Social Media Facilitate Medical Communication

Liability and privacy issues a concern, but may be outweighed by ability to improve outcomes.

BY M. ALEXANDER OTTO

FROM A SWEDISH MEDICAL CENTER HEALTH CARE SYMPOSIUM

SEATTLE – Social media are making inroads into medicine; doctors are blogging, engaging patients on Facebook, and using Twitter to keep up to date, panelists said during a discussion of the phenomenon.

A few panelists, like Dr. Jennifer Dyer, a pediatric endocrinologist at Nationwide Children's Hospital in Columbus, Ohio, are texting patients, too.

In a preliminary study, Dr. Dyer texted three of her teenage diabetes patients weekly reminders about glucose testing and mealtime boluses, and asked them about the frequency of their blood sugar highs and lows.

The approach had previously been shown to help Scottish teens with diabetes (Diabet. Med. 2006;23:1332-8).

At the end of 3 months, Dr. Dyer's teenage patients were missing only about three boluses a week, instead of nine or more, and their hemoglobin A_{1c} levels averaged 9%, instead of 11%, according to a hospital press release and a post by Dr. Dyer on the Diabetes Mine blog.

She plans to expand the study to include 50 patients. "The use of social media to help outcomes is powerful," Dr. Dyer said during the panel discussion.

Social media help in other ways, too, panelists said.

"For me, [Twitter has] extended my colleagues and created an ability for me to keep up to date," said Dr. Kent Bottles, a health care consultant based in Philadelphia and recent past president of the Institute for Clinical Systems Improvement.

Dr. Bottles, who blogs at Kent Bottles Private Views, said he tweeted recently about attending a health care meeting in Colorado. A nurse he had never met before but who followed his Twitter stream offered to pick him up at the airport and took him to a vineyard, because she also knew from his tweets that he's a wine aficionado.

In response to another tweet, a physician sent him a paper that helped at the meeting. Neither "would have happened without Twitter," Dr. Bottles said.

Another panelist, Dr. Bryan Vartabedian, an assistant professor of pediatrics at Baylor College of Medicine, Houston, said his blog, 33Charts, has given him "a powerful voice" regarding the convergence of social media and medicine, the blog's topic, as well as other matters.

More than influence is at stake. Eventually, "being in the [social media] space will confer market advantage," he said.

Dr. Dyer and the fourth panelist, Dr. Mike Sevilla, a family physician in Salem, Ohio, who blogs at Doctor Anonymous, both said they share some personal information on their Facebook pages, but are careful not to post anything they could later regret.

Dr. Dyer has friended four patients on Facebook; she said it helps them see she's a regular person, making her more approachable. Also, her teen patients don't like e-mail, preferring Facebook's messaging service, another reason she engages some of them on Facebook.

E-mail is also an increasingly important tool, panelists said.

Because of her hospital's policy, Dr. Dyer can't initiate patient e-mails, so she tells patients to e-mail her first for test results and other matters. She cuts-and-pastes exchanges into the electronic health record so colleagues know what transpired.

Although e-mail takes less time than trying to reach patients by phone, Dr. Dyer has office staff help with the messages so she's not overwhelmed.

That was a concern among all the panelists – dealing with the extra work social media bring.

Dr. Vartabedian said he knows colleagues who are "spending their evenings opening e-mails" from patients, and not getting paid for it. Social media also raise concerns about patient privacy and legal liability.

A robust digital presence has its benefits, Dr. Vartabedian said, including countering negative online reviews. But it also opens the possibility that offhand remarks could show up later in legal proceedings. "A lot of this stuff hasn't been tested in courts," he said.

An audience member even noted that lawyers at her hospital banned physicians from engaging in social media.

Dr. Bottles acknowledged the concerns, but said that "you can never [completely] protect yourself against malpractice suits."

"You have to do what's best for your patients, give it your best shot, and get over it. We have patients to take care of, lives to live, and pinot noir to drink," he said. ■

Medical Home Pilot Project: Happier Physicians, Better Care

BY M. ALEXANDER OTTO

FROM A SYMPOSIUM HELD BY SWEDISH MEDICAL CENTER

SEATTLE – After 2 years, a pilot medical home project in a Seattle suburb cut emergency department visits by 29% and hospitalizations by 6%, recouping $1.50 for every $1.00 invested.

"We thought it would take years to see savings," but after 1 year, the pilot was "so successful that we've spread the model to all of our 26 primary care sites," said Dr. Claire Trescott, primary care medical director at Group Health Cooperative, a nonprofit, Seattle-based health care system.

Patients involved in the pilot reported better doctor interactions, better care, and increased access to care, compared with those at other Group Health clinics, Dr. Trescott reported at the symposium.

Work life improved for physicians, too. Compared with colleagues at other clinics, those in the pilot had lower mean emotional exhaustion and depersonalization scores on the Maslach Burnout Inventory.

"Group Health's experience demonstrates that primary care investments in the form of the medical home can improve patients' experiences … and providers' work environment, and at the same time save money," according to Dr. Robert Reid, a scientific investigator with the Group Health Research Institute and lead author on a review of the project (Health Affairs 2010 May [doi:10.1377/hlthaff.2010.0158]).

Group Health launched its medical home in 2007 at its Factoria, Wash., clinic. Managers "wanted to see if there really were savings and quality improvements from better primary care," Dr. Reid said in an interview.

They also wanted to see if it would make the clinic a better place to work. The situation there had not been "favorable in terms of recruiting and sustaining the workforce. There was a large motivation to try something different," Dr. Reid said.

Better staffing was the key change at Factoria. Managers hired additional physicians and nurses. They also hired more pharmacists, medical assistants, and licensed practical nurses, and increased their involvement in direct patient care.

As a result, physician panels at Factoria dropped from 2,300 to 1,800 patients per doctor. For every 10,000 patients, there were 5.6 physicians, 5.6 medical assistants, 2 licensed practical nurses, 1.5 physician assistants or nurse practitioners, 1.2 registered nurses, and 1 pharmacist.

To deemphasize rapid patient turnover, Group Health eliminated productivity incentives for Factoria physicians.

Seattle-based Group Health found that 'the medical home can improve patients' experiences … and providers' work environment, and at the same time save money.'

Patients in the pilot were assigned to care teams; nurses, pharmacists, and other staff helped them manage their conditions with personalized care plans, medication monitoring, test result updates, chronic illness workshops, and other measures. When patients called the clinic, they were connected directly with their team, instead of having to struggle through a phone tree.

It was no longer about "the physician being responsible to do everything," but instead about team care led by the physician, Dr. Reid said.

Daily, short, all-team meetings helped to coordinate the efforts, distribute tasks, and troubleshoot problems. To help with the planning, medical assistants called patients before each appointment to learn the reason for their visit. The clinic's existing electronic health records system helped, too, enabling patients to access after-visit summaries, review lab results, and refill prescriptions. The system also sent health maintenance reminders and other alerts.

The changes led to a drop in patient visits during the pilot, but visit duration went from a mean of 20 minutes up to 30.

There were also 80% more e-mail exchanges between patients and providers, and 5% more telephone encounters, compared with those at other Group Health sites.

To assess the results, Dr. Reid and his colleagues compared the utilization and cost numbers for Factoria's 7,018 continuously enrolled adults with those of the 200,970 adults enrolled at Group Health's other clinics.

Primary care cost $1.60 more per member per month in Factoria, and specialty care there approximately $5.80 more per member per month.

But Factoria patients visited emergency departments and urgent care clinics less often, saving $4 per member per month, and had fewer inpatient admissions, saving $14.18 per member per month. Balanced against increased staffing and other costs, Factoria saved an estimated $10.30 per member per month.

The changes have had another benefit, as well: It's easier to fill positions at Group Health now.

"My suspicion is that being a physician here is being seen now as a doable job. The panel sizes are manageable, and you have a supportive team in place. It's the type of place many physicians would want to work in," Dr. Reid said.

For those thinking of their own medical home project, Dr. Reid suggested making changes gradually, not all at once.

The pilot and review were both conducted by Group Health Cooperative. The investigators are employees and shareholders of Group Health Permanente, the physician group affiliated with the Group Health Cooperative. ■