as Facebook, Twitter, and LinkedIn play an increased role in professional settings, including the health care industry, and show no signs of slowing down. Over 1,100 hospitals have some type of social networking site, including over 1,000 Facebook pages and almost 800 Twitter feeds.¹ Not only are medical providers joining the social media world, but their employees have as well, with “as many as 50 percent of their employees utiliz[ing] some form of social media.”² Both health care providers and patients can benefit from the use of social media. But, providers – and their employees – should be aware of the inherent risks associated with such use.

I. Physicians’ Use of Social Media and the Physician-Patient Relationship

In Nebraska, a physician must undertake treatment of a patient in order for a physician-patient relationship to arise. But what if that “treatment”

occurs electronically by a physician giving medical advice or discussing medical conditions and treatments on a social media site? Can a physician-patient relationship arise if a physician and a patient become “friends” on Facebook, or if a physician “tweets” medical advice to his Twitter followers? If so, what are the ethical and legal implications of those relationships?

These questions become increasingly important to answer in light of the widespread use of social media by medical providers and their patients. Indeed, a recent survey of over 3,000 social media-using physicians and medical students found that 34 percent of all physicians and 42 percent of family practitioners received a social media “friend” request from a patient or a patient’s family member; of the physicians who received such “friend” requests, 57 percent had a blanket policy prohibiting acceptance, while 43 percent considered requests on a case-by-case basis.³

Simply becoming friends with another individual on a social media site likely does not form a physician-patient relationship, but if a physician were to assist or advise someone with medical needs

through such a site, a relationship potentially could be formed.⁴ Physicians are generally aware of implications stemming from the formation of new relationships and interactions with the public and are careful to avoid unexpected physician-patient relationships; those same precautions should apply when using social media.⁵

The American Medical Association’s (“AMA”) Council on Ethical and Judicial Affairs has recognized the same, noting that the AMA’s *Code of Medical Ethics* governs physicians’ communications both with patients and regarding patient information, and that these guidelines apply in *all settings*, including online.⁶ In early 2012, the AMA enacted the Council’s recommendations regarding the use of social media within the medical field, which provide as follows:

- Physicians should be aware of patient privacy and confidentiality standards that must be maintained in all environments, including online, and must avoid posting identifiable patient information online.



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Social (Media) Security: *Navigating the Pitfalls & Promises of the Modern Internet*

by Jordan Warchol
M4

University of Nebraska Medical Center

The other day, I was scrolling through my Facebook homepage when I noticed some new “friends” I wasn’t sure I had ever met: Bob the Builder and Ted E. Bear were suddenly in my social circle. Soon I realized that these profiles were in fact those of people I actually know. These users changed their names in preparation for the thorough scouring of personal information that many assume will be undertaken as they apply for Residency.

Social media sites such as Facebook, Twitter, LinkedIn, Flickr, Pinterest and Instagram are increasingly intertwined in the day-to-day living of life. Commercials no longer display individual websites for the products they present, but instead direct consumers to “Check Us Out On Facebook.” Some couples choose to create social media profiles for their unborn children, presumably so that all events of the child’s life can be easily accessible for family and friends (and the rest of the world). This is our new norm, and it would be a shame for those in health care to be left behind the curve. However, the high standards for physician professionalism as well as the need to keep the boundaries of a physician-patient relationship can make the use of social media more challenging.

The question becomes, then, how do we balance these competing forces

of sharing and privacy when the medium of expression is one that emphasizes wide-open information sharing? This is not an answer that can be easily found in one session at a professional meeting or laid out in your favorite medical journal’s editorials; it is an ongoing conversation that must evolve as quickly as the Internet.

Several well-known entities have already begun this discussion and have started to develop social media strategies for medical professionals. A recent editorial from The Lancet discussed the guidance currently given in the UK. The General Medical Council, which is the governing body for medicine, “emphasizes the need to maintain patient confidentiality, provide accurate information, treat colleagues with respect, avoid anonymity online if writing in a professional capacity, be aware of how content is shared, review privacy settings and online presence, declare conflicts of interest, and maintain separate personal and professional profiles.” Mentally checking off each of those boxes before hitting the “send” button on every post one makes on a social media site would be utterly exhausting, but that is what is being asked of physicians who choose to use these sites. A general recommendation that is less daunting to follow is one being dubbed “The Elevator Test”: If you were in a crowded elevator at the hospital would you say out loud what you are about to post? Would you want that picture projected on the ceiling for all to see?

This not only is true about the posts we contribute, but also the general

information that is built in to many social media profiles. Religious beliefs and political ideals are generally not considered appropriate topics of conversation between physicians and their patients, but these are easily accessible via the World Wide Web with a few keystrokes in the Google search bar.

With the pitfalls that must be avoided with social media, it is easy to overlook the positive contributions that the added access can provide to the care of patients. Many medical practices have Facebook fan pages, an easy and inexpensive means of advertising. My dentist’s Facebook page includes weekly tips for proper dental hygiene and links to articles on the health benefits of regular cleanings. The office even posted a birthday wish on my profile. The American Society of Nephrology used Twitter throughout their annual meeting to demonstrate a means of giving the general public easily accessible and accurate information about renal disease. Recently, a hospital in Houston used Twitter to let the general public follow along with the resection of a brain tumor, complete with pictures and video from inside the OR.

While use of social media is not the standard practice yet, the integration of social media and medicine is definitely upon us. Take a few extra seconds to think of the possible repercussions before posting those pictures from your Mexico vacation or ranting about the frustrations of implementing a new EMR. Taking into consideration the expanding audience provided by the Internet before each virtual interaction

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Using an iPad in Practice

by Michael L. Zaruba, MD
Auburn

iPads have become a commonplace tool used by many in our society. I would like to share my experiences using an iPad in the everyday practice of medicine. I have found it to be a very powerful and versatile resource that benefits both patients and me.

I am able to use my iPad to execute Practice Partner (the EMR system I use in my clinic) and access the EMR system at my local hospital. However, the real power of the iPad is the ability to access and seamlessly switch between numerous medical apps to enhance the clinical encounter for the patient. Currently, there are well over 5000+ medical apps available for the Apple iPad. Hence, there are many ways the iPad can be used in everyday practice. For example, the iPad can be used to illustrate the anatomy of an injury to the patient utilizing a high definition

anatomy app. Patients seem to find this helpful and I feel it enhances their visit as they leave with increased insight and knowledge of their condition. As physicians, we all know that patient satisfaction is very important to a successful practice and I feel that patient satisfaction is heightened with the use of the iPad in this manner. There are other apps that perform medical calculations such as BMI, Ideal Body Weight, creatinine clearance, pediatric dosing and numerous other medical calculations. There are apps that can be used to visually identify pills, crosscheck drug-drug interactions, and provide the most current drug information. The Monthly Prescribing Guide, that many of us are using every day, is available digitally on the iPad and is much easier to search than the paper version.

The iPad in the hospital or clinic setting can be used to view digital X-rays. This is very useful in discussing X-ray findings with patients and their

families. Prior to tablets, doctors, including myself, would do their rounds in the wards and then return to a desktop computer or the radiology department to view images. This can now be done at the bedside utilizing the iPad. However, one important factor to remember is that iPads or tablets should only be used when high resolution LCD monitors are not readily available. The displays of an iPad or other tablets are not as good as the LCD monitors made specifically for reading X-rays. Nonetheless, they can be used to help educate and illustrate findings to the patients at the bedside.

Imagine being able to access hundreds of medical textbooks, The Medical Letter, the Prescriber's Letter, or the UpToDate clinical decision support system without being in your office or sitting at a computer. The iPad

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Apps Popular with Physicians

CPT E/M: Billing codes reference (from the AMA)

Calculate By Qxmd: Clinical calculator with formulas for disease diagnosis and treatment

Diagnosaurus: Searchable database by disease, symptom or organ system

DocBookMD: Networking and referral

Epocrates Rx: Mobile drug reference

iPhone ECG: Turns an iPhone into a medical device that, when held to the chest, displays, stores and wirelessly transmits an electrocardiogram.

Lexicomp: Searchable databases on conditions, drugs, interactions, and laboratory and diagnostic tests

Medcalc: Clinical calculator for diagnosis and treatment

Medicine Central: Searchable database on drugs and diseases

Mobile Mim: Displays medical images on mobile devices, including single-photon-emission computerized tomography, PET and CT scans, MRIs, X-rays and ultrasound images

My Medications: Medication tracking for patients (from the AMA)

Netter's Anatomy Atlas: Database of illustrations of the human anatomy

Quantiamd: Physician-to-physician educational tool

Rounder: Continuity of care (winner of AMA app contest)

Sermo consultation: Network visual and messaging consultation

Uptodate: Drug and clinical reference

Medical Blogging in your Practice

by Les Spry, MD
Lincoln

We all strive to better communicate with our patients. In trying to communicate, we must use the means of communication that our patients use. When I first started practice, this meant one-on-one communication with my patient in an exam room and occasionally providing them with a pamphlet that was developed by a national organization that I endorsed.

I often tried to write out instructions for them as well. Currently our patients are exposed to a wide variety of communications and all of these forms of communication require content that vies for the attention of the patient. As we see more and more patients, we need to develop a means of communicating complex issues to our patients in shorter and shorter times allotted to office visits. One way to accomplish this is to create written documents that reflect your personal opinions and recommendations for specific care of the patients in your practice and post them to a blog.

According to Wikipedia, “A **blog** (a portmanteau of the term **web log**) is a discussion or information site published on the World Wide Web consisting of discrete entries (“posts”) typically displayed in reverse chronological order so the most recent post appears first.” In this format, it is available to everyone who can access the World Wide Web from a computer. Suddenly, rather than spending 20 or 30 minutes giving an individualized instruction to your patient with diabetes or hypertension, you can give them a web link to the blog

that you created and emphasize things that you want for patients in your practice. Rather than try to remember all of the points you want to make with your patient, you can write it out once and then post and edit it as new information comes along. This information becomes current and consistent.

My experience with blogging started about four years ago when I was approached by the National Kidney Foundation (NKF) to start an informational blog for the NKF website. Fortunately, I had the assistance of specialists in communications and public relations teaching me how to do this. I had been a member of the NKF Patient Education committee and the Public Policy committee for years and helped to develop many of those pamphlets that I mentioned above. I initially started just writing informational blog articles but then started to post answers to patient’s individual questions as posted on the NKF web site. I started doing a blog for the Huffington Post this year. While I do not consider myself an expert about medical blogs, I can offer the following advice for those who wish to start using this form of communication with their patients.

My first recommendation is to use simple language. Those who study communications for a living recommend that the words and phrases used in the blog be aimed at or below a fifth grade reading level. Many times it is better to run this past your kids rather than just try to dumb down your writing. There are services that can review your blog and based on the words used, commercial services can give you a graded reading level for your article. Rather than pay the money for this, use your kids. It’s cheap-

er. Sometimes your spouse can read the piece and help you simplify. Medical jargon and acronyms should be avoided. Do not say “DM,” but rather say “diabetes mellitus (DM).” This will make sure all the readers get all the information you intend. Do not use medical abbreviations such as noc, h.s., prn, and tid. This will lead to confusion and frustration by the reader trying to understand the instructions. Do not use abbreviations for medical tests, such as BMP, CBC or Lipid panel. Use the names of the actual tests that you are discussing.

The length of the article should generally be no longer than 800 to 1000 words. Patients will not read articles that are any longer than this. After writing a rough draft, go back through and ask yourself “Can I say this in fewer simpler words?” “Can I combine more than one sentence into a simpler single sentence?” Simple and short should be the goal of any blog piece. Try to use common phrases that you hear your patients use, rather than technical jargon that you might use with your peers. If you need to supply references or technical language, use a hyperlink to allow the reader to get further information. Most writing programs, such as Microsoft Word, provide ways to link words to websites. By just highlighting the word and creating a hyperlink, your patients can read the blog article and then, if they want more information, click on the word and go to the web site for more information. Linking to major web sites such as the National Kidney Foundation, American Heart Association or American Diabetes Association is simple and informative.

I find the most difficult paragraph to write is the first paragraph. You need to

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Digital Technology

by Marvin Bittner MD
Omaha

The most outstanding application of digital technology in my professional work is one that I use nearly every day. Yet it's very, very different from typical applications of digital technology. I don't run it on my iPhone. Nor does it run on my iPad. Let me explain.

The application that I use nearly every day is a billing scorecard. It's my response, as an infectious diseases specialist, to the Byzantine rules for coding so-called "Evaluation and Management" services that I perform when I visit hospitalized patients. There are two problems with those 1995 rules for "E&M" coding. This application addresses both.

The first problem is that the E&M rules are complicated. For example, they take into account the number of diagnoses and treatments considered at a visit. To do so, there's a point system that's commonly used. Was there a new problem needing additional work-up? Score four points. Was it an established problem that was considered? Score one point if it's stable, two if it's worsening. What about a new problem needing no further work-up? That's three points, but you can only score one of those each day. If the problem is self-limited or minor, score one point, but you can only score two of those each day. All that may seem complicated, but there's more! That's right, even more complicated rules! The application summarizes the rules so it's easy to score a visit.

The second problem is that the E&M rules use nonstandard terminology. "Problem Focused" and "Expanded Problem Focused" may have a clear

meaning to some people. To physicians, though, that kind of terminology simply isn't precise. Definitions are needed for physicians. We don't carry those definitions around in our heads. The application obviates the need to do so. The application asks me, for example, how many systems I examined (and it includes the list of systems from the rules—so I'll count them the same way the auditors do). It guides me through the process of scoring my visit, based on what I have done, so I don't need to learn the definitions of the nonstandard terminology of the E&M rules.

That's part of the reason that my application is so different from typical applications of digital technology. Are you an AMA member? Do you know about the AMA's iPhone application, "CPT E/M"? It has the same goal as my application: to assist physicians with documentation and coding of evaluation and management services. CPT, or Current Procedural Terminology, is an AMA enterprise. So the AMA application is authoritative. The problem is that it's vague. It tells you to distinguish "moderate complexity" from "high complexity" in the number of diagnoses or management options considered by distinguishing whether the number is "multiple" or "extensive." What's "multiple"? What's "extensive"? "CPT E/M" won't tell you.

To me, it's performance that counts. When I thought about smart phone and iPad applications, I didn't stop thinking with the iPhone app "CPT E/M." I knew the NMA was looking for conventional digital apps, but I wanted to tell you about my scorecard, which is even better.

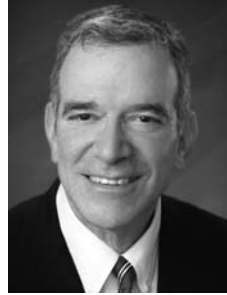
The impact of the scorecard was striking. My billing doubled. My errors plummeted. Should I really have been surprised that I would get better results by paying close attention to the rules?

What is odd about the application is that I don't run it from a computer or a smart phone day after day, patient after patient. Using my computer, I developed a very complicated file in Microsoft Word. That complicated Word file is my "digital technology." That file is a concise summary of the rules, based on my study of the rules and my thinking about my work. I print the file on paper. I carry that paper score sheet and use that to score each visit. Digital technology is simply a tool for expressing the results of my study of the E&M rules. I depend on digital technology to display my summary clearly. Digital technology is not a fancy calculator. Maybe that's why it's such a success. It's a case where study and thought solved a problem!

Moreover, it's easy for me to use. Just consider one situation, perhaps the most common one I face: documenting and coding follow-up visits in the hospital. There are three possible codes to use. From least complex to most complex, they are: 99231, 99232, and 99233.

In the lower right hand corner of my billing score sheet, I have a table. It summarizes the requirements to bill for each of the three codes. It has a heading: "Subsequent hospital codes need only 2 out of 3 (history, exam, decision making):" (*See table on page 12*)

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Online Reviews: *The Best Defense...*

by Sharla Hooper
Associate Vice President for
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Arizona Medical Association

Despite the worst fears of battling negative comments from anonymous combatants online, a 2010 study found that patients reviewing their physicians online are more likely to praise than criticize. And criticisms tend to be about environmental factors rather than actual health care or physician-patient interaction.

Physicians concerned about dealing with unflattering and unedited online comments can take proactive measures. It may be cliché, but the best defense for an online reputation scrub is a good offense.

Know thyself

Or at least know what is being said about you online. Google yourself and learn about what information you need to consider managing about your online reputation. Experts recommend conducting monthly or more frequent searches to help you stay ahead of a potential problem. Additionally, you can set up online alerts, such as the Google and Yahoo alerts feature that allow you to register keywords such as physicians' or practices names, then send an e-mail with a link to any new mention of those keywords. Be sure to include all reasonable variations of your

name in the alert. This can allow you to monitor what is being said online and respond more effectively to negative comments.

Correct misinformation

The easiest places to start are websites that show up high in Google searches and tend to be physician finder or rating sites or health plan physician finders. They often include wrong or outdated contact information and incomplete biographical and educational history, but will likely give doctors the opportunity to edit their own profiles. Take advantage of this; bolster the information that is presented and highlight positive aspects.

Create and manage your online presence

Create your own online presence through a practice website, blog, Facebook page or Twitter account. The more active a practice is on a site like Twitter, the more likely it will jump to the top of any search someone might do on the practice's name. Practices can use the sites to solicit positive feedback.

Drum up positive reviews

Encourage your patients to go online and provide comments and ratings at specific ratings sites that you trust, or control, such as your office Facebook page. You might have your office staff tell patients about the sites, hang signs in the waiting room, and hand out fliers at the check-out desk. Some website management resources automatically email post-appointment

surveys to your patients that can then be reviewed and posted by you or your office staff.

Avoid a negative response

If at all possible, avoid attacking the person through a lawsuit or counter-post on the same website. This can backfire if it's perceived that you're validating their claims.

Have a plan

When information posted about a physician or a practice is clearly false, there are actions that can be taken. Many websites have policies against posting defamatory or false statements. Contact the site administrator to ask about its policy and request removal of the comment. Try to approach and remain cordial in your communications with them. Most experts agree that suing over negative online posts should be a last resort. If you are considering employing a reputation management firm, be sure to pick one that demonstrates understanding of a physician's business, has a relationship with a reputable attorney, and is familiar with First Amendment and copyright laws.

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Hyper-connected Digital Doc: *True Confessions of “Geek-man”*

by Richard J. Baltaro, MD, PhD
and John C. Baltaro
Omaha

At a typical Metro Omaha Medical Society Board Meeting, I have with me a smart phone connected with one service provider, a tablet computer, an old fashioned flip-phone connected with a different service provider and a pager. I definitely consider myself a hyper-connected physician. On more than one occasion I have helped my fellow physicians connect to the internet using wireless passwords or by troubleshooting other basic issues. Some marvel at my technological expertise, which always surprises me.

My smart phone and tablet are used primarily to keep my calendar, to alert me to appointments with patients and meetings, and last, (but certainly not least,) to connect to the Internet for access to the library of the World Wide Web. When I am connected to the resources of this vast and nebulous library, I have more knowledge at my disposal than the Library of Alexandria, the British Museum and the Smithsonian all put together. I am frequently researching diseases, laboratory tests, drugs, government rules and regulations, the geography of Nebraska, not to mention my state legislators' websites.

I have several free medical apps on my smart phone. The medical students and residents are good at alerting me to technological advances in these resources; and through trial and error, I have learned whose recommendations are most likely to be useful. (I have downloaded apps that I never use.) My

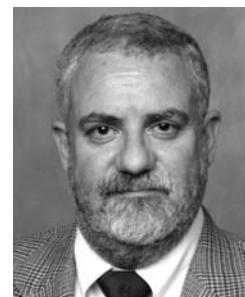
favorite apps are for prescription medications, for medical calculations (e.g. BMI or anion gap), another for cholesterol guidelines and risks, and yet another for eponyms. I sometimes use a New England Journal of Medicine app.

My personal life is enriched daily by free apps for news, both U.S. and European. Years ago, I used to get up at 5 or 6 a.m. to speak by telephone with European relatives. It was noon or 1 p.m. for them. When the internet first became widely available I started connecting with a slow dial-up and I would wait while European newspaper pages would load up at 3200 bauds. At the time, I was so happy just to access them. It was the latest technology! Now I have apps in Spanish, French, Italian and German, usually newspapers. Many apps that used to be free are now requiring payment and/or passwords. I am frequently forgetting one of the hundreds of passwords I have on an app. When the app is no longer easy to use or when I have forgotten or lack a password I am unlikely to use that app.

Until three years ago, I had successfully resisted all temptations to use social media. But when I saw the connections being made by my son, my wife, my son-in-law and my almost-MD daughter I took the plunge. Once I realized that I could easily converse daily with my relatives across the U.S., Europe, Canada and Latin America, I started a Facebook page and began to connect with friends from my past (high school, college, medical school), as well as old coworkers and neighbors. In less than a year I had connected

with over one thousand “friends”!

I share interesting articles on medicine, international events, and humor; but I



Richard J. Baltaro, MD, PhD John C. Baltaro, PhD

refuse any game requests. About a year ago I started a LinkedIn profile. I find the conversation threads time consuming and do not participate. Although I have never considered using Facebook or LinkedIn at work, I am currently suffering from a serious daily Facebook addiction/fascination. My daily “fix” usually occurs in the evening or early morning, which is a serious strain on my wife's patience. In moments when it is particularly bad she has labeled me “Geek-man.” She's one to complain! She works in epilepsy and gets updates from Medscape and Epilepsy.com multiple times a day. She posts about epilepsy news on Twitter and her dedicated Facebook page, EpilepsyAce.

Due to my increasing use of multi-functioning devices, I have eliminated the daily wearing of a wristwatch, as every device I carry tells time. I only have my wristwatch when I travel, because it is not required to be turned off on airplanes. I would like to get rid of my old fashion flip-phone, but (due to the vagaries of different carriers) it is connected in places where my smart

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Physicians and Facebook: *Implications of Social Media Usage in the Health Care Industry (continued)*

- b. If physicians interact with patients on the Internet, physicians must maintain appropriate boundaries of the physician-patient relationship in accordance with professional ethical guidelines, just as they would in any other context.
- c. To maintain appropriate professional boundaries, physicians should consider separating personal and professional content online.⁷

II. Possible Ethical and Legal Consequences of Using Social Media in the Medical Field

Inappropriate use of social media within medical practices can raise ethical issues under the AMA's *Code of Medical Ethics*. Under the *Code of Medical Ethics*, providers have a duty of confidentiality, and that duty is breached by a disclosure to a third party, without patient consent or court order, of private information that the provider has learned within the physician-patient relationship.⁸ The ease of using social media and unauthorized access to online communication tools increase the risk of unauthorized disclosures of confidential information. Providers should take note of the AMA's *Code of Medical Ethics* and its application to all settings.

The use of social media in the medical field also raises potential legal liability including possible violations of the Health Insurance Portability and Accountability Act ("HIPAA"), which requires the protection of individually-identifiable patient health information pursuant to HIPAA's privacy and security standards, as well as claims for invasion of privacy. Additionally, the 2009 American Recovery and Reinvestment

Act ("ARRA") HITECH Act established more rigorous regulations for protecting patient data, enacted new federal patient breach notification requirements, and increased civil and criminal penalties for HIPAA violations.

While there is little case law covering health care employees' use of social media, in 2009 the Minnesota Court of Appeals addressed the issue in *Yath v. Fairview Clinics, N.P.*, where a patient brought an invasion of privacy action against her healthcare provider and two of its employees.⁹ In *Yath*, an employee of the clinic where the patient received medical care disclosed information from the patient's medical records to another employee, who then told others. Later, a MySpace page was created disclosing the patient's confidential medical information. Considering whether posting the patient's medical information on the MySpace page constituted a "publication," the court found in the patient's favor and held "the publicity element of an invasion-of-privacy claim is satisfied when private information is posted on a publicly accessible Internet website."¹⁰

Although this holding does not bind Nebraska courts, it does suggest Nebraska physicians and other medical employees could be held liable for unauthorized disclosure of patient information on social media sites. Thus, physicians must be aware of the potential impact of their social media communications and govern their conduct accordingly.

III. Conclusion

The increased use of social media raises concerns about its effect on the physician-patient relationship and relat-

ed ethical and legal issues. As the recently released AMA policy on social media recommends, physicians should understand the potential consequences of their social media activities and should apply the same precautions to their social media presence as they do in other contexts. By following these guidelines and acting cautiously and professionally while interacting through social media, physicians can reap the benefits of these online communication tools without exposing themselves to ethical and legal risks.

** The author wishes to thank law student Katherine Kelley for her assistance in the research and preparation of this article.*

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Social (Media) Security: *Navigating the Pitfalls & Promises of the Modern Internet (continued)*

has become as necessary as washing your hands before each patient interaction.

Glossary

Flickr—a photo-sharing site

Instagram—a photo-sharing site that allows users to use filters to create vintage-looking photos

LinkedIn—the so-called professional networking social media site

Pinterest—a social media site that acts as a virtual pin board

Twitter—a “micro blogging” site that allows users to craft their thoughts into 140 characters or less

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Using an iPad in Practice *(continued)*

makes this possible. I find it much easier and less time consuming to find the information I need digitally than the “old-fashioned” way of looking in a book. The best part of these apps is that they automatically update as the new information is put forth. The demands on our time, as physicians, are great and this is an easy way to become more efficient while obtaining the most current medical information.

I routinely use the iPad to communicate with patients through email. I find it much faster to check email on the iPad as opposed to using a desktop computer as the iPad is an “instant on” type device. I feel this allows me to more efficiently communicate patients and decreases the number of daily

phone calls to the office. In addition, there are apps available that allow you to scan/copy lab results and other reports so that these reports can be easily emailed or faxed to patients and/or consultants. Newer iPads are equipped with high resolution cameras that can be used to document medical findings and shared through email with a consulting colleague. One can even use an iPad for excellent video conferencing in the right setting.

I have provided a very brief overview of how I use the iPad in my practice of medicine. The iPad has even more uses outside of medicine to enhance productivity in your personal life. Every day new apps are being developed for the device. There are apps that allow it

to be an electronic book reader, perform online banking, provide current weather and radar information, track flights and check flight status, book hotel rooms, view local TV news stations and numerous other functions. The possibilities really are endless with what one can do with this device.

I have focused on the iPad but almost all the apps discussed are available for both Apple (iPad) and Android-based tablets. In addition, most of the apps are free to use. Hopefully, based on the information I have provided, you will soon discover the benefits of iPad technology in your own medical practice. □

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Medical Blogging in your Practice *(continued)*

get your reader interested quickly and try to keep their attention. Writing personal history about yourself or relate a patient story that is interesting and relevant to the topic you are discussing. This can be a very good “hook” for starting the article. Another “hook” that I use is to relate new information about a research study I have just read or a news item that has just been covered by some major media. This will usually get them interested in what you have to say. As you start,

decide what two or three major points you want to make and then start. Do not try to impart too much information. Readers will likely read only part of the article so try to make your major points early and then expand on those points in the latter part of the article. Just like you learned in high school writing, tell them what you are going to tell them, tell them and then tell them what you told them.

Bottom Line

Paragraph headers that announce the subject of the paragraph and bullet points are very conducive to imparting information in an article. The use of bullets can also be very helpful to get the essential information to your patient. Remember:

- Keep it simple and short
- No more than two or three essential messages
- Let your personality show in the article. This will keep them interested. ☐

Digital Technology *(continued)*

Subsequent hospital care code requirements	99231	99232	99233
History of present illness elements	1-3	1-3	>4
Personal, family, and social history elements	-	-	-
Review of systems elements	-	1	2-9
Examination elements	1	2-4	5-7
Medical decision making	Straightforward or Low Complexity	Moderate Complexity	High Complexity

If I'm not sure what code to bill, I can take a look at the table. How many elements do I have in the history of the present illness? Do I have 1-3 elements? Or 4? How many elements do I have in the review of systems? None? One? Or at least two? What about my examination? One, two to four, or five to seven? Those issues are relatively straightforward. To determine the complexity of medical decision making, I need to turn to another part of the score sheet.

That other part of the score sheet is the one that I described above. It's the one where I list and classify the diagnoses and treatments considered at the visit. The diagnoses and treatments, however, are only one of three issues

used to determine the complexity of medical decision making. The other two are the extent of data reviewed and the risk of complications and morbidity.

My score sheet does have a list of items to consider in classifying the extent of data reviewed. It's a point system. Some items that I document are able to generate one point each. They are: clinical lab tests (reviewing or ordering them); radiology (reviewing or ordering); medicine tests such as echocardiograms (also reviewing or ordering); discussion of test results with performing physician; and a decision to obtain history from a source other than the patient (or a decision to obtain old

records). Two points are generated when I independently visualize an image, tracing or specimen. Two points are also generated for certain activities involving discussion: reviewing and summarizing old records; obtaining history from someone other than the patient; or discussion of the case with another health care provider.

The risk of complications and morbidity is determined from a table of risk that is part of the AMA's CPT code book. This table is widely available. Most of my patients are at least moderate risk because I'm involved in prescription drug management.

There's more to my scoresheet. After all, it just about fills up two sides of letter-size paper with Arial Narrow in a 6-point font. Yet I've found that infectious diseases fellows who want to get paid for the work they do—to be frank—can pick it up quickly.

If you'd like to learn more about my scorecard contact me at marvin.bittner@gmail.com. ☐

Hyper-connected Digital Doc:

True Confessions of “Geek-man” (continued)

phone's reception is poor.

I am overwhelmed by email, and have email fatigue. Let me restate that, I am literally drowning in e-mail. Everyday, I must delete close to one thousand emails (more time consuming than I want to admit). I have two email accounts for work, one for the medical school and the other for VA hospital work. At home I have two private emails, and I am not counting the LinkedIn or Facebook messages and notifications.

Soon we doctors will be “wirelessly connected” with our patients and with other physicians, either through video calling (video telephone) software

application and related protocol or with smart phones with sensors.

Telemedicine has already begun to do this. The Nebraska Telehealth Network has had the capacity to link rural residents with specialists in Omaha for over 40 years. Neurologists located in Omaha are talking with and examining patients across the state, saving patients hundreds of miles of travel, hours of car time, time away from work or school, not to mention hotel and meal costs for the trip. Emergency rooms can link up with specialists or even with the patients' families in remote areas of our state.

Already, some companies are developing apps that are turning smart

phones such as iPhone or Android into medical devices for monitoring blood sugar or blood pressure. The smart phones can even function as scopes, using the built-in cameras to view the eyes, ears, throats and more. There are early adopters and later adopters. Some really progressive digital doctors, who recognized early on the opportunities for better care and prevention, have jumped right in. The information revolution is growing the economic, social and technological role of information. Physicians have the “RAM” and “hard drive” capacity to profit from these changes and when they do, it will benefit our patients. □

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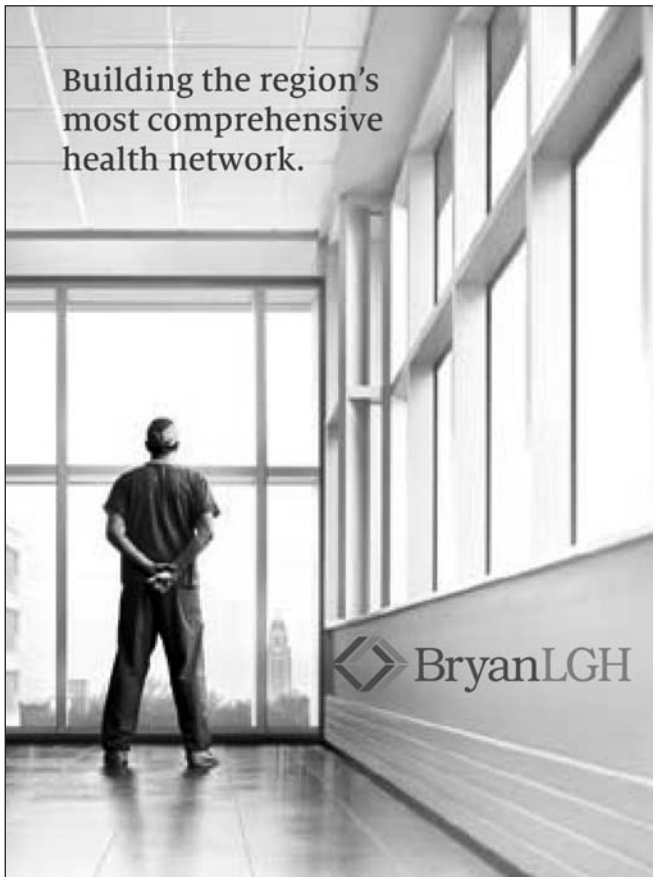



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Healthcare Reform

by Ross Polking

Provided by the Foster Group

“**S**urprised, but not shocked,” was the assessment from a high profile, well-respected individual within the Nebraska medical community. His words to me referenced the 5-4 ruling from the Supreme Court upholding the majority of the Patient Protection and Affordable Care Act (PPACA). The surprise was the deciding vote cast by conservative, Bush-43-appointee and Chief Justice, John Roberts. Virtually no one had tabbed Roberts, who re-characterized the “penalty” for not purchasing individual insurance a “tax” instead, as the swing vote. The constitutionality of the PPACA was, and remains, in question to many. Twenty-eight states and numerous organizations have since filed actions challenging implementation of the law.

Healthcare reform has been a polarizing issue for years. We are poised to see the most sweeping changes since Medicare and Medicaid were implemented in the mid-1960’s. The details and complexities are overwhelming, calling to mind Speaker Nancy Pelosi’s infamous statement, “We have to pass the bill so that you can find out what is

in it.” Certainly not a great confidence-builder. Nevertheless, the 2,700 page document is a daunting read, even for those responsible for its creation and passage. A Google search of “healthcare reform” returns over 100 million entries; information and opinions are limitless. The need for *some* type of reform of our healthcare system is something most Americans agree on.

What should be done, and *how*, quickly devolves into seemingly infinite alternatives. Some notable features of the PPACA:

- Individual and/or group mandate to obtain insurance coverage,
- Establishment of health insurance exchanges to facilitate purchasing and benchmarking,
- Expansion of Medicaid eligibility,
- Requirements on insurance providers to increase dependent eligibility, - reduce pre-existing condition restrictions, and eliminate lifetime limits.

The January 1, 2014 deadline by which these provisions must be in place is rapidly approaching.

How will it be funded? A fantastic question, considering the poor financial condition of Medicare and Medicaid currently. Revenue is expected from

elevated taxation of investment income and an increased Medicare contribution to Social Security by the “wealthy” (those with individual income over \$200,000 or joint income over \$250,000), annual fees on insurance providers, formerly uninsured individuals now paying premiums, as well as an array of other taxes, fees and penalties.

Virtually no one is left untouched by the changes on the horizon. Because of the number of physicians and medical-related organizations we serve, we are often asked what steps one should take in response. Our best answer today: “Don’t over-react.” The unknowns in the provisions of the law are significant, and the extent to which the PPACA will actually be implemented is yet to be determined. Much depends on the balance of power resulting from the November elections. Stay informed and be aware of how you could be impacted, based on your stage of life, goals you may have and financial standing – particularly if you fall into the previous definition of “wealthy.” Continue planning for the future which, interestingly, has *always* been filled with uncertainty and potential pitfalls. And more than ever, stay diversified. □



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